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An Advance Directive: The Elective, Effective Way to Be Protective of Your Rights

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Casenote

An Advance Directive: The Elective, Effective Way to Be Protective of Your Rights*

I. INTRODUCTION

Death is an eternal theme within all cultures; the Grim Reaper coming to collect a person's soul, death riding in on a pale horse, mythical characters like Hades and Thanatos. A seemingly inescapable proposition emerged over time: the nature of death is unpredictable and unavoidable. Eventually, due to changes in technology, the world's perspective on the nature of death shifted. Advancements in medical technology introduced a plethora of life-sustaining procedures, and death was no longer completely beyond a human's control.

A breakthrough in the medical means used to control the dynamic nature of death occurred when the Georgia General Assembly enacted the Georgia Advance Directive for Health Care Act (the Act)[1] in 2007. The Act created a single form, the advance directive, and resolved the inconsistencies between the living will and the durable power of attorney for health care.[2] The resolutions contained in the advance directive served two goals: to clarify the role of the medical providers and to give greater power to patients to have the ultimate decision making power in their medical treatment.[3]

Along with these two goals, the Act also intended to provide a straightforward mechanism to transfer the decision making power of the patient

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1. O.C.G.A. § 31-32-1 (2007).
2. *See generally* O.C.G.A. § 31-32-4 (2007).
3. *See generally* O.C.G.A. § 31-32-7 (2007).

to a health care agent, while ensuring the power would still have the full effect as if the patient were still the one making decisions. As one of the first cases in Georgia to consider the reach of the Act, *Doctors Hospital of Augusta v. Alicea*[4] defined what is required of a health care provider who fails, or is unwilling, to comply with a health care agent's directions to qualify for immunity from civil liability under the Act's good faith reliance standard.[5]

II. FACTUAL BACKGROUND

Bucilla Stephenson executed an advance directive for health care (advance directive) on November 12, 2009, two years before being admitted to the hospital for her final illness. The advance directive designated Stephenson's granddaughter, Jacqueline Alicea, as her health care agent. As an agent, Alicea was authorized to make all health care decisions for Stephenson, if Stephenson became incapable of making her own decisions. This authority also allowed Alicea to make decisions regarding providing, withholding, or withdrawing artificial nutrition and hydration, and all other forms of health care. Alicea's decisions were required to be in accordance with the instructions Stephenson documented in the advance directive and Stephenson's other wishes to the extent known to Alicea.[6] Stephenson notified Alicea and other members of her family that her wish was to not be kept alive on a machine if her condition was terminal.[7] Specifically, Stephenson expressed "'she was ready to go when the good Lord called her,' and often repeated, 'when it's my time, it's my time, don't prolong it.'"[8]

In the advance directive section addressing "end-of-life decisions," Stephenson initialed:

> Choice NOT to Prolong Life.
>
> I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of

4. 299 Ga. 315, 788 S.E.2d 392 (2016).

5. *Id.* at 325, 788 S.E.2d at 401.

6. *Id.* at 316, 788 S.E.2d at 395.

7. Doctors Hosp. of Augusta, LLC v. Alicea, 332 Ga. App. 529, 531, 774 S.E.2d 114, 117 (2015).

8. *Alicea*, 299 Ga. at 316, 788 S.E.2d at 395. Alicea was particularly aware of Stephenson's wishes in regard to end-of-life decisions. Stephenson had instructed Alicea individually that she did not want to rely on a machine to have to live because two years earlier, Alicea had to make the decision to take her father, Stephenson's son-in-law, off of a ventilator and Stephenson did not want Alicea to have to make that kind of decision again. *Id.*

> medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.[9]

Stephenson was admitted to the hospital on March 3, 2012. Alicea gave her contact information and a copy of Stephenson's advance directive to the hospital as Stephenson was admitted. Upon filing, the advance directive was not placed behind the admission tab of Stephenson's medical record as required by hospital policy.[10] Instead, the advance directive was misfiled in Stephenson's separate medical chart at the Intensive Care Unit (ICU) main desk.[11]

The following morning, Dr. Phillip Catalano called Alicea to inform her of his intentions to perform a computed tomography scan (CT scan).[12] Alicea agreed and informed Dr. Catalano of Stephenson's advance directive. She specifically instructed cardio-pulmonary resuscitation (CPR) was not to be administered and no heroic measures were to be used to prolong Stephenson's life. Later, Dr. Carmel Joseph called Alicea with the results of the CT scan and for consent on the next step of treatment. Alicea consented to a right chest thoracentesis.[13] Again, she expressed her earlier instructions regarding CPR and heroic measures.[14] In response, Dr. Joseph asked Alicea about ventilation and she instructed him to call her before Stephenson was intubated or put on a ventilator. Pursuant to the hospital's policy requiring physicians to make notes of any discussions with designated health care agents about an advanced directive, Dr. Joseph made a progress note in Stephenson's medical chart documenting Alicea's instructions.[15]

Two days after Stephenson's admission, on March 5, Dr. Catalano, who had not read Stephenson's advance directive or the progress note in her medical chart, called Alicea to request consent for a surgical thoracentesis to drain more infection from Stephenson's lung. He explained Stephenson would be under general anesthesia, but he did not explain that the procedure required intubation and the use of a ventilator, nor was Alicea told Stephenson had been intubated and put on a ventilator

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9. *Id.*

10. *Id.* at 317, 788 S.E.2d at 395.

