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ARTICLES

AN OKLAHOMA PERSPECTIVE: END OF LIFE DECISION-MAKING AND TERMINATION OF TREATMENT

Teresa Meinders Burkett & Samantha Weyrauch

Death is one of the few certainties in life and is one of the most difficult topics to discuss. Attorneys are in a unique position to raise this topic with their clients and impress upon them the advantages of discussing end of life issues with their families while they are capable of doing so. By utilizing various combinations of legal documents, an attorney can help a client document their decisions to ensure that their end of life directions are carried out.

Numerous state and federal laws govern patients and physicians in end-of-life decision-making as well as the use of pain control medication which often is prescribed for seriously ill or injured individuals. Those of greatest significance include the state laws governing: (1) Advance Directives for Health Care; (2) DNR Orders and (3) Durable Power of Attorney for Health Care. This article examines these three issues from an Oklahoma perspective with a particular focus on treatment decisions before the end of life.

I. ADVANCE DIRECTIVES FOR HEALTH CARE

A. *The Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act*

The Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act gives legal effect to the document popularly known as a "living will."¹ This

document, called the Advance Directive for Health Care, becomes effective after a physician determines that a patient is suffering from a terminal condition or is persistently unconscious.²

The Advance Directive for Health Care is composed of three major parts: (1) the "Living Will," in which an individual advises the physician regarding treatment decisions; (2) the "Health Care Proxy," in which an individual appoints a surrogate decision-maker to communicate with physicians; and (3) the "Anatomical Gifts" section which expresses the individual's wishes regarding organ donation.³

The Rights Act allows a competent adult to sign an Advance Directive for Health Care instructing that life-sustaining procedures be withheld or withdrawn in the event the adult develops "a terminal condition" or becomes "persistently unconscious."⁴ This document permits the individual to reject artificial nutrition and hydration under the same circumstances.⁵ Finally, the individual may direct other treatment to be given or withheld, including cardiopulmonary resuscitation (CPR).⁶ The Oklahoma form and content of the Advance Directive for Health Care is provided by statute and must be substantially followed.⁷ It must be signed by two witnesses who are not related to the declarant⁸ but does not require a Notary Public.⁹ The Advance Directive becomes part of the patient's medical record, until revoked,

1. OKLA. STAT. tit. 63 § 3101.1-16 (West 1997 & Supp. 2000) [hereinafter Rights Act]. See *Cruzan v. Director* 497 U.S. 261, 323 n. 21 (1990) (Brennan, J., dissenting) (despite the great deal of discussion of living wills, "[s]urveys show that the overwhelming majority of Americans have not executed such written instructions"); BARRY FURROW, *BIOETHICS: HEALTH CARE LAW AND ETHICS* 254-258 (West Group, 3d ed. 1997) (providing a historical discussion of living wills and the structure of the respective statutes) [hereinafter FURROW]; see generally Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737 (1987) (providing a broad view of the history and scope of living will statutes); Leslie P. Francis, *The Evanesence of Living Wills*, 14 J. CONTEMP. L. 27 (1988) (discussing useful perspectives on the value of living wills).

2. OKLA. STAT. tit. 63 § 3101.4 (West 1997 & Supp. 2000); See ALAN MEISEL, *THE RIGHT TO DIE 5* (John Wiley & Sons, Inc. (2d ed. 1989)). "The hallmark of advanced directives is that they are a form of anticipatory medical decisionmaking." *Id.* This is in contrast to ordinary medical processes that is contemporaneous. *Id.* See generally Schneiderman et al., *Effects of Offering Advance Directives on Medical Treatment and Costs*, 117 ANNALS INTERNAL MED. 599 (1992), for a discussion on the question on whether it costs less to treat a patient who is near death who have advance directive compared to those individuals who do not. But see J. Teno et al., *Do Advance Directives Provide Instructions that Direct Care*, J. AM. GERIATRIC SOC'Y 508 (1997) (discussing the notion that advance directives were helpful in naming a proxy but not in providing directions about care).

3. OKLA. STAT. tit. 63, § 3101.4 (B) (West 1997 & Supp. 2000). See generally MEISEL, *supra* note 2, at 6-7 (providing an in depth discussion of the three general and interrelated purposes of an advance directive). The three purposes of an advanced directive are the following: (1) provide a means of exercising some degree of control over medical care even if they lack capacity to do so at the time that treatment decisions need to be made; (2) avoid some of the more serious procedural problems associated with making decisions for patients who lack decisionmaking capacity; and (3) provide health care providers from civil and criminal liability. *Id.* See, e.g., Loren Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977) (describing a frequently cited test to determine competency for medical decisionmaking).

4. OKLA. STAT. tit. 63, § 3101.4(B) (West 1997 & Supp. 2000). An advance directive may be issued by a person who is in good or poor health, but must be issued by one who possesses medical decisionmaking capacity. MEISEL, *supra* note 2, at 5. See generally MEISEL, *supra* note 2, at 54-56 (discussing the enforcement of advance directives in medical emergencies).

5. OKLA. STAT. tit. 63, § 3101.4(B) (West 1997 & Supp. 2000).

6. See *id.*

7. See *id.*

8. See MEISEL, *supra* note 2, at 13 (stating that an individual who issues a living will is frequently referred to in advance directive statutes as a declarant, and the advance directive is sometimes referred to as a declaration).

9. OKLA. STAT. tit. 63, § 3101.4(B) (West 1997 & Supp. 2000).

and provides effective documentation of a patient's decision not to be placed on life support or receive artificial nutrition and hydration.¹⁰ The Rights Act provides that a physician or hospital which withholds treatment in compliance with the directive cannot be held civilly or criminally liable unless they are otherwise negligent.¹¹

B. The Hydration and Nutrition for the Incompetents Act

The Advance Directive for Health Care provides a section for a patient to withdraw hydration and nutrition under certain circumstances.¹² Further, Oklahoma has also enacted the Hydration and Nutrition for Incompetents Act¹³ which prohibits the withdrawal of hydration and nutrition from any patient in order to hasten death unless one of the following enumerated conditions are met:

- (1) A patient with a terminal condition or who is persistently unconscious, when competent, gave informed consent for hydration and nutrition to be withheld. This may be documented in an Advance Directive for Health Care.¹⁴

10. OKLA. STAT. tit. 63, § 3101.4 (C) (West 1997 & Supp. 2000)

11. *See id.* § 3101.10 (West 1997 & Supp. 2000); *see MEISEL supra* note 2, at 37-38 (discussing in depth immunity and non-conforming advance directives). It is possible that there is little or no difference in immunity when it is made on the basis of a statutory directive, a non-conforming directive, or no directive at all because the courts have held that the health care professions who comply with the decisions of surrogates in the absence of any directive are also presumed to be immune from liability. *Id.* at 37. *See also* John F. Kennedy Memorial Hospital v. Bludworth, 452 So.2d 921, 926 (Fla. 1984) (holding that to be relieved of civil and criminal liability, guardians, consenting family members, physicians, hospitals, or their administrators need only act in good faith); Degrella v. Elston, 858 S.W.2d 698, 710 (1993) (specifically addressing the issue of physician liability in a case where all the necessary facts are established and carefully documented by the parties involved).

