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A Good Death: Personal Autonomy and Medical Decision Making in Louisiana

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INTRODUCTION

Death is a solitary experience. We will each experience our own deaths as we experienced our own lives, in a manner that is a decidedly personal and individual experience. Trying to come to terms with what it means to live and to die is a defining aspect of the human experience. For generations, humans have questioned what it means to die well, to experience a "good death." Like death itself, the good death is a highly individualized concept. What constitutes a good death for me, may not be a good death for you.

Contemporary societal views of what constitutes a good death are rooted in the hospice and palliative care movement of the l960s and 1970s.[1] The model of good death that emerged from that movement was one focused on the preferences and informed decision making of the dying person.[2] The individualistic nature of those personal preferences, however, means that a uniform definition of a good death is not possible. Rather, a good death is one that reflects the dying person's unique personal preferences about death.[3]

Personal autonomy in medical decision making is deeply entrenched in American law[4] and in the American psyche.[5] The concept is protected by the U.S. Constitution, the common law, and many state constitutions.[6] Yet, many legal, social, and structural barriers routinely restrict the exercise of that personal autonomy, particularly at the end of life. So long as a dying person is capable of expressing personal preferences, a good death can usually be achieved by simply respecting those preferences. The reality, however, is that most decisions regarding treatment for serious

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1. Karen E. Steinhauser & James A. Tulsky, *Defining a Good Death*, *in* OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 77 (5th ed. Nathan Cherney et al. eds., 2015).

2. *Id.*

3. *See also id.*; Emily A. Meier et al., *Defining a Good Death (Successful Dying): Literature Review and a Call for Research and Public Dialogue*, AM. J. GERIATRIC PSYCHIATRY, Apr. 2016.

4. *See generally* Carol J. Wessels, *Treated with Respect: Enforcing Patient Autonomy by Defending Advance Directives*, 6 MARQ. ELDER'S ADVISOR 217 (2005).

5. *See, e.g.*, Alexander Smith & Vyjeyanthi S. Periyakoil, *Should We Bury 'The Good Death'?*, 66 J. AM. GERIATRICS SOC'Y 856, 856–58 (2018).

6. *See, e.g.*, Wessels, *supra* note 4, at 219–25. *Accord* Smith & Periyakoil, *supra* note 5, at 857 ("A good death is individual, and is highly influenced by social relationships and cultural, religious, and historical factors.").

illnesses and end-of-life decisions are, in fact, made by someone other than the patient because the patient is incompetent.[7]

Achieving a good death depends on several factors. It depends on who is empowered to make decisions on behalf of the incompetent patient. Some people will be better able to make decisions that reflect the decisions the patient would have made had the patient been competent. The good death depends on whether the patient's previously expressed wishes will be respected or ignored by health care providers, surrogate decision makers, and legislators. The good death will also depend on what social and legal barriers prevent the exercise of personal autonomy. The goal of this Article is to help guide attorneys and legislators in removing those barriers and in facilitating greater autonomy.

This Article proceeds as follows. Part I introduces the key terminology used in this Article and describes the governing legal regimes applicable to advance-planning documents. Part I also offers suggestions for improving some global aspects of the Louisiana legal regime. Part II considers the two primary manners in which decision makers are appointed for incompetent patients: by prior appointment by the patient or by the default legislative framework. Part II also points out problems with (and legislative solutions to) the current Louisiana legislative scheme. Where relevant, Part II also provides drafting guidance to practitioners. Part III considers what types of decisions a surrogate decision maker can make. This question turns on three primary factors: (1) the extent of prior advance planning by the patient; (2) the strength of the evidence required by state law; and (3) the specific medical decision being made. Part III also identifies problems in the Louisiana legislative regime and offers legislative solutions. Where relevant, Part III also provides drafting guidance to practitioners to facilitate the exercise of each client's personal autonomy. Part IV gives practical advice for drafting documents that facilitate the exercise of client autonomy and addresses the challenges described in the previous sections.

I. TERMINOLOGY AND LEGAL REGULATION

Attorneys need a basic understanding of the terms and legal concepts relating to advance-planning documents. Attorneys should also understand how laws differ from state-to-state so that they can better draft documents that are usable in all states. Subpart A identifies the key advance-planning

7. *See* Julia W. Buckey & Christina N. Browning, *Factors Affecting the LGBT Population When Choosing a Surrogate Decision Maker*, 39 J. SOC. SERV. RES. 233, 233, 235 (2013).

documents relevant to medical decision making. Many of those documents do not take effect unless a patient is deemed incompetent. Subpart B examines the legal and medical notion of incompetency. Subpart C outlines the laws governing medical decision making and advance-planning documents. Subpart C also sets forth suggestions for global improvements to those laws in Louisiana.

A. Advance-Planning Documents

Three terms refer to documents that are often prepared by attorneys for their clients: the advance directive, the living will, and the medical power of attorney. Two other terms, the DNR (Do Not Resuscitate Order) and the POLST ("Provider Orders for Life-Sustaining Treatment" or "Physician's Orders for Scope of Treatment"), refer to documents prepared by health care providers. Each is considered below.

1. Lawyer-Prepared Documents: Advance Directives, Living Wills, and Medical Powers of Attorney

The terms used to describe the lawyer-prepared documents are confusing, overlapping, and idiosyncratic in their usage.[8] This Article uses the terms *advance directive*, *living will*, and *medical power of attorney* to refer to three distinct legal concepts that may be combined into a single document.

As the name suggests, the advance directive is a document in which a competent adult provides *directions* regarding health care decisions in *advance* of incapacity.[9] Those directions typically relate to end-of-life

8. *Cf.* Timothy P. O'Sullivan, 88 J. KAN. BAR ASS'N 32, 33 (2017) (asserting that there are three sets of advance directives: "instruction directives, proxy directives, and directives that combine aspects of both instruction and proxy directives"); Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249, 250 (1997) (describing living wills and durable powers of attorney for health care as types of advance directives); Charles P. Sabatino, *Commentary on the Terminology of Healthcare Planning*, 23 EXPERIENCE 38, 38 (2013) (observing that doctors and lawyers use the terminology differently and that the "forms lawyers use often conflate these terms").

9. *Cf.* O'Sullivan, *supra* note 8, at 33 (asserting that there are three sets of advance directives: "instruction directives, proxy directives, and directives that combine aspects of both instruction and proxy directives"); Larson & Eaton, *supra* note 8, at 250 (describing living wills and durable powers of attorney for health care as types of advance directives); Sabatino, *supra* note 8, at 38

treatment, but they may also be broader in scope. The advance directive gives a competent adult the opportunity to express consent to, or rejection of, certain courses of medical treatment prior to the adult's incapacity. The advance directive may also be referred to as the *health care directive*, *advance medical directive*, or some other similar term.

The term *living will* usually refers to a statutorily created sub-species of the advance directive. The living will is a document that sets forth a person's wishes with respect to artificially prolonging life if the person has a terminal and irreversible medical condition.[10] The language for the living will is often prescribed by state statute and is usually more limited in scope than the more general advance directive.[11]

Finally, the term *medical power of attorney* (or power of attorney for health care) refers to a document in which a competent adult grants some other person the authority to make medical decisions on the adult's behalf if the adult is unable to do so personally.[12] That person is sometimes referred to as the *agent*, *proxy*, or *surrogate* for health care decisions.

From a practical standpoint, these distinct concepts are routinely combined together into a single document.[13] Advance planning usually involves the creation of a single document that appoints an agent and provides specific guidance to that agent about various courses of treatment and end-of-life decisions.

2. Health Care Provider-Prepared Documents: The DNR and the POLST

Health care providers are responsible for the preparation of the DNR and the POLST. The DNR is a medical order that instructs health care providers not to perform CPR (cardiopulmonary resuscitation) if a patient

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(observing that doctors and lawyers use the terminology differently and that the "forms lawyers use often conflate these terms").

10. *See, e.g.*, ALA. CODE § 22-8A-4 (2023) (describing a living will as a document "directing the providing, withholding, or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration.").

11. *See, e.g.*, LA. REV. STAT. § 40:1151.2 (2023).

12. *See, e.g.*, DEL. CODE tit. 16, § 2501 (2023) (defining a "power of attorney for health care" as "the designation of an agent to make health-care decisions for the individual granting the power").

13. *See* Sabatino, *supra* note 8. *Accord* ALA. CODE § 22-8A-3 (2023) (providing that an advance directive "may include a living will, the appointment of a health care proxy, or both such living will and appointment of a health care proxy").

stops breathing or if the patient's heart stops beating.[14] A DNR is usually issued only after consultation with the patient or with the patient's surrogate decision maker.[15] Traditionally, a DNR was only effective within a health care setting. Outside of a hospital or similar setting, emergency medical personnel are generally obligated to attempt resuscitation.[16] Recognizing the desire of many Americans to die outside of the hospital setting, many states, including Louisiana, enacted "out of hospital DNR" statutes that will provide a mechanism for a DNR order to be recognized outside of a hospital setting.[17]

The POLST is a medical order that provides guidance to health care providers regarding the patient's end-of-life care preferences.[18] It is usually broader in scope than the DNR. The POLST is usually issued only after consultation with the patient or the patient's surrogate decision maker.[19] The POLST addresses a variety of health care issues for seriously ill patients.[20] In essence, the POLST is an advance directive that has been translated into a medical order.

B. When is a Patient Incompetent?

The doctrine of informed consent is the bedrock of patient autonomy in American law.[21] Informed consent to medical treatment is both a legal

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14. *See, e.g.*, ALA. CODE § 22-8A-3 (2023) (explaining that a DNR is a "physician's order that resuscitative measures not be provided" and that the "order must be entered with the consent of the person, if the person is competent"); WIS. STAT. § 154.17 (2023) (defining a DNR as "a written order . . . that directs [various medical personnel] not to attempt cardiopulmonary resuscitation on a person for whom the order is issued if that person suffers cardiac or respiratory arrest."); WIS. STAT. § 154.19 (2023) (providing that only an "attending health care professional may issue a do-not-resuscitate order").

15. *See* ALA. CODE § 22-8A-3 (2023); WIS. STAT. § 154.17 (2023); WIS. STAT. § 154.19 (2023).

16. *See generally* Karen L. Schultz & Timothy D. Schultz, *Advance Directives: A Primer*, 63 TEX. BAR J. 1034 (2000).

17. *See, e.g.*, IND. CODE § 16-36-5-6 (2023); LA. REV. STAT. § 40:1151.7 (2023); TEX. HEALTH & SAFETY CODE § 166.089 (2023).

18. *See generally* Robert B. Wolf et al., *The Physician Orders for Life-Sustaining Treatment (POLST) Coming Soon to a Health Care Community Near You*, 40 ACTEC L.J. 57 (2014).

19. *Id.* at 69.

20. *Id.* at 71–73.

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

and an ethical requirement.[22] Health care providers are generally under an affirmative duty to obtain the patient's consent before beginning medical treatment and to disclose the material risks associated with treatment to the patient in advance.[23]

Not all patients are capable of providing informed consent to medical treatment. In drafting advance-planning documents, attorneys attempt to preserve that right for their clients once their clients are no longer able to communicate for themselves or are deemed to lack the capacity to make their own decisions. Therefore, a threshold question in medical decision making is whether the patient is competent to consent to or refuse medical treatment.

Like many things in law and medicine, reality offers a lot of gray area. A person who is unconscious and unable to communicate is obviously unable to give informed consent. But, what about a person in the early or middle stages of Alzheimer's dementia? What about a person experiencing acute mental illness? What about a person subject to an interdiction or similar protective proceeding? What about a person with a life-long cognitive impairment? How should it be determined whether these individuals possess the requisite capacity to determine the course and scope of their own medical care? Moreover, who decides whether a person has capacity to consent to treatment? The answers to these questions are not always clear.

Clients might prefer the autonomy to stipulate how and when their capacity (or lack thereof) can be determined. Clients might justifiably fear that they will be deprived of their personal autonomy because doctors unilaterally deem them to lack capacity. After all, paternalism and prejudice in the medical field are well documented.[24] Clients will also vary considerably in when they are comfortable placing their autonomy in another person's hands.[25] Unfortunately, the lawyer's hands are mostly tied. Capacity is a decision that cannot realistically be personalized in advance-planning documents.

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22. *See* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 267 (1999).

23. *Id.*

24. *See* Michele Goodwin & L. Song Richardson, *Patient Negligence*, 72 L. & CONTEMP. PROBS. 223, 230–39 (2009).

25. *See* Carol J. Whitlatch & Heather L. Menne, *Don't Forget About Me! Decision Making by People with Dementia*, 33 GENERATIONS: J. AM. SOC'Y AGING 66, 67 (2009).

1. How is Capacity Defined in the Law?

Adults are typically presumed to possess the requisite legal capacity to consent to treatment or to refuse treatment. This general legal rule[26] is either expressly or impliedly recognized by various medical-consent laws in most states.[27] Whether an adult patient, in fact, possesses the requisite capacity is primarily a medical decision, a fact that is often reflected in state statutory regimes.

In some states, the medical-consent statutes offer little, if anything, in the way of guidance regarding whether an adult possesses the requisite capacity to consent to medical treatment.[28] The statutory regime in Louisiana, for example, simply implies that a patient either possesses capacity or lacks it.[29] Some jurisdictions have attempted to legislatively define capacity in a more detailed manner.[30] The lack of definitions in Louisiana, and elsewhere, is not necessarily a legislative failure. Because capacity to make medical decisions is primarily a medical decision, it is not necessary for states to legislate capacity standards. The practical reality, in all states, is that capacity determinations are often made by medical professionals who are rarely trained in the law, much less state-to-state statutory variations. Over-legislating the capacity question also

26. *See* LA. CIV. CODE arts. 27–29 (2023).

27. *See* LA. REV. STAT. § 40:1159.4 (2023) ("Any adult, for himself" is authorized to consent to medical treatment.); *accord* ARK. CODE §20-9-602 (2023) ("Any adult, for himself" is authorized to consent to or refuse medical treatment.); GA. CODE § 31-9-2 (2023) ("Any adult for himself" is authorized to consent to or refuse medical treatment.).

28. *See* LA. REV. STAT. § 40:1159.4 (2023) ("Any adult, for himself" is authorized to consent to medical treatment.); *accord* ARK. CODE § 20-9-602 (2023) ("Any adult, for himself" is authorized to consent to or refuse medical treatment.); GA. CODE § 31-9-2 (2023) ("Any adult for himself" is authorized to consent to or refuse medical treatment.).

29. *See* LA. REV. STAT. § 40:1159.4 (2023).

30. *See, e.g.*, ARK. CODE § 20-9-601 (2023) (providing that a patient lacks capacity if she is unable "to perceive all relevant facts related to one's condition and proposed treatment so as to make an intelligent decision based thereon"); GA. CODE § 31-9-2 (2023) (providing that a patient lacks capacity if she "'lacks sufficient understanding or capacity to make significant responsible decisions' regarding his or her medical treatment or the ability to communicate by any means such decisions").

runs the risk of inviting the courts to unduly interfere with nonjusticiable medical decisions.[31]

2. Medical Determinations of Capacity

The determination of whether a person possesses sufficient capacity to consent to or refuse medical treatment is usually made directly by the health care provider. Medical practice standards recognize that capacity has four elements: (1) understanding; (2) appreciation; (3) reasoning; and (4) communication.[32] First, the patient must "demonstrate *understanding* of the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment)."[33] Second, the patient must "demonstrate *appreciation* of those benefits, risks, and alternatives."[34] Third, the patient should be able to demonstrate "*reasoning* in making a decision."[35] Finally, the patient must be able to *communicate* the choice the patient made regarding care.[36] In practice, capacity is often assessed intuitively during each patient encounter based on the health care provider's interaction with the patient.[37]

This intuitive approach has well-documented limitations. Different health care providers may reach differing conclusions of patient capacity regarding the same patient.[38] For example, one small study asked five experienced physicians to watch videos of numerous competency interviews of patients with mild Alzheimer's disease and patients without

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31. *See In re* Quinlan, 355 A.2d 647, 665 (N.J. 1976). *See also* Gary Underwood Scharff, In re Quinlan *Revisited: The Judicial Role in Protecting the Privacy of Dying Incompetents*, 15 HASTINGS CONST. L.Q. 479, 509–10 (1988).