11. *Alicea*, 332 Ga. App. at 533, 774 S.E.2d at 118.

12. *Alicea*, 299 Ga. at 317, 788 S.E.2d at 396.

13. *Id.* (noting the procedure does not require intubation); "[A] surgical puncture of the chest wall into the parietal cavity for aspiration of fluids." *Thoracentesis*, THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY (1987).

14. *Alicea*, 299 Ga. at 317-18, 788 S.E.2d at 396.

15. *Id.* at 318, 788 S.E.2d at 396. This progress note was made in a separate file from Stephenson's advance directive which was still misfiled in the ICU main desk file. *See id.*

during the surgery. She would not have consented to the surgery had she been informed intubation was required.[16]

Two days after Stephenson's second procedure, around 5:00 a.m. on March 7, Stephenson began experiencing respiratory distress. Dr. Catalano unilaterally decided, and instructed the on-duty doctor, to intubate Stephenson and put her on a ventilator. This decision was made without reference to the progress note in Stephenson's medical file, without reference to Stephenson's advance directive, and without reference to Stephenson's agent, Alicea. When Alicea learned Stephenson had been intubated and put on a ventilator, she came to the hospital with another copy of the advance directive. The nursing staff finally located the hospital's first copy of the advance directive fifteen to twenty minutes after Alicea's arrival with the new copy.[17]

Alicea explained to Dr. Mehrdad (Michael) Behnia, the physician in charge of the ICU, that the actions taken that morning were directly contrary to her grandmother's wishes and her own specific instructions to call her before Stephenson was put on a ventilator.[18]

Dr. Behnia outlined Alicea's two options moving forward: Stephenson could be taken off the ventilator and extubated, which would cause her to suffocate and die, or Stephenson could undergo another thoracentesis. Alicea chose the latter option, consenting to yet another surgical procedure. Throughout the following days, Alicea consented to several more surgical procedures per the recommendations of various hospital employees.[19]

Seven days after Dr. Catalano's unilateral decision to intubate Stephenson, Dr. Behnia informed Alicea that Stephenson's kidneys were failing and recommended Stephenson be taken off the ventilator. So, Alicea authorized the removal of the ventilator and the provision of comfort measures until Stephenson's death on March 17, 2012.[20]

Alicea, as administrator of Stephenson's estate, filed a complaint against the hospital and Dr. Catalano (defendants). The defendants filed a motion for summary judgment containing an argument for immunity under Official Code of Georgia Annotated (O.C.G.A.) sections 31-32-10(a)(2) and (3).[21] The trial court denied summary judgment based on

16. *Id.*

17. *Id.* at 318-19, 788 S.E.2d at 396-97.

18. *Id.* at 319, 788 S.E.2d at 397.

19. *Id.* at 319-20, 788 S.E.2d at 397. The additional procedures included the placement of a feeding tube, a bronchoscopy, and a tracheostomy. *Id.*

20. *Id.* at 320, 788 S.E.2d at 397.

21. *Id.* at 320-21, 788 S.E.2d at 397-98; O.C.G.A. §§ 31-32-10(a)(2) & (3) (2007).

immunity, but granted a certificate of immediate review.[22] The court of appeals granted the defendants' application for interlocutory appeal and affirmed, holding that the defendants were not entitled to summary judgment on the basis of immunity under O.C.G.A. §§ 31-32-10(a)(2) and (3).[23] The Georgia Supreme Court granted certiorari to review this portion of the court of appeals' decision.[24]

On review, the supreme court held Dr. Catalano did not act in "good faith reliance" on any direction from Alicea, and he did not satisfy the requirements of a provider who is unwilling to comply to qualify for immunity under O.C.G.A. §§ 31-32-10(a)(2) and (3).[25] For that reason, the supreme court affirmed.[26]

III. LEGAL BACKGROUND

A. The Right to Decide

A patient has the right to complete control of his or her person, including control over decisions regarding which medical procedures are performed on him or her.[27] The right to decide includes the right to *consent* to treatment and the right to *refuse* treatment.[28] The nature of the treatment does not affect the patient's right to make decisions regarding the treatment, even decisions that result in death have been consistently upheld.[29]

B. Legal Approaches to the Right to Decide

Courts use various theories to uphold the patient's right to decide.[30] Under the common law doctrine of self-determination, a patient is free from unwanted bodily intrusion. [31] Thus, for a treatment to be valid, a

22. *Alicea*, 299 Ga. at 321, 788 S.E.2d at 398.

23. *Id.*

24. *Id.*

25. *Id.* at 330-31, 788 S.E.2d at 404.

26. *Id.* at 331, 788 S.E.2d at 405.

27. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 270 (1990).

28. *Id.*

29. *See, e.g.*, *Cruzan*, 497 U.S. 261, 277; Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137 (1986); Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980).

30. *See* Kelly Mulholland, *Protecting the Right to Die: The Patient Self-Determination Act of 1990*, 28 HARV. J. ON LEGIS. 609, 610 (1990).