12. A significant number of statutes, including Oklahoma, explicitly prohibit the withholding or withdrawal of artificial nutrition or hydration: COLO. REV. STAT. § 15-14-506(1) (1999); CONN. GEN. STAT. ANN. § 19A-571(a) (1999) (must be provided unless the patient is in terminal condition); HAW. REV. STAT. § 551d-2.5(c) (1999) (if such authority is explicitly stated in health care power of attorney); KY. REV. STAT. ANN. § 311.629 (1999); ME. REV. STAT. ANN. tit. 18-A, § 5-702(c) (West 1999) (may be withheld or withdrawn unless optional provision regarding principal's desire to receive artificial nutrition and hydration is signed); MD. CODE ANN., HEALTH GEN. II § 5-603(II)(A)(2)(D) (1999); MIN. STAT. ANN. § 145c.04(1) (West 1999), MIN. STAT. ANN. § 145B.03(2)(B)(2) (West 1999) (if declaration states declarant's preferences regarding artificial administration of nutrition and hydration); MO. ANN. STAT. § 404.820.1 (West 1999); NEB. REV. STAT. § 30-3418(2) (1999); NEV. REV. STAT. ANN. § 449.830.6 (Michie 1999) (if principal had expressly requested attending physician not to withhold or withdraw in power of attorney document); N.H. REV. STAT. ANN. § 137-J:3(III) (1999); N.Y. PUB. HEALTH LAW § 2982(2)(B) Gould, McKinney or Consol. 1999); OHIO REV. CODE ANN. § 1337.13(C), (E) (Anderson or West 1999); OKLA. STAT. ANN. tit. 63, § 3101.4(B) (West 1999) (under "Hydration and Nutrition for Incompetent Patients Act," OKLA. STAT. ANN. tit. 63, §§ 3081-0.1-5 (West 1997 & Supp. 2000) (nutrition and hydration may be withheld or withdrawn if specifically authorized by a living will or health care power of attorney executed pursuant to a statute); OR. REV. STAT. § 127.540(6), (7) (1999); PA. STAT. ANN. tit. 20, § 5414(a) (West 1999) (nutrition and hydration must be provided to a pregnant woman who is incompetent and has a termination condition or is permanently unconscious); S.D. CODIFIED LAWS § 59-7-2.7 (Michie 1999) (may not be withheld or withdrawn if needed for comfort care or relief of pain, or if it can be physically assimilated by principal, or if its benefits of providing artificial nutrition and hydration outweigh its burdens, or if there is no clear and convincing evidence that artificial nutrition and hydration was refused by the principal prior to loss of decisional capacity); UTAH CODE ANN. § 75-2-1106 (1999); W. VA. CODE § 16-30A-4(D)(6) (1999); WIS. STAT. ANN. § 155.20(4) (West 1999) (may consent to withholding or withdrawal or non-orally ingested nutrition or hydration if authorized to do so by instrument). *See also* MEISEL, *supra* note 2, at 174 (commenting that the controversy over the propriety of forgoing artificial nutrition and hydration is reflected in the large number of health care power of attorney statutes that have provisions dealing with this matter).

13. OKLA. STAT. tit. 63, § 3080.1- § 3080.5 (West 1997 & Supp. 2000)

14. A proxy is permitted to authorize the withholding or withdrawing of artificial nutrition and hydration only if the principal has specifically refused it. *See* OKLA. STAT. ANN. tit. 63, § 3101.4(B) (West 1997 & Supp. 2000), OKLA. STAT. ANN. tit. 63, § 3080.4(A)(1) (West 1997 & Supp. 2000) (if provision regarding withdrawal or artificially

- (2) Two physicians concur in writing that artificially administered nutrition or hydration is medically impossible or would cause intractable pain, or
- (3) Two physicians agree that an incompetent patient is in the end stage of a terminal condition and death is imminent and would occur as a result of the disease or injury rather than as a result of the withholding of hydration and nutrition.¹⁵

A patient is most assured that his or her wishes regarding artificial nutrition and hydration will be honored if the patient's decision is set forth in an Advance Directive for Health Care.¹⁶ However, an Advance Directive becomes operable only if a patient is terminally ill or persistently unconscious.¹⁷ Significantly, those individuals suffering from dementia, pneumonia, or another debilitating condition that is not necessarily terminal will almost certainly be tube-fed if their health care providers comply with this law.¹⁸

C. *The Federal Patient Self-Determination Act*

In 1990, the United States Supreme Court heard its first right-to-die case in *Cruzan v. Directors*.¹⁹ This landmark case provided an impetus for individuals to draft advance directives in the event that the state in which they live might come to require them. Shortly after *Cruzan*, Congress enacted the Patient Self-Determination Act, giving further impetus for advance directives.²⁰

administered nutrition and hydration is not signed by declarant, artificial nutrition and hydration will be provided).

15. OKLA. STAT. tit. 63, § 3080.4 (West 1997 & Supp. 2000). See FURROW, *supra* note 1, at 278-280 (discussing the issue of medical futility and defining the American Medical Association's determinations on the subject); Daniel Callahan, *Medical Futility, Medical Necessity: The Problem-Without-A-Name*, HASTINGS CENTER REP., July-Aug. 1991, ; Judith Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J. L. & MED. 221 (1995).

16. See generally Robert Steinbrook et al., *Artificial Feeding—Solid Ground, Not a Slippery Slope*, 318 NEW ENGL. J. MED. 286 (1988) (describing "the emerging consensus" that "artificial feeding can be viewed on a level with other medical interventions— cardiopulmonary resuscitation, mechanical ventilation, dialysis, antibiotic therapy").

17. OKLA. STAT. tit. 63, § 3101.5 (West 1997 & Supp. 2000).

18. See generally MEISEL, *supra* note 2, at 592-603, for a detailed discussion on the number of interrelated arguments that are given for distinguishing artificial nutrition and hydration from other life-sustaining medical treatments.