32. *See* Craig Barstow et al., *Evaluating Medical Decision-Making Capacity in Practice*, 98 AM. FAM. PHYSICIAN 40 (2018); *accord* Barton W. Palmer, *Assessment of Decisional Capacity*, 24 PSYCHIATRIC TIMES (2007), https://www.psychiatrictimes.com/view/assessment-decisional-capacity [https://perma.cc/R2MS-D7TL].

33. Barstow et al., *supra* note 32, at 40 (emphasis added).

34. *Id.* (emphasis added).

35. *Id.* (emphasis added).

36. *Id.* (emphasis added).

37. *Id.* ("Because the four elements of capacity (understanding, appreciation, reasoning, and communication) are built into everyday dialogue and interactions, it can be assumed that patients have the capacity to make medical decisions if their conversation demonstrates basic logic.").

38. *See generally* Rahime Aydin Er & Mine Sehiralti, *Comparing Assessments of the Decision-Making Competencies of Psychiatric Inpatients as Provided by Physicians, Nurses, Relatives and an Assessment Tool*, 49 J. MED. ETHICS 453 (2014).

the disease.[39] The physicians had an excellent agreement rate (98%) regarding the competency of the patients that did not have Alzheimer's disease.[40] The agreement rate among the physicians regarding the patients with mild Alzheimer's disease, however, was only 56%.[41] These findings suggest that the ability of a person with Alzheimer's disease to continue to exercise personal autonomy would depend, in part, on which physician happened to be working on the day the person sought care.

On the whole, physicians appear to under-diagnose lack of capacity.[42] Yet, some factors that may be unrelated to a patient's actual capacity may lead a physician or other health care provider to determine that a competent patient lacks capacity. One study involving the assessment of capacity in older adults revealed that health care providers tended to give lower capacity scores when the patient's preferences about health care did not align with the provider's preferences.[43] This concerning phenomenon is well documented in the literature. On one hand, decisions that are "unpopular with the medical team [can] trigger formal capacity assessments."[44] Adhering to medical advice, on the other hand, is less likely to trigger questions about capacity.[45]

3. Special Situations

The general rule that adults are presumed capable of consenting to medical treatment is subject to some important exceptions. These exceptions include emergencies, minors, and adults with certain legal limitations on their decisional freedom. These issues are considered below.

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39. *See* D.C. Marson et al., *Consistency of Physician Judgments of Capacity to Consent in Mild Alzheimer's Disease*, 45 J. AM. GERIATRIC SOC'Y 453, 453 (1997).

40. *Id.*

41. *Id.*

42. *See* Barstow et al., *supra* note 32, at 41; *accord* Er & Sehiralti, *supra* note 38.

43. Michelle M. Braun et al., *Are Clinicians Ever Biased in Their Judgments of the Capacity of Older Adults to Make Medical Decisions?*, 33 GENERATIONS: J. AM. SOC'Y AGING 78, 80 (2009).

44. Toby Schonfeld & Kristine Galich, *Waiting it Out*, 39 HASTINGS CTR. REP. 16, 16 (2009).

45. *Id.* at 16–17.

a. Emergency

Consent is usually implied or presumed in emergencies; a rule is sometimes reduced to statute.[46] The presumption of consent in emergencies reflects long-established legal doctrine.[47] Legislative definitions of what constitutes an emergency are often quite broad,[48] reinforcing the notion that patient capacity is primarily a medical question rather than a legal question.

From a practical standpoint, once a health care provider determines that an emergency exists, there may be little the patient or the patient's agent can do to direct the course of treatment because the medical provider may not include the patient or agent in the decision-making process. Further, the ability of a health care provider to decide, often unilaterally, that an emergency exists could lead to abuse. While that potential is concerning, there is really nothing that the lawyer can do to ameliorate the issue in advance-planning documents.

b. Minors, Adults with Developmental Disabilities, Mental Health, and the Incarcerated

The presumption favoring the competency of adults does not apply to minors. The medical-decision-making rights of minors are generally governed by other statutory regimes and legal doctrines.[49] Adults with developmental disabilities, prisoners, and adults residing in mental health facilities are likewise subject to different legal regimes.[50] The issues

46. LA. REV. STAT. § 40:1159.5 (2023); *accord* GA. CODE § 31-9-3 (2023); MISS. CODE § 41-41-7 (2023); N.H. REV. STAT. § 153-A:18 (2023).

47. *E.g.*, Stewart-Graves v. Vaughn, 170 P.3d 1151, 1155–56 (Wash. 2007) (reaffirming the emergency exception and noting that "[t]he emergency exception has deep roots in the common law").

48. *See, e.g.*, LA. REV. STAT. § 40:1159.5 (2023) (providing, in part, that an emergency "is defined as a situation wherein: (1) in competent medical judgment, the proposed surgical or medical treatment or procedures are reasonably necessary; and (2) a person authorized to consent under R.S. 40:1159.4 is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected, or could reasonably result in disfigurement or impair faculties.").

49. *See generally* Kimberly M. Mutcherson, *Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents*, 14 CORNELL J.L. & PUB. POL'Y 251 (2005).

50. *See id.*; LA. REV. STAT. §§ 28:451.1–455.2. *See generally* M. Scott Smith et al., *Healthcare Decision-Making for Mentally Incapacitated Incarcerated Individuals*, 22 ELDER L.J. 175 (2014).

relating to personal autonomy of these particularly vulnerable populations are not addressed in this Article.

C. Governing Laws

Several bodies of law govern medical decision making. This Subpart provides a general overview of the legal landscape applicable to living wills, advance directives, and medical powers of attorney. It also provides some criticisms of and suggestions for improvement to Louisiana's current regulatory regime.

1. Constitutional Recognition of Personal Autonomy

Personal autonomy in medical decision making is, for now,[51] a constitutionally protected liberty interest. In 1990, the U.S. Supreme Court expressly recognized the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" under the Fourteenth Amendment's right to privacy.[52] Although the Supreme Court's decision in *Cruzan* was a watershed moment in recognizing a constitutional right, it did not establish any meaningful regulatory framework.[53] Rather, states were left to establish their own legislative regimes.

More recently, the Supreme Court struck down constitutional protections to some of the most important aspects of personal autonomy in medical decision making. In *Dobbs v. Jackson Women's Health Organization*, the Supreme Court ruled that there is no constitutionally protected right to abortion.[54] The opinion has already dramatically eroded personal autonomy over certain reproductive medical decisions—particularly in restrictive states like Louisiana.[55] It remains to be seen what other types of medical decisions the *Dobbs* decision will impact in the

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51. *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), casts considerable doubt on the future of constitutional protection for personal autonomy in medical decision making and essentially killed that autonomy with respect to certain reproductive decisions.

52. Cruzan v. Dir., Mo. Dep't Health, 497 U.S. 261, 278 (1990).

53. *See generally* Marni J. Lerner, *State Natural Death Acts: Illusory Protection of Individuals' Life-Sustaining Treatment Decisions*, 29 HARV. J. LEGIS. 175 (1992).

54. *Dobbs*, 142 S. Ct. 2228.

55. Rachel Treisman, *States with the toughest abortion laws have the weakest maternal supports, data shows*, NPR (Aug. 18, 2022, 6:00 AM ET), https://www.npr.org/2022/08/18/1111344810/abortion-ban-states-social-safety-net-health-outcomes [https://perma.cc/2SPD-JT46].

years to come. In the meantime, attorneys should consider including provisions in advance-planning documents that will make it easier for clients to seek medical care in more accommodating states.

2. Natural Death Acts

In response to *Cruzan* and other highly publicized cases, state legislatures enacted "Natural Death Acts" which specifically allowed adults to express their thoughts regarding end-of-life decisions prior to their incapacity.[56] The Natural Death Acts typically responded by addressing the rather narrow issues raised by *Cruzan* and similar cases, specifically the right of the incompetent patient to refuse treatment when the patient was in a persistent vegetative state or when death was relatively imminent.[57] Whether the Natural Death Acts actually preserve patient autonomy is debatable. As many commentators have observed, the Acts are usually too narrow in scope, and when they do apply, they give physicians a fair amount of discretion in interpreting the Acts.[58]

In many states, the Natural Death Acts became part of larger cohesive bodies of legislation regulating medical decision making.[59] In these states, statutory law went further than simply authorizing a living will pertaining to the narrow issue of refusing treatment at the end of life. Some state statutes offered a broader array of choices for patients to include in their advance-planning documents, essentially elevating them from the living will to a more comprehensive advance directive.[60] Some states enacted legislation facilitating the appointment of a health care agent.[61] Many states took a combination of approaches to give patients a wide-ranging

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56. *See, e.g.*, Martha S. Schwartz, *'Conscience Clauses' or 'Unconscionable Clauses': Personal Beliefs versus Professional Responsibilities*, 6 YALE J. POL'Y, L., & ETHICS 269, 283 (2006).

57. *See* Lerner, *supra* note 53, at 183–87.

58. *See id.* at 209–11; Alfred Conrad, *Elder Choice*, 19 AM. J.L. & MED. 233, 235–37 (1993); *see generally* Schwartz, *supra* note 56.

59. *See, e.g.*, CAL. PROB. CODE § 4600 (2023). The current legal regime in California brought together California's living will legislation, health care power of attorney provisions, and related matters under a single "roof," the California Uniform Health Care Decision Act. *E.g.*, Matthew S. Ferguson, *Ethical Postures of Futility and California's Uniform Health Care Decisions Act*, 75 S. CAL. L. REV. 1217, 1218 (2008).

60. *See, e.g.*, CAL. PROB. CODE § 4701 (2023); TEX. HEALTH & SAFETY CODE § 166.004 (2023).

61. *See, e.g.*, CAL. PROB. CODE § 4680-91 (2023); TEX. HEALTH & SAFETY CODE §§ 166.151–166 (2023).

set of options.[62] Attempting to simplify the execution of advance-planning documents, many states enacted statutory forms to facilitate the implementation of their legislation, an issue addressed in more detail below.

3. Applicable Louisiana Laws

The Louisiana legislative regime is uniquely problematic. The state failed to enact an organized and comprehensive body of law addressing medical decision making. Rather, the statutory laws were enacted in a piecemeal, disorganized, and often inadequate manner. This Subpart provides an overview of the most salient provisions of Louisiana law. Additional criticisms and calls for reform are included throughout this Article in other Parts. At a minimum, the Louisiana legislature should corral these laws and house them in a single legislative scheme to enhance clarity and eliminate easily avoidable contradictions in the law.

a. Louisiana's Qualified Patient Statutes (Natural Death Act)

Louisiana's living will or Natural Death Act legislation is contained in Title 40 of the Louisiana Revised Statutes under the remarkably vague chapter heading: "5-D. Health Provisions: Healthcare." This Article refers to this legislative scheme as Louisiana's "Qualified Patient" statutory regime. The legislative scheme only contemplates the exercise of patient autonomy about the very narrow issue of "the withholding or withdrawal of life-sustaining procedures in the event [that the patient] should have a terminal and irreversible condition."[63] Such patients are deemed *qualified patients* in the definitions section of the legislation.[64] The legislative scheme does not even purport to afford any significance to directions regarding any other aspect of medical care. Although directions on additional matters could be incorporated into the Louisiana POLST form at the end of life,[65] the Louisiana Qualified Patient legislative scheme simply ignores the fact that a good advance directive addresses more than the limited issue of withholding or withdrawing life-sustaining treatment in patients with terminal and irreversible conditions.

62. *See, e.g.*, CAL. PROB. CODE §§ 4600–4806 (2023); TEX. HEALTH & SAFETY CODE §§ 166.001–209 (2023).

63. LA. REV. STAT. § 40:1151.2A(1) (2023).

64. *Id.* § 40:1151.1.

65. *See id.* § 40:1155.2.1.

b. Louisiana's General Consent Statutes (Other Medical Decisions)

Medical decisions other than those addressed by Louisiana's Qualified Patient Statutes are indirectly addressed by a statutory regime titled the Louisiana Medical Consent Law.[66] This Article refers to this type of statutory regime as a "General Consent" statutory regime. Louisiana's General Consent statutory regime requires informed consent for medical treatment and authorizes various individuals, including "[a]n agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions[,]" to consent to treatment on behalf of an incompetent person.[67]

c. Louisiana's Medical Power of Attorney Laws

The appointment of a medical power of attorney or agent is not subject to any special legislation in Louisiana. Rather, it is governed by the general law of representation found in the Louisiana Civil Code.[68] For those who are unfamiliar with Louisiana's civil law tradition, a note about terminology is helpful. The theoretical underpinnings of fiduciary relationships evolved differently in the civil-law and common-law traditions.[69] One consequence of those different evolutions is a distinction in terminology. In the common-law tradition, the law of agency generally governs the appointment of a person to make decisions for another person, including an agent for health care decisions.[70] The instrument appointing the agent is sometimes referred to as a *power of attorney*.[71] Thus, a person appointed to make health care decisions may be called an *agent* or a *health care agent*.

The civilian terminology differs. In Louisiana, a person may represent another through a legal notion called *representation*.[72] A representative may derive authority from the law, a contract, or a unilateral act of the person to be represented.[73] As in other states, the appointment of a person to make health care decisions upon the incapacity of the principal is usually accomplished by unilateral act that is later accepted by the

66. *See id.* § 40:1159.1.
67. *See id.* § 40:1159.4A(3).
68. *See* LA. CIV. CODE art. 2997 (2023).
69. *See* Elizabeth R. Carter, *Fiduciary Litigation in Louisiana: Mandataries, Succession Representatives, and Trustees*, 80 LA. L. REV. 661, 665–72 (2020).
70. *See* RESTATEMENT (THIRD) OF AGENCY §§ 1.01, 1.04 (AM. L. INST. 2006).
71. *See id.*
72. LA. CIV. CODE art. 2985 (2023).
73. *Id.* art. 2986.

representative to form a contract. In Louisiana, the unilateral act is called a *procuration*, and the related contract is called the contract of *mandate*.[74] In Louisiana, therefore, the terms *procuration* and *mandate* are more appropriate legal terminology than *power of attorney*.[75] Similarly, the term *mandatary* is the more appropriate legal term than *agent*.[76] For ease of understanding, however, many Louisiana practitioners draft advance-planning documents utilizing both the common-law and civil-law terminology. The common-law terminology is likewise used more often in this Article.

Civil Code article 2997 recognizes the notion of a power of attorney (or mandate) for health care by providing that express authority is required to "[m]ake healthcare decisions, such as surgery, medical expenses, nursing home residency, and medication."[77] The Civil Code does not contain any additional rules that are specific to health care mandates or procurations. This omission creates problems that are explored in more detail in later Parts.

d. Other Related Laws

Other statutory regimes touch on issues commonly addressed in advance-planning documents. Louisiana Revised Statutes § 8:655 sets forth rules relating to the disposition of a person's remains after death. A person can leave directions for the disposition of their bodily remains.[78] A person can also give someone else the authority to dispose of the person's bodily remains at death.[79] If no directions are left or prior appointment made, then a hierarchical list of relatives is empowered to make those decisions.[80]

Louisiana's Anatomical Gift Act sets forth various rules relating to organ, tissue, and cadaver donation.[81] The Act allows a living person to either authorize or prohibit anatomical gifts to be made at death.[82] The Act also permits the "agent of the donor" to make an anatomical gift "unless the power of attorney for health care or other record prohibits it."[83] Absent

74. *See id.* arts. 2985, 2987, 2989.
75. *See* LA. CIV. CODE ANN. art. 2989 (2022); *id.* art. 2989 cmts. (a)–(e).
76. *See* LA. CIV. CODE art. 2989 (2023).
77. *Id.* art. 2997.
78. LA. REV. STAT. § 8:655 (2023).
79. *Id.*
80. *Id.*
81. *Id.* § 17:2351–2359.
82. *See id.*
83. *Id.* § 17:2352(B)(3).

a prior authorization or prohibition by a deceased person (or by the person's agent), the Act sets forth a hierarchical list of relatives empowered to consent to a donation.[84]

4. Statutory Forms

To remove barriers from executing advance-planning documents, many states enacted statutory forms for advance-planning documents. The state statutory forms are far from perfect and have had varying levels of success.[85] Yet, virtually every other state's approach is superior to Louisiana's approach. The Louisiana form is probably one of the absolute worst in the country. The following are some of the most basic suggestions and considerations for improving the Louisiana statutory form.