31. *See* Delio v. Westchester Cty. Med. Ctr., 129 A.D.2d 1, 3 (N.Y. 1987) (holding the right to refuse medical care is based on the common law right to self-determination).

patient must be fully informed of the medical risks involved and freely consent to a treatment.[32]

The doctrine of informed consent in Georgia is statutorily defined.[33] The statute requires the doctor to inform the patient of the nature and purpose of a procedure, the material risks involved, the likelihood of success, practical alternatives, and the prognosis of the patient's condition if the procedure is rejected.[34] The extensive nature of the information required to be divulged reflects the importance of an individual's right to control what happens to his or her own body.[35]

The Patient Self-Determination Act of 1990[36] requires healthcare providers to communicate (1) a patient's right to refuse treatment and (2) the healthcare provider's policies for implementing the patient's wishes to the patient.[37] The purpose of mandating this specific communication is to encourage patients to execute advance directives.[38] An advance directive may be in the form a living will, a durable power of attorney for health care, or both.[39] Advance directives are provided by state statutes.[40]

C. Patient's Right to Decide Includes the Right to Die

The "right to die" refers to a patient's right to refuse unwanted medical treatment or to have ongoing, life-sustaining medical treatment withdrawn even though the patient will die without the treatment.[41] Generally, competent people have the right to die because competent patients

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32. RESTATEMENT (SECOND) OF TORTS § 892A (AM. LAW INST. 1977); *see also* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

33. O.C.G.A. § 31-9-6.1 (2009); *see also* Roberts v. Connell, 312 Ga. App. 515, 516, 718 S.E.2d 862, 864 (2011).

34. O.C.G.A. § 31-9-6.1.

35. *See Cruzan*, 497 U.S. at 269.

36. H.R. 4449, 101st Cong. (1990).

37. *Id.*

38. Mulholland, *supra* note 30, at 609; "[A] legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate." *Advance Directive*, BLACK'S LAW DICTIONARY (10th ed. 2014).

39. Betsy Simmons Hannibal, *What Health Care Directives Are Called in Your State*, NOLO, http://www.nolo.com/legal-encyclopedia/health-care-declarations-your-state.html (last visited Nov. 3, 2016).

40. *See Cruzan*, 497 U.S. at 217.

41. *Id.*

are able to exercise their right to make decisions regarding medical treatment directly.[42] Alternatively, an issue arises when an incompetent patient cannot exercise this right directly.[43] The advancement of life-sustaining technology has forced many courts to analyze the right to refuse treatment when the patient is incompetent and the manner in which the right to decide may be exercised for an incompetent patient.[44] Three seminal cases detail the stories of Karen Ann Quinlan, Nancy Cruzan, and Terri Schiavo.[45]

The 1976 case, *In re Quinlan*,[46] was the starting point of extending patient autonomy to treatment that will result in the patient's death and allowing a guardian to make decisions on behalf of the patient.[47] Karen Ann Quinlan was declared to be in a chronic persistent vegetative state. She was being kept alive by medical technology, such as the ventilator assisting her breathing. Her father sought to discontinue the medical treatment that was only prolonging his daughter's death.[48] The Supreme Court of New Jersey, in a 7-to-0 decision, allowed the removal of the medical procedures maintaining Quinlan's life *only if* there was no reasonable possibility of Quinlan ever emerging from her present comatose condition.[49] The court based its reasoning on Quinlan's constitutional right of privacy.[50] Specifically, Quinlan's interest in removing the life-sustaining medical treatment exceeded the state's interest in preserving life, so long as medical authorities saw "no reasonable possibility" she would recover.[51] Although Quinlan could not make decisions for herself, the court

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42. *See generally In re* Conroy, 98 N.J. 321, 353 (N.J. 1985) (holding a competent adult generally has the right to refuse medical treatment).

43. *Id.* at 356.

44. The right to decide can be exercised by a surrogate decision maker applying one of three standards: (1) a "subjective" standard "when there was clear evidence that the incompetent person would have exercised it"; (2) an objective "best interest" standard when such evidence was lacking; or (3) a "pure-objective" standard (a person's suffering would make the administration of life-sustaining treatment inhumane) where such evidence does not exist. *See Cruzan*, 497 U.S. at 273.

45. *Cruzan*, 497 U.S. at 261; Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1289 (Fla. 2005); *In re* Quinlan, 70 N.J. 10 (1976).

46. 70 N.J. 10 (1976).

47. *Id.*

48. *Id.* at 18.

49. *Id.* at 55.

50. *See id.*; Roe v. Wade, 410 U.S. 113, 152 (1973) (establishing, three years before *In re Quinlan*, the right to privacy with regard to medical issues); no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. CONST. amend. XIV, § 1 (forming the basis to right to life).