19. *Cruzan v. Director*, 497 U.S. 261 (1990). Notably, the United States Supreme Court had no guidance on any right-to-die issue by any federal appellate court. The Supreme Court had previously denied certiorari in few right-to-die cases. See *Drabick v. Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988), *cert. denied*, 488 U.S. 958, *reh'g denied*, 488 U.S. 1024 (1989); *In re estate of Prange*, 520 N.E.2d 946 (Ill. App. Ct.), *vacated*, 527 N.E.2d 303 (Ill.), *cert. denied sub nom.* *Murphy v. Benson*, 488 U.S. 892 (1988); *In re Jobs*, 529 A.2d 434 (N.J.), reconsideration and stay denied, 531 A.2d 1360 (N.J.), *cert. denied sub nom.* *Lincoln Park Nursing & Convalescent Home v. Kahn*, 483 U.S. 1036 (1987); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); *In re Storar*, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981); William H. Colby, *Missouri Stands Alone*, HASTINGS CENTER REP., Sept.-Oct. 1990, at 5 (written by council for the Cruzans); John A. Robertson, *Cruzan: No Rights Violated*, Sept.-Oct. 1990, at 8.

20. 42 U.S.C.A. § 1395cc(f) (1999). See Omnibus Budget Reconciliation Act of 1990 (OBRA), Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115 tp -117, 1388-204 to -206 (codified at 42 U.S.C.A. § 1395 cc (f)(1) & § 1396a(a) (West Supp. 2000)) (containing provisions imposing responsibilities on institutional health care providers with respect to advance directives that grew out of the Patient Self-Determination Act of 1989); FURROW, *supra* note 1, at 263-265 (discussing the Patient Self-Determination Act in general).

The Patient Self-Determination Act (PSDA) requires, as a condition of participation in Medicare and/or Medicaid programs, that certain institutional health care providers (hospitals, nursing homes, hospices and home health agencies) furnish patients with information about advance directives at the time of admission.²¹ The central right that this legislation creates is the right of the patients to be provided with specific information.²² Managed care companies are required to make this request each time an individual enrolls in a managed care plan.²³ With regard to hospitals, the request must be made of inpatients only.²⁴ Providers must also advise patients or enrollees of their right to consent to or decline health care options according to both current law and that provider's own policies.²⁵

If a patient indicates that he or she has signed an Advance Directive, it must be made part of the patient's medical record.²⁶ If a patient has not signed such a document, there is no requirement that an Advance Directive form be provided to the patient.²⁷ The Act does not prescribe a federal format for an Advance Directive. Each state has its own laws and form for completing an Advance Directive.²⁸

II. THE OKLAHOMA DO-NOT-RESUSCITATE ACT AND DO-NOT-RESUSCITATE ORDERS

In 1997, the Oklahoma Legislature passed the state's first statutory provisions governing the use of Do-Not-Resuscitate (DNR) Orders in 1997.²⁹ A DNR Order is one of the primary means to convey the decision to avoid extraordinary measures to

21. 42 U.S.C.A. § 1395cc(f)(1) (1999). See MEISEL *supra* note 2, at 14 (stating that the validity and enforceability of advance directives is gradually shifting to the question of validity of advance directives not drafted in conformance with a living will or health care power of attorney statute).

22. MEISEL, *supra* note 2 at 51. The content of the information is governed by state law and by the policies of particular health care organizations. *Id.* at 51-52.

23. *Id.*

24. 42 U.S.C.A. § 1395cc(f)(2)(A) (1999).

25. 42 U.S.C.A. § 1395cc(f)(1)(A) (1999).

26. OKLA. STAT. tit.63, § 3104.4(C) (West 1997 & Supp. 2000).

27. See Gianelli, *Many Say Doctors Aren't Living Up to Expectations of Living Will Law*, AM. MED. NEWS, May 17, 1993, at 1 (some report that the PSDA has not had the effect of encouraging physicians to initiate end-of-life discussions with patients); Loewy, *Advance Directives and Surrogate Laws: Ethical Instruments or Moral Cop-out*, 152 ARCHIVES INTERNAL MED. 1973 (1992) (documenting that there has been concern that the PSDA is motivated more by not having to trouble themselves in making critical and agonizing decisions rather than genuine respect for actual informed choice of the patient).

28. See OKLA. STAT. tit. 63, § 3101.4(B) (West 1997 & Supp. 2000) (exemplifying the Advance Directive form that must be completed). See also Barber v. Superior Court, 195 Cal.Rptr. 484, 489 (Ct. App. 1983) ("The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused by those who might desire it"); MEISEL, *supra* note 3, at 14 (commenting that the insistence on using and enforcing only advance directives that strictly comply with state statutes can seriously frustrate the wishes of declarants and pose significant barriers to patients that have not executed an advanced directive or health care power of attorney).

29. OKLA. STAT. tit. 63, § 3131.1 (West Supp. 2000) [hereinafter DNR Act]. See MEISEL, *supra* note 2, at 555 ("DNR statutes do not echo one well-accepted scheme, but rather embody diverse and sometimes disjointed provisions").

prolong life.³⁰ The order is written by a physician in an individual's medical record to indicate that the individual should not receive cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest.³¹ The DNR Act not only regulates the circumstances under which DNR Orders may be written, but also makes such orders transferable between different health care facilities.

Before passage of the DNR Act, whether or not a DNR Order was written for a particular patient was primarily a medical decision made by a patient's physicians in consultation with the patient or, if the patient was not competent, the patient's family members. CPR was originally developed to resuscitate otherwise healthy individuals who suffered an unexpected cardiac or respiratory arrest.³²

Ordinarily, a person who suffers an arrest will be resuscitated through CPR unless it is not medically appropriate to do so.³³ CPR is generally considered medically appropriate for an individual whose death is not imminent. In contrast, if an individual is in the final stages of an illness or is so seriously injured that death is expected to occur, many would consider resuscitation futile given the patient's underlying medical condition.³⁴ While CPR is beneficial for healthy people who suffer an unexpected arrest, it has crept into common use for every person who dies, including those who are terminally ill or have little hope of survival.

A. Circumstances In Which A DNR Order May Be Written

Until passage of the Oklahoma Do-Not-Resuscitate Act, the decision of whether CPR should be administered in a particular instance was based primarily on the physician's professional judgment as to whether the intervention would be medically

30. Such an order is generally referred to as a do-not-resuscitate order (DNR order), an order not to resuscitate, or a no-code order. *E.g.*, C.A. v. Morgan, 603 N.E.2d 1171, 1175 (Ill. App. Ct. 1992) (do not resuscitate means do not give cardiac compression or intubation); Manning v. Twin Falls Clinic & Hosp., Inc., 830P.2d 1185, 1187 (Idaho 1992) ("no code"); Anderson v. St. Francis-St. George Hosp., 614 N.E.2d 841 (Ohio Ct. App. 1992) ("No Code Blue"); Belcher v. Charleston Area Medical Ctr., 422 S.E.2d 827, 830 (W. Va. 1992) (DNR order also known as a "no 1-2-3 order").

