IN CASE OF EMERGENCY, PLEASE COMPLY: LOUISIANA'S OUTMODED ADVANCE DIRECTIVE LEGISLATION AND THE PATIENT'S NEED FOR REFORM

I. INTRODUCTION

Karen, a forty-two year old woman, devotes her time to caring for her two children, working an office job, and managing her Type 2 diabetes.[1] Like 29 million Americans with diabetes,

1. Those with Type 2 diabetes are unable to use insulin properly—the pancreas

Karen must consistently monitor her condition to avoid health complications.[2] In a proactive effort to relieve her family from a difficult future decision, Karen drafts a document entitled "Karen's Living Will." In this document, she stipulates that if she were ever to require life-sustaining procedures while incapacitated, she preemptively refuses such treatment.[3] Upon executing this document, Karen's husband, Michael, and neighbor, Jennifer, act as two witnesses to her signature. Karen signs and dates her advance directive, and mails a copy to the Louisiana Secretary of State, with an enclosed fee of twenty dollars, to be filed in the State's Living Will Registry.[4] Karen then sends a copy of her advance directive to her sister, Kathy, whom Karen previously designated as her Healthcare Proxy.[5]

Recently, Karen's lifestyle has not permitted her to monitor her illness as recommended by her physician. She also has begun experiencing dehydration and frequent urination.[6] Interpreting these symptoms as consequences of her hectic schedule, Karen neither alters her habits nor seeks medical attention. One morning, three weeks after the appearance of her first symptoms, Karen does not wake up. Finding his wife unconscious late that afternoon, Michael rushes Karen to a nearby emergency room.

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makes extra insulin to compensate for the lack thereof, but over time, is unable to produce enough to maintain normal blood glucose levels. *Type 2*, AM. DIABETES ASS'N, http://www.diabetes.org/diabetes-basics/type-2/ (last visited Sept. 30, 2015). This fact pattern, while hypothetical, illustrates actual experience.

2. *Diabetes Latest*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/features/diabetesfactsheet/DiabetesFactSheet.pdf (last updated June 17, 2014). This statistic includes both Type 1 and Type 2 diabetes.

3. Life-sustaining procedures are those that merely prolong the process of death for incapacitated patients, such as artificial feeding and hydration. *See* LA. STAT. ANN. § 40:1299.58.2 (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1).

4. *See* LA. STAT. ANN. § 40:58.3(D) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(D)); *see also End of Life Registry Programs*, LA. SECRETARY ST., http://www.sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx (last visited Sept. 30, 2015).

5. "Durable Power of Attorney for Healthcare," which Louisiana refers to as "Healthcare Proxy," is an individual who has been designated by the patient, in appropriate form, to speak on the patient's behalf if she becomes incapable of speaking for herself. *See Advance Directives*, LA.-MISS. HOSPICE & PALLIATIVE CARE ORG., http://www.lmhpco.org/caregivers/advance-directives.shtml (last visited Sept. 30, 2015); *see also* LA. CIV. CODE ANN. arts. 2985, 2997(6) (2005) (requiring express authorization for a healthcare proxy to make decisions).

6. These symptoms are indicative of the severe complications associated with diabetes. *See DKA (Ketoacidosis) & Ketones*, AM. DIABETES ASS'N, http://www.diabetes.org/living-with-diabetes/complications/ketoacidosis-dka.html (last edited Mar. 19, 2015).

Karen is examined by the emergency room physician and diagnosed with diabetic ketoacidosis, which has progressed to a diabetic coma.[7] Unable to revive Karen, the attending physician requests to discuss end-of-life preparations with Karen's family in case the coma were to become irreversible. During this discussion, Kathy expresses that she is the acting Healthcare Proxy[8] on Karen's behalf and life-sustaining procedures[9] should be performed, if needed. Michael informs the physician that Karen has executed a Living Will, which explicitly refuses life-sustaining treatment. In response, the physician explains that if life-sustaining procedures become necessary, she would feel uncomfortable withholding such medical resources. Thus the dilemma appears—which perspective in this instance has authority over Karen's end-of-life strategy: the Living Will, Healthcare Proxy, or physician's discretion?

In Louisiana, the answer to this critical question is unclear. One might assume that a patient's articulated desires will determine the medical procedures inflicted on her body. This assumption is not unfounded. Scholars in bioethics have long been proponents of preserving the patient's right to determine which health care treatments they receive.[10] Since 1990, the United States Supreme Court has acknowledged the patient's "right to die," the protected right to refuse unwanted medical treatment under the Due Process Clause of the United States Constitution.[11] Furthermore, this respect for patient autonomy has been codified in both federal and state legislation.[12] For

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7. A diabetic coma is a "life-threatening diabetes complication that causes unconsciousness." *See Diabetic Coma*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions/diabetic-coma/basics/definition/con-20025691 (last visited Sept. 30, 2015). This form of coma is both preventable and reversible. *See generally* Aldo A. Rossini et al., *Diabetic Comas*, *in* IRWIN AND RIPPE'S INTENSIVE CARE MEDICINE 1256 (Richard S. Irwin & James M. Rippe eds., 6th ed. 2008).

8. *See supra* note 5.

9. *See supra* note 3.

10. Catherine V. Caldicott & Marion Danis, *Medical Ethics Contributes to Clinical Management: Teaching Medical Students to Engage Patients as Moral Agents*, 43 MED. EDUC. 283, 285 (2009) (finding theoretical foundations of patient autonomy in "Immanuel Kant's (1724–1804) work on the subject of respect," as well as in contemporary philosophers' works on ethics).

11. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990). The Court clarified this holding in *Washington v. Glucksberg*, where it ruled that the "right to die" did not extend to physician-assisted suicide and, instead, included only "the long legal tradition protecting the decision to refuse unwanted medical treatment." 521 U.S. 702, 725, 728 (1997).