51. *Quinlan*, 70 N.J. at 54. When considering the constitutionality, the court must weigh the interests of the state against the interests of the individual. *See Cruzan*, 497 U.S.

ruled incompetence should not deprive Quinlan of her constitutional right to refuse medical treatment and, therefore, permitted her guardian to make decisions on her behalf.[52]

Karen Ann Quinlan's story stirred up public discussions on the right to die. In 1990, five years after Quinlan's death, *Cruzan v. Director, Missouri Department of Health*[53] was the first case in which the Supreme Court of the United States examined the right to die.[54] A car accident left Nancy Cruzan in a persistent vegetative state for almost eight years. Her parents wished to terminate the artificial nutrition and hydration that was sustaining her life.[55] The Court, in its first ruling on the right to die, analyzed whether Cruzan had a constitutional right to require the hospital to withdraw life-sustaining treatment under these circumstances.[56] The Court determined under the Due Process Clause of the Fourteenth Amendment a competent patient possesses a right to refuse treatment.[57]

Nevertheless, the Court did not extend the right to refuse treatment to incompetent patients.[58] Instead, it relied on the state's interest in preserving and protecting life and held it is constitutional for the state to require clear and convincing evidence of an incompetent patient's wishes to withdraw life-sustaining treatment.[59] Essentially, the state is permitted to decide the evidentiary standards required to prove the incompetent

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at 273. State interests involved are the following: "the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession." *Id.* at 271; *see also* Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 739-43, 370 N.E.2d 417, 425-26 (1977).

52. *Id.* at 54-55. After the court's verdict, Quinlan's parents had the ventilator removed but did not request the removal of the feeding tube. Quinlan's father explained artificial breathing was an extraordinary measure that was preventing God's will whereas continuing nutrition was an ordinary care that still allowed God to determine when Quinlan would die. Quinlan began to breathe on her own after the ventilator was removed and lived in a nursing home until her death nine years later. Karen Ann Quinlan died on June 11, 1985. *How The "Right to Die" Came to America*, http://www.ncll.org/liberty-centers/center-for-life-defense/cld-articles/57-how-the-right-to-die-came-to-america (last visited Nov. 1, 2016).

53. 497 U.S. 267 (1990).

54. *Id.* at 269.

55. *Id.* at 266-67.

56. *Id.* at 269.

57. *Id.* at 278-79.

58. *See id.* at 280.

59. *Id.* at 280-84. After the Court's verdict, Cruzan's parents asked for a second hearing to present new evidence based on the ruling which required a showing of clearing and convincing evidence of Cruzan's wishes. Eventually, the Cruzans were granted the right to have the feeding tube that was keeping their daughter alive removed. Nancy Cruzan died on December 26, 1990. Although this case was monumental to the right to die issue, it took a toll on Cruzan's parents. Cruzan's father committed suicide in 1996 and Cruzan's mother was diagnosed with cancer, refused treatment, and died in 1998. Chris Tisch, *A fate unclear,*

patient's wishes as long as the standards account for the patient's rights under the Fourteenth Amendment.[60] In states with a high evidentiary standard, the patient's family cannot terminate treatment unless the patient has stated his or her intention in writing, or orally in very clear terms.[61] The Court suggested a patient whose wishes are clearly known may possess an absolute right to terminate life-sustaining treatment.[62] Thus, an advance directive may constitutionally require termination.

Interest in advance directives increased due to the Court's ruling which gave the state power to set its own evidentiary standard as to proving an incompetent patient's wishes. The advance directive received attention to ensure that clear and convincing evidence of an individual's wishes was present should he or she become incompetent.

Unlike Karen Ann Quinlan and Nancy Cruzan, whose parents were the interested parties seeking to terminate life-sustaining medical treatment against the state's interest, Terri Schiavo was married. It was Schiavo's husband who wished to remove the life-sustaining treatment while her parents wished to continue to provide treatment. The conflict between Schiavo's husband and her parents caused the litigation process to become quite complicated. Three separate court orders to discontinue artificial nutrition were entered in 2000, 2003, and 2005 as Schiavo's parents fought to continue their daughter's life.[63] The final order was the ultimate nail in the coffin, Terri Schiavo died on March 31, 2005.[64]

Although Terri Schiavo's case is the most recent as it was not decided until 2005, she was admitted to the hospital on February 25, 1990, around the time *Cruzan* was being decided.[65] Local and national media funneled the public's fears about the dying process into increased atten-

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a legacy assured, TAMPA BAY TIMES (Feb. 27, 2005), http://www.sptimes.com/2005/02/27/Tampabay/A_fate_unclear__a_leg.shtml.

60. *See Cruzan*, 497 U.S. at 281.

61. *See supra* note 30, at 614.

62. *See Cruzan*, 497 U.S. at 272.

63. *Schiavo*, 403 F.3d at 1291.

64. Terri Schiavo's autopsy revealed a severely damaged brain, specifically Schiavo's brain atrophied to less than half the weight a brain should weigh. The medical examiner who performed the autopsy confirmed the autopsy results were consistent with a person in a persistent vegetative state and no treatment could have reversed the damage. *See* Timothy Williams, *Schiavo's Brain was Severely Deteriorated, Autopsy Says*, N.Y. TIMES (June 15, 2005), http://www.nytimes.com/2005/06/15/national/schiavos-brain-was-severely-deteriorated-autopsy-says.html?_r=0.

