

A QUESTION AND ANSWER EXAMINATION OF THE 1997
AMENDMENTS TO ALABAMA'S NATURAL DEATH ACT

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I. INTRODUCTION

“Too many cooks spoil the broth.” The warning of this adage might seem a little outdated when considering our society’s new emphasis on teamwork and diversification. Indoctrination in this current philosophy validates and encourages multiple, differing viewpoints—leading to the conclusion that the more viewpoints participating in a group task, the better. However, at some point, the number of differing individual agendas will fail to result in a unified solution. The group disregards the original goal, and the effort becomes a struggle over which individual agenda will dominate. Therefore, the old adage does still ring true in real life, many times with consequences much more serious than spoiled broth.

The “too many cooks” scenario occurred recently in Ala-

bama, with the passage of major amendments to the Alabama Natural Death Act¹ and the Alabama Durable Power of Attorney Act.² Because these statutes deal with difficult and controversial topics—ranging from the right-to-die to abortion—many different interest groups³ influenced the drafting and legislative handling of the amendments. The sometimes uncompromising viewpoints of the groups produced a new Natural Death Act that is disjointed and confusing to lawyers and laypersons alike.

A. A Brief Historical Background

The Natural Death Act of 1981⁴ was Alabama's statutory response to the right-to-die movement, a campaign initiated by the existence of indeterminately life-prolonging medical technology and fueled by litigation of the past two decades.⁵ Since the 1976 *Quinlan* case,⁶ the first case to establish a patient's right to refuse medical treatment when there is no hope of recovery, states have been struggling to enact legislation that adequately balances an individual's right to personal autonomy with the state's interest in preserving life.

Alabama's Natural Death Act of 1981 expressly recognized one method of creating an advance medical directive (AMD)⁷—a way a person can give directions concerning how his or her medical care and treatment should be rendered if that person becomes unable to make such decisions.⁸ The major provision of

1. Natural Death Act of 1997, No. 97-187, 1997 Ala. Acts 281, 299 (codified as amended at ALA. CODE §§ 22-8A-1 to -10 (1997)).

2. ALA. CODE §§ 26-1-2 to -2.1 (1992 & Supp. 1998).

3. Estate planning lawyers, health care lawyers, the AARP, the Catholic Diocese, the Rutherford Institute, the Southern Baptist Convention, and other out-of-state groups representing right-to-die and right-to-life factions all participated in some phase of the amendments' lives. Telephone Interview with Richard Brockman, attorney with Johnston Barton Proctor & Powell, in Birmingham, Ala. (Aug. 21, 1998).

4. Natural Death Act of 1981, No. 81-772, 1981 Ala. Acts 1329, 1334 (codified as amended at ALA. CODE §§ 22-8A-1 to -10 (1990)).

5. See Anne W. Mitchell, *Alabama Living Will Statute*, 46 ALA. LAWYER 316, 317 (1985).

6. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

7. ALA. CODE § 22-8A-2 (1990) (amended 1997); see also 2 ALAN MEISEL, *THE RIGHT TO DIE* § 10.3 (2d ed. 1995) (discussing the purposes of advance medical directives).

8. The most common ways to create an AMD are through a living will, a stat-

the 1981 Act allowed adults to execute a living will to express whether they wanted "life-sustaining procedures withheld or withdrawn"⁹ if they became "terminally ill or injured."¹⁰ However, some doctors, hospitals, and nursing facilities were wary of honoring the 1981 Act.¹¹ Although protection from criminal and civil liability was statutorily furnished,¹² there was little to persuade these health care providers they would be shielded from suit because the 1981 Act was never litigated in the courts.¹³ In addition, the 1981 Act was outdated in many respects. For example, as of 1996, Alabama was one of the few, if not the only, state that did not expressly provide for a durable power of attorney for health care, an extremely important health care planning tool, in either its Natural Death Act or Durable Power of Attorney Act.¹⁴

Obviously, there was a need for change, and the 1997 Act

utory appointment of health care proxy through a durable power of attorney, an express oral declaration, and a written memorandum. See 2 MEISEL, *supra* note 7, § 10.5.

9. ALA. CODE § 22-8A-2 (1990) (amended 1997).

10. *Id.* § 22-8A-3 (1990).

11. See Mitchell, *supra* note 5, at 317.

12. ALA. CODE § 22-8A-7 (1990) (amended 1997). The statute provided:

No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this chapter shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct.

Id.

13. Mitchell, *supra* note 5, at 317.

14. Richard J. Brockman, Advance Medical Directives: Developments and Trends in Health Care Law 1996, at 5 (Sept. 6, 1996) (unpublished manuscript, on file with author). Before the 1997 Act, Alabama had no *express* provision, although at the time, many Alabama lawyers believed that, even though it was not expressly provided for in the code section, the Alabama Durable Power of Attorney Act was broad enough to encompass durable powers of attorney for health care. *Id.* at 19. Brockman noted that:

This long-established rule of construction was followed in a non-authoritative case decided in the Jefferson County Circuit Court, *Jackson v. The Village at Cook Springs*, CV 91-6854 (10th Cir. Ala. Sept. 1991). In *Jackson*, Judge Jack Carl ruled that a durable power of attorney executed by an individual authorizing her daughter to make medical decisions on her behalf was broad enough to be deemed a living will and that the daughter could therefore authorize the facility to withhold a feeding tube.

Id.

filled that need. However, for all its admirable inclusions, the 1997 Act is very ambiguous and confusing at points, and the statutory form provided is difficult to complete.¹⁵ This Comment is a question and answer analysis of Alabama's Natural Death Act of 1997. Substantive changes from the 1981 Act, the significance of the changes, potential problems, and emerging arguments of the right-to-die movement will be noted along the way where appropriate.

II. BRIEFLY, WHAT ARE THE MAIN SUBSTANTIVE DIFFERENCES BETWEEN THE 1981 ACT AND THE 1997 ACT?

A. *Living Wills and Health Care Proxies Provided*

One of the most significant changes in the Natural Death Act is that the 1981 Act only provided for the execution of a living will document—there was no express provision for the appointment of a health care proxy, also known as a durable power of attorney for health care.¹⁶ Although it was widely believed the old Alabama Durable Power of Attorney Act¹⁷ was broad enough to legally encompass the idea that an attorney-in-fact could make health care decisions for the principal,¹⁸ there was no express protection for a client attempting to accomplish such in either statutory provision. The 1997 Act provides for execution of a living will, a health care proxy, or both.¹⁹ The health care proxy option will be discussed in more depth later in this Comment. It is important to note here, however, that *unless otherwise provided in the directive*, if both a living will and a health care proxy are executed, decisions of the health care

15. See ALA. CODE § 22-8A-4(h) (1997).

16. See ALA. CODE §§ 22-8A-1 to -10 (1990) (amended 1997). A health care proxy or durable power of attorney for health care is an agency relationship where the agent may make most health care decisions for the principal when the principal is incompetent or unable to make them for himself. See 2 MEISEL, *supra* note 7, § 10.4-5.

17. ALA. CODE § 26-1-2 (1992) (amended 1997).

18. Brockman, *supra* note 14, at 17-19.

19. ALA. CODE § 22-8A-4(b) (1997).

proxy will override conflicting provisions in the living will.²⁰

*B. Artificially Provided Nutrition
and Hydration May Be Removed*

The introductory paragraph language of the section 22-8A-4(h) form, providing that "my dying shall not be artificially prolonged under the circumstances set forth below," encompasses two other major substantive changes.²¹ "Artificially prolonged" in the 1981 Act included only "life-sustaining procedures," which was not defined to include artificially provided nutrition and hydration.²² Although many believe instructions regarding nutrition and hydration in the advance directive could be accomplished through insertion of such language in the AMD, it was uncertain whether such insertions would be honored.²³

The 1997 Act eliminated this ambiguity by express inclusion of provisions regarding artificially provided nutrition and hydration.²⁴ Artificially provided nutrition and hydration is defined in section 22-8A-3(2) as "[a] medical treatment consisting of the administration of food and water through a tube or intravenous line, where the recipient is not required to chew or swallow voluntarily. Artificially provided nutrition and hydration does not include assisted feeding, such as spoon or bottle feeding."²⁵ Alabamians may now direct that artificially provided nutrition and hydration be withheld or withdrawn, but only if specifically authorized within the directive.²⁶

*C. Terminal Illness or Injury AND Permanent
Unconsciousness Activate AMDs*

The 1997 Act also expanded the "circumstances" under which the advanced directive would be executed. Previously,

20. *Id.* § 22-8A-4(g).