There are some practical problems with the format of the Louisiana form. The illustrative Louisiana living will form directs the withholding or withdrawing of "life-sustaining procedures" for so-called *qualified patients*.[86] Patients are asked to initial one of the following two options:

> That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.
>
> That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.[87]

Some people do not realize they are supposed to initial one of the options, and they fail to make any selection. Others decide to make handwritten changes to the options provided. For example, this author has observed one individual select the second option but mark out "nutrition." Presumably, the individual wanted the continued administration of hydration but not nutrition. At a minimum, these observations suggest that people find the format of the statutory form unclear or lacking in desirable options.[88] The author's own experiences from practice also suggest that many clients lack a basic understanding of the dying process. Many dying

84. *Id.*

85. *See generally* Dorothy D. Nachman, *Living Wills, Is it Time to Pull the Plug?*, 18 ELDER L.J. 289 (2011).

86. LA. REV. STAT. § 40:1151.2 (2023).

87. *Id.*

88. *Accord* John J. Scroggin, *Planning for Medical Decisions*, 51 PRAC. LAW. 37, 40 (2005) (noting that "[o]ne flaw in some statutory forms is that the form may not contemplate a signer wanting either nourishment or hydration, but not both").

people do not experience hunger or thirst, and in some cases, the continued administration of nutrition and hydration does little more than add additional pain and suffering at the end of life.[89] Moreover, there are real medical reasons why continuing nutrition and hydration but discontinuing other types of life-sustaining treatment might be problematic.[90] In the author's own experience, when clients understand that dying people often do not experience hunger or thirst they are much less likely to indicate a preference for invasive nutrition and hydration to be administered at the end of life.

Of course, not all clients want to terminate life-sustaining procedures in anticipation of death. The Louisiana form does nothing to accommodate those individuals. To better facilitate patient autonomy, the statutory form probably should provide an option for patients to indicate a preference for continued administration of treatment, even when it is likely futile.[91]

Statutory forms can address a host of additional issues that the Louisiana form fails to consider. Some statutory forms ask open-ended questions about a patient's thoughts, desires, and beliefs about end-of-life care.[92] Other forms take a check-the-box approach by listing various treatments and options and asking the patient to indicate which ones the patient wants or does not want.[93] At a minimum, the form should facilitate the appointment of a health care agent by the patient. Statutory forms in many other states do exactly that.[94] Louisiana's statutory form should also provide an opportunity for the patient to express preferences regarding organ donation.[95] It would also be helpful to inquire into preferences regarding burial and cremation considering the enormous financial

89. *See also* Biren Saraiya et al., *End-of-Life Planning and Its Relevance for Patients' and Oncologists' Decisions in Choosing Cancer Therapy*, 113 CANCER SUPPLEMENT 3540 (2008).

90. *See, e.g.*, Lois Sheppard, *The End of End-of-Life Law*, 92 N.C. L. REV. 1693, 1714 (2014) (pointing out that such an election could lead to "the dangerous and untenable possibility that one might continue artificial nutrition and hydration but refuse medically necessary dialysis to accommodate it").

91. *See, e.g.*, ARIZ. REV. STAT. § 36-3262 (2023); IND. CODE §§ 16-36-4-10–11 (2023).

92. *See, e.g.*, MINN. STAT. § 145B.04 (2023).

93. *See, e.g.*, ARIZ. REV. STAT. § 36-3262 (2023); 20 PA. CONS. STAT. § 5471 (2023); N.H. REV. STAT. § 137-J:20 (2023).

94. *See, e.g.*, FLA. STAT. § 765.303 (2023); KY. REV. STAT. § 311.625 (2023); MINN. STAT. § 145B.04 (2023); 20 PA. CONS. STAT. § 5471 (2023).

95. *See, e.g.*, KY. REV. STAT. § 311.625 (2023); MINN. STAT. § 145B.04 (2023); 20 PA. CONS. STAT. § 5471 (2023); TENN. CODE § 32-11-105 (2023).

impacts those decisions may have on the person's family.[96] Forms in some other statues include guidance and explanation to the patient executing the form.[97] The Louisiana form has practically no accompanying explanatory provisions.[98] Of course there are pros and cons to the varying approaches taken in other states,[99] but virtually every approach is superior to the Louisiana approach of ineptly facilitating autonomy on an extremely narrow medical issue.

II. WHO MAKES DECISIONS FOR THE INCOMPETENT PATIENT?

When a patient is unable to consent, some other person will be asked to consent on the patient's behalf. Patients who have engaged in advance planning may have previously appointed an agent to act on their behalf. Absent a prior appointment, states have default regulatory schemes to empower a spouse, close relative, or some other person to make medical decisions. This Part considers the various rules governing who can make decisions for an incompetent patient.

A. Agent Appointed by Patient

A competent adult may designate an agent or mandatary to make health care decisions if that adult lacks the capacity to make and communicate decisions. The benefits of appointing an agent are well established. Most people cannot possibly anticipate what their specific preferences will be in advance of diagnosis.[100] Yet, some statutory living will and advance directive forms ask people to make such predictions. Those forms usually treat all illnesses the same. They "assume[] that a patient's preferences for care at the end of life will be the same for different incurable and irreversible diseases . . . ."[101] In reality, the end stages of life, and accompanying patient preferences, can vary dramatically depending on the cause of illness and the types of treatments available.[102] Prior

96. *See generally* Victoria Haneman, *Funeral Poverty*, 55 U. RICH. L. REV. 387 (2021).

97. *See, e.g.*, MINN. STAT. § 145B.04 (2023); 20 PA. CONS. STAT. § 5471 (2023).

98. *See* LA. REV. STAT. § 40:1151.2 (2023).

99. *See* Saraiya et al., *supra* note 89, at 3542.

100. *See, e.g.*, Colleen Galambos et al., *Analysis of Advance Directive Documentation to Support Palliative Care Activities in Nursing Homes*, 41 HEALTH & SOC. WORK 228 (2016).

101. *See, e.g.*, Saraiya et al., *supra* note 89, at 3542.

102. *See generally id.*

appointment of an agent who understands the patient's core beliefs, relationships, and preferences allows needed flexibility in end-of-life decision making.[103]

Prior appointment of an agent is particularly important for individuals who are not well served by the default surrogate laws. Absent a duly appointed agent, most states have a default scheme that confers decision-making authority to a hierarchical list of relatives.[104] While the default scheme may reflect the desires of some people, it certainly will not reflect the desires of all people.

1. Form Requirements

Methods for appointing an agent vary by state. Many states require the appointment be in writing, witnessed, and/or notarized by disinterested persons.[105] However, a writing is not strictly required in all states.[106] Louisiana requires express, but not necessarily written, authority to appoint an agent for health care decisions.[107] Some common agent decisions do, however, require a more onerous form.[108] Louisiana's form requirements are varied and follow no discernable overarching policy rationale. For example, authority to execute a living will on behalf of the patient requires some specific reference made "by written instrument signed by the patient in the presence of at least two witnesses . . . ."[109] If a person wants to prohibit anatomical or organ donation at death, then the person must do so in the form of a will or by a signed record that is "witnessed by at least two adults, one of whom is a disinterested witness . . . ."[110] If a person wants to authorize an organ donation, the form is similar, but the person has an additional option of having the desire indicated on the person's driver's license.[111] Directions and authorizations

103. *See, e.g.*, Galambos et al., *supra* note 100, at 232.

104. *See* discussion *infra* Part II.B.

105. *See, e.g.*, TEX. HEALTH & SAFETY CODE § 166.154 (2023) (contemplating execution before two witnesses or a notary); W. VA. CODE § 16-30-4 (2023) (requiring a dated writing executed before two disinterested witnesses and attested to before a notary).

106. *See* LA. CIV. CODE art. 2993 (2023).

107. *See id.* art. 2997.

108. *See* discussion *supra* Part I.C.3.

109. LA. REV. STAT. § 40:1151.4A(2)(b) (2023).

110. *Id.* § 17:2354.1B. Oral or other forms of communication are permitted if "made by the person during a terminal illness or injury addressed to at least two adults, one of whom is a disinterested witness." *Id.* § 17:2354.1A(3).

111. *See id.* § 17:2354.

relating to a patient's bodily remains after death should be made in the form of a "notarial testament" or in the form of a "written and notarized declaration."[112] Presumably, an olographic will is sufficient to donate organs and dispose of property at death. Yet, inexplicably, it is not adequate to direct the disposition of bodily remains. The legislature should better coordinate the varying form requirements to ensure better consistency. Barring legislative action, practitioners are well advised to have their clients execute advance-planning documents in the form of an authentic act before two disinterested witnesses and a disinterested notary to ensure that any ancillary issues addressed in the document meet the wildly varying form requirements found in Louisiana law.[113]

Even where a writing is not strictly required, some formal writing is clearly desirable. Written instruments are the practice standard in most states. A written instrument provides more reliable evidence of the agent's authority than an oral grant of authority. Further, a written instrument may be required to empower the agent to act in other states. Although many states have express reciprocity statutes that recognize advance-planning documents which are made in compliance with the law of some other state, the statutes are usually premised on the assumption that the law of the other state requires a writing.[114] California's reciprocity statute, for example, applies to "[a] written advance health care directive or similar instrument."[115]

2. Conflicts of Interest

Some states recognize the potential for harmful conflicts of interest and impose restrictions on who may be appointed as a health care agent. Some states prohibit health care providers and their employees from serving as a patient's health care agent out of a concern for potential conflicts of interest.[116] In states with such prohibitions, exceptions to the

112. *Id.* § 8:655.

113. *See* LA. CIV. CODE art. 1835 (2023).

114. *See, e.g.*, ALA. CODE § 22-8A-12 (2023); KAN. STAT. § 58-630 (2023); W. VA. CODE § 16-30-21 (2023).

115. CAL. PROB. CODE § 4676 (2023); *accord* OR. REV. STAT. § 127.515 (2023) (referring to "a form appointing a health care representative or a similar instrument"); WIS. STAT. § 155.70 (2023) (referring to a "valid document . . . that is executed in another state").

116. *See, e.g.*, CAL. PROB. CODE § 4659 (2023); CONN. GEN. STAT. § 19a-576 (2023); KY. REV. STAT. § 311.625 (2023).

rule often exist if the agent and patient are related to each other.[117] Louisiana has no comparable statutory prohibitions. The legislature should consider whether similar prohibitions are desirable.

3. Duration of Agent's Authority

A critical issue in any agency relationship or contract of mandate is one of timing. When does the agent's power commence, and when does the agent's power terminate? In some instances, these questions are sufficiently answered by existing laws. In other instances, however, reform is needed. The following Subparts consider these important timing questions.

a. Springing Power

The health care agent's power is a *springing* power in most states with respect to decisions relating to medical treatment. The agent only has the authority to make health care decisions if the patient lacks the capacity to make or communicate her own decisions. Some states express the springing nature of the agent's power directly. Texas law, for example, explains that the health care "agent may exercise authority only if the principal's attending physician certifies . . . [that] the principal is incompetent."[118] In other states, the springing nature of the agent's authority is simply implied in the statutory regime.

The springing nature of the power is probably implied in Louisiana law; however, legislative clarification would be helpful. Although the Civil Code regulates procuration and mandate, it does not specify when a power of attorney for health care becomes operative. The overall codal language addressing representation seems to imply that any procuration or mandate is immediately effective. This implication is bolstered by Louisiana Revised Statutes § 9:3890, which specifically authorizes a "conditional procuration" that "becomes effective upon the disability of the principal."[119] To become operative, the conditional procuration typically requires an authentic act signed by two physicians stating that they personally examined the principal and that "the principal is unable consistently to make or to communicate reasoned decisions regarding the care of the principal's person or property."[120] At first blush, this language

117. *See, e.g.*, CAL. PROB. CODE § 4659 (2023); CONN. GEN. STAT. § 19a-576 (2023).

118. TEX. HEALTH & SAFETY CODE § 166.152 (2023).

119. LA. REV. STAT. § 9:3890 (2023).

120. *Id.*

seems to regulate the appointment of a health care agent in Louisiana. But, Louisiana practitioners have generally understood this provision as applying to financial powers of attorney rather than to medical appointments.[121]

The springing nature of the medical power of attorney is implied by Louisiana's Qualified Patient Statutes and General Consent Statutes. Both statutory regimes provide a hierarchal order of priority of decision making with respect to medical treatment. Louisiana's General Consent Statutes provide a hierarchy that begins as follows: "(1) Any adult, for himself. (2) The judicially appointed tutor or curator of the patient, if one has been appointed. (3) An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions . . . ."[122]

The implication of this language is that an adult patient retains sole decision-making authority so long as the patient is competent. If, however, the patient is incompetent, then the authority falls to some other person, including a previously appointed agent. The effect of Louisiana's Qualified Patient Statutes is similar. Louisiana Revised Statutes § 40:1151.2 allows any adult to "make a written declaration directing the withholding or withdrawal of life-sustaining procedures" if the adult becomes a qualified patient.[123] Only if the patient fails to make a declaration and is later "comatose," "incompetent," or "physically or mentally incapable of communication" can another party make a declaration on the patient's behalf.[124] The agent is permitted to make such a declaration so long as the agent was so authorized by the patient while the patient was competent in a "written instrument signed by the patient in the presence of at least two witnesses, to have the authority to make a declaration for the patient in the event of the patient's inability to do so."[125]

Of course, a comprehensive medical power of attorney usually authorizes the agent to make a variety of decisions, not just those strictly relating to consent or refusal of treatment. Professionally prepared documents often grant the agent the authority to enter into contracts and pay bills relating to health care on the patient's behalf. These types of powers are not necessarily springing powers and, unless the instrument specifies otherwise, could likely be exercised by the agent while the patient possesses capacity.

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121. *See* JOHN F. SHREVES, 2 LOUISIANA PRACTICE SERIES: LOUISIANA CIVIL PRACTICE FORMS § 15:32–33 (2021); DAVID L. SIGLER ET AL., 2 LOUISIANA PRACTICE SERIES, ESTATE PLANNING IN LOUISIANA §§ 4:101, 5:213 (2022).

122. LA. REV. STAT. § 40:1159.4A(1)–(3) (2023).

123. *Id.* § 40:1151.2.

124. *Id.* § 40:1151.4.

125. *Id.*

b. Revocation at Marriage

At least one state—Georgia—automatically revokes a prior appointment upon the marriage of the principal if the agent is not the spouse.[126] This approach offers a measure of protection to individuals who enter into advance-planning documents prior to marriage and fail to update the documents at marriage. Many married individuals who engage in advance planning do, in fact, name their spouse as their agent.[127] The Georgia approach captures the probable intent of most people by automatically revoking the appointment of someone other than a spouse upon marriage of the principal. Because most states provide that the default decision maker in the absence of a prior appointment is the patient's spouse, revocation-upon-marriage statutes preserve the likely intent of most people, that is, to give decision-making authority to their spouse.

Louisiana has no comparable rule. The prior appointment of an agent is unaffected by a subsequent marriage. The Louisiana legislature should at least consider whether a revocation at marriage rule is desirable. Louisiana practitioners might also consider whether a stipulation regarding a subsequent marriage is appropriate to meet the needs of a particular client. For example, if a client anticipates marrying in the future but wants the prior appointment of an agent other than the spouse to prevail, it would be helpful to specify that intent given the societal norms favoring spousal appointment.

c. Revocation at Divorce

As noted above, spouses often name each other as health care agents.[128] A subsequent divorce, however, usually makes that arrangement undesirable. Many states assume that a person would no longer want a former spouse to serve as health care agent following a divorce and, by statute, automatically revoke the appointment of a spouse upon divorce.[129]

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126. *See* GA. CODE § 31-32-6 (2023).