12. *See, e.g.*, Patient Self-Determination Act, 42 U.S.C. § 1395cc(f) (2012) (requiring health care providers receiving Medicaid or Medicare funds to inform

instance, the Louisiana law on advance directives begins by proclaiming the following: "[A]ll persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances where such persons are diagnosed as having a terminal and irreversible condition."[13]

The advance directive is an important mechanism for protecting this well-established right of patient autonomy. Advance directives are "legal documents allowing [patients] to plan for their future medical care, particularly when they are unable to make [their] own decisions."[14] Advance directive laws vary by state regarding their requirements and extent of their effect in medical practice. There are, however, components common to all advance directive statutes: the Living Will, Healthcare Proxy, and Do–Not–Resuscitate Order (DNR).[15] Living Wills are instruments that contain patients' instructions concerning "the kind of medical care they wish to receive if they become incapacitated or otherwise unable to participate in their own treatment decisions."[16] The Healthcare Proxy, also referred to as Durable Power of Attorney for Healthcare, allows patients to assign other individuals to speak on behalf of the patients if they become incapacitated.[17] The DNR prohibits emergency medical personnel from performing cardiopulmonary resuscitation (CPR) on patients when resuscitation would

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patients of their rights under state law "to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and right to formulate advance directives"); LA. STAT. ANN. § 40:1299.58.1(A)(1) (2008) (to be recodified at LA. STAT. ANN. § 40:1151(A)(1)) ("The legislature finds that all persons have the fundamental right to control the decisions regarding their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances where such persons are diagnosed as having a terminal and irreversible condition."); MISS. CODE ANN. § 41-41-209 (2013) ("You have the right to give instructions about your own health care."); TEX. HEALTH & SAFETY CODE ANN. § 166.032(a) (West Supp. 2015) ("A competent adult at any time may execute a written directive.").

13. LA. STAT. ANN. § 40:1299.58.1 (2008) (to be recodified at LA. STAT. ANN. § 40:1151) ("The legislature further finds that the artificial prolongation of life for a person diagnosed as having a terminal and irreversible condition may cause loss of individual and personal dignity and secure only a precarious and burdensome existence while providing nothing medically necessary or beneficial to the person.").

14. *See Advance Directives*, *supra* note 5.

15. *See generally* Catherine J. Jones, Annotation, *Decisionmaking at the End of Life*, 63 AM. JUR. TRIALS 1, §§ 27–38 (1997) (providing a brief history of advance directive law and its component parts).

16. *See Advance Directives*, *supra* note 5.

17. *See id.*

otherwise be required.[18]

Together, these documents allow patients "to articulate their preference for care, in the event they become unable to communicate such direction in the future, when faced with a terminal and/or life-threatening illness."[19] While all are essential in furthering patient autonomy in health care, each instrument varies in its requirements for valid execution, as well as its level of integration into practice.[20] This Comment focuses on the Living Will and its effect in advancing incapacitated patients' explicit instructions for their medical care.

While advance directive law in Louisiana exemplifies an effort to protect patient autonomy, the preservation of articulated patient decisions has failed in emergency medical care.[21] Specifically, the Living Will has been unsuccessful in four areas. First, patients who have executed Living Wills are often unsuccessful in fulfilling the requirements for validity in Louisiana.[22] For instance, state law requires Living Wills to include the signature of witnesses in order for the document to have legal effect.[23] However, state law also implements restrictions on persons able to act as witness to the Living Will.[24]

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18. *See Advance Directives and Do-Not-Resuscitate Orders*, 62 AM. FAM. PHYSICIAN 1683–84 (2001), http://www.aafp.org/afp/2000/1001/p1683.html.

19. *See Advance Directives*, *supra* note 5.

20. These instruments are conflated in some states and enacted separately in others. For instance, in Louisiana Living Wills and DNR Orders are included in the same statute, while the assignment of a Healthcare Proxy is not. *See* LA. STAT. ANN. § 1299.58.3 (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2) (authorizing the Living Will and DNR order); *see also* LA. CIV. CODE ANN. arts. 2985, 2997 (2015) (authorizing representation in health care decisions). This Comment focuses only on the portion of the statute relevant to the patient's instruction regarding the type of medical care to be received.

21. *See* Daniel P. Hickey, *The Disutility of Advance Directives: We Know the Problems, But Are There Solutions?*, 36 J. HEALTH L. 455, 455–56 (2003).

22. "[C]omplex execution requirements," stipulated by state legislation, are responsible for the failure of advance directives. Ben Kusmin, Note, *Swing Low, Sweet Chariot: Abandoning the Disinterested Witness Requirement for Advance Directives*, 32 AM. J.L. & MED. 93, 93–94 (2006) ("By imposing unnecessarily burdensome requirements on the process, state legislatures have removed the execution of advance directives from the purview of doctors and families, and shifted it to the legal profession. This shift has impacted the number, quality, and usability of these important planning tools."); *see also* Donna A. Casey & David M. Walker, *The Clinical Realities of Advance Directives*, 17 WIDENER L. REV. 429, 431–32 (2011) (discussing the lack of use of advance directives as well as their legal complexity).

23. *See* Kusmin, *supra* note 22, at 94 ("The laws of thirty-nine states and the District of Columbia require witnesses for advance directives, and prohibit certain parties from serving in that role.").

24. *See* LA. STAT. ANN. § 40:1299.58.2(15) (Supp. 2015) (to be recodified at LA.

Requiring witnesses and simultaneously restricting their eligibility often hinder patients from properly completing advance directives.[25]

Second, a large portion of the population is unable to access Living Wills when necessary because restrictions found in state laws render the instrument applicable only under exceptionally narrow circumstances.[26] In Louisiana, enforcement of the Living Will is contingent on particular diagnoses, a narrow range of available health care choices, and detailed standards for implementing the instrument.[27] As a result, these stringent criteria restrict the patient's fundamental "right to die," as recognized by the Supreme Court, to the right to die only in extraordinary circumstances.