21. *Id.* § 22-8A-4(h).

22. ALA. CODE § 22-8A-3(3) (1990) (amended 1997).

23. Brockman, *supra* note 14, at 19-21, 24.

24. ALA. CODE § 22-8A-2 (1997).

25. *Id.* § 22-8A-3(2).

26. *Id.* § 22-8A-4(a), (b).

AMDs activated only when a declarant became near death as a result of terminal illness or injury.²⁷ Now an advance directive for health care executed under Alabama's Natural Death Act of 1997 will also come into effect when the declarant is not necessarily dying, but is in a state of "permanent unconsciousness."²⁸ The addition of "permanent unconsciousness" to the statute will be discussed further in Section VII(C) of this Comment.

*D. Surrogates May Make Decisions for
Those with No AMD*

Finally, the last major substantive difference is the surrogate provision of section 22-8A-11, where, if *no* advance directive for health care has been executed, life-sustaining treatment decisions can be made by the patient's family without any judicial action.²⁹ Although this was often the unofficial practice of hospitals before the 1997 Act, this amendment is crucial. Under the 1981 Act and Alabama common law, no legal authority existed for a patient's family to make that kind of decision.³⁰ The 1997 Act also provides the hospital with protection from civil and criminal liability for following a surrogate's instructions, protections it did not have under the old Act.³¹

The surrogate provision will be discussed in depth in Part X of this Comment.

III. IF MY CLIENT WISHES TO MAKE A LIVING WILL OR
APPOINT A HEALTH CARE PROXY, DO I HAVE TO
FOLLOW THE STATUTORY FORM?

In short, no. However, if the statutorily suggested form is not followed, the declarant risks having an offending addition or variation dropped from the directive, because directives created under the statute are considered severable.³²

27. ALA. CODE § 22-8A-2 (1990) (amended 1997).

28. ALA. CODE § 22-8A-2 (1997).

29. *Id.* § 22-8A-11.

30. *See* ALA. CODE §§ 22-8A-1 to -10 (1990) (amended 1997).

31. *See* ALA. CODE § 22-8A-11(g) (1997).

32. *Id.* § 22-8A-4(h).

A. Looking at the Statutory Language

Section 22-8A-4(c)(1) of the Alabama Code requires an advance directive for health care executed in Alabama to be in writing.³³ But, does the form provided in the statute have to be followed expressly? That is a legitimate question probably posed by many lawyers since the introduction of the complex and detailed form of the 1997 Act. Alabama, by providing "[t]he advance directive for health care shall be substantially in the following form,"³⁴ falls short of the clarity of the more common statutory treatment of forms where the statute provides a suggested form, but does not require its use.³⁵ Thereby, the question develops: Does the statutory language "substantially in the following form" indicate the form is only a guide, and clients may tailor their personal directive to fit their own needs? Or, should the form be strictly followed, with the "substantially" language included only as an allowance for the "other specific directions" blanks³⁶ and typographical errors?

B. Alabama Common Law Clarifies

The fact that Alabama's common law recognizes oral directives is strong evidence toward showing the particular statutory form is not mandatory. In 1987, the Alabama Supreme Court stated in *Camp v. White*³⁷ that it would be "misread[ing] the statute" to hold the 1987 Alabama Natural Death Act "requires

33. *Id.* § 22-8A-4(c)(1) ("Any advance directive for health care made pursuant to this chapter shall be: . . . (1) In writing . . ."). Alabama's Natural Death Act does not expressly allow oral declarations. *But see* *Camp v. White*, 510 So. 2d 166, 169-70 (Ala. 1987) (finding that the cumulative provision language of the 1981 Natural Death Act did not supersede other ways of making an advance directive where an incompetent patient's previously given express oral direction to withhold life-sustaining medical treatment was held to be a valid advance directive).

34. ALA. CODE § 22-8A-4(h) (1997). Georgia's statute also provides for declarations in "substantially the form specified." GA. CODE ANN. § 31-32-3(b) (1996).

35. *See, e.g.*, MO. ANN. STAT. § 459.015 (West 1991); N.C. GEN. STAT. § 90-321 (1990); TEX. HEALTH & SAFETY CODE ANN. § 672.004 (West 1991); VA. CODE ANN. § 54.1-2984 (Michie 1990).

36. ALA. CODE § 22-8A-4(h).

37. 510 So. 2d 166 (Ala. 1987).

that a decision to terminate life support be in writing.³⁸ The Court held that, although the 1987 Act provided a specific method for creating an AMD, the Act's cumulative provision did not mean the living will method mentioned therein was "the exclusive procedure for withholding life sustaining systems."³⁹

The 1997 Act also indirectly reflects this recognition of oral directives in stating its provisions are cumulative.⁴⁰ The cumulative characteristic means the Natural Death Act will not supersede any right regarding health care decisions previously held by Alabamians under common law.⁴¹ Therefore, if, under Alabama common law oral statements are sufficient to create a directive for withholding or withdrawing life-sustaining treatment, it is logical to argue almost any kind of written statement clearly stating similar desires also creates an enforceable directive.⁴²

Following the common law cumulative provisions argument, the "written" and "substantially in the same form" requirements are meaningless limitations in the creation of an advance directive.⁴³ The issue of meaningless limitations within advance directive statutes is addressed in a law review article by David Orentlicher: "End-of-life statutes regularly state that their provisions are cumulative and include rights derived from other sources of law, but laypeople often fail to appreciate the significance of these provisions. . . . [P]eople may assume that an advance directive is not valid if they do not use the statutory form."⁴⁴ However, Orentlicher also points out the main advantage of following the statutory form—a better chance of enforcement by health care providers:

People are naturally skeptical of documents that do not have an

38. *Camp*, 510 So. 2d at 169.

39. *Id.* at 170.

40. ALA. CODE § 22-8A-9(d) (1997).

41. *See id.*

42. Brockman, *supra* note 14, at 17.

43. ALA. CODE § 22-8A-4(h) (1997). It should be noted here that although it is not necessary to follow the statutory form to have other life-sustaining treatment withdrawn or withheld, the statute clearly states artificially provided nutrition and hydration cannot be removed without express, written authorization in the directive. *Id.* § 22-8A-4(a), (b).

44. David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1265 (1994) (citation omitted).

“official” look to them; a handwritten, or even typewritten, advance directive is less likely to be implemented than a directive in which a patient has filled out the statutory form, even if the handwritten or typewritten document satisfies all of the statutory requirements. The situation is similar to trying to have a check accepted when the check is written on a plain piece of paper rather than a standard bank check draft. Although the plain paper check is legally valid, it will not be readily accepted.⁴⁵

Although non-statutory forms probably are not as readily accepted, the argument that common law rights allow deviation from the statutory form is an important one, especially with the huge boom in Internet use since the 1981 Act. Any Internet user can run a search on “living wills” and pull up multiple services offering ready-made advance directive forms claiming to be “valid in all 50 states.”⁴⁶ These one-size-fits-all living wills do not conform to the exact language of the Alabama Natural Death Act, yet they should still be valid under the statute’s cumulative provision and Alabama common law if executed correctly.