127. *See, e.g.*, Deborah Carr & Dmitry Khodyakov, *Health Care Proxies: Whom Do Young Old Adults Choose and Why?*, 48 J. HEALTH & SOC. BEHAV. 180, 188 (2007) ("Consistent with past studies, we found that married persons overwhelmingly choose their spouse . . . .").

128. *See* discussion *supra* note 61 and accompanying text.

129. *See, e.g.*, ARK. CODE § 20-6-104 (2023); CAL. PROB. CODE § 4697 (2023); GA. CODE § 31-32-6 (2023); TEX. HEALTH & SAFETY CODE § 166.155 (2023).

Louisiana, however, does not have a revocation-at-divorce rule.[130] The lack of a rule in Louisiana is likely a legislative oversight rather than an intentional policy decision. The legislature should remedy this problem in the same manner described in Part II.C below relating to the hierarchy statutes. As noted above, the appointment of a health care agent in Louisiana is governed primarily by the Civil Code provisions relating to representation.[131] Those Civil Code articles fail to contemplate the nuances that may arise when a spouse is appointed to serve as agent. Interestingly, as is discussed in more detail below, the Louisiana Qualified Patient Statutes and the Louisiana General Consent Statutes do contemplate revocation of a statutorily authorized decision maker upon divorce.[132] Yet, these statutes are also inadequate. Unless the Louisiana legislature remedies the law in this area, it may be advisable to specifically include a revocation-upon-divorce provision in any power of attorney for health care or similar advance-planning document granting authority to a spouse.

d. Termination of Authority by Patient

The appointment of a health care agent is usually revocable by the principal at any time the principal possesses capacity.[133] Louisiana has no particular form requirement for the termination of an appointment of a health care agent.[134] Civil Code article 3025 simply provides that the "principal may terminate the mandate and the authority of the mandatary at any time."[135] Presumably, a written power of attorney could be revoked orally. Problems with oral revocation may arise if the original documents or copies still exist. Civil Code article 3028 puts the burden of notifying third parties on the principal,[136] thus errant originals or copies may still be relied on by third parties until the third parties are actually notified of revocation by the principal. As a practical matter, the principal should destroy any original documents and copies, notify interested parties of the revocation, and execute new documents that specifically revoke any prior

130. For example, Louisiana recognizes revocation at divorce in the context of wills. LA. CIV. CODE art. 1608 (2023). Louisiana has no comparable rule applicable to the contract of mandate/health care power of attorney. *See id.* arts. 3024–32.

131. *See* discussion *supra* Part I.C.3.

132. *See* discussion *supra* Part I.C.5.

133. *See, e.g.*, GA. CODE § 31-32-6 (2023); LA. CIV. CODE art. 3025 (2023); TEX. HEALTH & SAFETY CODE § 166.155 (2023).

134. *See* LA. CIV. CODE art. 3025 (2023).

135. *Id.*

136. *Id.* art. 3028.

appointments. A patient who has already notified health care providers or other interested parties of the existence of the appointment should take care to notify them whenever the appointment changes and to ensure that providers accurately update their records.

Other states have more detailed rules governing revocation. In Georgia, for example, the principal can revoke the appointment by executing a subsequent inconsistent appointment, by a written and signed revocation, or by destroying the original or having it destroyed "by some person in the declarant's presence and at the declarant's direction indicating an intention to revoke."[137] Georgia also permits oral or other non-written revocations in some circumstances.[138] Louisiana's rules are probably adequate in this regard.

e. Termination Due to Interdiction

A court adjudication of incompetence, such as an interdiction, guardianship, or conservatorship, has varied effects on the validity of advance-planning documents. In some cases, the scope of authority granted to the court-appointed curator, guardian, or conservator is so broad that it will effectively supersede any similar power that was previously granted by the incompetent person to a third party. In other cases, the agent may retain power despite the court adjudication of incompetence of the principal. States address this authority question with various levels of detail.[139] Unfortunately, the effect of interdiction on the appointment of a health care agent is not entirely clear in Louisiana. Again, this lack of clarity should be resolved legislatively.

Some provisions of Louisiana law suggest that an agent's authority will terminate upon the appointment of a curator. For instance, Civil Code article 3024 provides that "both the mandate and the authority of the mandatary terminate upon the . . . qualification of the curator after the interdiction of the principal."[140] Similarly, the General Consent Statutes grant authority to the curator in preference to the agent.[141] However, the interdiction rules themselves cast doubt on the superior authority of the curator with respect to health care decisions made by previously appointed agent. In particular, Civil Code article 394 provides that "[i]nterdiction does not affect the validity of a juridical act made by the interdict prior to

137. GA. CODE § 31-32-6 (2023).
138. *Id.* § 31-32-6.
139. *See, e.g.*, CAL. PROB. CODE § 2355 (2023); TENN. CODE § 68-11-1807 (2023); TEX. HEALTH & SAFETY CODE § 166.156 (2023).
140. LA. CIV. CODE art. 3024 (2023).
141. *See* LA. REV. STAT. § 40:1159.4 (2023).

the effective date of the interdiction."[142] Thus, a prior appointment may retain some validity under this general rule. When a person is declared a full interdict, decisions relating to health care are generally relegated to the interdict's curator.[143] This rule makes sense in the case of a full interdict because the full interdict has been adjudicated incompetent with respect to decisions relating to "his person and property."[144] Limited interdicts, however, may retain the authority to make their own health care decisions depending on the terms of the limited interdiction.[145] A limited interdict who retains decisional authority over health care decisions may be able to continue to utilize a pre-interdiction appointment of a health care agent[146] and may also be able to make a new appointment or revoke a prior appointment.[147] The overarching constitutional protections[148] for personal autonomy in health care decisions suggest that the mere appointment of a curator should not automatically supersede the interdict's own decisions or the interdict's prior exercise of autonomy in advance-planning documents, particularly in the case of a limited interdict.

B. Surrogate Statutes, in General

Absent a prior appointment by the patient or the court, authority to make decisions for the incompetent patient usually falls to the patient's immediate family. Most states have so-called *surrogate statutes* or *proxy statutes* that authorize family members and some other individuals to consent to medical treatment on behalf of the incompetent patient.[149] The benefit of these statutes should be obvious: they eliminate the need for a judicial proceeding and provide clarity to health care providers who need to make quick decisions about patient care.[150]

If the patient has not previously appointed an agent for health care decisions, then the surrogate statutes usually allow the patient's spouse and immediate relatives to make decisions for the patient. There is

142. LA. CIV. CODE art. 394 (2023).
143. *See id.* arts. 389, 395.
144. *See id.* art. 389.
145. *See id.* arts. 390, 395.
146. *See id.* art. 394 (recognizing the validity of pre-interdiction juridical acts).
147. *See id.* art. 395 (providing that a limited interdict only "lacks capacity to make a juridical act pertaining to the property or aspects of personal care that the judgment of limited interdiction places under the authority of his curator").
148. *See* discussion *supra* Part I.C.1.
149. *See* Shana Wynn, *Decisions by Surrogates: An Overview of Surrogate Consent Laws in the United States*, 36 BIFOCAL 10, 10–11 (2014).
150. *See id.*

considerable variation from state-to-state, but some generalizations can be made. State statutes can usually be described as either "hierarchy statutes" or "consensus statutes."[151] Each is discussed below.

1. Hierarchy Statutes

Most states have enacted hierarchy statutes. Hierarchy statutes generally place a patient's relatives and spouse into ranked classes and give the member(s) of the highest ranked class the authority to make decisions for the patient in preference to those individuals in lower ranked classes. Rankings vary, but they generally start the same. Most hierarchy statutes confer authority in the following ranked order: (1) spouse; (2) adult children; (3) parents; (4) adult siblings.[152] If no one in the highest ranked class exists or if the person in that class is unavailable, then power falls to the next class.[153] Beyond those four classes of relatives, hierarchy statutes vary considerably. States sometimes include more remote relatives in their statutory lists.[154] Some states include "close friends" in the priority list when no relatives are available.[155] Some states even include members of the clergy.[156] A few states allow the medical care provider to appoint a decision maker or to otherwise proceed in the absence of any next of kin.[157]

In many states, the statutory hierarchy is straightforward. The availability of a person in a higher ranked class will preclude someone in a lower ranked class from acting.[158] A few states, however, explicitly give

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151. *See id.*

152. *See, e.g.*, FLA. STAT. § 765.401 (2023); IND. CODE § 16-36-7-42 (2023); LA. REV. STAT. § 40:1159.4 (2023); TEX. HEALTH & SAFETY CODE § 313.004 (2023).

153. *See, e.g.*, FLA. STAT. § 765.401 (2023); IND. CODE § 16-36-7-42 (2023); LA. REV. STAT. § 40:1159.4 (2023); TEX. HEALTH & SAFETY CODE § 313.004 (2023).

154. *See, e.g.*, LA. REV. STAT. § 40:1159.4 (2023) (including the "patient's other ascendants or descendants"); TEX. HEALTH & SAFETY CODE § 313.004 (2023) (including the "patient's nearest living relative").

155. *See* FLA. STAT. § 765.401 (2023); IND. CODE § 16-36-7-42 (2023); LA. REV. STAT. § 40:1159.4(9) (2023).

156. *See* TEX. HEALTH & SAFETY CODE § 313.004 (2023).

157. *See, e.g.*, FLA. STAT. § 765.401 (2023) (allowing the health care provider's bioethics committee to appoint a licensed clinical social worker to make decisions in certain circumstances).

158. *See, e.g.*, UTAH CODE § 72-2a-108(c) (2023) (providing that a person in a lower ranked class "may not direct an adult's care if a person of a higher priority class is able and willing to act as a surrogate for the adult"); VA. CODE § 54.1-

health care providers greater discretion in determining who should serve as surrogate.[159] In these states, the health care provider is directed to consider various factors relating to a potential surrogate's availability and suitability for making decisions.[160] The statutory hierarchy in these states is simply another factor to be considered by the health care provider in selecting a surrogate decision maker. This approach vests more authority in the health care provider and less in the patient's immediate family.

Louisiana is a hierarchy statute state. With respect to ordinary medical decisions, Louisiana Revised Statutes § 40:1159.4 (the Louisiana General Consent Statute) sets forth an order of priority that includes the following (in order): the patient's spouse not judicially separated, an adult child of the patient, any parent for a child, the patient's sibling, the patient's other ascendants or descendants, and an "adult friend."[161] Certain decisions relating to end-of-life treatment, however, are subject to a different statutory rule. Louisiana Revised Statutes § 40:1151.4 (the Louisiana Qualified Patient Statute) sets forth a similar, but not identical, hierarchy for withholding or withdrawing "life-sustaining procedures" for "qualified patients."[162] Qualified Patient Statutes are considered in more detail in Part III.B below. Louisiana also utilizes hierarchy regimes in related areas of the law. The right to dispose of a person's remains is subject to a hierarchy statute.[163] Anatomical gifts follow a similar rule.[164] Even the appointment of a curator has a hierarchy-type regime.[165] The legislature should unify the various hierarchy schemes to eliminate unnecessary discrepancies and conflicts. There is no logical reason for many of the inconsistencies seen among Louisiana's various hierarchy schemes.

2986 (2023) (setting forth a hierarchy that is a "specified order of priority" that health care providers should follow).

159. *See, e.g.*, ARK. CODE § 20-6-105 (2023); TENN. CODE § 68-11-1806 (2023).

160. *See, e.g.*, ARK. CODE § 20-6-105 (2023); TENN. CODE § 68-11-1806 (2023).

161. LA. REV. STAT. § 40:1159.4 (2023).

162. *Id.* § 40:1151.4.

163. *Id.* § 8:655.

164. *Id.* § 17:2354.3.

165. LA. CODE CIV. PROC. 4561 (2023).

2. Consensus Statutes

At least three states—Colorado, Hawaii, and Montana—adopted an alternative statutory regime: the "consensus statutes."[166] The consensus statutes identify a group of interested persons and directs them to reach a consensus as to who should make decisions for the patient.[167] The class of interested persons in all three states includes the patient's spouse, parent(s), adult children, and adult grandchildren.[168] The statutes also include certain friends among the group of interested persons.[169] Colorado and Montana include the patient's "close friend"[170] without further clarification. In lieu of a "close friend," Hawaii includes "any adult who has exhibited special care and concern for the patient and who is familiar with the patient's personal values."[171] If the various interested persons cannot reach a consensus, then one or more of them can initiate a guardianship proceeding. Similarly, if any of the interested persons disagrees with the selection of the surrogate, then they may institute a guardianship proceeding.[172]

One of the alternatives seen in some hierarchy states is also seen in two of the consensus states. If no interested person is available, Montana and Colorado permit the attending health care provider to appoint "another willing physician" to act as a surrogate in certain cases.[173] Montana also allows that appointment of an advance practice nurse.[174]

C. Problems with Health Care Agent Laws and Surrogate Statutes

The laws governing health care agents and surrogate appointments have quite a few shortcomings. In some instances, these shortcomings

166. *See, e.g.*, COLO. REV. STAT. § 15-18.5-101–105 (2023); HAW. REV. STAT. § 327E-1–16 (2023); MONT. CODE § 50-5-1301–1308 (2023).

167. *See, e.g.*, COLO. REV. STAT. § 15-18.5-101–105 (2023); HAW. REV. STAT. § 327E-1–16 (2023); MONT. CODE § 50-5-1301–1308 (2023).

168. COLO. REV. STAT. § 15-18.5-103 (2023); HAW. REV. STAT. § 327E-2 (2023); MONT. CODE § 50-5-1301 (2023).

169. COLO. REV. STAT. § 15-18.5-103 (2023); HAW. REV. STAT. § 327E-2 (2023); MONT. CODE § 50-5-1301 (2023).

170. COLO. REV. STAT. § 15-18.5-103 (2023); MONT. CODE § 50-5-1301 (2023).

171. HAW. REV. STAT. § 327E-2 (2023).

172. *See* references *supra* note 166.

173. COLO. REV. STAT. § 15-18.5-103 (2023); MONT. CODE § 50-5-1304 (2023).

174. MONT. CODE § 50-5-1304 (2023).

highlight the need for advance planning on the part of patients. In other instances, legislative revision is needed.

1. Determining Familial Relationships and Locating Family Members

Surrogate statutes usually require some initial determination of familial relationships. This begs the question: what responsibility does a health care provider have in determining the accuracy or legality of family relationships? Legislative schemes in most states are designed to protect health care providers from liability.[175] They are not designed to encourage a robust and thorough inquiry into the facts.[176] Rather, the health care provider can usually rely on the unproven assertions by alleged family members.[177] This is usually a reasonable approach. Health care providers are not in a good position to undertake a legal and factual analysis into familial relationships. Yet, this approach does run the risk of allowing health care providers to inject their own biases into the decision-making process. While statutory regimes often allow health care providers to rely on unproven assertions of familial relationships, they do not prevent health care providers from demanding more exacting proof of familial relationships. Demands for more exacting proof could be used to discriminate in some instances.

Many state hierarchy statutes, including Louisiana's,[178] direct health care providers to consult with those individuals who are *reasonably available*[179] or who can be located by *reasonable efforts*.[180] These terms are defined in some states but not others. The jurisprudence has not explored the parameters of these terms. In California, the term "means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care

175. *See, e.g.*, ALA. CODE § 22-8A-11 (2023) (providing that health care providers are entitled to rely on an attestation by a surrogate that the surrogate is authorized to act as such and that the health care provider is not under "a duty to investigate the truthfulness of the information").

176. *See, e.g., id.*

177. *See id.*; *accord* GA. CODE § 31-9-6 (2023); LA. REV. STAT. § 40:1159.4(G) (2023).

178. *See* LA. REV. STAT. § 40:1151.4 (2023); *id.* § 40:1159.4.

179. *See, e.g.*, ARK. CODE § 20-6-102 (2023); DEL. CODE tit. 16, § 2507 (2023); LA. REV. STAT. § 40:1159.4 (2023); MONT. CODE § 50-9-106 (2023); NEV. REV. STAT. § 449A.454 (2023); VT. STAT. tit. 18, § 9731 (2023).