Third, even if an eligible patient has appropriately executed a Living Will under Louisiana law, no adequate mechanism exists to ensure physician compliance with the instrument.[28] Louisiana fails to impose a duty on the physician to check for the existence of an advance directive, even though the state has established a registry for such documents.[29] In fact, the legislation even

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STAT. ANN. § 40:1151.1(15)) (establishing narrow eligibility of witnesses); *see infra* text accompanying notes 165-175.

25. *See* Kusmin, *supra* note 22, at 94 (describing the problem of requiring disinterested witnesses as "common" to the advance directive schemes in many states); *see also generally* NAOMI KARP & ERICA WOOD, AM. BAR ASS'N COMM'N ON LAW & AGING, INCAPACITATED AND ALONE: HEALTH CARE DECISION-MAKING FOR THE UNBEFRIENDED ELDERLY 9 (2003), http://www.americanbar.org/content/dam/aba/administrative/law_aging/2003_Unbefriended_Elderly_Health_Care_Decision-Making7-11-03.authcheckdam.pdf (analyzing the realities for elderly patient's that do not have family members or friends to act as witness to their treatment).

26. *See* KARP & WOOD, *supra* note 25, at 9 ("[A] living will is a very limited document, since it usually applies only to end-of-life decisions, and is frequently too general to provide adequate guidance."); Diana Anderson, *Review of Advance Health Care Directive Laws in the United States, the Portability of Documents, and the Surrogate Decision Maker When No Document Is Executed*, 8 NAT'L ACAD. ELDER L. ATT'YS J. 183, 186–92 (2012) (discussing the numerous and varied requirements for an advance directive to become effective from state to state); Kusmin, *supra* note 22, at 94 ("The living wills that are executed often contain ambiguous or contradictory instructions, reflecting a lack of comprehension of the medical issues and treatment possibilities involved.").

27. *See infra* Section III(B).

28. Some states have established registries to house advance directives of state citizens in an attempt to increase physician access and, ideally, compliance. *See End of Life Registries*, *supra* note 4. However, this initiative has been largely unsuccessful. *See* Hickey, *supra*, note 21, at 460 ("[S]tudies indicate that approximately 25% of validly executed [advance directives] are not honored."); *see also infra* Section III(C).

29. *See* LA. STAT. ANN. § 1299.58.3(B)(2) (2008) (to be recodified at LA. STAT.

provides that physicians who are put on notice of advance directives retain discretion for compliance.[30] Thus, although Karen properly filed her Living Will with the Louisiana Secretary of State, her attending physician has no incentive to search the registry for her directive, nor is the physician required to comply with the directive when Karen's husband presents it.[31]

Fourth, although the percentage of individuals living with chronic illness continues to increase, Americans at large fail to utilize advance directives.[32] Federal education initiatives have not produced significant levels of awareness, and therefore state reliance on federal efforts should be reevaluated.[33] Within Louisiana, community education regarding advance medical planning remains an exclusively voluntary and private effort. As a result, there are neither incentives for informing patients about the Living Will nor practical repercussions for failing to do so.[34]

In response to these inadequacies, state governments and private organizations have attempted to bolster the advance

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ANN. § 40:1151.2(B)(2)) ("In the event the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication, any other person *may* notify the physician of the existence of the declaration. In addition, the attending physician or health care facility *may* directly contact the registry to determine the existence of any such declaration." (emphasis added)); LA. STAT. ANN. § 1299.58.7(C) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.6(C)) ("No provision of this Part imposes a duty upon the physician or health care facility to make a search of the registry for the existence of a declaration."); *see also infra* Section III(C).

30. *See* LA. STAT. ANN. § 40:1299.58.7 (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.6) (discussing that physicians and health care providers alike are not bound by the instructions of the Living Will); *see also infra* text accompanying notes 191–202.

31. *See* LA. STAT. ANN. § 40:1299.58.7(B)–(D) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.6(B)–(D)); *see also infra* Section III(C).

32. *See Diabetes Latest*, *supra* note 2 (reporting that the number of Americans with diabetes increased from an estimate of 26 million in 2010 to more than 29 million in 2015); *see also* Jaya K. Rao et al., *Completion of Advance Directives Among U.S. Consumers*, 46 AM. J. PREVENTATIVE. MED. 65, 68 (2014) (indicating that only approximately 25% of a sample group reported having an advance directive for end-of-life medical care). Other studies have found between 18% and 36% of respondents have executed an advance directive. OFFICE OF DISABILITY, AGING, & LONG-TERM CARE POLICY, U.S. DEP'T OF HEALTH & HUMAN SERVS., ADVANCE DIRECTIVES AND ADVANCE CARE PLANNING: REPORT TO CONGRESS 13 (2008).

33. *See* Rao et al., *supra* note 32, at 69; *see also* Hickey, *supra* note 21, at 456. ("Studies consistently report that the completion rates of [advance directives] are one-third to one-half the awareness rates.").