There is another common way Alabamians may come into contact with advance directive forms that do not reflect the 1997 Act language. In 1990 Congress passed the federal Patient Self-Determination Act,⁴⁷ which requires information on advance directives to be given to patients upon admission to health care facilities. The Alabama Medicaid Agency adopted literature in 1994 that health care facilities receiving Medicaid must distribute to admitted patients.⁴⁸ This literature contains a summary of law and accompanying forms and is codified in the Alabama Administrative Code.⁴⁹ At the time of publication of this Comment, the information had not been updated to reflect the changes of the 1997 Act. Therefore, forms executed by patients receiving the Medicaid packets today also will not conform to the exact statutory language of the 1997 amendment.

45. *Id.* (citation omitted).

46. See, e.g., *Easy Wills Co.: Legal Will and Trust Forms* (visited Nov. 5, 1998) <<http://www.easylegalforms.com>>.

47. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388-115 (1990).

48. Brockman, *supra* note 14, at 15.

49. Ala. Admin. Code, r. 560-X-28-10 (1994).

IV. WHO CAN MAKE AN ADVANCE DIRECTIVE UNDER THE 1997 NATURAL DEATH ACT?

A. *Competent Adults*

According to section 22-8A-4(a), "[a]ny competent adult" may execute a directive.⁵⁰ "Adult" is defined within the statute as "[a]ny person 19 years of age or over."⁵¹ "Competent Adult" is defined as "[a]n adult who is alert, capable of understanding a lay description of medical procedures and able to appreciate the consequences of providing, withholding, or withdrawing medical procedures."⁵² Essentially, a competent adult is one who meets the age requirement and has the decision-making capacity to understand, analyze, and exercise his right of informed consent.

B. *Minors?*

Under common law, adults have the right of informed consent—a right to hear a description of their health care options and a right to accept or refuse that treatment.⁵³ The same does not hold true for minors. A "minor" is a statutorily created status that deprives the young of certain "adult" rights in order to protect them from potential harm caused by their own immature actions or decisions.⁵⁴

The age of majority in Alabama is nineteen.⁵⁵ It is easy to see the intent of the legislature in the Natural Death Act. Decisions involving life and death are too important and complex to entrust to a minor, so the drafters crafted the statute to enable no person under the age of majority to execute his or her own advance directive.⁵⁶ However, the importance of the Natural Death Act's "cumulative provision" once again surfaces. The pro-

50. ALA. CODE § 22-8A-4(a) (1997).

51. *Id.* § 22-8A-3(1).

52. *Id.* § 22-8A-3(5).

53. See *Cruzan v. Director Mo. Dep't Health*, 497 U.S. 261, 269-70 (1990).

54. Jeffrey F. Ghent, Annotation, *Statutory Change of Age of Majority as Affecting Pre-Existing Status of Rights*, 75 A.L.R. 3D 228, 238 (1977) (citing *In re Davidson's Will*, 26 N.W.2d 223 (Minn. 1947)).

55. ALA. CODE § 26-1-1(a) (1992).

56. See ALA. CODE § 22-8A-2 (1997).

vision states:

Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have, under case law, common law, or statutory law, to effect the withholding or withdrawal of life-sustaining treatment or artificially provided nutrition and hydration in any lawful manner. In such respect the provisions of this chapter are cumulative.⁵⁷

In all other Alabama Code sections, the definition of "minor" takes into account the fact that an individual may have the disabilities of minority removed other than by reaching his or her nineteenth birthday. This emancipation is accomplished either through successful petition to juvenile court⁵⁸ or through marriage if the individual is eighteen years old.⁵⁹ Therefore, because of the Natural Death Act's cumulative provision, it seems the provision setting a strict cut-off age of nineteen for execution of an AMD is a meaningless limitation for emancipated minors.⁶⁰ It is the constitutional right of those considered adults to refuse medical treatment,⁶¹ and in Alabama, these emancipated minors are considered adults.⁶² The Natural Death Act should recognize this fact.⁶³

To confuse matters further, the Natural Death Act's minimum age requirement is also in direct conflict with section 22-8-4 of the Alabama Code, which gives minors over the age of fourteen the ability to consent to their own medical treatment. The statute states:

Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be

57. *Id.* § 22-8A-9(d).

58. ALA. CODE §§ 26-13-1 to -8 (1992).

59. ALA. CODE §§ 30-4-15, -16 (1989).

60. David Orentlicher, *supra* note 44, at 1264-65.

61. *Cruzan v. Director Mo. Dep't Health*, 497 U.S. 261, 278 (1990).

62. ALA. CODE § 26-13-1 (1992); ALA. CODE §§ 30-4-15, -16 (1989).

63. Illinois permits emancipated minors to execute their own directives. *See* 755 ILL. COMP. STAT. ANN. 35/5 (West 1993); *see also* UNIF. HEALTH CARE DECISIONS ACT § 2(a)-(b), 9 U.L.A. 290 (Supp. 1998) (providing that an emancipated minor may give instructions concerning advance directives and may execute a power of attorney for health care).

necessary.⁶⁴

Whether this statutory right of minors over the age of fourteen changes this group's rights under the Natural Death Act is certainly an issue requiring clarification.

Another avenue providing minors the ability to execute an AMD is the application of the "mature minor" doctrine in some jurisdictions.⁶⁵ This doctrine is based on the idea that some people mature fast enough to be given the chance to make their own medical decisions before reaching the age of majority.⁶⁶ A few courts in other states have followed the doctrine to a limited extent, almost always with terminally ill minors.⁶⁷ Some scholars advocate the introduction of this principle to advance directive statutes.⁶⁸

V. WHAT ARE THE FORMAL REQUIREMENTS FOR EXECUTING AN ADVANCE DIRECTIVE UNDER THE NATURAL DEATH ACT?

A. Basic Requirements

As discussed previously, only competent adults aged nineteen or over may execute an advance directive, and it is not necessary to strictly follow the form. To meet the statutory requirements, the directive must be in writing, dated, and signed by the declarant⁶⁹ in the presence of two or more witnesses.⁷⁰ However, the directive does not have to be notarized.⁷¹

There are very strict requirements placed upon the selection

64. ALA. CODE § 22-8-4 (1997).

65. See *In re E.G.*, 549 N.E.2d 322, 326-27 (Ill. 1989); see also *In re Swan*, 569 A.2d 1202, 1205-06 (Me. 1990) (enforcing the oral advance directive of a seventeen-year-old).

66. 2 MEISEL, *supra* note 7, § 15.3.

67. See *id.*

68. See Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1, 98 (1996). But see Jessica A. Penkower, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment—Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1215-16 (1996).

69. The directive is also valid if signed by another "in the declarant's presence and by the declarant's expressed direction." ALA. CODE § 22-8A-4(c)(2) (1997).

70. *Id.* § 22-8A-4(c).

71. See *id.*

of witnesses to AMDs in order to prevent controversies about conflicts of interest and inducement.⁷² Witnesses, like the declarant, must be nineteen years of age.⁷³ Witnesses may *not* be the person who signed the instrument at the direction of the declarant; the declarant's health care proxy; anyone related to the declarant by blood, adoption, or marriage; an heir of the declarant (either by intestate succession or will); or anyone directly financially responsible for the declarant's medical care.⁷⁴

B. *Written Acceptance by Health Care Proxy*

In addition to the eligibility and witnessing demands, execution of an advance directive appointing a health care proxy requires another formality.⁷⁵ Because the health care proxy (sometimes called an attorney in fact or durable power of attorney for health care) involves an agency relationship,⁷⁶ the declarant (principal) must obtain written acceptance of the position from the proxy (agent) and attach it to the proxy designation.⁷⁷ If an alternate proxy designation is made, written acceptance should be obtained for that person, as well. Although written acceptance is required by the proxy, the statute does not mandate acceptance at the time of execution.⁷⁸ Under rules of statutory construction, the omission of a provision requiring accep-

72. See 2 MEISEL, *supra* note 7, § 13.15.

73. ALA. CODE § 22-8A-4(c)(4) (1997). This is an interesting requirement, considering minors in Alabama may witness a testamentary will. ALA. CODE § 43-8-134 (1991).