31. See MEISEL, *supra* note 2, at 543 (explaining that DNR orders are frequently written in clinical practice, and courts have also authorized the withholding of CPR when confronted with the issue). See generally Sullivan, N.Y. TIMES, Nov. 17, 1982, at B-13 (documenting a time when withholding CPR was considered so controversial that DNR orders were often not written or discussed leading to procedures in at least one hospital that a grand jury described them as "shocking procedural abuses").

32. See OKLA. STAT. tit. 63, § 3131.3(2) (West Supp. 2000). See also Wright v. Johns Hopkins Health Sys. Corp., 728 A.2d 166, 177 n.13 (Md. 1999) ("The Attorney General defines cardiac arrest as "the sudden unexpected cessation of heartbeat cessation of heartbeat and blood pressure. It leads to loss of consciousness within seconds, irreversible brain damage in as little as 3 minutes, and death within 4 to 15 minutes.").

33. See, *e.g.*, In re Dinnerstein, 380 N.E.2d 134, 135-136 (Mass. App. Ct. 1978) (*citing* Houts & Houts, Courtroom Medicine Series: Death § 1.01(3)(d)(1976)). [m]any of these procedures are...highly intrusive, and some are violent in nature. The defibrillator, for example, causes violent (and painful) muscle contractions which, in a patient suffering (as the patient is) from osteoporosis, may cause fracture of vertebrae or other bones. Such fractures in turn, cause pain, which may be extreme. *Id.*

34. OKLA. STAT. ANN. tit. 63, § 3131.4(C)(2) (West Supp. 2000) (resuscitation "will not prevent the imminent death of the patient"). *E.g.*, GA. CODE ANN. § 31-39-2(4) (Harrison or Michie 1999); N.Y. PUBLIC HEALTH LAW § 2965(3)(c) (McKinney, Colsol. or Gould 1999) (surrogate may consent to DNR order if CPR futile); WASH. REV. CODE ANN. § 43.70.480 (West 1999) (if a person executed directive requesting withholding futile emergency medical treatment).

appropriate considering the patient's condition and expressed desires.³⁵ Under current law, DNR Orders are governed by state-prescribed procedures and, although the provisions are not mandatory, no physician or health care facility may legally take any action that will conflict with the new Act.³⁶

In regulating the issuance of DNR Orders, the DNR Act creates a presumption that every person consents to the administration of CPR unless one of six situations exists:

- (1) The patient has advised his attending physician that he does not consent to CPR and this is noted in the patient's medical records³⁷;
- (2) The parent or guardian of a minor child, after consulting with the child's physician, has notified the child's physician that the parent or guardian does not consent to CPR and, if the child is old enough to understand the consequences of this decision, does not object to the decision (and the decision does not violate federal laws prohibiting withholding of treatment from disabled infants)³⁸;
- (3) An incapacitated patient's legally appointed representative has notified the patient's attending physician that the patient does not consent to CPR and this is noted in the patient's medical records;
- (4) An attending physician of an incapacitated patient without a "representative" knows by clear and convincing evidence that the patient, when competent, decided based on sufficient information to constitute informed consent that he would not consent to CPR and the physician then signs a statutory form entitled "Certificate of Physician" before placing a DNR Order in the chart;

35. See MEISEL, *supra* note 2, at 555, stating that it can be difficult to determine rapidly whether or not the patient had previously authorized the forgoing of CPR because the procedure is normally administered under emergency situations.

36. See the following DNR statutes for detail in what is required for a legally binding DNR Order: ALASKA STAT. §§ 18.12.035-.100 (Michie 1999); ARIZ. REV. STAT. ANN. § 36-3251 (West 1999); ARK. CODE ANN. §§ 20-13-901 to -908 (Michie 1999); CAL. HEALTH & SAFETY CODE § 1569.74 (Deering 1999), CAL. PROB. CODE § 4753 (Deering 1999); COLO. REV. STAT. §§ 15-18.6-101 to -108 (1999); CONN. GEN. STAT. ANN. § 1999a-580d (West 1999); FLA. STAT. ANN. § 401.45(3) (West 1999); GA. CODE ANN. §§ 31-39-1 to -9 (Harrison 1999); HAW. REV. STAT. § 321-229.5 (1999); IDAHO CODE §§ 39-151 to -165 (1999); 210 ILL. COMP. STAT. ANN. 45/2-104.2 (West 1999); IND. CODE ANN. § 16-36-5 (West or Michie 1999); KAN. STAT. ANN. §§ 65-4941 to -4948 (1999); LA. REV. STAT. ANN. § 40:1299.58.2, .58.3, & .58.7-10 (West 1999); MD. CODE ANN., HEALTH GEN. I § 5-608 (1999); MICH. COMP. LAWS ANN. §§ 333.1051-1067 (West 1999); MONT. CODE ANN. §§ 50-10-101 to -107 (1999); NEV. REV. STAT. ANN. §§ 450b.400-590 (Michie 1999); N.J. STAT. ANN. § 26:2h-68 (West 1999); N.M. STAT. ANN. § 24-10b-4(j) (Michie 1999); N.Y. PUB. HEALTH LAW §§ 2960-2979 (Mckinney, Consol. Or Gould 1999); OHIO REV. CODE ANN. § 2133.02 (West 1999); OKLA. STAT. ANN. Tit 63, §§ 3131.1-.14 (West 1999 and Supp. 2000); PA. CONS. STAT. ANN. Tit. 20, § 5413 (West 1999); R.I. GEN. LAWS § 23-4.10-4, § 23-4.11-14 (1999); S.C. CODE ANN. §§ 44-78-10 to -65 (Law. Co-op. 1999); TENN. CODE ANN. § 68-11-224, §§ 68-140-601 to -604 (1999); TEX. HEALTH & SAFETY CODE ANN. §§ 674.001-.024 (West 1999); UTAH CODE ANN. § 75-2-1105.5 (1999); VA. CODE ANN. §§ 54.1-2982, -2987.1, -2901, 63.1-174.3 (Michie 1999); WASH. REV. CODE ANN. § 43.70.480 (West 1999); W. VA. CODE §§ 16-30c-1 to -16 (1999); WIS. STAT. ANN. §§ 154.17-29 (West 1999); Wyo. Stat. Ann. §§ 35-22-201 to -208 (Michie 1999).