34. *See infra* text accompanying notes 203–08 for a discussion on the need to educate patients in Louisiana on advance medical planning and lack of incentive to provide this information.

directive,[35] yet in some cases, have chosen to abandon the advance directive altogether. For instance, Louisiana has chosen to incorporate "Physician Orders for Life-Sustaining Treatment" (POLST) into its legislation, rather than further troubleshoot advance directive law.[36] POLST is an "actionable medical order," signed by both the patient and her physician.[37] The goal of POLST is to encourage dialogue between a patient and physician based on the patient's current health conditions, as well as create a binding document that follows the patient with her medical records throughout the larger health care system.[38] Unfortunately, while the evolution of POLST has demonstrated an increase in compliance, this statute incorporates many of the same limitations as those that encumber the Living Will.[39]

In short, these efforts demonstrate a continued need for reform in this area of legislation, as these initiatives have not

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35. For instance, a number of states have established advance directive registries in order to promote compliance with the expressed wishes of patients. *See* Allison Hughes, *State Advance Directive Registries: A Survey and Assessment*, 31 BIFOCAL 23, 36–46 (2009). The American Bar Association has created a smartphone application that stores patients' advance directives and provides family members access to the documents. James R. Silkenat, *Will Your Health Care Advance Directive Be There When It's Needed?* 35 BIFOCAL 99, 99–100 (2014). Many states, in addition to advance directives, have enacted POLST statutes, medical orders that may function as either an alternative or supplement to the advance directive. *See generally* CHARLES P. SHAPIRO & NAOMI KARP, IMPROVING ADVANCED ILLNESS CARE: THE EVOLUTION OF STATE POLST PROGRAMS (2011), http://assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf.

36. Referred to in state legislation as "POLST," "POST," "MOST," or some other similar acronym, the function of this alternative is the same nationwide. *See* SHAPIRO & KARP, *supra* note 35, at v.

37. *Id.* Upon completion, the medical order is filed in the patient's chart to become effective in the stipulated circumstances, as determined by either the patient or the state-specific POLST program. *See, e.g.*, LA. STAT. ANN. § 40:1299.64.2(8) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1153.5(8)) (mandating that the form follow the patient through health care treatment); La. Health Care Quality Forum, *LaPOST FAQs*, LAPOST, http://lhcqf.org/lapost-old/lapost-about/faqs (last visited October 17, 2015) (educating patients about the purpose and use of LaPOST orders).

38. *See* SHAPIRO & KARP, *supra* note 35, at 1.

39. *See, e.g.*, LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1(11)) (defining "qualified patient" for the Living Will as "a patient diagnosed and certified in writing as having a terminal and irreversible condition by two physicians who have personally examined the patient, one of whom shall be the attending physician"); *id.* § 40:1299.64.2(11) (to be recodified at LA. STAT. ANN. § 40:1153.5(11)) (defining "qualified patient" for POLST as "a patient diagnosed and certified in writing as having a life-limiting and irreversible condition by the attending physician or personal physician of the patient"); *see also infra* text accompanying notes 133–35, 186–88, 192–93.

rectified the complications of current advance directive law. Efforts in Louisiana, though somewhat innovative, have ignored the crucial downfalls of advance directive legislation described above.[40] However, by amending the Louisiana Revised Statutes to fill critical gaps of advance health care planning, heightened patient autonomy could become reality.[41]

Section II of this Comment provides a background on the emergence of advance directives throughout the United States and varying perspectives on them. Section III specifically details Louisiana's legislative efforts surrounding advance directives and provides a critical analysis based on the inadequacies of such initiatives. Section IV offers a legislative proposal to ameliorate these inadequacies and protect the patient's right to choose which emergency medical procedures will be performed in critical moments of incapacitation.

This proposal addresses the need for Louisiana to reconsider its legislation on Living Wills in four areas. Foremost, the Louisiana legislature should eliminate unnecessary restrictions for validity when the desires of the patient are explicit. Next, the Living Will legislation should expand the eligibility of patients in an effort to provide greater access to advance decision-making. Alleviating these requirements will reduce the number of patients denied compliance due to the common dilemma—as demonstrated by Karen—of those facing end-of-life decisions. Also, physician discretion must be restrained, and duties should be imposed on medical professionals to search for and comply with a patient's Living Will. This will incentivize medical practitioners to uphold the binding nature of legally executed advance directives. Lastly, Louisiana should incorporate a requirement to inform patients of advanced planning resources available to them in order to comply with federal law and increase awareness.

II. THE EMERGENCE OF PATIENT AUTONOMY

Over the past thirty years, medical advancements in life-sustaining technology, as well as the increasing elderly population, have heightened the need to make medical decisions in advance.[42] Currently, "the average American can expect to spend the final two years of life too disabled to perform even the

40. *See supra* text accompanying notes 21–39.

41. *See infra* Section IV.

42. *See* Kusmin, *supra* note 22, at 93.

routine activities of life unassisted."[43] This increased likelihood of disability, which may manifest through incapacitation, necessitates advance directives. While advance planning may be challenging and emotional for a patient acknowledging the realities of death, these hardships become exacerbated when third parties must make decisions for incapacitated patients.[44] Under these circumstances, family members, medical practitioners, and the courts are forced to make end-of-life determinations on behalf of others.[45]

The ethical complexities associated with substituting one's personal perspective on end-of-life care for another's are monumental.[46] As a result, "[b]oth state legislatures and courts at every level, including the United States Supreme Court, have struggled with determining whether such decisions *should* be made and, if so, where the boundaries of such authority lie."[47] As remedy to this dilemma, Congress and state legislatures have enacted advance directives into law in an effort to offer guidance on avoiding this traumatic situation and allow patients to stipulate their desires.[48]

However, advance directive law varies widely across the United States.[49] This fragmentation has produced uncertainty surrounding advance planning, rendering these statutes

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43. *See* Kusmin, *supra* note 22, at 93.

44. *See* Alexia M. Torke et al., *Substituted Judgment: The Limitations of Autonomy in Surrogate Decision-Making*, 23 J. GEN. INTERNAL MED. 1514, 1514 (2008) ("Since many patients do not have advance directives, or existing directives do not apply to the decision at hand, substituted judgment must frequently be evoked in decision making." (footnote omitted)).

45. *See id.*

46. *See id.* ("[R]esearch has shown that the concept of substituted judgment rests upon false assumptions and is unable to meet the stated goals of maintaining patient autonomy.").

47. Joseph T. Monahan & Elizabeth A. Lawhorn, *Life-Sustaining Treatment and the Law: The Evolution of Informed Consent, Advance Directives and Surrogate Decision Making*, 19 ANNALS HEALTH L. 107, 107 (2010) (emphasis added).