74. ALA. CODE § 22-8A-4(c)(4) (1997).

75. Unless otherwise provided, if the declarant appoints his or her spouse as health care proxy, divorce, dissolution or annulment of marriage, and legal separation revoke the designation of the spouse as health care proxy. *Id.* § 22-8A-4(b)(3). In the case of revocation of designation, the alternate health care proxy would gain authority to make the health care decisions. *Id.* § 22-8A-4(h). If no alternate health care proxy were named, it appears the entire proxy directive would be invalid. See *id.* In addition, the declarant's health care provider and any nonrelative employee of the health care provider are forbidden from making decisions in the capacity of a patient's health care proxy. *Id.* § 22-8A-4(b)(4). A health care provider is defined as "[a] person who is licensed, certified, registered, or otherwise authorized by the law of this state to administer or provide health care in the ordinary course of business or in the practice of a profession." ALA. CODE § 22-8A-3(6) (1997).

76. See 2 MEISEL, *supra* note 7, § 12.2, at 129.

77. ALA. CODE § 22-8A-4(b) (1997).

78. *Id.*

tance at the time of execution implies a proxy designation may be made at execution and written evidence of acceptance may be given at a later time.⁷⁹

C. *Necessary Steps After Execution*

After the advance directive has been executed, it is the *declarant's* responsibility to give a copy to all of his doctors or health care providers.⁸⁰ The health care providers are then required by law to make the directive part of the declarant's medical records.⁸¹ It is also recommended the declarant give copies of the directive to family and close friends.⁸² The more the directive is circulated, the better the chance it will not be ignored if the time ever comes for its use.

VI. HOW DOES THE NEW HEALTH CARE PROXY PROVISION OF THE NATURAL DEATH ACT WORK, ESPECIALLY IN CONJUNCTION WITH THE REVISED DURABLE POWER OF ATTORNEY ACT?

A. *What Is a Durable Power of Attorney for Health Care?*

A durable power of attorney for health care⁸³ is a power of attorney given to an individual appointed by a competent person to make health care decisions for that person in the case he or she ever becomes incompetent.⁸⁴ This is an excellent health care planning tool because it is impossible to cover within a living will document every conceivable medical situation arising

79. See, e.g., *Jefferson County v. Alabama Criminal Justice Info. Ctr. Comm'n*, 620 So. 2d 651, 658 (Ala. 1993) (explaining that the legal maxim *expressio unius est exclusio alterius* means the express inclusion of requirements in law implies the intention to exclude other requirements not so included).

80. ALA. CODE § 22-8A-4(f) (1997).

81. *Id.*

82. PETER J. STRAUSS & NANCY M. LEDERMAN, *THE ELDER LAW HANDBOOK* 27 (1997).

83. A durable power of attorney for health care is also called an "attorney-in-fact" or a "health care proxy." 2 MEISEL, *supra*, note 7, § 12.2, at 129.

84. *Id.*

from a terminal illness or injury or a state of permanent unconsciousness. The knowledge that a living, breathing, thinking person will be making decisions for you in default of a living will is a comfort to many people. Under current Alabama law, the attorney in fact or the health care proxy is required to comply with the declarant's specific instructions actually given before losing decision-making capacity.⁸⁵ This is called the subjective standard of decision-making.⁸⁶ If there are no applicable instructions, the proxy must comply with what he or she believes the wishes of the patient would have been had he been able to make the decision himself.⁸⁷ This is called the substituted judgment standard.⁸⁸

B. *The Problem*

It is now clear that Alabamians have the express right to create a durable power of attorney for health care.⁸⁹ What is not clear is the extent of decision-making authority of the health care proxy created from the Natural Death Act compared with that of the attorney-in-fact created from the Durable Power of Attorney Act. They can both become durable powers of attorney for health care, but can each accomplish the same health care goals regarding general medical decision-making?

85. ALA. CODE § 22-8A-6 (1997).

86. This is one of three standards used for surrogate decision-making. The subjective standard requires the proxy to make the decision based upon expressed desires actually given by the patient while competent. 1 MEISEL, *supra* note 7, § 7.4-.6. Another standard is the best interests standard, where the proxy makes the medical decision by determining what the proxy thinks is in the best interest of the patient. *Id.* § 7.11-.18. The last standard is the substituted judgment standard, where the proxy makes decisions conforming as closely as possible to what the patient would have done under the circumstances, even though the patient did not previously make statements communicating those desires. *Id.* § 7.7-.10. For a comprehensive discussion of surrogate decision-making standards, see Chapter Seven of Meisel's *THE RIGHT TO DIE*.

87. ALA. CODE § 22-8A-6 (1997).

88. The substituted judgment standard is also the most commonly used by states with advance directive statutes. See *supra* text accompanying note 86.

89. ALA. CODE § 22-8A-4(b) (1997); ALA. CODE § 26-1-2(g) (Supp. 1998).

1. *Attorney-In-Fact (Durable Power of Attorney Act)*.—It is clear an attorney-in-fact under the Durable Power of Attorney Act can make general health care decisions for the principal.⁹⁰ In addition, the attorney-in-fact may make decisions involving withholding or withdrawing life sustaining treatment for the principal if the attorney-in-fact instrument conforms to the signing requirements of the Natural Death Act.⁹¹ However, like living will documents, the attorney-in-fact designation must have specific authorization for the withholding or withdrawing of artificially provided nutrition and hydration.⁹²

2. *Health Care Proxy (Natural Death Act)*.—The ambiguity arises when examining the scope of the health care proxy's decision-making ability within the 1997 Natural Death Act. Does the health care proxy have the authority to make general health care decisions when the declarant is incompetent, in addition to having the ability to withhold or withdraw life-sustaining treatment when the declarant is terminally ill or permanently unconscious? The answer is very unclear. The length and unwieldiness of the Natural Death Act provisions regarding health care proxies are the main causes for the confusion.

The Natural Death Act defines "health care proxy" as "[a]ny person designated to act on behalf of an individual pursuant to Section 22-8A-4."⁹³ Section 22-8A-4 provides that "[a] competent adult may execute at any time a living will that includes a writ-

90. ALA. CODE § 26-1-2(g)(1) (Supp. 1998). The applicable provision of the statute states:

Subject to the express limitation on the authority of the attorney in fact contained in the durable power of attorney, *the attorney in fact may make any health care decision on behalf of the principal* that the principal could make but for the lack of capacity of the principal to make a decision, but not including psychosurgery, sterilization, abortion when not necessary to preserve the life of the principal, or involuntary hospitalization or treatment covered by Subtitle 2 of Title 22.

Id. (emphasis added).

91. *Id.* According to the statute:

A principal may designate under a durable power of attorney an individual who shall be empowered to make health care decisions on behalf of the principal, *in the manner set forth in the Natural Death Act*, if in the opinion of the principal's attending physician the principal is no longer able to give directions to health care providers.

Id. (emphasis added).

92. *Id.* § 26-1-2(g)(2).

93. ALA. CODE § 22-8A-3(7) (1997).

ten health care proxy designation appointing another competent adult to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration.⁹⁴ No mention is made of the appointed health care proxy's ability to make general health care decisions. Furthermore, the legislative intent section of the statute states:

[T]he laws of this state shall recognize the right of a competent adult person to . . . designate by lawful written form a health care proxy to make decisions on behalf of the adult person concerning the providing, withholding, or withdrawing of life-sustaining treatment and artificially provided nutrition and hydration in instances of terminal conditions and permanent unconsciousness.⁹⁵

Therefore, once again the statute fails to even imply whether general health care decisions may also be made by the proxy. The water is muddied even further by the next paragraph in the Natural Death Act, where again, no mention is given as to the health care proxy's power to make general health care decisions for an incompetent patient.⁹⁶ However, the statute finally makes a comprehensible stance in subsection (b)(2) of section 22-8A-4:

Any powers granted to a health care proxy in an advance directive for health care executed pursuant to this subsection that permit a health care proxy to make general health care decisions not related to the provision, withdrawal, or withholding of life-sustaining treatment or artificially provided nutrition and hydra-

94. *Id.* § 22-8A-4(b) (emphasis added).