65. *See Schiavo*, 403 F.3d at 1289.

tion on the right to decide. Many legislative acts resulted from the interest sparked by the rising number of cases involving incompetent patients who had not executed advance directives.[66]

D. The Right to Die is (Mostly) Not Extended to Physician-Assisted Suicide

Although *In re Quinlan* held physicians who cease patients' life-sustaining medical treatment will not be held civilly or criminally liable for causing death, Dr. Kevorkian was prosecuted for assisting suicide activities of competent, terminally ill patients in 1997.[67]

The disparity in liability protection between physicians complying with directions that result in death and physicians assisting a patient's death has led many to fight for the "right to die with dignity."[68] A right to die with dignity refers to a terminal patient's "right to authorize a physician to perform an act that intentionally results in the patient's death, without the physician's being held civilly or criminally liable for having caused the death."[69] Four states have statutorily extended the liability protection of *Quinlan* to physicians who assist a patient's death.[70] In June 2016, California became the fourth state to authorize physician-assisted suicide.[71]

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66. *See, e.g.*, OKLA. STAT. tit. 63, § 3102.1 (2009); O.C.G.A. tit. 31, ch. 32 (2007); UTAH CODE ANN. § 75-2a-107 (2007); IDAHO CODE § 39-4515 (2006).

67. *Quinlan*, 70 N.J. at 55; *see* Kevorkian v. Thompson, 947 F. Supp. 1152, 1179 (E.D. Mich. 1997) (holding the "Equal Protection Clause of the Fourteenth Amendment is not violated by denying a mentally competent, terminally ill, or intractably suffering adult not on life support the right to assisted suicide.").

68. Art Swift, *Euthanasia Still Acceptable to Solid Majority in U.S.*, GALLUP.COM (May 4-8, 2016), http://www.gallup.com/poll/193082/euthanasia-acceptable-solid-majority.aspx. Gallup polls have found a majority of Americans are in favor of physicians legally assisting ending a patient's life if requested since 1973. In 1990, the percentage in favor was 65%. The percentage has ranged from 64% to 75% between 1990 and 2016, with the current percentage accounting for 69% of Americans in favor of death with dignity laws. *Id.*

69. *Physician-Assisted Suicide and The Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2023 (1992).

70. Oregon, California, Vermont, and Washington are the four states with death with dignity laws. OR. REV. STAT. § 127.897 (1995); CAL. HEALTH & SAFETY CODE § 443.2 (2016); VT. STAT. ANN. § 5283 (2013); WASH. REV. CODE § 70.245.020 (2017).

71. *See* CAL. HEALTH & SAFETY CODE § 443.2 (otherwise known as the "End of Life Option Act"); *see also* Michael H. White, *Physician-Assisted Dying: Developments in State Law*, 33 NO. 4 GPSOLO 30 (2016) (observing in 2014 a terminally ill 29-year-old, Brittany Maynard, moved to Oregon to end her life under Oregon's Death with Dignity Act, sparking the enactment of California's End of Life Option Act).

There are safeguards within the text of the death with dignity statutes to ensure the patient's request for assistance in dying is voluntary.[72] Specifically, the patient must be competent and mentally capable of making and directly communicating decisions, and must be diagnosed with a terminal illness that will cause the patient's death.[73] This is entirely different from the right to die which the Court has extended to incompetent patients.

E. Georgia Law Before and After 2007

Georgia law emphasizes an individual's right to control all aspects of his or her medical treatment, including decisions to withhold or withdraw medical treatment.[74] Georgia law allows this deciding power to be transferred to an agent appointed by an individual.[75] A health care agent is permitted to make decisions on behalf of the individual when the individual is not able to communicate his or her decisions due to incompetency.[76]

1. Before 2007

Until 2007, Georgia laws contained two separate forms that established two different types of health care agencies: a living will and a durable power of attorney for health care.[77] O.C.G.A. § 31-32-1[78] defined the first form as "the right of a competent adult person to make a written directive, known as a *living will*, instructing his [or her] physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition, a coma, or a persistent vegetative state."[79] The second form, a durable power of attorney for health care was described in O.C.G.A. § 31-36-2.[80] A durable power of attorney for health care enables an individual to delegate the decision-making power to a trusted agent

72. *See* CAL. HEALTH & SAFETY CODE § 443.2(a)(2).

73. CAL. HEALTH & SAFETY CODE § 443.5.

74. O.C.G.A. tit. 31, ch. 32. Georgia does not extend patients the right to physician-assisted suicide. O.C.G.A. § 16-5-5 (2015) (prohibiting physician-assisted suicide).

75. O.C.G.A. tit. 31, ch. 32.

76. O.C.G.A. § 31-32-7.

77. Prior to the 2007 legislation, the laws relating to living wills appeared at Chapter 32 of Title 31 of the O.C.G.A. (1992); prior to the 2007 legislation, the laws relating to durable powers of attorney for health care appeared at Chapter 36 of Title 31 of the O.C.G.A. (1990). O.C.G.A. ch. 32 (1992); O.C.G.A. ch. 36 (1992).

78. O.C.G.A. § 31-32-1 (1992).

79. *Id.* (emphasis added).