48. Advance directives—the Living Will, Healthcare Proxy, and DNR order—absolutely serve to alleviate the stresses of substituting one's judgment for another without guidance from the incapacitated patient. However, Living Wills more particularly remedy this occurrence, as no individual is charged with making end-of-life decisions on another's behalf. Instead, with the Living Will, patients explicitly state their wishes before incapacitation occurs. For a discussion of state and federal advance directive legislation, see *infra* Sections II(A)(2) and II(B)(1)–(2).

49. *See* Casey & Walker, *supra* note 22, at 431–32 ("[S]tatutory provisions relating to advance directives can differ substantially from state to state. . . . These statutory differences demonstrate the importance of educating patients and providers on the range of decision-making options and capability.").

essentially futile.[50] This inconsistency began with the Supreme Court's recognition of patient autonomy and has persisted in the evolution of state legislation, as demonstrated by three contiguous states: Mississippi, Texas, and Louisiana.

A. NATIONAL INITIATIVES ON ADVANCE PLANNING

The Living Will is founded on the concept of patient autonomy in health care—"a protected liberty interest in refusing unwanted medical treatment."[51] The Supreme Court of the United States and Congress have recognized this right and mandated that medical professionals shall respect and encourage instruction by patients in preemptive health care decisions.[52] Yet, the states have discretion in determining the appropriate level of patient authority in medical care, and as a result, respect for patient directives varies throughout the United States.

1. CRUZAN V. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH AND THE "RIGHT TO DIE"

On June 25, 1990, Chief Justice Rehnquist affirmed the principal that "a competent person has a constitutionally protected interest in refusing unwanted medical treatment."[53] This assertion—known as "the right to die"—was made in the Supreme Court's 1990 decision in *Cruzan v. Director, Missouri Dep't of Health*.[54] Nancy Cruzan, the victim of a tragic car accident and the focus of this case, remained in a "persistent vegetative state," where she survived only by artificial feeding and hydration.[55] Several weeks after the accident, Nancy's parents sought to cease life-sustaining procedures due to their daughter's unceasing comatose state.[56] However, the Missouri Supreme Court denied their petition and held that, without clear and convincing evidence of Nancy's intent, the treatment could

50. *See* Hickey, *supra* note 21, at 460 ("Advance treatment preferences are difficult to form, communicate, and implement. One study revealed that older adults who plan to complete [directives] need assistance in completing the forms. Also, standardized and statutorily-prescribed [directives] use vague terminology. . . . As such, they invite problems of interpretation." (footnotes omitted)).

51. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring).

52. *See id.* at 278 (1990) (majority opinion); *see also* Patient Self-Determination Act, 42 U.S.C. § 1395cc(f) (2012).

53. *Cruzan*, 497 U.S. at 278.

54. *Id.*; *see generally* George Annas, *Nancy Cruzan and the Right to Die*, 323 NEW ENG. J. MED. 670 (1990).

55. *Cruzan*, 497 U.S. at 266–68.

56. *See id.* at 267–68.

not be terminated.[57] Nancy Cruzan did not have an advance directive to illustrate her desires concerning end-of-life care.[58]

Upon review of the lower court's decision, the Supreme Court affirmed.[59] In its opinion, the Court explained that while competent patients have a constitutional right to die, that right does not extend to incompetent individuals.[60] As such, the Court held that Missouri's Living Will statute, which required clear and convincing evidence in the absence of a Living Will, was constitutional.[61] Without a clear showing of intent on behalf of the incapacitated patient, the Court refused to terminate treatment.[62] Presenting a worst-case scenario for end-of-life care, *Cruzan* illustrated to the American public the ethical horrors associated with a lack of advance planning in emergency circumstances.[63]

Unfortunately, avoidance of the circumstances in *Cruzan* requires more than mere execution of a document entitled "Living Will." Dissenting in *Cruzan*, Justice Brennan explained that even a patient determined to avoid life-sustaining treatments "would still need to know that such things as living wills exist and how to execute one. Often, legal help would be necessary . . ." for this task.[64] Thus, education on the requirements for executing a valid directive under state law is essential for a patient to successfully protect his or her medical instructions. Within the same year, Congress attempted to provide these resources to the public.[65]

2. THE PATIENT SELF-DETERMINATION ACT

Following the Court's *Cruzan* decision, Congress acknowledged the imperative nature of advance medical planning and passed the Patient Self-Determination Act (PSDA) (1990),

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57. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 265 (1990).

58. *See id.* at 268–69.

59. *See id.* at 287.

60. *See id.* at 278–80.

61. *See id.* at 280–83.

62. *See id.* at 286–87.

63. *See* Monahan & Lawhorn, *supra* note 47, at 109 ("The *Cruzan* decision drew national attention and highlighted the use of advance directives as a means for competent individuals to clearly state their wishes with regard to life-sustaining treatment in advance of an unforeseen crisis.").

64. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 323 (1990) (Brennan, J., dissenting).

65. *See infra* Section II(A)(2).

which remains the federal authority on advance directives.[66] In general, the PSDA furthers advance planning awareness and "requires that healthcare providers in every state respect patients' wishes regarding their end-of-life care."[67] This principle is significant in that it codifies the fundamental autonomy that is the right to die—or, in the context of advance medical planning, the right to choose. Specifically, the PSDA includes four requirements to be enforced by health care institutions that receive federal Medicare or Medicaid funding.