95. *Id.* § 22-8A-2 (emphasis added).

96. *Id.* § 22-8A-4(b)(1). This subsection provides:

The designation of an attorney-in-fact, made pursuant to Section 26-1-2, as amended from time to time, who is specifically authorized to make decisions regarding the providing, withholding, or withdrawing of life-sustaining treatment or artificially provided nutrition and hydration in instances involving terminal illness or injury and permanent unconsciousness, constitutes for purposes of this chapter a proxy designating another individual to act for the declarant pursuant to this subsection, provided, however, that the authority granted to an attorney-in-fact to make such decisions shall be the same as the authority granted in this chapter to a health care proxy. The appointment shall be limited to the specific directions enumerated in the appointment.

Id.

tion shall be limited to those powers permitted under the Alabama Durable Power of Attorney Act, Section 26-1-2, as the same shall be amended from time to time.⁹⁷

This paragraph implies a health care proxy may make general health care decisions in addition to life-prolonging or life-ending ones. The proxy is limited only in the same manner as the attorney-in-fact in this regard.⁹⁸ Although nonbinding, additional evidence of the legislature's intent to give health care proxies the ability to make general health care decisions comes from the proxy designation in the statutory form. The designation states: "My health care proxy is authorized to make *whatever medical treatment decisions I could make if I were able*, including decisions regarding the withholding or withdrawing of life-sustaining treatment."⁹⁹

If a general appointment within an AMD is desired by the client, a lawyer executing a health care proxy designation should consider the insertion of the phrase "including, but not limited to" before "decisions regarding the withholding or withdrawing of life-sustaining medical treatment" in section 22-8A-4(b) to make the declarant's wishes more clear. In addition, the permission to make these general health care decisions should also be inserted within the "other directions" blanks of the statutory form to help ensure the health care proxy of these powers. Note, however, there is no legal precedent in Alabama that establishes that these steps will successfully enable a health care proxy in an AMD to also carry general health care decision-making powers. Therefore, to be safe, practitioners might want to execute a Durable Power of Attorney for Health Care for their clients in this situation.

97. ALA. CODE § 22-8A-4(b)(2) (1997) (emphasis added).

98. See *supra* text accompanying note 91.

99. ALA. CODE § 22-8A-4(h)(II)(b) (1997) (emphasis added).

VII. WHEN WILL AN ADVANCE DIRECTIVE BECOME EFFECTIVE?

A. *Incompetence*

Competent persons have an almost absolute right to refuse medical treatment through the doctrine of informed consent.¹⁰⁰ If a patient is competent and able to communicate with his or her physician about the treatment options available, there is no need to discuss whether an advance directive is effective. It is not. Advance directives *never* have an impact upon medical treatment while the patient is competent because the patient can still make decisions for himself.¹⁰¹

Two conditions must be satisfied before an advance directive becomes effective, and incompetence is the first. The Natural Death Act does not give specific requirements for the determination of incompetence. It simply provides that a patient is incompetent when "the attending physician determines that the declarant is no longer able to understand, appreciate, and direct his or her medical treatment . . ."¹⁰² If the health care provider has serious questions about the patient's abilities, a judicial hearing may be held to determine competence.¹⁰³

The second condition required for an advance directive to take effect is that the incompetent patient must be determined

100. See *Cruzan v. Director Mo. Dep't Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

101. See, e.g., *Camp v. White*, 510 So. 2d 166, 168 (Ala. 1987) (describing a situation in which a physician was required to honor a competent patient's directions). The *Camp* court offered this description:

The doctors decided that the time had come to discuss the situation with Mrs. Camp's family. A consultation was arranged and the doctors informed the family of the situation and conveyed to them their recommendation that Mrs. Camp not be put back on the respirator-ventilator. The family in turn consulted with Mrs. Camp. She was informed of her situation and of the doctor's opinion that a return to the breathing machine would be permanent. Mrs. Camp was mentally alert. She made the decision not to return to the respirator-ventilator.

Id.

102. ALA. CODE § 22-8A-4(d) (1997).

103. See 1 MEISEL, *supra* note 7, § 3.3.

to be either terminally ill, terminally injured, or permanently unconscious.¹⁰⁴ The statute provides that two physicians—the attending physician and another qualified and experienced doctor—must personally examine the declarant to determine whether the patient has a terminal illness or injury or is in a state of permanent unconsciousness.¹⁰⁵

B. Terminal Illness or Injury

A terminally ill or injured patient is defined by the statute as:

[a] patient whose death is imminent or whose condition, to a reasonable degree of medical certainty, is hopeless unless he or she is artificially supported through the use of life-sustaining procedures¹⁰⁶ and which condition is confirmed by a physician who is qualified and experienced in making such a diagnosis.¹⁰⁷

This definition is very arbitrary since the statute never defines “hopeless condition” or “imminent.” Is an imminent death one that comes within hours? Days? Two weeks? Six months? The only mention of a prognosis timeline for the termi-

104. ALA. CODE § 22-8A-4(d) (1997).

105. *Id.* Specifically, the statutory language states:

[T]wo physicians, one of whom shall be the attending physician, and one of whom shall be qualified and experienced in making such diagnosis, have personally examined the declarant and have diagnosed and documented in the medical record that the declarant has either a terminal illness or injury or is in a state of permanent unconsciousness.

Id.

106. “Life-sustaining procedures” is not defined within the statute, but section 22-8A-3(8) defines life-sustaining treatment as follows:

Any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to the patient, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, assisted ventilation, cardiopulmonary resuscitation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs and antibiotics. Life-sustaining treatment shall not include the administration of medication or the performance of any medical treatment where, in the opinion of the attending physician, the medication or treatment is necessary to provide comfort or to alleviate pain.

Id. § 22-8A-3(8).

107. *Id.* § 22-8A-3(14).

nally ill comes within the suggested statutory form, which is not binding law. Section (a), labeled "Terminal illness or injury," provides directives are to be carried out if the doctors determine "that I have an incurable terminal illness or injury which will lead to my death *within six months or less . . .*"¹⁰⁸ This non-binding provision might hint at the intent of the legislature, but even if defined, the combination of the phrases "terminally ill" and "imminent death" as the only criteria for execution of advance directives has been criticized by some authors.¹⁰⁹

C. *Permanently Unconscious*

The other way an incompetent patient's advance directive may become effective is if the declarant is determined to be permanently unconscious. Permanently unconscious is defined by the statute as:

A condition that, to a reasonable degree of medical certainty: a) Will last permanently, without improvement; and b) In which cognitive thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent; and c) Which condition has existed for a period of time sufficient, in accordance with applicable professional standards, to make such a diagnosis; and d) Which condition is confirmed by a physician who is qualified and experienced in making such a diagnosis.¹¹⁰

This mouthful of criteria is a new and helpful addition to the Natural Death Act. Under the 1981 Act a patient had to be terminally ill and incompetent in order for his advance directive to be administered.¹¹¹ However, limiting qualified patients to those who are terminally ill leaves out an extremely large population of patients who might not be facing an immediate or imminent death, but nonetheless are irreversibly unaware of themselves or their surroundings.¹¹² With modern medical care,

108. ALA. CODE § 22-8A-4(h) (1997) (emphasis added).

109. See 1 MEISEL, *supra* note 7, § 8.10; Orentlicher, *supra* note 44, at 1268.

110. ALA. CODE § 22-8A-3(10) (1997).

111. See ALA. CODE § 22-8A-4(a) (1990) (amended 1997).

112. See 1 MEISEL, *supra* note 7, § 9.53 (citing sources estimating the number of patients in a permanently vegetative state at anywhere from 5,000 to 100,000 in the United States alone).

these permanently unconscious individuals can remain alive indefinitely—one patient in a persistent vegetative state survived thirty-seven years.¹¹³ This type of situation is surely one that declarants envision as activating their advance directives, and in the 1997 amendments, the legislature expressly assures patients of this option.¹¹⁴

D. *The Big Exception—Pregnancy*

There is one glaring exception to the standards which activate an advance directive. The Natural Death Act broadly states advance directives of women will not be honored during their pregnancy.¹¹⁵ Alabama is not the only state to include a so-called “pregnancy clause” in its advance directive statute.¹¹⁶ The vast majority of states in some way prohibit pregnant women the ability to forego life-sustaining treatment through a directive.¹¹⁷

These pregnancy provisions have caused much debate within the academic realm,¹¹⁸ especially since no on-point case directly concerning the constitutionality of pregnancy clauses has

113. See *id.* § 9.53.

114. See ALA. CODE § 22-8A-4(d) (1997).

115. *Id.* § 22-8A-4(e) (“The advance directive for health care of a declarant who is known by the attending physician to be pregnant shall have no effect during the course of the declarant’s pregnancy.”).