180. *See, e.g.*, HAW. REV. STAT. § 327E-5 (2023); WASH. CODE § 7.70.065 (2023).

needs."[181] Some other states have similar definitions.[182] Vermont defines *reasonably available* as meaning "able to be contacted with a level of diligence appropriate to the seriousness and urgency of a principal's health care needs, and willing and able to act in a timely manner considering the urgency of the principal's health care needs."[183] The *reasonableness* qualifier is a sensible one. Health care decisions often need to be made quickly, and in many cases, it is not practical to gather consent of the entire class of relatives permitted to weigh in on an issue. However, this flexibility may also present an opportunity to discriminate against certain family members by simply deeming them unavailable.

2. Multiple People in Same Class

Hierarchy statutes can be difficult to implement when there are multiple individuals in the same class. Co-agents and multiple default decision makers in the same class present slightly different issues. Each issue is considered below.

a. Co-Agents

Some clients want to appoint co-agents for their health care decisions. Co-agents can cause some unique problems. If all co-agents are present but disagree on the appropriate course of action, how should a health care provider proceed? If a document appoints co-agents, can the health care provider rely on directions made by one co-agent in the absence of the other co-agent? The law in this area is poorly defined in Louisiana. The Civil Code articles governing mandate provide no answer to either question.[184] The General Consent Statutes arguably adopt a majority rule approach in the case of disagreement among co-agents.[185] The legislative wording, however, is sloppy. The wording of the General Consent Statute suggests that a majority rule approach applies when the patient does not agree with themself—a rather unlikely scenario.[186] Even if the majority rule approach does apply, it is not helpful if there are only two co-agents present and they disagree with each other. There is simply no clear guidance for how an impasse should be resolved. The Qualified Consent Statute has some additional problems. While the Qualified Consent Statute

181. CAL. PROB. CODE § 4635 (2023).
182. *E.g.*, N.M. STAT. § 24-7A-1 (2023).
183. VT. STAT. tit. 18, § 9701 (2023).
184. *See* LA. CIV. CODE arts. 2989–3032 (2023).
185. *See* LA. REV. STAT. § 40:1159.4(B) (2023).
186. *See id.*

also has a majority rule provision, it does not appear to apply to agents.[187] This creates yet another inconsistency between the two statutory regimes. Clearly, the law should contemplate this reasonably common scenario, and the default rule should be the same under all relevant statutory regimes.[188]

b. Multiple Persons in Highest Class Under Hierarchy Statutes

Hierarchy statutes can be problematic when there is more than one person in the highest-ranking class. What happens if the members of the class are not in agreement with each other? Some states, like Louisiana,[189] take a majority-rule approach.[190] Statutes in other states are vague or silent on the issue.[191] Some essentially force the parties to go to court if they cannot reach a unanimous decision.[192] Clarity is obviously desirable, and Louisiana's majority-rule approach seems reasonably clear and efficient. But, as is pointed out above, it is unclear what would happen if the vote has an even split. Legislative attention is needed to address that particular issue.

3. Non-Marital Romantic Relationships

Non-marital romantic partners are not accounted for by the surrogate statutes of most states. Hierarchy surrogate statutes usually confer the highest priority on the patient's spouse absent advance planning by the patient.[193] Yet, few states confer any rights on a non-marital partner in a spouse-like relationship with the patient. Given declining marriage rates and the increase in non-marital pairings, Louisiana should consider making an appropriate provision for non-marital romantic partners.

A handful of states do give consideration to non-marital romantic partners.[194] Louisiana could look to these states for model legislation. In Maine, authority falls first to the "spouse, unless legally separated" and next to the "adult who shares an emotional, physical and financial

187. *Id.* § 40:1151.4.

188. By comparison, Louisiana's trust laws do have default laws relating to co-trustees. *See id.* §§ 9:2113–2114.

189. *See id.* § 40:1151.4(A)(3); *id.* § 40:1159.4(C).

190. *See* IND. CODE § 16-36-1-5(e) (2023); S.C. CODE § 44-66-30 (2023); VA. CODE § 54.2-2986 (2023).

191. *See* DEL. CODE tit. 16, § 2507 (2023).

192. *See* S.C. CODE § 44-66-30 (2023).

193. *See infra* Part II.B.1.

194. ME. REV. STAT. § 5-806 (2023); N.M. STAT. § 24-7A-5 (2023).

relationship with the patient similar to that of a spouse."[195] New Mexico uses a slightly different wording to accomplish a similar result.[196] Authority in New Mexico falls first to the spouse and then to "an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being."[197] These approaches may better reflect widespread societal preferences.

Absent legal recognition, non-marital partners should take extra care to document their desires in advance. A non-martial partner may qualify as a friend in states that recognize friends in their surrogate statutes.[198] Recognition as a friend, however, will often be inadequate because friends are usually much lower in the hierarchy than other relatives. Absent statutory friend provisions, non-marital partners are usually treated as strangers to the patient.

4. LGBTQ+ Clients

Existing statutory regimes often fail to address the needs of members of the LGBTQ+ community and their children. LGBTQ+ clients face some unique obstacles. Some LGBTQ+ individuals do not disclose their identities to family members out of fear of rejection or discrimination by those family members.[199] Lack of disclosure and outright discrimination can create real conflict among an incapacitated patient's family members, health care agent, and romantic partners. Health care providers may also view care and decision making through a heteronormative lens, leading to additional discrimination and undermining the quality of patient care.[200] Even when an LGBTQ+ patient has engaged in advance planning, the patient might justifiably fear that biased health care providers and institutions will ignore that documentation.[201]

195. ME. REV. STAT. § 5-806 (2023).
196. N.M. STAT. § 24-7A-5 (2023).
197. *Id.*
198. *See, e.g.*, GA. CODE § 31-9-2 (2023); LA. REV. STAT. § 40:1159.4 (2023).
199. *E.g.*, Buckey & Browning, *supra* note 7, at 238.
200. *E.g.*, *id.*
201. *Id.*

a. Parent-Child Relationships

Hierarchy statutes may not adequately empower the children of LGBTQ+ parents to make decisions for their parents. In the absence of a spouse, hierarchy statutes in most states, including Louisiana, confer decision-making authority on the patient's adult children.[202] This appears to be consistent with the real life advance-planning decisions made by most unmarried people with children.[203] After the patient's adult children, hierarchy statutes often confer authority to either of the patient's parents.[204] LGBTQ+ parents, however, have often found it difficult to be recognized as the legal parents of their own children.[205]

Though recent U.S. Supreme Court decisions[206] have ameliorated some of the harms discriminatory legislation caused, many real barriers to parental rights for LGBTQ+ parents remain.[207] The parent-child relationship between some LGBTQ+ parents and their children may not be legally recognized. In some cases, the parent-child relationship was established before more recent liberalization of the laws, and the family has not since sought formal legal recognition. In other cases, remaining discriminatory laws may still preclude the legal recognition of the parent-child relationship.[208] In the absence of a legally recognized parent-child relationship, these families are not adequately provided for by the hierarchy statutes. A health care provider might simply accept a parent's or child's assertion that a legal parent-child relationship exists without requiring more exacting legal proof such as adoption papers or a birth certificate. A health care provider or facility with discriminatory views or policies, however, might easily thwart the decision-making authority of a LGBTQ+ parent or child by demanding exacting proof of a legal

202. *See, e.g.*, LA. REV. STAT. § 40:1159.4 (2023).

203. *See* Carr & Khodyakov, *supra* note 127, at 188; Galambos et al., *supra* note 100, at 231 (Given the age and life stage of the subjects in this study, it is reasonable to assume that many had outlived their spouses.).

204. *See, e.g.*, LA. REV. STAT § 40:1159.4 (2023).

205. *See generally* Mary Kay Kisthardt & Richard A. Roane, *Who is a Parent and Who is a Child in a Same-Sex Family?—Legislative and Judicial Issues for LGBT Families Post-Separation, Part II: The U.S. Perspective*, 30 J. AM. ACAD. MATRIM. L. 55 (2017).

206. *See* Pavan v. Smith, 137 S. Ct. 2075 (2017); Obergefell v. Hodges, 576 U.S. 644 (2015).

207. *See* Kisthardt & Roane, *supra* note 205.

208. *See, e.g.*, Adar v. Smith, 639 F.3d 146 (5th Cir. 2011) (affirming Louisiana's refusal to reissue an adoptive child's birth certificate in the names of same-sex parents); Cook v. Sullivan, 330 So. 3d 152 (La. 2021) (denying parental rights to non-biological mother of child).

relationship. Other family members that disapprove of the parent-child relationship might also interject themselves into the decision-making process and raise the lack of a legally recognized parent-child relationship as an issue.

At a minimum, the Louisiana legislature should revise its laws to include a more expansive view of the parent-child relationship to adequately account for those relationships that were adversely impacted by historical discrimination. More importantly, the Louisiana legislature should embark on a wholesale review of Louisiana law to remove and remedy the hateful and discriminatory provisions aimed at LGBTQ+ individuals. Until such changes are made, attorneys should ensure that LGBTQ+ clients have adequate advance-planning documents in place.

b. Spousal Relationships

Although same-sex marriage is legal throughout the country, some LGBTQ+ couples may not find adequate protection in the hierarchy surrogate statutes. LGBTQ+ couples may have simply decided not to marry for any number of reasons. Historical exclusion from marriage may have convinced some couples to forgo marriage entirely. Some LGBTQ+ couples may simply be following the declining marriage trends more generally.[209] Actual or anticipated intolerance by a LGBTQ+ person's family may also result in marriage avoidance. Regardless of the cause, unmarried romantic couples are rarely adequately provided for by hierarchy surrogate statutes, regardless of their sexuality or sexual identity.[210] To better address the needs of these individuals, legislatures should consider affording recognition to non-marital romantic partners, as discussed in Part II.C.3 above.

Even where a LGBTQ+ client has a legal marriage or has executed advance-planning documents, discrimination by family members and health care providers can present real barriers. A LGBTQ+ client might have hidden their sexuality, sexual identity, and even their legal marriage from members of their immediate family. Some family members may dispute the existence of the relationship. This sort of family dispute may place an undue burden on the legal spouse and place health care providers in a difficult situation when trying to identify the appropriate decision-maker. More nefariously, family conflict may give a health care provider

209. Dian Zhang, *Valentine's Day is a time for engagements. Where are Americans tying the knot?*, USA TODAY (Feb. 14 2023, 7:40 AM ET), https://www.usatoday.com/story/life/2023/02/14/wedding-planning-marriage-rates-by-state-database/11212435002/ [https://perma.cc/BZ4Q-S4UE].

210. *See* discussion *supra* Part II.C.3.

the confidence to discriminate against the LGBTQ+ patient's spouse by demanding more exacting proof of the marriage relationship than what would ordinarily be required.

5. Divorcing Spouses

Existing laws often fail to appropriately address the needs and desires of divorcing spouses. As discussed above, divorce does not appear to affect the appointment of a spouse in a Louisiana medical power of attorney, an obvious shortcoming.[211] In most states, including Louisiana, divorced spouses will no longer have decisional authority under surrogate statutes. Yet, lingering problems remain, and Louisiana's approach is particularly troublesome.

All divorces take time. No fault divorces in Louisiana require a waiting period ranging from six months to two years depending on whether the couple has minor children and whether the marriage is a covenant marriage.[212] No fault divorces in Louisiana generally take one of two procedural routes. The couple may live apart for the requisite time period and then go to court and seek an immediate divorce.[213] Alternatively, the couple may first file for divorce, then live apart for the requisite period of time, then return to court to obtain a judgment of divorce.[214] Both procedural routes involve a significant delay between the decision to divorce and the actual termination of the marriage. Most divorcing couples would likely prefer to terminate spousal-decision-making authority at the beginning of that interim period rather than waiting until the judgment of divorce.

Louisiana's General Consent Statutes and Qualified Patient Statutes fail to adequately account for that interim period. Both statutory regimes grant decision-making authority to "[t]he patient's spouse not judicially separated."[215] Tying the termination of decisional authority to legal separation is wholly inadequate because legal separation is a rarity in Louisiana. In 1990, the notion of legal separation was essentially terminated legislatively.[216] Today, legal separation is only a legal remedy

211. *See* discussion *infra* Part II.A.3.c.

212. *See* LA. CIV. CODE art. 103.1 (2023); LA. REV. STAT. § 9:307 (2023).

213. *See* LA. CIV. CODE arts. 103, 103.1 (2023); LA. REV. STAT. § 9:307 (2023).

214. *See* LA. CIV. CODE art. 102 (2023); LA. REV. STAT. § 9:307 (2023).

215. LA. REV. STAT. § 40:1151.4 (2023); *id.* § 40:1159.4.

216. *See* Monica Hoff Wallace, *A Primer on Divorce in Louisiana*, 64 LOY. L. REV. 617, 621 (2019).

for the handful of couples in covenant marriages.[217] For the vast majority of married Louisianians who do not have a covenant marriage,[218] the term *legal separation* offers no relief at all. The term is probably also inadequate for some divorcing couples in covenant marriages because they may divorce without first obtaining a legal separation.[219] Quite simply, there are better indicators that a marriage is effectively over and that the spouse should no longer be a default decision maker.

Louisiana's Qualified Patient Statutes also contemplate terminating spousal authority when the patient's spouse "is cohabited with another person in the manner of married persons."[220] The General Consent Statutes have no comparable rule, leading to a potentially problematic conflict. Presumably, the cohabitation language was a legislative attempt to capture people whose marriages are over but who were not yet divorced. It is poorly designed and is both over and underinclusive. Many marriages end without either spouse immediately co-habiting with new romantic partners. The cohabitation test, therefore, fails to account for spouses who are living apart with the intention of divorcing but who have not yet jumped into new relationships. The cohabitation test is also over-inclusive because it runs the risk of removing decision-making authority from a spouse in an in-tact marriage where the spouses are part of a less traditional romantic arrangement, such as a polyamorous relationship involving cohabitation.

A better approach is to tie the definition of spouse in the medical-decision-making context to the social and legal reality of the divorce process. At a minimum, a spouse's decision-making authority should terminate upon the filing of a petition for divorce, or some other filing made in anticipation of divorce, by either spouse. A similar approach is taken in several other states.[221] Perhaps an even better approach would be to also terminate the decision-making authority of spouses who are living separate and apart for divorce purposes but who have not yet filed for divorce.

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217. *See id.* at 622.

218. *See id.* at 619 (asserting that "covenant marriages account for less than 1% of marriages in Louisiana").

219. *See* LA. REV. STAT. § 9:307 (2023).

220. *Id.* § 40:1151.1.

221. *See, e.g.*, DEL. CODE tit. 16, § 2507 (2023); IND. CODE § 16-36-1-9.5 (2023); MD. CODE § 5-605 (2023); OHIO CODE § 2133.08 (2023); 20 PA. CONS. STAT. § 5430 (2023); S.C. CODE § 44-66-30 (2023).

6. Step-Relationships and Similar Relationships

Surrogate statutes rarely grant decisional authority to individuals other than spouses who are not related by blood or by adoption. Although most statutes allow parents to make decisions for children and vice versa, that authority is rarely extended to step-relatives.[222] Louisiana has a somewhat limited exception to this generalization.[223] Louisiana's General Consent statutory regime includes an express preference for a liberal interpretation including "the marital, adoptive, foster and step-relations as well as the natural whole blood."[224] Yet, Louisiana's Qualified Patient statutory regime does not include a similar interpretive rule. This inconsistency results in yet another legislative conflict that should be remedied. Further, the legislature should thoughtfully consider the circumstances under which step-relatives should be granted decision-making authority.

7. Domestic Abuse and Elder Abuse

The existing statutory regimes often fail to adequately account for victims of domestic abuse, elder abuse, or similar abusive relationships. Should a decision-maker recognized by the default statute be allowed to make decisions when there is an abusive relationship between the decision maker and the patient? Many statutory regimes ignore the issue completely. Some surrogate statutes attempt to address the issue,[225] with varying degrees of success. Interestingly, states that disqualify default surrogates in cases of abuse or violence do not usually apply the same rule to agents appointed by the patient in advance-planning documents or to court-appointed decision makers.[226] They probably should.