37. See OKLA. STAT. tit. 63, § 3131.4(B)(2)(b) (West Supp. 2000) (requiring a physician to note in the medical record when an explanation has been made to the representative and family member of the nature and consequences of the decision to be made); MEISEL, *supra* note 2, at 547-555 (providing an extensive discussion on informed consent orders and the case law surrounding the issue).

38. See *infra* notes 46, 47.

- (5) The patient or his legally appointed representative has signed a form prescribed by statute to consent to a DNR Order; or
- (6) The patient has signed an Advance Directive for Health Care expressly directing that life-sustaining treatment not be performed in the event of a cardiac or respiratory arrest.

The Act leaves open to interpretation whether this presumption of consent to CPR would require CPR to be performed absent one of the six specified circumstances. Nevertheless, the Act presumes that even those terminally ill patients who have little or no chance of survival want to receive CPR, even if its provision would provide no benefit and possibly cause additional suffering.³⁹

B. Important Statutory Definitions Related to the DNR Act

Certain definitions in the DNR Act are crucial to an understanding of the six statutory conditions by which the presumption of consent to CPR may be rebutted. First, a "representative" who can communicate a patient's wishes to the patient's physician omits any reference to family members.⁴⁰ Rather, under the Act, a "representative" is limited to a legally appointed guardian, an attorney-in-fact for health care decisions named in a durable power of attorney, or a health care proxy named in the patient's Advance Directive for Health Care.⁴¹ Contrary to the traditional practice before the DNR Act was passed, the physician can only act on a communication with the patient's family under strictly prescribed legalistic circumstances.

As noted above, if an incapacitated patient has not appointed a legal "representative," the presumption that the patient desires CPR remains unless the physician determines that there is "clear and convincing evidence that the incapacitated person, when competent, decided on information sufficient to constitute informed consent that such person would not have consented to the administration of [CPR] in the event of cardiac or pulmonary arrest."⁴² According to the Act, this evidence may include "communication between the patient and . . . others close to the patient with knowledge of the patient's personal desires."⁴³ The difficulty this language presents for physicians is that it may be almost impossible to determine with any degree of confidence whether this standard has been met.

39. See Leslie J. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281 (1987) (analyses cases in which CPR would be inappropriate); Council on Ethical and Judicial Affairs, American Medical Association, *Guidelines for the Appropriate Use of DNR Orders*, 265 JAMA 1868 (1991); Stuart J. Younger, *Do-Not-Resuscitate Orders: No Longer Secret But Still a Problem*, 17 HASTINGS CENTER REP., Feb. 1987, at 24. See also *infra* note 15.

40. OKLA. STAT. tit. 63, § 3131.3 (D) (West Supp. 2000). See FURROW, *supra* note 1, at 264-265 (discussing physician deference to family members concerning an incompetent patient)

41. OKLA. STAT. tit. 63, § 3131.3 (10) (West Supp. 2000).

42. OKLA. STAT. tit. 63, § 3131.4(4) (West Supp. 2000).

43. *Id.*

"Clear and convincing evidence" is a legal standard of proof which lies between (1) the most common civil standard of "preponderance of the evidence," meaning the evidence indicates a matter is more likely true than not or the decision maker is just slightly more convinced of the truth of an assertion than not, and (2) the criminal law standard of proof "beyond a reasonable doubt," meaning the person asked to decide has no reasonable way to reach a different conclusion as to the truth of an assertion.⁴⁴ Further, the "clear and convincing evidence" standard is not a symmetrical one; it applies to an individual seeking to terminate life sustaining treatment, but not to an individual seeking to maintain it.⁴⁵

The "clear and convincing" standard of proof requires a "firm belief or conviction as to the truth of an assertion" according case law.⁴⁶ "Firm belief or conviction" is an imprecise description of the level of confidence a physician must have in the information a patient's family or friend provides as to the patient's wishes. This standard requires something more than a simple belief that the family members' report of the patient's wishes is true, but something less than absolute certainty that the report is accurate.

Under the "clear and convincing" standard, the Act requires the physician to have a "firm belief or conviction" that the patient was competent when the communication of his wishes was made and that, before stating those wishes, the patient had sufficient information to give what amounted to informed consent concerning his stated choice regarding CPR. This heightened level of certainty the physician must have concerning the patient's choice is further complicated by the subjective standard for informed consent recognized in Oklahoma. The physician must determine that the patient had sufficient information that would be important to that particular patient to make an informed choice as opposed to merely having sufficient information for a reasonable person to make a decision. The subtle difference between the objective standard applied in most states and the subjective standard for informed consent required in Oklahoma may not be appreciated by many physicians.

If a physician were merely making a notation in an incompetent patient's record concerning reported information about a patient's wishes regarding CPR, this requirement may not be so troublesome. However, the DNR Act requires a physician to sign a "Certificate of Physician" to be placed in the medical record certifying the physician's belief that clear and convincing evidence exists of the patient's informed

44. *Cruzan v. Directors*, 497 U.S. 261 (1990) (holding that "a state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state"). See FURROW, *supra* note 1, at 288 (stating that most states have adopted the "clear and convincing evidence" standard in right to die cases, although what that evidentiary standard means varies from state to state); see generally *In re Eichner*, 438 N.Y.S.2d 266 (N.Y. 1981) (discussing the appropriate burden of proof raised before the New York Court of Appeals); *In re Martin*, 538 N.W.2d 405 (Mich. 1995) (holding that the clear and convincing standard is not in itself a substantive standard for the removal of life sustaining treatment).

45. FURROW, *supra* note 1, at 289. The application of this evidentiary standard serves to recognize a policy that it is better to err on the side of maintaining life rather than terminating it. *Id.*

46. See MEISEL, *supra* note 2, at 43 (describing the difference in what constitutes "clear and convincing evidence" among the states). "In some states, it is clear and convincing evidence that the patient would have decided to forgo treatment—in effect, clear and convincing evidence of the substituted judgement standard. *Id.* In other states, it is clear and convincing evidence that it is not in the patient's best interests, as determined by the family and the doctor, that the treatment be continued." *Id.*

decision to refuse CPR and that the decision was made while the patient was competent.⁴⁷ Physicians should exercise great caution before entering such a certification in the patient's record.⁴⁸

Finally, the DNR Act does not define the term "every person" as it is used in the Act. Presumably, "every person" would be limited to persons who are legally capable of giving consent to medical care. However, unlike other laws concerning end of life decision making, this Act does not specify that the individual who may sign the DNR Consent Form must be 18 years of age or older.⁴⁹ Until this issue is clarified, only individuals who are capable of giving informed consent to medical care should be permitted to sign these statutory DNR Consent Forms.⁵⁰

C. Recent Amendments to the DNR Act

Numerous amendments to the DNR Act were passed in the last legislative session becoming effective November 1, 1999. The changes include the following:

"Health care agencies," including hospitals, physician's offices, nursing homes, clinics, home health agencies and hospices, must draft written policies and procedures with respect to the use of DNR Orders, DNR consent forms, and Certificates of Physicians. The policies must reflect that DNR decisions must be made by the patient unless a patient's statutorily-defined "Representative" is required to communicate such decisions in light of the patient's incapacity. The patient's incapacity must be documented in the medical record before relying on the patient's Representative.⁵¹

A physician cannot rely on the patient's Representative's consent until the physician provides a written instruction concerning the patient's condition to the patient's Representative and that Representative provides a written statement to the physician that the Representative "is deciding what the incapacitated person would have wanted if the incapacitated person could speak for himself or herself."