116. Michael Schuster, Health-Care Decision-Making Training Module (1996), reprinted in PRACTISING LAW INSTITUTE, 9TH ANNUAL ELDER LAW INSTITUTE 189 (1997).

117. See 2 MEISEL, *supra* note 7, § 12.27; Molly C. Dyke, *A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes*, 70 B.U. L. REV. 867, 870 (1990).

118. See, e.g., Timothy J. Burch, *Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes*, 54 MD. L. REV. 528 (1995); Dyke, *supra* note 117; Joel E. Frader, *Have We Lost Our Senses?—Problems with Maintaining Brain-Dead Bodies Carrying Fetuses*, 4 J. CLINICAL ETHICS 347 (1993); James M. Jordan III, *Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 GA. L. REV. 1103 (1988); Anne D. Lederman, *A Womb of My Own: A Moral Evaluation of Ohio’s Treatment of Pregnant Patients with Living Wills*, 45 CASE W. RES. L. REV. 351 (1994); Hope E. Matchan & Kathryn E. Sheffield, *Adding Constitutional Deprivation to Untimely Death: South Dakota’s Living Will Pregnancy Provision*, 37 S.D. L. REV. 388 (1991-92); John A. Robertson, *Posthumous Reproduction*, 69 IND. L.J. 1027 (1994); Janice MacAvoy Smitzer, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987).

been decided.¹¹⁹ The few related cases have not involved women who made advance directives. Instead, they involve situations where the courts attempt to determine whether invasive measures should be performed to save the viable fetus of an incompetent and terminally ill mother¹²⁰ or situations where competent pregnant women refuse potentially life-sustaining treatment.¹²¹ In addition, when confronted with the problem directly, courts have blatantly skirted the issue.¹²² In a leading case, *In re A.C.*,¹²³ the court stated:

The issue presented in this case is not whether A.C. (or any woman) should have a child but, rather, who should decide how that child should be delivered. That decision involves the right of A.C. (or any woman) to accept or forego medical treatment. The Supreme Court has not yet focused on this question in the context of a pregnancy, and we are not so adept at reading tea leaves as to predict how it might rule.¹²⁴

This practice of avoidance results because the issue, especially of blanket prohibitions like Alabama's, raises serious constitutionality questions.

Blanket pregnancy clauses allegedly violate the fundamental rights of privacy guaranteed by the "penumbra" of rights in the Bill of Rights and the "liberty" interest in the Fourteenth Amendment.¹²⁵ The Supreme Court has decided many cases defining this liberty interest in the past three decades.¹²⁶ One author summed up the basic principles derived from the Court's decisions in the following manner:

119. See 1 MEISEL, *supra* note 7, § 9.55.

120. See, e.g., *In re A.C.* 573 A.2d 1235 (D.C. 1990).

121. See, e.g., *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017 (Mass. 1991) (involving a woman refusing blood transfusions because they were against her religion as a Jehovah's Witness).

122. See *DiNino v. State ex rel. Gorton*, 684 P.2d 1297, 1298 (Wash. 1984) (finding no justiciable controversy in a declaratory judgment action brought by a woman who was not terminally ill or pregnant to validate the addition of a clause in her living will that said the directive would still be enforced if she were pregnant and terminally ill).

123. *In re A.C.*, 573 A.2d at 1235.

124. *Id.* at 1245 n.9.

125. See *Burch*, *supra* note 118, at 540.

126. See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

[C]ertain realms of personal decision-making fall under a right of privacy and bodily integrity which restricts the state from infringing upon those decisions unless there is a compelling state interest to do so and the statute is narrowly drawn to effectuate those compelling state interests. These protected areas include decisions regarding contraception, marriage, procreation, child rearing and education, family relationships, and bodily integrity.¹²⁷

Under the conglomerate of these Supreme Court holdings, an incompetent pregnant woman's decision to forego life sustaining treatment seems to be protected by the rights of privacy and liberty.

On the other hand, because of the unique physical and legal status of a pregnant woman, the answer cannot be so clear. Although the right of competent adults to have medical treatment withdrawn or withheld is established, interests of a pregnant woman are not absolute.¹²⁸ After the fetus is viable, the state's interest in preserving life usually outweighs the right of the mother to terminate her pregnancy.¹²⁹ This legal stance leads to two positions of thought. First, supporters of pregnancy clauses argue that an incompetent pregnant woman who is permanently unconscious or terminally ill (especially one who is "brain dead") either has no constitutional rights or has a very weak interest in those rights.¹³⁰ Therefore, the state's right to protect the life of the fetus becomes compelling.¹³¹ Conversely, opponents may argue that, by analogy, it is probable the Supreme Court could rule a competent woman executing an advance directive has the right to determine whether she wishes

127. Burch, *supra* note 118, at 544 (citing *Casey*, 505 U.S. at 833; *Cruzan v. Director Mo. Dep't Health*, 497 U.S. 261 (1990); *Roe*, 410 U.S. at 113; *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Loving v. Virginia*, 388 U.S. 1 (1967); *Griswold*, 381 U.S. at 479; *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923)).

128. *Casey*, 505 U.S. at 879 ("[A] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.").

129. *Id.*

130. *But see In re Quinlan*, 355 A.2d 647, 664 (N.J. Sup. Ct. 1976) ("[T]he State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest.").

131. *See id.*

her directive to be followed when she is pregnant with a fetus that is not viable.

Before viability, the law is well-established that competent women can terminate their pregnancy.¹³² Competent women may also withdraw or withhold life-sustaining treatment for themselves with no resistance. However, this is not the case for incompetent pregnant women in Alabama. Under the 1997 Natural Death Act, the legislature took away a woman's voice in the matter of whether her advance directive will take effect. No matter what the stage of pregnancy, life-sustaining treatment will not be removed via an advance directive if the declarant is pregnant.

A few states provide that a pregnant declarant's directive is invalid only if the fetus is viable.¹³³ Alabama's strict blanket provision likely would be found unconstitutional. The Natural Death Act should at least provide women the option to decide whether they want their advance directive to be followed if they became permanently unconscious or terminally ill and incompetent before their fetus reaches viability.

Women concerned with the blanket prohibition in the statute today may attempt to add an "other specific direction" that expressly overrides or alters the pregnancy clause.¹³⁴ If not upheld and honored, the extra provision would not invalidate the rest of the advance directive since the provisions are severable.¹³⁵

132. See *supra* note 128.

133. See, e.g., ARIZ. REV. STAT. ANN. § 36-3262 (West 1993); ARK. CODE ANN. § 20-17-206(c) (Michie 1991); GA. CODE ANN. § 31-32-3(b) (1996).