The federal HIPAA regulations offer some measure of relief. Health care providers subject to HIPAA may refuse to turn over medical records or share other protected health care information with a surrogate health care decision maker if a two-part test is satisfied.[227] First, the provider must

222. Georgia is an exception to that general rule. *See* GA. CODE § 31-9-6 (2023).

223. *See* LA. REV. STAT. § 40:1159.6(A) (2023).

224. *Id.*

225. *See* DEL. CODE tit. 16, § 2507 (2023); IND. CODE § 16-36-1-9.5 (2023); MD. CODE § 5-605 (2023); NEB. REV. STAT. § 30-604 (2023); TENN. CODE § 68-11-1806 (2023).

226. *See* DEL. CODE tit. 16, § 2507 (2023); IND. CODE § 16-36-1-9.5 (2023); MD. CODE § 5-605 (2023); NEB. REV. STAT. § 30-604 (2023); TENN. CODE § 68-11-1806 (2023).

227. 45 C.F.R. § 164.502 (2023).

have a "reasonable belief" that the patient "has been or may be subjected to domestic violence, abuse, or neglect by such person; or [t]reating such person as the personal representative could endanger the individual."[228] Second, the provider must also decide that "in the exercise of professional judgment . . . it is not in the best interest of the individual to treat the person as the individual's personal representative."[229] The HIPAA regulation essentially allows the health care provider to refuse to share a patient's medical records with the surrogate decision maker if the health care provider determines there is a risk of harm or an abusive relationship. The regulation appears to be most useful in protecting minors from having their health care records disclosed to their parents.[230] The regulation does not speak to the ability of a health care provider to disregard the authority of an otherwise authorized surrogate decision maker in cases of suspected abuse. Rather, that issue falls to state law.

Among the states that address abusive situations, many look to whether a protective order has been granted or whether there are relevant criminal proceedings.[231] Delaware, for example, prohibits a person from serving as surrogate decision maker if "the patient has filed a petition for a Protection From Abuse order against the individual or if the individual is the subject of a civil or criminal order prohibiting contact with the patient."[232] Similarly, in Arkansas, "a person who is the subject of a protective order or other court order that directs that person to avoid contact with the principal is not eligible to serve as the principal's surrogate."[233] Statutes tied to existing protective orders may have the benefit of providing a bright-line rule for health care providers. In reality, however, these statutes are far too narrow because most abuse victims do not have protective orders in place. Even if protective orders are in place, it is unclear how the health care provider is supposed to become aware of the existence of that protective order. Afterall, an incompetent patient is unlikely to be able to inform the health care provider of the existence of the protective order.

Louisiana's surrogate statutes address abuse in very limited contexts. The General Consent Statutes contain no provisions relating to abuse. Louisiana's Qualified Patient Statutes exclude certain abusive spouses—but not other default decision makers—from making decisions for the

228. *Id.*

229. *Id.*

230. *See, e.g.*, *In re* Berg, 886 A.2d 980 (2005) (father seeking access to child's therapy records in custody dispute).

231. DEL. CODE tit. 16, § 2507 (2023); IND. CODE § 16-36-1-9.5 (2023).

232. DEL. CODE tit. 16, § 2507 (2023).

233. ARK. CODE § 20-6-105 (2023).

incompetent patient.[234] As used in the Louisiana Qualified Patient Statutes, the term *spouse* excludes a spouse "who has been convicted of any crime of violence as defined in R.S. 14:2(B) against the other spouse, that has resulted in the terminal and irreversible condition as defined in Paragraph (15) of this Section, or who has violated any domestic abuse protective order affecting the other spouse."[235] This exclusion is practically useless. By requiring either a criminal conviction or a violated protective order, the definition offers no relief for most victims of domestic violence. It is also unclear how a health care provider should determine whether a spouse has a previous conviction or whether a protective order has been violated. After all, the victim-patient will be unable to communicate that information if the patient is a qualified patient and unable to communicate with health care providers. The exclusion is also too narrow because it is limited to spousal relationships. Thus, the exclusion will not apply in most cases of elder abuse or other types of family abuse or violence. The requirement that the crime of violence have "resulted in the terminal and irreversible condition" also seems too restrictive.[236] Why should decision rights only be terminated if the criminal act was so severe as to result in a terminal condition? Surely other criminal acts of violence sufficiently demonstrate that a surrogate should not be trusted to make decisions for the victim of their violent act. Similarly, why should the violation of a protective order be required? Is the existence of the protective order not sufficient evidence to call the abusive spouse's ability to make good decisions for the incapacitated patient-victim into question?

There are some obvious legislative corrections needed in this setting. At a minimum, the scope of Louisiana's abuse rule should apply to more individuals than spouses. The rule should be broadened to apply to any surrogate decision maker, including an agent appointed in advance-planning documents. The abuse rules should also be unified so that the same rule applies in all settings where a surrogate decision maker is authorized to act. For example, the rule should apply to Qualified Patient Statutes, General Consent Statutes, and similar regimes. Louisiana should also broaden the circumstances when abuse is relevant. At a minimum, the existence of a protective order should be sufficient to terminate the authority of a patient appointed or statutorily anointed decision maker, as is the case in many other states. Louisiana's existing rule only applies if there is a criminal conviction that resulted in the patient's terminal

234. *See* LA. REV. STAT. § 40:1151.1(13) (2023).
235. *Id.*
236. *Id.*

condition or if a protective order has been violated.[237] This requires too high of an evidentiary standard to be usable. Finally, health care providers should be given access to the Louisiana Protective Order Registry and encouraged to consult it whenever a surrogate decision maker is suspected of abuse.[238]

Louisiana could go even further in allowing health care providers to protect patients from abusive situations. Nebraska law, for example, gives a health care provider the discretion to disqualify a surrogate "if the provider has documented or otherwise clear and convincing evidence of an abusive relationship or documented or otherwise clear and convincing evidence of another basis for finding that the potential surrogate is not acting on behalf of or in the best interests of the individual."[239] This approach is not without risk, and Louisiana should carefully consider how best to strike the appropriate balance of various competing concerns.[240]

III. WHAT DECISIONS CAN A SURROGATE OR AGENT MAKE?

The scope of a surrogate decision maker's authority depends on three primary factors: (1) the specific treatment decision involved; (2) evidence required by the applicable state law of the patient's wishes; and (3) the extent of prior planning, if any, on the part of the patient.

Different treatment decisions sometimes require different types of evidence. For example, a surrogate decision maker, whether appointed in advance by the patient or acting under a surrogate statute, might be able to make ordinary medical decisions without evidence of specific directions on the part of the patient prior to the patient's incapacity. Certain other decisions—particularly those relating to end-of-life decisions and reproductive rights—sometimes require evidence of the patient's wishes with respect to a particular course of action. Advance-planning documentation is important to fully empower a surrogate decision maker. The laws are complex and can vary significantly from state-to-state. The following Subparts will attempt to provide a general overview of the major legal issues involved and provide guidance for ensuring multi-state usability of documents.

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237. *Id.*

238. *See* LA. REV. STAT. § 46:2136.2 (2023).

239. NEB. REV. STAT. § 30-604 (2023).

240. For a cautionary tale, see *Bohn v. Providence Health Services*, 484 P.3d 584 (Alaska 2021).

A. Ordinary Medical Decisions

Many states set forth a statutory decision-making standard that applies to agents or surrogates making ordinary medical decisions on a patient's behalf. Although precise articulations of the standard vary, some generalizations are possible. Agents or surrogates are often directed to make decisions in good faith, in accordance with the patient's previously expressed wishes, if they are known, and in the patient's best interest considering a variety of factors. In Georgia, for example, the person giving consent for the patient is instructed to "act in good faith to consent to surgical or medical treatment or procedures which the patient would have wanted had the patient understood the circumstances under which such treatment or procedures are provided."[241] Similarly, Massachusetts law directs that decisions be made: "(i) in accordance with the agent's assessment of the principal's wishes, including the principal's religious and moral beliefs, or (ii) if the principal's wishes are unknown, in accordance with the agent's assessment of the principal's best interests."[242]

Louisiana law does not articulate any particular decision-making standard with respect to health care decisions.[243] However, an obligation to act in good faith is probably inherent under Louisiana's civil law system regardless of whether it is stated expressly.[244] Advance-planning documents might include directive or precatory language to help guide agents in making decisions. Other bodies of Louisiana law might also offer guidance in some situations. An agent or mandatary, for example, is bound to act in good faith[245] and to "fulfill with prudence and diligence the mandate he has accepted."[246] Similarly, a curator serving as decision-maker will also be bound by the more general decision-making standards applicable to curators. Curators are also subject to an obligation of good faith[247] and are required to "exercise reasonable care, diligence, and prudence and [to] act in the best interest of the interdict."[248] The Louisiana legislature should study the issue and consider whether an express statutory standard is advisable.

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241. GA. CODE § 31-9-2 (2023); *accord* TEX. HEALTH & SAFETY CODE § 313.004 (2023) (directing the decision maker to make decisions "based on knowledge of what the patient would desire, if known").

242. MASS. GEN. LAWS ch. 201D, § 5 (2023).

243. *See* LA. REV. STAT. § 40:1159.4 (2023).

244. Carter, *supra* note 69, at 672.

245. *Id.*

246. LA. CIV. CODE art. 3001 (2023).

247. Carter, *supra* note 69, at 672.

248. LA. CIV. CODE art. 392 (2023).

B. End-of-Life Decisions for Qualified Patients

Many states require specific evidence or findings before a patient or surrogate decision maker can consent to the withdrawal or withholding of life-sustaining treatment. Most states have statutes that govern the withholding or withdrawal or *life-sustaining treatment* or *life-prolonging treatment* of so-called *qualified patients*. The nuances of state statutes vary, of course, but there are some common terms and themes.

1. Definitions

a. Patient Must be a "Qualified Patient"

Generally, life support must be provided to an incompetent patient unless the patient is determined to be a "qualified patient." A qualified patient is one who is in some sort of terminal and irreversible state where death is likely to result in a relatively short timeframe. The term *qualified patient* is often used in advance-planning documents to reference the state law.

While many states, including Louisiana, use the term *qualified patient*, they do not use any uniform definition. In Louisiana, a qualified patient must have a "terminal and irreversible condition" which is defined as "a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death."[249] A qualified patient in Iowa is one with a "terminal condition."[250] A terminal condition, in Iowa, is

> an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.[251]

249. LA. REV. STAT. § 40:1151.1 (2023).
250. IOWA CODE § 144A. 2 (2023).
251. *Id.*

Definitions in other states are similar.[252] There are, however, subtle variations that may be meaningful in some clinical contexts.

b. Certification Required

Most states will require a certification by one or more physicians that the patient meets the criteria for being a qualified patient. Some states also permit advanced practice registered nurses[253] or physicians assistants[254] to certify patients as qualified patients. Usually, certification must be made by the *attending physician, attending advanced practice registered nurse*, or *attending physician assistant* in states that permit nurse or PA certification.[255] The *attending physician* is usually defined, by statute, as the physician who has the primary responsibility for treating the patient.[256]

In some states, the opinion of only one health care provider is sufficient to certify the patient as a qualified patient.[257] Other states require a second opinion.[258] Louisiana requires written certification "by two physicians who have personally examined the patient, one of whom shall be the attending physician."[259] More nuanced approaches also exist. In Washington, for example, the number of opinions required depends on the reason the patient is a qualified patient.[260] The attending physician, acting alone, can certify that a patient is a qualified patient due to a terminal condition.[261] The opinion of a second physician, however, is required to

252. *See* NEV. REV. STAT. §§ 449.A427, 449A.430 (2023); TEX. HEALTH & SAFETY CODE §§ 166.002, 166.031 (2023).

253. *See* NEV. REV. STAT. § 449A.427 (2023).

254. *See* N.H. REV. STAT. § 137-J:2 (2023).

255. *See, e.g.*, NEV. REV. STAT. § 449A.427 (2023); N.H. REV. STAT. § 137-J:2 (2023).

256. *See, e.g.*, COLO. REV. STAT. § 15-18-103 (2023) ("the physician, whether selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient"); KAN. STAT. § 65-28.102 (2023) ("the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient").

257. *See, e.g.*, 755 ILL. COMP. STAT. 35/2 (2023) (certification only by "attending physician"); R.I. GEN. LAWS § 23-4.11-2 (2023) (certification only by "attending physician").

258. *See, e.g.*, COLO. REV. STAT. § 15-18-103 (2023) (certification by "attending physician and one other physician"); KAN. STAT. § 65-28.102 (2023) (certification by "two physicians who have personally examined the patient, one of whom shall be the attending physician").

259. LA. REV. STAT. § 40:1151.1 (2023).

260. WASH. REV. CODE § 70.122.020 (2023).

261. *Id.*

certify the patient as a qualified patient due to a "permanent unconscious condition."[262]

c. Life-Sustaining Treatment or Life-Prolonging Treatment, Defined

The Qualified Patient Statutes usually also define *life-sustaining treatment* or *life-prolonging treatment*. Definitional approaches vary. Some states define the terms broadly. Arkansas, for example, defines life-sustaining treatment broadly as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying or to maintain the patient in a condition of permanent unconsciousness."[263] Other state statutes include illustrative lists of treatments that are included in the scope of life-sustaining treatment.[264] In Louisiana, a life-sustaining procedure "means any medical procedure or intervention which, within reasonable medical judgment, would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition, including such procedures as the invasive administration of nutrition and hydration and the administration of cardiopulmonary resuscitation."[265] New Hampshire's illustrative list is more comprehensive. It defines life-sustaining treatment as "any medical procedures or interventions which utilize mechanical or other medically administered means to sustain, restore, or supplant a vital function."[266] The statute goes on to explain that life-sustaining treatment "includes, but is not limited to, the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis, or the use of other external mechanical or technological devices."[267] It may also include "drugs to maintain blood pressure, blood transfusions, and antibiotics."[268] Alabama also has an illustrative list that includes "assisted ventilation, cardiopulmonary resuscitation, renal dialysis, surgical procedures, blood

262. *Id.*
263. ARK. CODE § 20-17-201 (2023).
264. *See, e.g.*, MONT. CODE § 50-9-102 (2023) ("any medical procedure or intervention that, when administered to a qualified patient, serves only to prolong the dying process"); NEB. REV. STAT. § 20-403 (2023) ("any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying or maintain the qualified patient in a persistent vegetative state").
265. LA. REV. STAT. § 40:1151.1 (2023).
266. N.H. REV. STAT. § 137-J:2 (2023).
267. *Id.*
268. *Id.*

transfusions, and the administration of drugs and antibiotics."[269] Some statutory regimes, including Louisiana's, make it clear that life-sustaining treatment does not include palliative care.[270]

2. Withholding or Withdrawing Life-Sustaining Treatment

If a patient is a qualified patient, then it may be appropriate to terminate or withdraw life-sustaining treatment, including nutrition and hydration. If the patient is not competent to express the patient's own wishes, then the decision rests with the agent or surrogate decision maker. The authority of the agent or surrogate to make decisions varies by state, but some generalizations are possible. First, many states will set out some decision-making standard for the surrogate.[271] Second, a number of states draw a distinction between life-sustaining treatments and medically administered nutrition and hydration.[272] The cessation of nutrition and hydration sometimes requires more exacting proof of the patient's desires.

a. Decision-Making Standard for Withdrawing or Withholding Life-Sustaining Treatment (Other than Nutrition and Hydration)

In many states, a surrogate decision maker is bound by a substituted judgment and best interests standard when making decisions regarding life-sustaining treatment for qualified patients.[273] Under this approach, the surrogate is first directed to make decisions in accordance with the patient's previously expressed wishes or in a manner consistent with the patient's moral, religious, and other beliefs.[274] If, however, the patient's desires are unknown, many states then direct that the surrogate make decisions according to the patient's best interests.[275]

State statutes articulate these standards in varying ways. Some states, like Illinois, give a detailed list of considerations for the surrogate:

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269. ALA. CODE § 22-8A-3 (2023).