Physicians are to encourage "consultation" among all family members,

47. OKLA. STAT. tit. 63, § 3131.4(B)(2)(b) (West Supp. 2000).

48. See David H. Miller, *Right-to-Die Damage Actions: Developments in the Law*, DEN. U.L.REV. 181 (1988) (describing the host of causes of action that could be filed against a health care provider who improperly fails to discontinue life sustaining treatment including: ordinary medical malpractice, informed consent, battery, negligent or intentional infliction of emotional distress and civil rights actions).

49. OKLA. STAT. tit. 63, § 3131.4(2) (West Supp.2000). In situations where the minor is clearly not capable of consent, the statute specifically provides for parental consent to a DNR order for the child. *Id.* But see MEISEL, *supra* note 2, at 563 (commenting that these types of provisions are not necessary because parents have the authority to forgo life-sustaining treatment on behalf of their children in the first place); see generally Lisa Hawkins, *Living Will Statutes: A Minor Oversight*, 78 VA. L. R. 1581 (1992) (discussing the ways in which children could be included in advance directive legislation).

50. Some statutes provide that a minor is authorized to consent to a DNR order if the attending physician determines that the minor has adequate decisionmaking capacity or that a minor's consent is needed in addition to the consent of the parents. *E.g.*, GA. CODE ANN. § 31-49-4(d) (check to see if Michie or Harrison 1999) (if attending physician thinks a minor sufficiently mature, DNR order not valid without minor's consent); N.Y. PUB. HEALTH LAW § 2967(2)(a) (McKinney, Consol. Or Gould 1999); OKLA. STAT. tit. 63, § 3131.4(2) (West 1999); W. VA. CODE § 16-30C-6(d) (1999) (if attending physician believes minor between the ages of 16 and 18 to be sufficiently mature, order not valid without minor's consent; minor wishes prevail in case of conflict between minor and parents).

51. See OKLA. STAT. tit. 63, § 3131.4 (West Supp. 2000).

Representatives and others close to the incapacitated person, to the extent feasible. There is no description as to the form this "consultation" is to take. However, the fact that a "consultation" among these individuals was encouraged by the physician should be documented in the patient's record.⁵²

Physicians must explain the nature and consequences of the decision to be made concerning a DNR Order to the Representative and family members. The fact that this explanation was provided must also be documented in the medical record. Family members still cannot make a DNR consent decision for the patient, but can communicate statements made by the patient while competent concerning the patient's wishes in this regard.

"Health care agencies" must provide "ongoing education" to patients, staff and the community regarding the DNR Consent Form.⁵³

No physician or other health care provider is required to perform CPR "when, in reasonable medical judgment, it would not prevent the imminent death of the patient." This means that CPR does not need to be provided in cases of medical futility. It is important that medical futility be documented in the patient's medical record by stating that "in this physician's reasonable medical judgment, CPR would not prevent the imminent death of this patient." This language in the patient's record will support a decision to withhold CPR, but will not support a written DNR Order unless otherwise authorized by the Act (patient consent, legal representative consent, physician certification, parent consent for minor child). This change may represent the most significant departure from current practice: the permissible withholding of CPR without a DNR Order.

D. Facility Policies Regarding DNR Orders

An early version of the Act would have permitted health care facilities to continue to follow their own policies regarding DNR Orders without violating the new Act. Those provisions were subsequently modified to require any DNR Orders issued to comply with a facility's policies so long as those policies do not conflict with the new Act. Thus, hospitals and other facilities will need to review their current DNR policies to make sure they conform to the new law.⁵⁴ In addition, the information given to patients concerning their rights under state law as required by the federal Patient Self-Determination Act must be updated to describe these latest statutory additions. There is no requirement that the Oklahoma DNR Consent Form set forth in the Act be made available to patients at health care facilities.

E. Use of the DNR Consent Form

The statutorily prescribed form to consent to a DNR Order does not contain any

52. OKLA. STAT. tit. 63, § 3131.4(B)(2)(b) (West Supp. 2000).

53. OKLA. STAT. tit. 63, § 3131.3 (West Supp. 2000).

54. OKLA. STAT. tit. 63, § 3131.4(B) (West Supp. 2000) Health care agencies are required to maintain written policies and procedures with respect to do-not-resuscitate orders, do-not-resuscitate consent forms, and certification of physicians. *Id.*

language that would limit its use to situations in which CPR is not medically appropriate.⁵⁵ For that reason, it is probably inadvisable for individuals to sign such a form unless they are in the end stages of a terminal illness and there is no question that CPR should not be administered. Otherwise, CPR may be prematurely withheld under circumstances the patient may not have anticipated when the form was signed.

As an alternative to signing the statutory form before being diagnosed as terminally ill, an individual may be better advised to add a statement to his Advance Directive for Health Care that, should his physicians determine that CPR would not be medically appropriate, that he consents to the entry of a DNR Order.⁵⁶ This would comply with the sixth statutorily enumerated situation in which CPR consent is no longer presumed. It also would reinsert the concept of medical appropriateness for CPR into the physician's decision-making, and at the same time, prevent a legal "representative" from revoking the patient's DNR consent contrary to the patient's wishes.

While strictly limiting a representative's authority to consent to a DNR Order, the DNR Act grants liberal authority to the representative to cancel a DNR Order, even when such action is contrary to the patient's stated wishes. A representative may revoke the DNR consent of an incapacitated person at any time. Moreover, without regard to medical necessity, the physician must "immediately cancel" a DNR Order whenever advised of such a revocation. As a result, a representative would have the power to require a full resuscitative effort without regard to the patient's wishes or medical condition. Including one's directions concerning CPR in an Advanced Directive rather than in the DNR Consent Form will protect against such an action.