80. O.C.G.A. ch. 36 (1992).

in the event the individual becomes disabled, incapacitated, or incompetent.[81]

Prior to the 2007 revision, each statute performed its own separate function.[82] A living will informed the physician of the patient's wishes, but the decision ultimately rested with the physician.[83] A durable power of attorney for health care, on the other hand, ensured an agent appointed by the patient had power to make personal and health care decisions that would be effective to the same extent as though made by the patient.[84]

Efforts to alleviate the confusion surrounding statutory form living wills and durable powers of attorney began during the 2006 session of the Georgia General Assembly.[85] Georgia State Representative R. Steve Tumlin, Jr. and the Fiduciary Law Section's Legislation Committee set about reviewing and revising the statutory form living will and durable power of attorney for health care after the 2006 session closed.[86]

Various professionals including lawyers, doctors, and other persons interested in Georgia's law on advance directives for health care convened a roundtable to discuss how the current statutory forms are understood from different viewpoints.[87] The members of the roundtable decided to combine the living will and the durable power of attorney for health care into a single form.[88] Accordingly, legislation was prepared to amend Title

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81. *Id.*

82. A helpful website resource defines relevant terminology for the public. "Living Will: The document that describes your health care wishes"; "Power of Attorney for Health Care: The document in which you name someone to make healthcare decisions for you"; "Advance Directive: A combined living will and power of attorney for health care." Hannibal, *supra* note 39.

83. O.C.G.A. § 31-32-2(11) (1992).

84. O.C.G.A. § 31-36-2 (1990).

85. Nikola R. Djuric, *A New Advance Health Care Directive for Georgia*, *in* 52ND ANNUAL ESTATE PLANNING INSTITUTE 1 (Institute of Continuing Legal Education in Georgia, 2007).

86. *Id.*

87. *Id.* Patients, physicians, nurses, patient advocates, hospital lawyers, estate planning lawyers, and the general public all have varying perspectives on the importance, function, and nature of these statutory forms. *Id.*

88. *Id.* Twenty-four states have a single form advance directive. *See* ALA. CODE § 22-8A-4 (2001); ALASKA STAT. § 13.52.010 (2016); ARK. CODE. ANN. § 20-6-103 (2013); CAL. PROB. CODE § 4674 (2000); DEL. CODE ANN. tit. 16, § 2503 (1996); O.C.G.A. § 31-32-4; HAW. REV. STAT. § 286-109.4 (1993); IDAHO CODE § 39-4515 (2005); KY. REV. STAT. ANN. § 311.625 (1994); LA. STAT. ANN. § 40:1151 (2015); ME. REV. STAT. ANN. tit. 18-A, § 5-804 (1995); MD. CODE ANN., HEALTH-GEN. § 5-602 (1993); MINN. STAT. § 145B.03 (1989); MISS. CODE ANN. § 41-41-209 (1998); N.H. REV. STAT. ANN. § 137-J:20 (2014); N.M. STAT. ANN. § 24-7A-1 (2015); N.D. CENT. CODE § 23-06.5 (1991); OKLA. STAT. tit. 63, § 3102.1 (2009); OR. REV. STAT. § 127.515 (1993); TENN. CODE ANN. § 68-11-1803 (2004); UTAH CODE ANN. § 75-2a-

31 of the O.C.G.A. to create a new form, the Advance Directive for Health Care.[89]

2. After 2007

The limited number of cases litigating Georgia's advance directive leaves much to be interpreted.[90] The advance directive has four sections: (1) Health Care Agent; (2) Treatment Preferences; (3) Guardianship; and (4) Effectiveness and Signatures.[91] The four sections were drafted to be comprehensive and, as a result, the low level of cases may be a reflection of the fulfillment of the Act's purpose. Alternatively, the cases that get reported may underrepresent the true number of people still struggling to invoke a loved one's end of life wishes. People want to let the dead rest peacefully and not fight over it and prolong the anguish.

IV. COURT'S RATIONALE

The Georgia Supreme Court, with Justice Nahmias writing its unanimous decision, divided its opinion into three distinct parts. First, the court emphasized the purpose of the Act.[92] Second, the court thoroughly explained the duties of a health care provider under the Act by looking to its statutory language.[93] Third, the court addressed and rejected the defendants' contention for immunity.[94]

In *Doctors Hospital of Augusta v. Alicea*, the court first focused on the Act's purpose.[95] The court noted the Act was proposed to alleviate confusion and update laws relating to end-of-life care by replacing two prior statutes in Title 31 of the O.C.G.A.[96] Further, the court acknowledged the Act was designed to ensure the will of the patient or his or her designated agent controls, not the will of the health care provider.[97]

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107 (2007); VT. STAT. ANN. tit. 18, § 9702 (2010); VA. CODE ANN. § 54.1-2983 (2009); WYO. STAT. ANN. § 35-22-401 (2005).

89. Djuric, *supra* note 85, at 5-7. Living wills and durable powers of attorney for health care executed before 2007 are still effective. O.C.G.A. § 31-32-3 (2007).

90. *See Alicea*, 299 Ga. 315, 788 S.E.2d 392; Ussery v. Children's Healthcare of Atlanta, Inc., 289 Ga. App. 255, 656 S.E.2d 882 (2008).

91. O.C.G.A. § 31-32-4 (2007). For an analysis of Wills, Trusts, and Estates during the 2007 survey period, see Mary Radford, *Wills, Trusts, Guardianships, and Fiduciary Administration*, 59 MERCER. L. REV. 447 (2007).

92. *Alicea*, 299 Ga. at 322, 788 S.E.2d at 399.