270. *Id.*; LA. REV. STAT. § 40:1151.1 (2023); N.H. REV. STAT. § 137-J:2 (2023).

271. *See* 755 ILL. COMP. STAT. 40/20 (2023); N.Y. PUB. HEALTH § 2994-d (2023).

272. *See* 755 ILL. COMP. STAT. 40/20 (2023); N.Y. PUB. HEALTH § 2994-d (2023).

273. *See* 755 ILL. COMP. STAT. 40/20 (2023); N.Y. PUB. HEALTH § 2994-d (2023).

274. *See* 755 ILL. COMP. STAT. 40/20 (2023); N.Y. PUB. HEALTH § 2994-d (2023).

275. *See* 755 ILL. COMP. STAT. 40/20 (2023); N.Y. PUB. HEALTH § 2994-d (2023).

> A surrogate decision maker shall make decisions for the adult patient conforming as closely as possible to what the patient would have done or intended under the circumstances, taking into account evidence that includes, but is not limited to, the patient's personal, philosophical, religious and moral beliefs and ethical values relative to the purpose of life, sickness, medical procedures, suffering, and death. Where possible, the surrogate shall determine how the patient would have weighed the burdens and benefits of initiating or continuing life-sustaining treatment against the burdens and benefits of that treatment . . . If the adult patient's wishes are unknown and remain unknown after reasonable efforts to discern them or if the patient is a minor, the decision shall be made on the basis of the patient's best interests as determined by the surrogate decision maker. In determining the patient's best interests, the surrogate shall weigh the burdens on and benefits to the patient of initiating or continuing life-sustaining treatment against the burdens and benefits of that treatment and shall take into account any other information, including the views of family and friends, that the surrogate decision maker believes the patient would have considered if able to act for herself or himself.[276]

In some states, the presumption favoring the continuation of treatment is very difficult to overcome without advance planning on the part of the patient. Nebraska law only permits the surrogate to withhold or withdraw life-sustaining treatment if the treatment "would be an extraordinary or disproportionate means of medical treatment to the individual" and "the individual explicitly grants such authority to the surrogate and the intent of the individual to have life-sustaining procedures or artificially administered nutrition or hydration withheld or withdrawn under such circumstances is established by clear and convincing evidence."[277]

Louisiana law is somewhat unique in that it does not set forth any specific decision-making standard. Advance-planning documents in Louisiana certainly could include their own directive or precatory decision-making standards. For example, a patient's advance-planning documents might direct the agent to "make decisions in accordance with my best interests" or to make those decisions that the agent "believes that I would have made under the circumstances." Absent that sort of guidance,

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276. 755 ILL. COMP. STAT. 40/20 (2023); *accord* N.Y. PUB. HEALTH § 2994-d (2023).

277. NEB. REV. STAT. § 30-610 (2023).

however, it is unclear what, if any, standard applies to decisions made by surrogates.

b. Decision-Making Standard for Nutrition and Hydration

In many states, the decision to withdraw or withhold medically administered nutrition and hydration is made according to the exact same standard as other types of life-sustaining treatment decisions. Louisiana presumably falls in this category because Louisiana does not specify any specific standard for either decision. Some states, however, subject the decision to withdraw or withhold medically administered nutrition and hydration to a different, usually more onerous, standard.

Oklahoma law creates a presumption that "every incompetent patient has directed his health care providers to provide him with hydration and nutrition to a degree that is sufficient to sustain life."[278] Absent explicit directions from the patient while the patient was competent, the presumption is difficult to overcome.[279] If death would result from lack of nutrition or hydration, then withdrawal is only permitted if the "patient's attending physician and a second consulting physician" determine that "artificially administered hydration or artificially administered nutrition will itself cause severe, intractable, and long-lasting pain to the incompetent patient or such nutrition or hydration is not medically possible."[280]

Alabama also applies a more onerous standard in the case of a permanently unconscious patient. Generally, the surrogate decision maker should follow any instructions set forth by the patient in the advance-planning documents.[281] Absent advance planning or relevant instructions, then the surrogate "shall make those decisions that conform as closely as possible to what the patient would have done or intended under the circumstances, taking into account the patient's personal, philosophical, religious and moral beliefs, and ethical values relative to the decisions."[282] Withholding or withdrawing artificial nutrition and hydration from a person who is permanently unconscious, however, "shall only be made upon clear and convincing evidence of the patient's desires."[283] In light of the more onerous standards relating to nutrition and hydration in some

278. OKLA. STAT. tit. 63, § 3080.3 (2023).
279. *See id.* § 3080.4.
280. *Id.*
281. ALA. CODE § 22-8A-6 (2023).
282. *Id.*
283. *Id.* § 22-8A-11.

states, advance-planning documents should address the issue with more specificity than is required by Louisiana law alone.

3. Withdrawal or Withholding of Life-Sustaining Treatment: Pregnant Patients

Pregnant patients face even more barriers to the exercise of personal autonomy. States take a wide variety of approaches relating to the termination or withholding of life-sustaining treatment when the patient is known to be pregnant.[284] The constitutionality of these approaches has not been considered by the courts, and there is very little guidance other than the plain language of state statutes. Adding to the complexity in this area, there is little medical evidence regarding the viability of a fetus in a pregnant patient who is also a qualified patient.

a. Per Se Prohibitions on Withholding or Withdrawal of Life-Sustaining Treatment

Some states invalidate a pregnant patient's advance directive with respect to life-sustaining treatment if the patient is pregnant.[285] In these states, the applicable statutes purport to require the continued administration of life-sustaining procedures until the patient is no longer pregnant, regardless of the patient's previously expressed wishes or those of the patient's family or surrogate decision maker.[286] Prior to the recent decision in *Dobbs v. Jackson Women's Health Organization*, these approaches were arguably unconstitutional.[287] With its decision in *Dobbs*, however, the Supreme Court sent a clear message that states can constitutionally restrict the personal autonomy of pregnant people.

Texas has such a statute that has been considered by a court, though that consideration occurred prior to *Dobbs*.[288] The Texas statute's *per se* prohibition on reproductive autonomy provides that "[a] person may not withdraw or withhold life-sustaining treatment . . . from a pregnant patient."[289] As the case of Marlise Muñoz demonstrated, even a *per se*

284. For a comprehensive, 50-state survey, see Shea Flanagan, *Decisions in the Dark: Why 'Pregnancy Exclusion' Statutes are Unconstitutional and Unethical*, 114 NW. U. L. REV. 969 (2020).

285. *Id.*

286. *Id.*

287. Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

288. TEX. HEALTH & SAFETY CODE § 166.049 (2023).

289. *Id.*

prohibition can be complicated.[290] Ms. Muñoz suffered an apparent blood clot in her lungs and was discovered by her husband on the kitchen floor.[291] She was 33 years old and 14 weeks pregnant at the time.[292] Doctors declared Ms. Muñoz brain dead.[293] Both Mr. Muñoz and Ms. Muñoz's parents asked that she be taken of life support noting that her wishes were clear.[294] The hospital refused to do so, citing Texas's law.[295] Later exams showed that the fetus was not viable.[296] Mr. Muñoz sued the hospital, essentially arguing that the law did not apply to his wife because his wife was already dead.[297] The district court agreed and ordered that the law did not apply because Ms. Muñoz was brain dead—which meant that she was dead under Texas law.[298] The hospital declined to appeal the decision, and all life-sustaining treatment was terminated.[299] Given the current landscape of reproductive rights post-*Dobbs*, particularly in the most restrictive states like Texas and Louisiana, it is not clear if a court would reach a similar outcome today.

b. Options Depend on Fetus Viability

A handful of states consider the viability of the fetus in determining whether the pregnant patient's advance directive can be honored.[300] How viability is determined varies considerably. In Arkansas, the pregnant patient must continue to receive life-sustaining treatment so "long as it is possible that the fetus could develop to the point of live birth with

290. To learn more about the case, see, for example, Manny Fernandez, *Texas Woman Is Taken off Life Support After Order*, N.Y. TIMES (Jan. 26, 2014), https://www.nytimes.com/2014/01/27/us/texas-hospital-to-end-life-support-for-pregnant-brain-dead-woman.html [https://perma.cc/2U99-7J2G]; Wade Goodwyn, *The Strange Case of Marlise Munoz and John Peter Smith Hospital*, NPR (Jan. 28, 2014, 5:44 PM ET), https://www.npr.org/sections/health-shots/2014/01/28/267759687/the-strange-case-of-marlise-munoz-and-john-peter-smith-hospital [https://perma.cc/G9QU-SAQ2].

291. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

292. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

293. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

294. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

295. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

296. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

297. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

298. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

299. Fernandez, *supra* note 290; Goodwyn, *supra* note 290.

300. *See* ARK. STAT. § 20-17-206(c) (2023); NEV. REV. STAT. § 449A.451 (2023).

continued application of life-sustaining treatment."[301] Nevada uses nearly identical language but uses the word "probable" rather than "possible."[302]

Louisiana considers fetal viability in a somewhat different way. Rather than requiring the continued administration of life-sustaining treatment, Louisiana provides this general interpretive rule:

> It is the policy of the state of Louisiana that human life is of the highest and inestimable value through natural death. When interpreting this Subpart, any ambiguity shall be interpreted to preserve human life, including the life of an unborn child if the qualified patient is pregnant and an obstetrician who examines the woman determines that the probable postfertilization age of the unborn child is twenty or more weeks and the pregnant woman's life can reasonably be maintained in such a way as to permit the continuing development and live birth of the unborn child . . . .[303]

Despite the nuanced approach in Louisiana's statute, the state may actually have a *per se* ban in the post-*Dobbs* era. Louisiana's near-total statutory abortion ban could override the more nuanced approach contained in statutory language above.[304] Indeed, Louisiana hospitals and health care providers have already demonstrated a reluctance to terminate pregnancies in the narrow circumstances that are likely authorized by the near-total abortion ban.[305] Practitioners should anticipate similar resistance on the part of health care providers to recognize the personal autonomy rights of pregnant patients facing the end of life.

c. Patient's Previously Expressed Wishes Respected

Some states grant considerably more deference to the patient's personal autonomy with respect to reproductive decisions. For example, Oklahoma has a default rule that favors the continuation of treatment "unless the patient has specifically authorized, in her own words, that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or

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301. ARK. STAT. § 20-17-206(c) (2023).
302. NEV. REV. STAT. § 449A.451 (2023).
303. LA. REV. STAT. § 40:1151.9 (2023).
304. *See id.* § 40:1061.
305. *See* Sam Karlin, *Doctors say Louisiana's abortion exceptions list has created an atmosphere of terror'*, THE ADVOCATE (Oct. 25, 2022), https://www.theadvocate.com/baton_rouge/news/politics/doctors-say-louisianas-abortion-exceptions-list-has-created-an-atmosphere-of-terror/article_a67daa8a-548b-11ed-a6fa-c39feaf64f6a.html [https://perma.cc/B6FC-DYAX].

withdrawn."[306] Like Louisiana, Oklahoma now has an abortion ban that casts considerable doubt on the continued significance of this permissive statutory language.[307]

4. Other Situations Involving Reproductive Rights

Incompetent patients may be faced with many other difficult decisions relating to reproductive health and reproductive rights beyond just end-of-life decisions. The law in this area is probably even less well defined than in the case of end-of-life decisions. Some of those issues are considered below.

a. Conception While Incompetent

Reports of women who become pregnant despite being in a coma, vegetative state, or who are otherwise wholly incapable of consent are unusual.[308] They do, however, occur. These cases are difficult for various reasons—including the fact that the pregnancy is necessarily the result of some type of sexual assault. There is hardly any legal guidance on the issue, and it is not one that is routinely addressed in advance-planning documents.

b. Procedures Resulting in Sterility

States vary regarding whether a surrogate decision maker can consent to the elective sterilization of a patient. Consent by a surrogate is particularly troublesome when the procedure is essentially elective in nature. The ethical and legal dilemmas stem, in part, from "the sordid history of compulsory eugenic sterilization laws in the United States."[309] The legal issues relating to patients who are permanently unable to provide informed consent, such as those with developmental disabilities, are

306. OKLA STAT. tit. 63, § 3101.8(C) (2023).

307. *See* Associated Press, *Oklahoma governor signs the nation's strictest abortion ban*, NPR (May 26, 2022, 5:58 AM ET), https://www.npr.org/2022/05/26/1101428347/oklahoma-governor-signs-the-nations-strictest-abortion-ban [https://perma.cc/LLW3-4D6M].

308. *See* Elizabeth Chuck, *Pregnancy in women in vegetative states is rare, but not unprecedented*, NBC NEWS (Jan. 12, 2019, 4:06 AM CST), https://www.nbcnews.com/news/us-news/pregnancy-women-vegetative-states-rare-not-unprecedented-n957611 [https://perma.cc/4P3L-BBGH].

309. *In re* Moe, 432 N.E.2d 712, 717 (Mass. 1982) (citing *In re* Grady, 426 N.E.2d 467 (N.J. 1981)).

especially challenging. State laws and health care provider policies generally express a strong preference for patient consent to elective sterilization.

In some states, the surrogate can consent to sterilization if the patient has expressly authorized the surrogate to do so in advance.[310] Individual health care providers, however, may have more restrictive policies in place. In other states, consent to sterilization must be obtained from the patient—not the surrogate.[311] Louisiana purports to be one of those states.

IV. SOME PRACTICAL ADVICE

This Part provides some more practical advice to attorneys who counsel clients on medical and end-of-life decisions. The following Subparts provide practical considerations for ethical and professional work in this difficult area of the law.

A. Ethical and Professional Considerations

Competent end-of-life planning requires attorneys to discuss emotionally and politically charged issues with their clients. Some attorneys may prefer to simply give clients impersonal form documents. Professionalism requires more. All lawyers owe their clients a fundamental duty of competent representation.[312] Competent representation requires attorneys to discuss the difficult questions that they might otherwise want to avoid. Attorneys must be prepared to assist clients

310. *See, e.g.*, ALASKA STAT. § 13.52.050 (2023) ("Unless there is a durable power of attorney for health care or another writing clearly expressing an individual's intent to the contrary, an agent or surrogate may not consent on behalf of a patient to an abortion, sterilization, psychosurgery, or removal of bodily organs except when the abortion, sterilization, psychosurgery, or removal of bodily organs is necessary to preserve the life of the patient or to prevent serious impairment of the health of the patient."); FLA. STAT. § 765.113 (2023) ("Unless the principal expressly delegates such authority to the surrogate in writing, or a surrogate or proxy has sought and received court approval pursuant to rule 5.900 of the Florida Probate Rules, a surrogate or proxy may not provide consent for: (1) Abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56, or voluntary admission to a mental health facility . . . .").

311. *See* LA. REV. STAT. § 40:1159.2 (2023).

312. *See* LA. RULES PRO. CONDUCT r. 1.1 (2022); MODEL RULES OF PRO. CONDUCT r. 1.1 (AM. BAR ASS'N 2022).

whose values may differ than their own—particularly with respect to reproductive choices, religious beliefs, and views about death and dying.

An attorney's personal beliefs relating to various end-of-life issues may create a prohibited conflict of interest. Attorneys are generally prohibited from representing clients when there is a concurrent conflict of interest in the representation.[313] Under Rule 1.7 of both the Louisiana Rules and the Model Rules of Professional Conduct, a concurrent conflict of interest exists when "there is a significant risk that the representation of one or more clients will be materially limited by . . . a personal interest of the lawyer."[314] An attorney whose personal beliefs inhibit the attorney's ability to discuss sensitive issues with clients or inhibits the attorney's willingness to advise clients on the various options available to enable client autonomy has a concurrent conflict of interest that may preclude the attorney from representing clients in the preparation of advance-planning documents.[315] For example, an attorney whose religious or political beliefs would prevent the attorney from helping a client fully document the client's desires to terminate a pregnancy under various circumstances should disclose the conflict and should probably decline the representation.