First, at the time of admission, the health care institution must inquire whether a new patient has executed an advance directive and provide information on how to complete such a document under state law.[68] Second, the institution must inform a patient of her right to make advance medical decisions and of the health care institution's policy on recognition of advance directives.[69] Third, the institution must not discriminate against patients on the basis of an advance directive.[70] Fourth, the institution must educate its staff and the local community on advance planning.[71]

Despite these requirements, the PSDA lacks a variety of essential initiatives. Foremost, the attending physician is not required to search for a patient's advance directive, as there is a presumption that the institution has previously inquired.[72] Nevertheless, the institution is only required to ask a new patient whether she has executed an advance directive; follow-up inquiries are not necessary under the law.[73] The PSDA also limits physicians' duties to those articulated by state law. If state

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66. The Patient Self-Determination Act was part of a larger spending bill. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to -117, 1388-204 to -206 ((codified at 42 U.S.C. § 1395cc(f), 1396a(a)(57)–(58), (w) (2012)).

67. Ruth F. Maron, Note, *Who Has a Will To Live?: Why State Requirements for Advance Directives Should Be Uniform(Ly Revised)*, 24 REGENT U. L. REV. 169, 171 (2011).

68. 42 U.S.C. § 1395cc(f)(1)–(2) (2012). Whether the patient has executed an advance directive must be documented in "a prominent part" of the patient's medical record. *Id.* § 1395cc(f)(1)(B).

69. *Id.* § 1395cc(f)(A).

70. *Id.* § 1395cc(f)(1)(C).

71. *Id.* § 1395cc(f)(1)(E).

72. *See id.* § 1395cc(f)(1)(B) (requiring the institution to document whether or not a new patient has executed an advance directive, but failing to impose a duty to obtain that document prior to treatment).

73. *See id.* § 1395cc(f)(2) (requiring that information be provided only upon admission to the health care institution).

law allows for a conscience exception, which Louisiana does, the physician is not required to comply with an advance directive if the medical instruction therein is in contention with either the physician's personal beliefs or the institution's policy.[74] Finally, "[u]nder the PSDA, states retain the discretion to determine advance directive provisions and the specific requirements for them to be effective."[75]

The immense discretion afforded by the PSDA has fragmented both state legislation and physician application. Consequently, the inconsistencies across state legislation on advance directives have produced significant ambiguity when determining which requirements are necessary for executing directives.[76] For instance, advance directive laws differ in their requirements for validity.[77] An advance directive executed appropriately in one state may not comply with another state's criteria. Thus a patient injured during an out–of–state vacation cannot be certain that even if the attending medical professionals become aware of the patient's Living Will, they will enforce the document.

Furthermore, physician application of the Living Will has been less than ideal under the PSDA. Often, even when a patient has completed an advance directive, "the medical care provider may have no way of knowing that there is an advance directive on file or of accessing the document."[78] Despite the PSDA requirement to ask if a patient has an advance directive, "more than sixty-five percent of the time the physician is not aware that the patient has an advance directive, and more than thirty-five percent of the time cannot find the document."[79] These statistics become even more shocking when measured against the finding that a much larger percentage of long-term care patients, unlike the general population, have executed advance directives in the belief that their decisions will be honored during anticipated

74. *See* 42 U.S.C. §§ 1395cc(f)(1)(A)(ii), 1396a(w)(3) (2012).

75. *See* Maron, *supra* note 67, at 171 (citing 42 U.S.C. § 1395cc(f)(3) (2012)).

76. *See id.* at 172.

77. *Compare* MISS. CODE ANN. § 41-41-209 (2013) (requiring two witness or a notary) *with* LA. STAT. ANN. § 1299.58.3 (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2) (requiring two witnesses).

78. Maron, *supra* note 67, at 177. The PSDA fails to establish a uniform regimen for filing a patient's Living Will. Consequently, compliance with the federal statute can be achieved by checking "yes" or "no" when asking the patient if she has executed an advance directive. In emergency situations, that information is useless if the document is not on file.

79. *Id.* at 177.

circumstances.[80]

Nevertheless, this failure to locate and comply with a patient's advance directive does not indicate that physicians disregard patient autonomy. Instead, various competing factors diminish concern for the existence of a Living Will. First, medical practitioners aim to preserve life.[81] While the emergence of the right to die and establishment of the Living Will should suggest that life-sustaining procedures are not the default preference of the patient, the denial of such resources is counter-intuitive for most healthcare professionals.[82] Second, family members may be present and encourage the use of all possible treatments to preserve their loved one's life.[83] Third, and often most influential, the representative of an incapacitated patient may be less likely to file suit for a physician's actions to preserve life than for letting the patient die or for refusing to treat.[84] These obstacles to compliance with, and even consideration for, the patient's instruction demonstrate the need for a stronger mechanism of protection.

Though the statute may have provided for an increase in advance directive policies within health care institutions,[85] the PSDA has proven ineffective in furthering its purposes: ensuring awareness of the advance directive and protecting the patient's

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80. *Compare* Maron, *supra* note 67, at 172 ("[O]nly eighteen to thirty-six percent of American adults actually have an advance directive.") *with* ADRIENNE L. JONES ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., USE OF ADVANCE DIRECTIVES IN LONG-TERM CARE POPULATIONS 1 (2011), http://www.cdc.gov/nchs/data/databriefs/db54.pdf. ("Overall, 28% of home health care patients, 65% of nursing home residents, and 88% of discharged hospice care patients had at least one advance directive on record."). However, the majority of those who had executed a directive were white care recipients over the age of eighty-five—demonstrating that use is not universal across demographics. *Id.* at 7.

81. U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-95-135, PATIENT SELF-DETERMINATION ACT: PROVIDERS OFFER INFORMATION ON ADVANCE DIRECTIVES BUT EFFECTIVENESS UNCERTAIN 11 (1995), http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf.

82. *See* Hickey, *supra* note 21, at 458.

83. *See id.* at 461.