93. *Id.* at 323-24, 788 S.E.2d at 400.

94. *Id.* at 327, 788 S.E.2d at 402.

95. *Id.* at 322, 788 S.E.2d at 399.

96. *Id.*

97. *Id.*

After the court articulated the purpose of the Act, the court next focused on the text of O.C.G.A. § 31-32-8(2) to determine the duties of health care providers under an advance directive for health care.[98] The court interpreted the Act to require a health care provider to comply with the health care agent's decision unless one of two exceptions applied: (1) the decision involves pain treatment or; (2) the provider is unwilling to comply on medical, moral, or other grounds.[99] The court explained an unwilling provider under the second exception is not entitled to begin making decisions on behalf of the patient or to simply walk away.[100] Instead, according to the text of the statute, the unwilling provider must promptly inform the agent of the provider's unwillingness to comply and must provide reasonably necessary consultation and care in connection with the transfer of the patient to another caregiver as arranged by the agent.[101]

The court next interpreted the immunity provisions of O.C.G.A. § 31-32-10(a), specifically subsections (2) and (3), and, as a result, rejected the hospital's claim that it was qualified for immunity.[102] In doing so, the court considered the parallel nature of the statutory duties of health care providers and the statutory immunity provisions afforded to such providers (O.C.G.A. § 31-32-10(a)(1)-(3) and O.C.G.A. § 31-32-8(2)).[103]

Moreover, the court rejected the hospital's argument that O.C.G.A. § 31-32-10(a)(2) and (3) provide freestanding immunity that is not limited by the requirement to act in good faith reliance on the decision of the health care agent.[104] Instead, the court identified no requirement that each subsection contain an explicit textual link to the introductory clause.[105] Due to the basic grammar rules governing colons, the requirement of good faith reliance in the introductory clause was intended to apply to the subsections that followed.[106]

Moreover, after the court declared a "good faith reliance" was required of providers to be immune under all subsections of § 31-32-10, the court clarified the definitions of "good faith" and "reliance."[107] The court accepted the court of appeals definition of good faith as the proper definition

98. *Id.* at 325, 788 S.E.2d at 400-01.
99. *Id.* at 325, 788 S.E.2d at 401.
100. *Id.*
101. *Id.*
102. *Id.*
103. *Id.* at 327, 788 S.E.2d at 402.
104. *Id.*
105. *Id* at 328, 788 S.E.2d at 402-03.
106. *Id.* at 327-28, 788 S.E.2d at 402.
107. *Id.* at 328, 788 S.E.2d at 403.

in the statute's context.[108] But the court then explained the approach used by the court of appeals skipped over an important consideration, defining the doctor's reliance.[109] Accordingly, the court emphasized that the health care provider must be able to show the provider acted in dependence on the agent's decision to act be considered acting in reliance under the statute.[110] Further, the court explained acting without reference to the agent's direction is not acting in reliance.[111]

Based on these definitions, the court decided a provider who is aware of what the agent has decided must either comply with the agent's decisions or take the steps required when the provider is unwilling to comply in order to be protected by the immunity provisions provided in O.C.G.A. § 31-32-10(a).[112] Consequently, the court held a provider who "makes the patient's health care decisions on his own, without relying in good faith on what the patient's agent directed, must defend his actions without the immunity given in O.C.G.A. § 31-32-10(a)."[113]

V. IMPLICATIONS

The holding of *Doctors Hospital of Augusta v. Alicea* will likely impact the general public, physicians, nurses, and lawyers in various ways.

In regard to the general public, the way in which people die has changed. Historically, people died in their homes without the involvement of medical technology.[114] Today, increasing numbers of people are dying in hospitals where life-sustaining procedures are available.[115]

Advance directives have become increasingly important due to the availability of modern medical technology. An advance directive can ease

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108. *Id.* "[A] state of mind indicating honesty and lawfulness of purpose and a belief that one's conduct is not unconscionable or that known circumstances do not require further investigation." *Id.* (quoting O'Heron v. Blaney, 276 Ga. 871, 873, 583 S.E.2d 834, 836 (2003)).

109. *Id.*

110. *Id.* at 329, 788 S.E.2d at 403.

111. *Id.* at 329, 788 S.E.2d at 403-04.

112. *Id.* at 329, 788 S.E.2d at 403.

113. *Id.* at 329, 788 S.E.2d at 403-04.

114. *But see* Kathleen Negri, *Advance Care Planning: The Attorney's Role in Helping Client's Achieve a 'Good Death,'* 41 COLO. LAW. 67 (2012).

115. Georgia defines life-sustaining procedures as "medications, machines, or other medical procedures or interventions which, when applied to a declarant in a terminal condition or in a state of permanent unconsciousness, could in reasonable medical judgment keep the declarant alive but cannot cure the declarant and where, in the judgment of the attending physician and a second physician, death will occur without such procedures or interventions." O.C.G.A. § 31-32-2(9) (2007).

the mind of the general public by providing a streamlined method of expressing end-of-life wishes. In Georgia, many people were not aware there was a difference between expressing their wishes through a living will instead of a durable power of attorney for health care.[116] In essence, many people thought a living will would do the things that a durable power of attorney does, and vice versa.[117] The easiest way to avoid confusion was to execute both documents. The 2007 revision eases the process by providing only one form that needs to be executed.