B. Client Counseling Suggestions

Clients sometimes come with an inaccurate or inadequate understanding of end-of-life decisions, and many lawyers are likewise deficient in their own understanding. To draft effective documents, attorneys must ask clients to express their preferences regarding various end-of-life options. Yet, clients cannot make reasonably informed decisions if they lack a fundamental understanding of end-of-life care.

1. Educating Yourself on the Fundamentals

To provide competent representation, the attorney should have a thorough understanding of the various legal issues discussed in the previous Parts of this Article. Cultural competency and emotional intelligence on the part of the attorney are just as important as an

313. *See* LA. RULES PRO. CONDUCT r. 1.7 (2022); MODEL RULES OF PRO. CONDUCT r. 1.7 (AM. BAR ASS'N 2022).

314. *See* LA. RULES PRO. CONDUCT r. 1.7 (2022); MODEL RULES OF PRO. CONDUCT r. 1.7 (AM. BAR ASS'N 2022).

315. *See, e.g.*, Stephen Gillers, *A Bid to Forbid Bias and Harassment in Law Practice: A Guide for State Courts Considering Model Rule 8.4(G)*, 30 GEO. J.L. ETHICS 195, 234 n.129 (2017).

understanding of the legal issues. Planning for end-of-life decisions requires the lawyer to create legal documents that accommodate a client's individual beliefs and desires. The attorney must approach representation with an open mind and accommodate the unique, and sometimes idiosyncratic, concerns a client may have.

Cultural, moral, and religious identities may impact client decisions about end-of-life care. Attorneys must approach their clients with an open mind and remember that the attorney's own preferences and experiences may differ significantly from those of the client. For example, a client who is a member of any marginalized group may have very valid concerns about receiving adequate and appropriate medical treatment. These clients may be more concerned that they will be denied care rather than that they will be provided with care they do not want.[316] Similarly, cultural identity may affect whether the client prefers to make decisions in advance or if the client prefers that decisions be made by family members.[317] Attorneys should have a basic understanding and appreciation of how cultural, moral, and religious identities may affect client beliefs.

2. Educating Clients on the Fundamentals

Depending on the client's existing knowledge and comfort level, it may be helpful to begin by educating the client on some fundamentals before asking the client to make specific decisions about what language to include in advance-planning documents. At the outset, it may be useful to explain to clients that there are legal safeguards to terminating life support. Some clients are concerned that there are inadequate safeguards protecting their life. These clients are usually reassured to learn about some of the basic features of Qualified Patient Statutes. In particular, some clients' fears are alleviated upon learning that the decision to terminate or withdraw life support is not usually available unless the client meets the statutory definition of a qualified patient.

Some clients find it difficult to make decisions because they have a mistaken belief that their decisions are final. With these clients, it is usually helpful to remind the client that documents can be changed or revised at a later date. Of course, many clients will, in fact, fail to ever update or review their documents. For that reason, among others, the attorney should not pressure the client to make a decision that may not ultimately reflect the client's desires.

316. *See* Steinhauser & Tulsky, *supra* note 1, at 7–8.
317. *See id.*

C. Selecting the Agent

Selecting the agent is one of the most important decisions a client is asked to make in advance-planning documents.[318] Attorneys should emphasize the importance of this decision to their clients and counsel clients on the importance of selecting the right agent. The following discussion considers some of the specific issues that advance-planning documents ought to address with respect to agent selection.

1. Agents and Successors

Attorneys should counsel clients on the qualities that make for a good agent. For example, shared values with the client, trustworthiness, reliability, availability and willingness to serve as agent, ability to communicate effectively with health care providers, ability to make emotionally challenging decisions, and ability to deal with any family dynamics that may arise are important qualities in an agent.[319] Individuals that do not possess these characteristics are usually poorly equipped to serve as a competent agent. Not only should the client appoint an agent, but the client should also name one or more back-up or successor agents to serve in the event the initial agent cannot or will not serve.

2. Curators

An agent's authority might be terminated upon the appointment of a curator—or similar appointment in another state. One way to help ensure continuity of decision making and to reduce the incentive to seek the appointment of a curator is to also contemplate that the agent will be named curator. A client may specify in advance who the client nominates to serve as curator if the client is later interdicted.[320] Although the advance nomination of a curator is not absolutely binding in Louisiana, courts are required to give preference to such a nomination.[321] Laws in other states often have similar rules for the appointment of a guardians, conservators,

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318. *See* discussion *supra* Part II. *See also* Grace Orsatti, *Attorneys as Healthcare Advocates: The Argument for Attorney-Prepared Advance Healthcare Directives*, 50 J.L. MED. & ETHICS 157, 158–89 (2022).

319. *See* Orsatti, *supra* note 318, at 159; *see also* Nina A. Cohn, *Matched Preferences and Values: A New Approach to Selecting Legal Surrogates*, 52 SAN DIEGO L. REV. 339, 408–14 (2015).

320. *See* LA. CODE CIV. PROC. art. 4561 (2023).

321. *Id.*

and similar positions.[322] Advance-planning documents should usually nominate the agent to serve in such a position. Care should be taken to ensure that any similar nomination in a financial power of attorney does not conflict with the nomination in the medical power of attorney.

3. Prohibitions

Some clients want to ensure that certain family members are precluded from being involved in future health care decisions. For example, a parent may want to exclude an estranged adult child from making decisions. Given the general legal and societal preference for involving immediate family members in decision making, a client's desire to exclude a close family member should be expressed clearly in the advance-planning documents.

4. Co-Agents

Co-agents are not generally advisable for the reasons discussed above.[323] When a client suggests co-agents, the attorney should explore why the client wants that arrangement. Some clients ask for co-agents because they are concerned about putting the burden of making decisions on one person's shoulders alone. Others may be concerned about ensuring multiple family members are included in the decision-making process. These concerns can often be addressed by including precatory language in the advance-planning documents that directs the agent to communicate with and consult with other individuals. The advance-planning documents might also permit the agent to delegate decisions to certain other family members.

If the client insists upon co-agents, then the advance-planning documents should clearly specify how decisions are to be made among the co-agents. As discussed in Part II.C.2 above, Louisiana law has no clear default rule for decision making among co-agents. For that reason, advance-planning documents should clearly specify how authority is allocated among co-agents.

D. Allocating Power Between Patient and Agent

In preparing advanced-planning documents, the attorney must decide how much power should be given to the agent to make decisions and how

322. *See, e.g.*, ARIZ. STAT. § 14:5410 (2023); TEX. ESTATES CODE § 1104.202 (2023).

323. *See* discussion *supra* Part II.C.2.

many decisions should be made in advance by the client. In other words, should specific health care decisions be made in advance by the patient? Or should they be made later by the agent? There are pros and cons to each approach.

1. Power to the Agent

Clients are often hesitant to mandate a particular course of treatment for hypothetical end-of-life scenarios. This instinct is usually a good one. It is impossible to anticipate all the medical circumstances a client might face in the future and the treatment options that will be reasonably available. Many clients simply want to make sure that the agent can make any decisions that need to be made. For these clients, the goal of advance-planning documents is to fully empower the agent to make decisions on behalf of the client without mandating any particular course of action.

Because of the proof required in some states with respect to certain medical decisions, such as life-sustaining treatments, nutrition and hydration, and pregnancy decisions, some aspects of future medical care do need to be addressed with specificity. Those issues are discussed in more detail below. When the client's overarching desire is to vest decision-making authority with the agent, the attorney must thread the needle carefully. The advance-planning documents should convey the client's wishes under those circumstances where it is legally important that the client do so in advance. However, those wishes should not be so rigidly expressed that they override the exercise of the agent's judgment so as to require a particular course of action on the part of the agent or health care providers.

2. Power to the Patient

Some clients are adamant about some aspects of end-of-life care. For these clients, personal autonomy is best preserved by executing advance-planning documents that direct a particular course of action. Although it would be unusual to give no discretion to the agent, there may be certain decisions that the client wants to decide in advance. Advance-planning documents for these clients should include a general grant of authority to the agent along with more specific, binding provisions with respect to certain decisions. The more specific provisions say "if my prognosis is X, then my agent must do Y." This approach may be appropriate for clients who already have a terminal condition and have more certainty about the types of decisions that will need to be made at the end of life.

3. Additional Safeguards

Finally, some clients may want to incorporate some additional safeguards into their advance-planning documents. For example, a client might want to require a second or third opinion before life-sustaining treatments are withheld or withdrawn. The client may want to mandate some minimum waiting period before life-sustaining procedures can be terminated. The client might want to require the approval of an additional friend or family member for certain types of medical decisions.

E. Topics that Should be Specifically Addressed

A general grant of authority to an agent is sufficient for many, but not all, medical decisions. As discussed above, certain types of medical decisions should be addressed with more specificity to help ensure that the agent is fully authorized to act in any state. In particular, the client's views with respect to life-sustaining treatments other than nutrition and hydration, and the client's views on nutrition and hydration, should be addressed with specificity. Palliative care should also be addressed and distinguished from life-sustaining treatments.

1. Life-Sustaining Treatments

The client's preferences with respect to life-sustaining treatment should be addressed with some specificity. To ensure usability of their advance-planning documents in other states, Louisiana attorneys should include language that is sufficient to meet the standards of states that require more exacting proof of the client's previously expressed wishes. The language used will depend on whether the client wants to put power in the hands of the agent or whether the client prefers to make decisions in advance.

Advance-planning documents aimed at empowering the agent should express the client's preferences with respect to life-sustaining procedures in a manner sufficient to meet the more onerous evidentiary requirements seen in some states. In particular, if the client wants to authorize the agent to terminate or withdraw life-sustaining treatments, the advance-planning documents should clearly indicate that the client authorizes such a course of action. However, that authorization should not be couched in mandatory language that directs the agent or health care provider to take a particular course of action. Decisions should ultimately rest within the agent's judgement and discretion. In other words, the lawyer's goal is to draft documents that fully empower the agent to act in states with the most

onerous evidentiary standards, without requiring the agent to take a particular course of action.

Some clients, however, might prefer to mandate a particular course of action regarding life-sustaining treatments, rather than give discretion to the agent. If the client is adamant that life-sustaining treatments be terminated under particular circumstances, then the advance-planning documents should be drafted differently. They should actually direct the agent and health care provider to terminate life-sustaining treatments under whatever circumstances the client indicates.

Some clients might prefer that life-sustaining treatments be continued to be administered despite having a poor prognosis. Those desires should also be indicated with specificity so that the client's wishes are known by the client's agent and health care providers.

2. Defining Life-Sustaining Procedures

Advance-planning documents should usually include a broad list of life-sustaining treatments that is expressly illustrative. An illustrative list is particularly useful when the client wants to authorize the termination and withdrawal of treatments. A list in the advance-planning documents provides an easy reference for health care providers and agents who may be unfamiliar with applicable statutes or medical jargon. The list can provide assurance that the patient authorized the termination or cessation of a particular treatment. An illustrative list might include treatments such as cardiopulmonary resuscitation, mechanical ventilation, assisted feeding or hydration, tube feeding or hydration, dialysis, chemotherapy, radiation, blood transfusion, antibiotics, and antivirals.

3. Nutrition and Hydration

Nutrition and hydration should be specifically addressed because of the more onerous evidentiary standards seen in some other states for withholding or withdrawing invasive nutrition and hydration. The inclusion of nutrition and hydration in the advance-planning document's definition of life-sustaining procedures coupled with language indicating the patient's desires and a grant of authorization to the agent to terminate or withdraw those treatments should meet the evidentiary standards of the more onerous states. Of course, some clients may prefer the continued administration of nutrition or hydration. Advance-planning documents for these clients should clearly reflect those preferences.

4. Palliative Care

Palliative care should also be addressed with specificity. Pain management at the end of life is a concern for many clients.[324] Some treatments needed to alleviate pain or to provide comfort might also be treatments that are considered life-sustaining treatments. In some states, the legal definition of life-sustaining treatment specifically excludes palliative care.[325] Regardless of whether state law draws that distinction, it is helpful to draw the distinction in the client's advance-planning documents to give both the agent and health care providers a better understanding of the client's desires regarding palliative care.

Clients will express different preferences for palliative care.[326] Some clients may want to be made as comfortable as possible, even if the palliative care itself may cause death to occur more quickly. However, some clients may have religious or moral objections to forms of palliative care that may result in death more quickly. Some clients may want to balance their comfort with their continued ability to interact with others and retain lucidity. Whatever the client's preferences are, they should be documented in the advance-planning documents.

F. Reproductive Decisions

Preserving client autonomy regarding certain reproductive decisions can be challenging, particularly in states like Louisiana where reproductive rights have been severely curtailed even for adults who are competent to make their own decisions. The following suggestions are aimed at preserving client autonomy to the extent that it is feasible.

1. Patient Preferences

Advance-planning documents for clients who may become pregnant should address at least two different issues with some specificity. First, advance-planning documents should address client preferences regarding life-sustaining procedures any time the client is pregnant and is also a qualified patient. Second, advance-planning documents should indicate whose life the client believes should take precedence—the client's or the fetus's.

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324. *See* Steinhauser & Tulsky, *supra* note 1, at 5.

325. ALA. CODE § 22-8A-3 (2023); LA. REV. STAT. § 40:1151.1 (2023); N.H. REV. STAT. § 137-J:2 (2023).

326. *See* Steinhauser & Tulsky, *supra* note 1, at 5.

a. Life-Sustaining Procedures

Advance-planning documents should indicate the client's preferences regarding life-sustaining procedures if the client is pregnant. Some clients may have the same preferences regarding life-sustaining procedures regardless of whether they are pregnant. Others may prefer a different approach in the event of pregnancy. As with other types of decisions, the client may want to vest decision-making authority with the agent. Language such as "I specifically grant my Agent the authority to withhold or withdraw life-sustaining procedures even if I am pregnant" may accomplish this goal in some jurisdictions. Alternatively, the client may prefer to stipulate a course of conduct in advance, rather than leaving the issue to the discretion of the agent. For example, language such as the following could be considered: "If I am pregnant, I direct that the survival of my unborn child be given paramount importance, and I direct that life-sustaining procedures be administered and continued so long as it may benefit my unborn child."

b. Choice Between Patient and Fetus

Advance-planning documents should also indicate the client's preferences in the unlikely event that a choice is to be made between the life of the fetus and the life of the client. The client may prefer for the client's life to take precedence. Or the client may prefer that the fetus's life take precedence over that of the client.

2. Durability, Relocation, and Choice of Law Provisions

As discussed above, reproductive autonomy has been severely curtailed in many states, including in Louisiana. Even within more permissive states, individual hospitals or health care providers may have their own restrictive policies that do not align with the client's desires. To better facilitate the exercise of client autonomy, documents for clients who may become pregnant should clearly indicate that the documents are intended to remain viable during pregnancy. This statement coupled with relocation and choice-of-law provisions will enhance the likelihood of the advance-planning documents being usable in less restrictive jurisdictions.

Advance-planning documents should authorize the agent to relocate the client to another provider, hospital, or jurisdiction. The agent should also be authorized to have the client discharged from care, even when it is against medical advice. The agent should further be authorized to establish a new domicile or residency for the client, particularly when doing so will

allow the client's stated intentions to be more fully followed. These authorizations may allow the agent to relocate the patient to a more accommodating provider or to a more accommodating jurisdiction.

Finally, the choice-of-law provision in any advance-planning document should be written to allow the application of laws that more fully comport with the client's stated intentions. For example, Louisiana law will likely conflict with some reproductive decisions that involve terminating a pregnancy. The advance-planning documents should make it clear that Louisiana law can be disregarded in favor of some other more desirable law whenever Louisiana law conflicts with the preferences or directions set forth in the advance-planning documents.

CONCLUSION

Personal autonomy is the bedrock of medical decision making in America, particularly at the end of life. Yet, many legal and societal barriers impede the exercise of that personal autonomy. Removing those barriers requires changes in health care and changes in the law. This Article has outlined some of the numerous areas in which Louisiana's laws should be reformed, harmonized, and modernized. This Article has also outlined some of the ways attorneys can assist clients in exercising their personal autonomy through advance-planning documents.