134. ALA. CODE § 22-8A-4(h) (1997).

135. *Id.* Interestingly enough, there is no parallel "pregnancy clause" within the surrogacy provision of the Natural Death Act. *Id.* § 22-8A-11. Therefore, it appears that if a pregnant woman with no advance directive or health care proxy becomes terminally ill or permanently unconscious in Alabama, the surrogate may remove life sustaining treatment from the woman using the same substituted judgment standard as if the patient was not pregnant. *Id.* § 22-8A-11(c). Additionally, artificially provided nutrition and hydration could be removed with the same clear and convincing evidence needed for a nonpregnant female. *Id.* Because the Natural Death Act takes such a clearly opposite stance in the case of advance directives, this discrepancy is probably a drafting oversight where a court would be willing to find an implied restriction. See, e.g., *First Ala. Bank of Dothan v. Renfro*, 452 So. 2d 464, 468-69 (Ala. 1984) (explaining there are occasions when courts must correct or ignore obvious inadvertences in order to give a law the effect which was plainly intended by the legislature). In addition, the right to refuse medical treatment is not absolute,

VIII. WHAT ARE OTHER "QUIRKS" OF THE STATUTE?

A. *Express Authorization to Withdraw/Withhold Artificially Provided Nutrition and Hydration*

As mentioned throughout this Comment, the legislature has clearly provided that artificial nutrition and hydration may not be removed via advance medical directive unless specifically authorized within the living will or health care proxy directive.¹³⁶ This is imperative to remember when drafting a directive.

B. *What Exactly Does "Medically Indicated" Mean?*

"Medically indicated" is an undefined phrase used within the *acceptance* options of life-sustaining treatment in the statutory form.¹³⁷ No other state uses this phrase in its advance directive statute. The absence of usage within other advance directive statutes probably results from confusion surrounding the meaning of the term.¹³⁸ Health care lawyers, doctors, and medical ethicists can only agree that "the term *medically indicated treatment* is often nebulous given today's debate surrounding futility."¹³⁹ Medical futility is a great debate because it is questionable, at best, that doctors have the common law duty to administer futile treatment—treatment that will not contribute

and if the fetus were viable, the weighing of interests would automatically begin. However, this contemplation of events within the surrogacy provision more closely follows previously existing rights of pregnant women and trends in case law describing fetal rights than the blanket prohibition found within the advance directive.

136. ALA. CODE § 22-8A-4(a), (b) (1997).

137. See *id.* § 22-8A-4(h).

138. See 2 MEISEL, *supra* note 7, § 19.1; ROBERT M. VEATCH, *THE PATIENT-PHYSICIAN RELATION* 264 (1991); Franklin G. Miller, *The Concept of Medically Indicated Treatment*, 18 J. MED. & PHIL. 91, 93 (1993); Patricia L. Rizzo, *Religion-Based Arguments in the Public Arena: A Catholic Perspective on Euthanasia*, *Compassion in Dying v. State of Washington and Quill v. Vacco*, 1 DEPAUL J. HEALTH CARE L. 243, 251 (1996).

139. Scott Obernberger, *When Love and Abuse Are Not Mutually Exclusive: The Need for Government Intervention*, 12 ISSUES L. & MED. 355, 372 (1997).

to the healing process—requested by a patient.¹⁴⁰ Because providing nutrition and hydration to a permanently unconscious patient could be conceived as futile, it is probably wise to omit this phrase when drafting a living will or health care proxy directive.

In addition, the federal Child Abuse Amendments of 1984, which does use and define the term “medically indicated treatment,”¹⁴¹ provides treatment is not required to be administered *if it merely prolongs dying*—such treatment is *not* medically indicated.¹⁴² The Alabama statutory form states, “I DO want medically indicated life-sustaining treatment, even if it will *not* cure me and *will only prolong the dying process*.”¹⁴³ Therefore, the use of “medically indicated” within the Alabama statutory form is contrary to the usage of the phrase as defined in federal law. The federal definition is certainly not binding upon Alabama, but the contrary usage only supports the proposition that “medically indicated” is unclear, evokes the medical futility quagmire, and should be omitted when drafting an advance directive.

C. *The “Discuss with the Following Persons” Clause*

Another possible source of confusion comes from the paragraph in the statutory form following each health care decision which reads: “In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons, if they are available, the benefits and burdens of taking such action and my stated wishes in this advance directive.”¹⁴⁴ The blank following this paragraph is NOT the place for the name of the health care proxy. There is a separate provision for designation of the health care proxy, and once that has been executed,

140. See 2 MEISEL, *supra* note 7, § 19.2.

141. See 42 U.S.C.A. § 5106g(10) (1995).

142. See Child Abuse and Neglect Prevention and Treatment Program, 50 Fed. Reg. 14,878, 14,889 app. (1985) (to be codified at 45 C.F.R. pt. 1340) (emphasis added); 2 MEISEL, *supra* note 7, § 16.13-18.

143. ALA. CODE § 22-8A-4(h) (1997) (emphasis added).

144. *Id.* § 22-8A-4(h).

there is no reason for naming the proxy again.

The "discuss with the following persons" paragraph results from concern regarding the fact that a living will is a self-executing document.¹⁴⁵ Once a patient becomes qualified, the living will goes into effect. Therefore, situations are conceivable where a declarant's directive to withhold life-sustaining treatment is followed by the health care provider or proxy before the family is notified.

Although the occurrence of such a situation is hypothetically possible, the wisdom of such a "discuss with the following persons" paragraph is uncertain. The paragraph is largely unnecessary since health care providers, always wary of liability, are generally hesitant to follow life-ending directives, especially if the family has not been given notice. In addition, listing certain family members within a legally enforceable advance directive implies they have some kind of power to affect the decisions being made, when in reality, they do not (unless a listed member is also the legal health care proxy or surrogate). Inclusion of such a "discuss with the following persons" paragraph in an AMD only creates the possibility of more confusion and uncertainty in a situation already precariously perched on the legally untrained health care provider's understanding of the complex right-to-die law.

IX. WHAT IF MY CLIENT EXECUTED A LIVING WILL UNDER THE OLD NATURAL DEATH ACT?

A. *Living Wills Under the Old Act*

According to section 22-8A-13, if a declarant's living will or health care proxy designation was executed prior to the effective date of the amendments, April 15, 1997, the declaration is still

145. *See id.* This intent is evidenced by part (d) of the "Other Provisions" section of the statutory form:

Nothing herein shall be construed as a directive to exclude from consultation or notification any relative of mine about my health condition or dying. Written directives by me as to whether to notify or consult with certain family members shall be respected by health care workers, attorneys in fact, or surrogates.

Id.

valid as long as the instrument "was legally effective when written."¹⁴⁶ Living wills crafted from and executed by the "old" statute should be adequate. However, it should be noted that, as the law stands today, a patient with a living will or health care proxy may *not* have artificially provided nutrition and hydration withheld or withdrawn unless his directive specifically and expressly authorizes such action.¹⁴⁷ Therefore, if your clients have strong feelings about artificially provided nutrition and hydration and their previous living wills do not expressly provide for that issue, a new directive should be executed reflecting such.¹⁴⁸

B. Health Care Proxies Under the Old Act

Before amendments were added to the Durable Power of Attorney Act, there could have been some question whether health care proxy documents executed prior to May 8, 1997, were "legally effective." The 1981 Natural Death Act only expressly provided for creation of a living will and the version of the Durable Power of Attorney Act at that time¹⁴⁹ did not expressly provide for creation of a durable power of attorney for health care. However, the amended statute extinguishes any fears regarding this ambiguity since it implies durable powers of attorney for health care were legally effective under the old statutes.¹⁵⁰ A new health care proxy designation executed un-

146. *Id.* § 22-8A-13(a).

147. *See* ALA. CODE §§ 22-8A-13(b), -4(a),(b) (1997).

148. This express authorization requirement creates an interesting situation under the current Alabama law. Under the 1997 Natural Death Act, a person who has weighed future medical care decisions and previously executed a living will under the 1981 Act has no right to have artificial nutrition or hydration withheld or withdrawn unless expressly provided for within the document. *See id.* § 22-8A-4. Many of these living wills probably do not expressly provide for removal of these treatments because they were not mentioned in the 1981 Act. *See* ALA. CODE §§ 22-8A-1 to -10 (1990). However, under the 1997 Act a person who becomes terminally ill or permanently unconscious and has *no written advance directive of any kind* may have nutrition and hydration removed by a surrogate with clear and convincing evidence of that intent. *See* ALA. CODE § 22-8A-11(a) (1997).