84. *See id.*

85. *See* OFFICE OF DISABILITY, AGING, & LONG-TERM CARE POLICY, *supra* note 32, at xv ("The [PSDA] was found not to increase the overall proportion of patients with an advance directive but increased the proportion of advance directives documented in patient medical records as well as the proportion of patients who reported having discussed advance care planning with their physicians. . . . [T]here was a large increase in advance directive completion among nursing home residents. However, legislation, in general, has not been seen as a major influence in improving care toward the end of life.").

preference of care.[86] Reminiscent of Justice Brennan's concerns in his *Cruzan* dissent, the continued lack of understanding in executing a Living Will, as well as the lack of enforcement on behalf of physicians, emphasize the need for an alternative remedy to the problem of inconsistency across the United States.[87]

3. UNIFORM HEALTH-CARE DECISIONS ACT

Three years after Congress enacted the PSDA, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Health-Care Decisions Act (Uniform Act) in an effort to remedy discrepancies in state advance directive law.[88] The Uniform Act provides states with comprehensive model legislation on advance directives.[89] In particular, the Uniform Act avoids the complications often found in state law by expanding the criteria for eligible patients and reducing the requirements for valid execution of the Living Will.[90]

Most significantly, the Uniform Act establishes minimal requirements for the validity of a Living Will. Rather than impose strict form requirements on the instrument, the Uniform Act only requires the patient to stipulate her desires either orally or in writing.[91] The sample advance directive form included in the act provides space for either the signature of two witnesses or notarization;[92] however, since these signatures are optional for completion of a Living Will, "a failure to witness does not invalidate the document."[93]

The Uniform Act also allows the patient to make advance

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86. *See* OFFICE OF DISABILITY, AGING, & LONG-TERM CARE POLICY, *supra* note 32, at 13 ("[S]tudies find that only 18–36 percent of Americans have completed an advance directive.").

87. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 323 (1990) (Brennan, J., dissenting); Hickey, *supra*, note 21, at 459–62; Maron, *supra* note 67, at 177.

88. *See* Nat'l Conference of Comm'rs on Uniform State Laws, *Health–Care Decisions Act Summary*, UNIFORM L. COMMISSION, http://www.uniformlaws.org/ActSummary.aspx?title=Health-Care%20Decisions%20Act (last visited Oct. 2, 2015).

89. *See id.*

90. *See id.*

91. UNIF. HEALTH-CARE DECISIONS ACT § 2(a) (UNIF. LAW COMM'N 1994).

92. *Id.* § 4(13).

93. Nat'l Conference of Comm'rs on Uniform State Laws, *Why States Should Adopt the UHCDA*, UNIFORM L. COMMISSION, http://www.uniformlaws.org/Narrative.aspx?title=Why%20States%20Should%20Adopt%20UHCDA (last visited Oct. 2, 2015); *see* UNIF. HEALTH-CARE DECISIONS ACT § 4 cmt. (UNIF. LAW COMM'N 1994).

determinations regarding any aspect of medical care.[94] The patient is not limited to instruction solely on life-sustaining procedures and, instead, is encouraged to stipulate any treatment desires to be performed or withheld while the patient lacks capacity.[95] Additionally, the Uniform Act allows a Living Will to become effective at the moment of incapacitation unless otherwise expressed by the patient.[96] Many states, including Louisiana, require medical professionals to perform procedures and make diagnoses before the directive may take effect.[97] The Uniform Act eliminates such obstacles by conditioning effect upon incapacitation unless otherwise provided.[98]

Along with these improvements, the Uniform Act encourages compliance with the Living Will by necessitating patient transfer and authorizing judicial relief.[99] Like many states' advance directive laws, the Uniform Act includes a "conscience exception"—a medical professional's authority "to decline to comply with a health care decision or instruction for reasons of conscience."[100] Nevertheless, if the conscience exception is invoked, the Uniform Act mandates that the health care institution transfer the patient to a physician or institution willing to comply with the advance directive.[101] Moreover, in the event that a physician or health care institution fails to comply with the patient's instructions without reason, the Uniform Act authorizes judicial relief in the form of a court order for a health care decision or other equitable relief.[102] Thus, while a physician retains discretion in compliance, the Uniform Act provides for a requisite level of accountability, thereby ensuring legitimacy on

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94. UNIF. HEALTH-CARE DECISIONS ACT §§ 2(a), 4 pt. 2 (UNIF. LAW COMM'N 1994).

95. *See id.*

96. *See id.* Patients are allowed to make medical decisions, which *may be limited* to take effect only if specific circumstances arise. By allowing patients to set parameters for the effect of advance directives, the statute implies that the default condition for efficacy is mere incapacitation.

97. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.031(2) (West 2010) (defining "qualified patient"); LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1(11)) (same); *see infra* text accompanying notes 179–85.

98. *See* UNIF. HEALTH-CARE DECISIONS ACT § 1(3) (UNIF. LAW COMM'N 1994). ("'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a healthcare decision.").

99. *See id.* §§ 7(g)(3), 14.

100. *Id.* § 7(e).

101. *See id.* § 7(g)(3).

102. *See id.* § 14.

behalf of the practitioner.

While these provisions[103] of the Uniform Act are significant in promoting validity, access, and compliance around advance directives, the Uniform Act also contains inadequacies. As for compliance, the Uniform Act does not require a state registry to house advance directive documents, despite physicians' frequent failure to locate and record patient instructions.[104] Likewise, the Act does not impose a duty on medical professionals to search for the existence of advance directives prior to performing treatment on incapacitated patients. With regard to education, the Uniform Act lacks a requirement to inform patients of the existence and requirements of the Living Will. As such, the Uniform Act does not attempt to rectify the nationwide ignorance of advanced medical planning.[105] Together, the shortcomings of the Uniform Act avoid areas of critical reform that, if remedied, have the potential to overcome evidence-based hindrances, such as ignorance and noncompliance, on a national scale.