F. Recommendations for Physicians

In order to comply with the Act, when writing a DNR Order, physicians should take the following steps:

1. Document a DNR Order when a competent patient consents – this may be done verbally and then recorded in the chart. Use of the DNR Consent form is optional.
2. Document a DNR Order when an incapacitated patient's guardian, health care proxy or attorney-in-fact who holds a valid durable power of attorney for health care consents. Use of the DNR Consent form is optional. Consent must be documented in the chart.
3. When relying on consent to a DNR Order by a Representative, document the following in the patient's medical record:
 - that written instruction was given to the Representative by the physician concerning the effect of a DNR Order and that the Representative gave written instruction to the physician that the incapacitated person would have consented to the DNR Order. The Representative's instruction should be placed in the record.
 - that "consultation" among family members and the Representative was

55. See OKLA. STAT. tit. 63, § 3131.5(B) (West Supp. 2000).

56. OKLA. STAT. tit. 63, § 3101.4(B) (West Supp. 2000).

encouraged.

- the reason the Representative, rather than the patient, has given consent to the DNR Order.
- that the physician explained to the incapacitated patient's family members and Representative the nature and consequences of the DNR Order.

When a patient's condition is medically futile, a DNR Order does not have to be written if neither the patient nor Representative consented to a DNR Order. Document the medical futility by stating in the medical record that "in the physician's reasonable medical judgment, CPR would not prevent the imminent death of the patient." CPR may then be withheld.

G. Transferability of DNR Orders

Possibly the most beneficial provision of the Oklahoma Do-Not-Resuscitate Act permits DNR Orders or consents to remain in effect when a patient is transferred from one health care facility to another.⁵⁷ A DNR Order or consent also remains effective if a patient with either document in his medical record is admitted to a health care facility from his home.⁵⁸ This is particularly useful for health care providers when a nursing home resident with a DNR Order is transferred to a hospital and is no longer capable of communicating his wishes concerning CPR. The hospital may honor the DNR Order or consent which was in place at the nursing home without obtaining a new Order from the physician or new consent from the patient.

Health care providers need to become familiar with the latest amendments to the Act and its effect on their current DNR policies and Patient Self-Determination Act procedures.⁵⁹ Physicians should be encouraged to talk with their patients while they are capable of discussing their wishes concerning CPR. Patients may want to update their Advance Directives for Health Care to include specific directions concerning DNR Orders. Finally, transfer policies should be updated to include a requirement that any DNR Order in place at a transferring facility will be included in records sent with the patient to any receiving facility.

III. OKLAHOMA AND FEDERAL STATUTES GOVERNING PAIN CONTROL MEDICATIONS AND ASSISTED SUICIDE

A. Relevant Supreme Court Decisions

Individuals have become increasingly interested in directing their own medical

57. OKLA. STAT. tit. 63, § 3131.10 (West Supp. 2000).

58. *Id.*

59. 42 U.S.C.A. § 1395cc(f) (1999).

decisions.⁶⁰ This is especially so since the United States Supreme Court issued its ground-breaking decision in *Cruzan v. Director, Missouri Department of Health*.⁶¹ In *Cruzan*, the court permitted but does not require states to insist on proof of the patient's actual intent, but also that it does not require, a clear and convincing evidentiary standard of proof before life support may be terminated.⁶²

In *Washington v. Glucksberg*⁶³ and *Vacco v. Quill*⁶⁴, the Supreme Court turned down an opportunity to extend the liberty interest recognized in *Cruzan* to permit terminally ill patients to recognize the "time and manner" of their death by foregoing life-sustaining treatment and also seeking the assistance from their physician to provide a lethal dose of medication. In *Glucksberg*, a state law prohibiting physician-assisted suicide for terminally ill patients was stricken in an *en banc* decision by the 9th Circuit Court of Appeals. In *Vacco*, the Second Circuit Court of Appeals more recently held that a New York statute prohibiting physician-assisted suicide violates the Equal Protection Clause of the United States Constitution.

In reviewing both circuit decisions on appeal in 1997, the United States Supreme Court specifically permitted states the right to determine whether to prohibit physician-assisted suicide, reversing the Second Circuit's finding of constitutional protection for terminally ill patients seeking the end of their lives with their physician's help.⁶⁵ Oklahoma exercised its legislative prerogative to prohibit physician-assisted suicide the following year enacting the Oklahoma Assisted Suicide Prevention Act.

B. The Oklahoma Assisted Suicide Prevention Act

The Oklahoma Assisted Suicide Prevention Act is designed to protect "vulnerable persons" from suicide by providing specific preventative civil remedies.⁶⁶

60. See Edmund D. Pellegrino, *Decisions to Withdraw Life-Sustaining Treatment*, 283 JAMA 1065 (2000) (discussing the general framework for decisions to withhold or withdraw treatment as well as practical ethical considerations); see generally Jill A. Rhymes et al., *Withdrawing Very Low-Burden Interventions in Chronically Ill Patients*, 283 JAMA 1061 (2000) (addressing the distinctive ethical issues that arise when the physician considers withdrawing low-burden clinical management from chronically—but not critically ill patients).

61. 497 U.S. 261 (1990).

62. See MEISEL, *supra* note 2, at 41-49 (discussing of the *Cruzan* decision and its implications in significant depth); Ronald E. Cranford, *A Hostage to Technology*, HASTINGS CENTER REP., Sept.-Oct. 1990, at 8; see generally Joanne Lynn and Jacqueline Glover, *Cruzan and Caring for Others*, HASTINGS CENTER REP., Sept.-Oct. 1990, at 10 (written by physicians, exploring the effect of the case on the doctor/patient relationships).

63. *Glucksberg v. Washington*, 117 S. Ct. 2258 (1997).

64. *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

65. *Glucksberg v. Washington*, 117 S.Ct. 2258 (1997); *Vacco v. Quill*, 117 S.Ct. 2293 (1997). See L. Gostin, *Deciding Life and Death in the Courtroom: From Quinlan to Cruzan, Glucksberg, and Vacco—A Brief History and Analysis of Constitutional Protection of the 'Right-to Die'*, 278 JAMA 1523 (1997); T. Rillo, Comment, *Constitutional Law: The Limits of a Patient's Right to Refuse Medical Treatment*, 46 FLA. L. REV. 347 (1994). See generally P. Rizzo, *Religion-Based Arguments in the Public Arena: A Catholic Prospective on Euthanasia, Compassion in Dying v. State of Washington and Quill v. Vacco*, 1 DEPAUL J. HEALTH CARE 243 (1996).