As of 2009, twelve states have attempted to establish a registry where people can store their advance directives to be accessed by the designated health care agent or health care provider.[118] For example, Nevada has an electronic registry of advance directives that is maintained by the Secretary of the State on its website so it is accessible by all of the hospitals in the state.[119] Essentially, the advance directive is electronically reproduced and readily accessible for viewing, downloading, or printing through the registry from a secure portion of the Secretary of State website.[120] A national registry would protect the rights of people injured while travelling or after moving out of a state with its own registry.[121] It is not difficult to imagine that a native of Nevada has never given much thought to the location of his or her advance directive because it is stored in the state registry so he or she has never had a need to know. Now, stranded at a hospital without access to the patient's home state registry, he or she is directly disadvantaged because of the lack of a uniform registry among the states. A national registry increases the likelihood that documented health care wishes will be found.

Even when documented wishes are found, the provider must follow the wishes for the advance directive purpose to be fulfilled. With the need for provider compliance in mind, a foreseeable problem with advance directives is the potential lack of use, even when the patient's wishes are clear.[122] Additionally, another problem arises if the provider does not rely

116. *See supra* note 85.

117. *Id.*

118. *See* Allison Hughes, *State Advance Directive Registries: A Survey and Assessment, in* BIFOCAL Vol. 31 No. 2 (Journal of the ABA Commission on Law and Aging, 2009).

119. NEV. REV. STAT. tit. 40, ch. 449 (2007).

120. NEV. REV. STAT. § 449.920 (2007).

121. U.S. LIVING WILL REGISTRY, http://www.uslivingwillregistry.com/howitworks ind.shtm (last visited Nov. 8, 2016).

122. *See Alicea*, 299 Ga. 317, 788 S.E.2d 396.

on the appointed agent's directive.[123] Even where agents or family members are proactive, the provider must comply for the proactivity to have any effect.[124]

Unfortunately, death is not a pervasive conversational topic; many people feel uncomfortable discussing death. In December 2010, President Barack Obama proposed a new Medicare regulation in which the federal government would provide bonuses to physicians who advise patients on options for end-of-life care.[125] The proposal aimed to encourage discussion on the traditionally taboo topic of death.[126] Conversations with physicians on end-of-life choices often include, but are not required to include, advance directives and the individual's ability to control decisions regarding life-sustaining treatment despite incompetency.[127] The proposed rule stated physicians could provide information to patients on how to prepare an advance directive and what type of instruction should be included in the advance directive, including how aggressively to treat illness that prevents the patient from making decisions directly.[128] In January 2011, the rule was rescinded in response to criticism and allegations that the rule was a "return to death panels."[129]

In regard to physicians, nurses, and health care providers in general, when a doctor interferes with a patient's control over the patient's body by acting without consent or makes unauthorized contact or takes unauthorized action with regard to a patient's treatment, a malpractice or intentional tort arises.[130] Intentional tort suits are much cheaper than wrongful death suits, so doctors may be inclined to err on the side of violating an advance directive to avoid a wrongful death suit.[131] This is a

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123. *See id.* The defendant doctor testified that "when this happened I really didn't go into any of the code/no code/do not intubate/resuscitate. Save the patient's life first and then we'll do whatever it takes to make the family and the patient whatever, but we can't undo death. So that's what I was thinking." *Alicea*, 332 Ga. App. at 536, 774 S.E.2d at 120.

124. *See* Donna A. Casey & David M. Walker, *The Clinical Realities of Advance Directives*, 17 WIDENER L. REV. 429 (2011).

125. *See* Negri, *supra* note 114.

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.* Sarah Palin earned PolitiFact's "Lie of the Year" when she deemed the Obamacare proposed panels that would decide whether or not a healthcare procedure was worth paying for, "death panels." Angie Holan, *PolitiFact's Lie of the Year: 'Death Panels'* (Dec. 18, 2009), http://www.politifact.com/truth-o-meter/article/2009/dec/18/politifact-lie-year-death-panels/.

130. *Ussery*, 289 Ga. at 263, 656 S.E.2d at 890; *see also* Irwin v. Arrendale, 117 Ga. App. 1, 159 S.E.2d 719 (1967) (holding any physician who treats a patient without express or implied consent is guilty of at least technical battery).

131. Casey & Walker, *supra* note 124; *Arrendale*, 117 Ga. App. 1, 159 S.E.2d 719.

problem because patients execute advance directives to feel in control. Advance directives seem to overpromise control to the declarant. It is really the appointed agent who has most of the control.

The task of drafting legislation can be compromised by disagreements over basic definitions.[132] Similarly, for doctors and medical providers, the entire medical field may not agree with what a certain word means. So, some providers may fail to comply or be unwilling to comply because of a difference of understanding.[133]

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132. The statute expressly provides for artificial nutrition and hydration, indicating that such measures are not generally accepted among the life-sustaining procedures. *See* O.C.G.A. § 31-32-9.

133. In the advance directive form, phrases that could have multiple interpretations include "terminal condition," "permanent consciousness," "incurable or irreversible condition." O.C.G.A. § 31-32-4.