149. *See* ALA. CODE § 26-1-2 (1992).

150. The 1997 Natural Death Act states:

Any durable power of attorney regarding health care decisions made prior to May 8, 1997, shall be given effect provided that the durable power of

der the 1997 statute is only necessary if the old health care proxy instrument was not legally executed or did not have specific provisions regarding artificially provided nutrition and hydration.¹⁵¹ The old proxy designation must meet the strict signing requirements and have a written acceptance by the attorney-in-fact attached to be legally executed.¹⁵²

C. Advance Directives Executed in Another State

Advance directives executed in another state are valid in Alabama if: a) they were executed in compliance with the law of the other state, or b) they did not meet the requirements of the state where executed, but they are valid under the laws of Alabama.¹⁵³ Once again, if the advance directive does not provide specific authorization, the removal of artificially provided nutrition and hydration will not be allowed in Alabama.¹⁵⁴

X. TELL ME ABOUT THE NEW SURROGACY PROVISION.
WHAT IF MY CLIENT IS TERMINALLY ILL OR INJURED OR
PERMANENTLY UNCONSCIOUS AND DID NOT MAKE A LIVING
WILL OR APPOINT A HEALTH CARE PROXY?

A. Why Surrogacy Is Needed

The vast majority of citizens do not have some form of an advance medical directive. It is estimated only 9-23% of U.S. citizens have thought ahead and executed directives concerning future medical treatment.¹⁵⁵ Therefore, knowing what happens

attorney was legally effective when written and artificially provided nutrition and hydration shall not be withdrawn pursuant to the durable power of attorney unless specifically authorized herein.

ALA. CODE § 26-1-2(g)(14) (Supp. 1998). Note, however, this savings clause only applies to documents executed *prior* to the effective date of the statute. *See id.*

151. *See* ALA. CODE § 22-8A-4(b) (1997).

152. *See supra* text accompanying notes 89-99.

153. ALA. CODE § 22-8A-12 (1997).

154. *Id.*

155. *See* 2 MEISEL, *supra* note 7, § 10.2.

when someone does not have an advance directive is just as important as knowing the ins and outs of the statutory creation of living wills and health care proxies.

B. Surrogate Decision-Makers in Alabama

Previously under Alabama law, the family of an incompetent, terminally ill or injured patient who had not executed an advance directive had no legal recourse to have life-sustaining medical treatment withheld or removed from their family member.¹⁵⁶ This led to the unfortunate situation where husband, wife, parent, or child was forced to either watch the patient die a slow, prolonged death or to take legal action for court-ordered removal of treatments. Both courses of action are emotionally painful ones for a family already suffering from the stress of the patient's condition. Today, the 1997 Natural Death Act cures this ill.

A surrogate can be obtained for a qualified patient under three conditions: 1) if no advance directive has been executed by the patient; or 2) if the patient has a legally appointed health care proxy, but the proxy is not "reasonably available;" or 3) if the patient has a valid living will that does not address his or her particular medical situation.¹⁵⁷

The surrogate must be a competent adult, as defined within the Natural Death Act.¹⁵⁸ In addition, there is a hierarchy established within the statute for possible surrogates:

Any of the following persons, in order of priority stated, when persons in prior classes are not available or willing to serve, may serve as a surrogate pursuant to the provisions of this section:

- (1) A judicially appointed guardian . . .
- (2) The patient's spouse, unless legally separated or a party to a divorce proceeding;
- (3) An adult child of the patient;
- (4) One of the patient's parents;
- (5) An adult sibling of the patient;

156. See Brockman, *supra* note 14, at 22.

157. See ALA. CODE § 22-8A-11(a) (1997).

158. See discussion *supra* text accompanying notes 50-52.

- (6) Any one of the patient's surviving adult relatives who are of the next closest degree of kinship to the patient; or
(7) If the patient has no relatives known . . . a committee composed of the patient's primary treating physician and the ethics committee of the facility where the patient is undergoing treatment . . .¹⁵⁹

The surrogate must make the qualified patient's health care decisions based upon the substituted judgment standard.¹⁶⁰ However, consistent with the rest of the Natural Death Act, there is a higher standard to be met before artificially provided nutrition and hydration may be withdrawn. The surrogate must prove by clear and convincing evidence the patient would have wanted the nutrition and hydration withheld or withdrawn.¹⁶¹ There is also a mechanism within the statute for cases in which the surrogate's authority is disputed.¹⁶²

C. Requirements for the Surrogate

The surrogate must complete a form providing certification before his protection from liability is established.¹⁶³ Completion of the form shows the surrogate has contacted all more qualified parties within the surrogacy hierarchy, and they have assented to his fulfilling the surrogate position.¹⁶⁴ This form,¹⁶⁵ adopted in the Alabama Administrative Code, is not part of the material required to be given out by hospitals under the Patient Self Determination Act. The surrogate must acquire it from a lawyer

159. ALA. CODE § 22-8A-11(d) (1997).

160. See *id.* § 22-8A-11(c). The statute provides:

The surrogate shall . . . make decisions . . . that conform as closely as possible to what the patient would have done or intended under the circumstances, taking into account any evidence of the patient's religious, spiritual, personal, philosophical, and moral beliefs and ethics, to the extent these are known to the surrogate. Where possible, the surrogate shall consider how the patient would have weighed the burdens and benefits of initiating or continuing life-sustaining treatment . . . against the burdens and benefits to the patient of that treatment

Id.; see also *supra* note 86 (discussing standards of decision making).

161. ALA. CODE § 22-8A-11(c) (1997).

162. See *id.* § 22-8A-11(j).

163. See *id.* § 22-8A-11(e).

164. See *id.* § 22-8A-11(e), (f).

165. See *id.* § 22-8A-11(i).

or another informed individual. The Administrative Code form must be used—no substitutes or variations are acceptable.¹⁶⁶

Once the surrogate is certified, he or she may proceed in good faith to make the medical decisions for the qualified patient.¹⁶⁷ Health care providers are also given statutory protection from liability when following the instructions of the surrogate in good faith.¹⁶⁸

XI. CONCLUSION

Although close examination of the statute and common law answers many questions surrounding the 1997 amendments to Alabama's Natural Death Act, many mysteries still remain unsolved. For instance, what happens if a layperson executes the statutory form and initials every blank? What if the layperson does not make decisions in a certain category of the form during execution, but later goes back and initials those blanks? Does the more specific, and graphic, statutory form¹⁶⁹ actually hinder the AMD movement because it forces clients to consider and confront tough decisions surrounding an undesirable death more closely than they would wish?

These questions and others will have to be answered by the Alabama courts or the legislature. Hopefully, the Alabama legislature will try to provide solutions to the ambiguities in its Natural Death Act before those ambiguities are fleshed out in the courts. In advocacy of hastening this response, the legislature should be reminded that these potential court cases are not run-of-the-mill legal questions; lives will literally hang in the balance.

Elizabeth Jones Hemby

166. Ala. Admin. Code r. 420-5-19-01 (1997). This requirement creates new problems regarding how the potential surrogate is expected to have knowledge of this form's existence and its whereabouts. The health care provider is the most logical potential informant, but the provider is currently under no legal obligation to be informed of these facts. See ALA. CODE § 22-8A-11(g) (1997).

167. See *id.* § 22-8A-11(c).

168. See *id.* § 22-8A-11(g).

169. See, e.g., *id.* § 22-8A-4(h). The statute states in part, "I DO want medically indicated artificially provided nutrition and hydration, *even if it will only prolong the dying process*" and "I do NOT want artificially provided nutrition and hydration . . . *even if withholding or withdrawing causes me pain.*" *Id.* (emphasis added).