66. OKLA. STAT. tit. 63, § 3141.1 (West Supp. 2000).

An injunction can be sought to preempt an expected act of attempted suicide.⁶⁷ In addition, if one proves a violation of the Act, both compensatory and punitive damages may be awarded.⁶⁸

The Oklahoma Assisted Suicide Prevention Act also contains certain protections for health care professionals who prescribe or administer high levels of pain medications without any intent to cause the patient's death.⁶⁹ Protected professionals include physicians, nurses, dentists, podiatrists, physician assistants and pharmacists.⁷⁰ Such professionals who provide pain medication solely in an effort to relieve pain, even if the medication increases the risk of death, will not be in violation of the law.⁷¹

The Assisted Suicide Prevention Act has been in effect since November 1, 1998.⁷² To date, there are no reported cases construing the Act.⁷³ The primary effect of these provisions may be to encourage physicians to provide appropriate pain management for their patients without fear of prosecution under the criminal statutes prohibiting assisted suicide.⁷⁴

The Oklahoma Assisted Suicide Prevention Act has provided greater certainty to physicians who attempt to control severe pain in their terminally ill patients. So long as the physician's goal is to provide pain control, there should be no criminal or civil liability associated with the prescription or administration of pain medication.⁷⁵ Patients who are able to obtain some assurance of adequate pain relief may be less likely to request assistance in ending their lives. Both patients and health care professionals need increased awareness of this new law so its benefits can be fully realized.

C. The Federal Assisted Suicide Funding Restriction Act

On April 30, 1997, President Clinton signed The Assisted Suicide Funding Restriction Act of 1997.⁷⁶ This law prohibits federal health care programs from reimbursing any costs associated with assisted suicide.⁷⁷ This may be only "window dressing" because it is unlikely a provider would submit a bill for an overt act of assisted suicide. So long as state law is followed with regard to pain medication use,

67. See *id.* § 3141.5 (West Supp. 2000).

68. See *id.* § 3141.6 (West Supp. 2000).

69. See *id.* § 3141.4 (West Supp. 2000).

70. See *id.* § 3141.2(1) (West Supp. 2000).

71. OKLA. STAT. tit. 63, § 3141.4 (West Supp. 2000). See *State v. Naramore*, 965 P.2d 211 (Kan. Ct. App. 1998) ("palliative care refers to medical intervention in which the primary purpose is to alleviate pain and suffering"); Mina L. Levin et al., *Management of Pain in Terminally Ill Patients: Physician Reports of Knowledge, Attitudes, and Behavior*, 15 J. PAIN & SYMPTOM MGMT. 27 (1998); Orentlicher, *Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 BOSTON C. L. REV. 8 (1997) ("greater use of palliative care would reduce the demand for assisted suicide, but would not eliminate it").

72. OKLA. STAT. tit. 63, § 3141 (West Supp. 2000).

73. Legal antecedents to the Oklahoma right to die legislation include the following two appellate reported cases: *Edinburgh v. State*, 896 P.2d 1176 (Okla. Crim App. 1995) and *Sparks v. Hicks*, 912 P.2d 331 (Okla. 1996).

74. OKLA. STAT. tit. 63, § 3141.1 (West Supp. 2000) (describing the legislative intent).

75. OKLA. STAT. tit. 63, § 3141.4(A).

76. 42 U.S.C.A. § 14401 (1999).

77. *Id.*

the issue is unlikely to arise. This is particularly true so long as Medicare does not cover prescription medications. This federal law also includes funding for a suicide prevention program aimed at reducing suicide among the terminally ill and disabled populations and to further effective palliative care for these individuals.

IV. DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

One of the most useful tools for health care decision-making is the Durable Power of Attorney for Health Care.⁷⁸ A person who wishes to appoint another person to make health care decisions for him or her in the event of future incapacity may do so instead of or in addition to a living will.⁷⁹ Health care providers may rely on patient's Advance Directive only after two physicians agree that the patient is terminally ill or persistently unconscious. There are many circumstances in which an individual may no longer be capable of making decisions but not be terminally ill or persistently unconscious.⁸⁰ In those cases, the physician cannot rely on the patient's instructions in the living will, or on a Health Care Proxy's direction unless the incapacitated patient signed a Durable Power of Attorney for Health Care, no one is legally able to make medical decisions for the patient until a guardian of the person is appointed by a court. In order to avoid this expensive and time-consuming legal proceeding, every one should consider signing a Durable Power of Attorney for Health Care.⁸¹

A Durable Power of Attorney for Health Care must include certain language and specifications to be legally binding. The document must contain language that makes it "endure" past the time the individual signing it becomes incompetent. The document must also state that the power of attorney "is intended as a durable power of attorney given under the provisions of Uniform Durable Power of Attorney Act and shall not be affected by my subsequent disability or incapacity or lapse of time." In addition, the document must specify that the holder named in the document, known as the "attorney in fact" is given the right to make health care decisions. Unlike the Advance Directive, the Durable Power of Attorney for Health Care must be signed before a Notary Public as well as two witnesses.

To reduce the possibility of conflict or confusions, it is a good practice to name the same individual identified as a Health Care Proxy in one's Advance Directive as the attorney in fact in one's Durable Powers of Attorney for Health Care. Impor-

78. See FURROW, *supra* note 1, at 258-261 (setting forth the historical path of durable powers of attorney in the health care setting). *Id.* at 261 ("legal significance of a durable power of attorney for health care is defined by each state's durable power of attorney statute"). See generally David A. Peters, *Advance Medical Directives: the Case for the Durable Power of Attorney for Health Care*, 8 J. LEGAL MED. 437 (1987); Susan R. Martyn and Lynn Balshone Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779 (1984); Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUMBIA L. REV. 985 (1984).

79. MEISEL, *supra* note 2, at 12.

80. See Roth, *supra* note 3, at 279.

81. See FURROW, *supra* note 1, at 260 (asserting that in drafting durable powers of attorney under state statutes which permit deviation from statutory form, it makes sense to be expansive and properly directive).

tantly, an attorney in fact cannot make decisions regarding the withholding or withdrawal of life-sustaining treatment or artificial nutrition and hydration unless that person is also named as the individual's Health Care Proxy in an Advance Directive. Therefore, most individuals are best protected by signing both an Advance Directive and a Durable Power of Attorney for Health Care.

V. CONCLUSION

Unless one experiences an untimely accidental death, the need for end of life decision-making is inevitable. Whether an individual makes these decisions himself or the decision is ultimately forced on him by the vagaries of state law, the decisions will be made. For those with foresight, decision-making can be made in advance through a combination of state-sanctioned documents, thereby ensuring that health care decisions are made based on the individual's purposeful choices and not by fiat.