Still, the liberal initiatives of the Uniform Act, coupled with its ideal of uniformity across jurisdictions, position the patient with the requisite level of authority for controlling her care—in any circumstance in which the patient is unable to communicate such desires. Unfortunately, since its approval in 1993, only seven states have adopted the Uniform Act as their legislation on advance directives, and Louisiana is not among them.[106] Nevertheless, although Louisiana is unlikely to adopt the Uniform Act, the innovation of the Act emphasizes the importance—and limitations—of advance directives and provides significant guidance for reevaluating Louisiana law on Living Wills.

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103. The advance directive form in the Uniform Act also includes other components, such as assignment of Healthcare Proxy, identification of a Primary Care Physician, or authorization for organ transplant. *See, e.g.*, UNIF. HEALTH-CARE DECISIONS ACT § 4, pts. 1, 3–4 (UNIF. LAW COMM'N 1994). These sections are not discussed in this Comment.

104. *See* Hughes, *supra* note 35, at 36.

105. *See* Hickey, *supra* note 21.

106. Nat'l Conference of Comm'rs on Uniform State Law, *Legislative Fact Sheet-Healt-Care Decisions Act*, UNIFORM L. COMMISSION, http://www.uniformlaws.org/LegislativeFactSheet.aspx?title=Health-Care%20Decisions%20Act (last visited Oct. 2, 2015). Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico, and Wyoming have adopted the Uniform Act. *Id.*

B. STATE INTERPRETATIONS OF THE LIVING WILL

Every state has enacted advance directive legislation, yet these statutes vary "in form, requirements, and even in what provisions the state must honor."[107] This patchwork of legislation has the potential to create significant ethical dilemmas regarding how a patient is able to enforce her directive across state lines.[108] In addition to creating confusion on the provisions of advance directive law, such legislation has not been effective. According to a study published in 2014 by the American Journal of Preventative Medicine, only 26.3% of nearly 8,000 surveyed individuals testified that they had executed an advance directive.[109] Still, this minority, though seemingly prepared, risks unawareness or noncompliance on behalf of treating physicians—unless the conditions of the Living Will, as well as the illness, comply with state law.

Upon first impression, the variations from state to state appear trivial.[110] However, slight differences in language significantly alter the effect of patients' pre-determined medical choices—that is to say, whether these documents will have any effect. Specifically, slight dissimilarities in how states mandate validity, access, and compliance have the potential to render most advance directives ineffective.[111] This section focuses on the laws of two states contiguous to Louisiana in order to demonstrate this incongruity and discuss the dramatic impact slight variation can have on a state's advance directive legislation.[112] First, this section discusses the advance directive initiatives enacted in Mississippi, modeled after the Uniform Act. Next, this section examines Texas legislation, contrasting the latter's state-specific

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107. Maron, *supra* note 67, at 172.

108. *See id.* at 176. The "conflict of law" implications are significant and, as such, are reserved for another discussion.

109. *See* Rao et al., *supra* note 32, at 68 (surveying 7,946 individuals). In other studies, the rate ranges from 18% to 36%. OFFICE OF DISABILITY, AGING, & LONG-TERM CARE POLICY, *supra* note 32, at 13.

110. *Compare* TEX. HEALTH & SAFETY CODE ANN. § 166.031(2) (West 2010) *with* LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1(11)).

111. *See* Maron, *supra* note 67, at 172, 176.

112. This discussion of legislation focuses solely on the nature of the law, interpreted from the text of the statutes. Case law in this area is inaccessible for a number of reasons: those in end-of-life care often do not have representatives to act on their behalf, representatives of patients are often grieving and lack the ability to file suit, and most state law mandates that complaints be filed with the state's respective medical board rather than the judiciary.

advance directive statutes with the former's uniform model.[113] This discussion underlines the need for careful evaluation of Louisiana's law on Living Wills.

1. MISSISSIPPI'S ENACTMENT OF THE UNIFORM ACT

In 1998, Mississippi became the fourth state to adopt the Uniform Act as its advance directive legislation.[114] Demonstrating a heightened concern for patient autonomy, the Mississippi advance directive provides the patient—rather than the physician—with wide discretion in treatment strategy.[115] The statute allows patients to stipulate extensive health care instruction to become effective upon the patient's incapacitation.[116]

Under Mississippi law, the Living Will is less vulnerable to being declared invalid because no form requirements are necessary to provide advance medical instruction.[117] Several states, including Louisiana, require either the signature of two "disinterested" witnesses or notarization for a Living Will to be deemed valid.[118] In contrast, Mississippi only mandates this form requirement for the assignment of a Healthcare Proxy, and even then only one witness must be disinterested.[119] Still, this option is available for the Mississippi Living Will, if desired by the patient, and encouraged by the statute's sample language: "After completing this form (referring to all aspects of the advance directive), sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below."[120]

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113. This Comment focuses on Mississippi as a demonstration of the Uniform Act passed through state legislation and on Texas as an example of state-specific legislation more similar to Louisiana, yet departing from the Louisiana law in significant areas. The disparity amongst the three contiguous states also emphasizes the incongruity of advance directive law nationwide.

114. Uniform Health-Care Decisions Act, ch. 542, 1998 Miss. Laws 756 (codified as amended at MISS. CODE ANN. §§ 41-41-201 to -229 (2013)).

115. *See* MISS. CODE ANN. § 41-41-209 (2013).

116. *Id.* § 41-41-205 (outlining available directives). Like the Uniform Act, the statute implies that the default condition for efficacy is mere incapacitation. *See id.* § 41-41-205(1); *see also supra* note 96.

117. MISS. CODE ANN. § 41-41-205(1) (2013).

118. Kusmin, *supra* note 22, at 94 ("The laws of thirty-nine states and the District of Columbia require witnesses for advance directives, and prohibit certain parties from serving in that role.); *see, e.g.*, LA. STAT. ANN. § 40:1299.58.2(15) (Supp. 2015) (to be codified at LA. STAT. ANN. § 40:1151.1(15)) (establishing narrow eligibility of witnesses).

119. MISS. CODE ANN. § 41-41-205(2)(a) (2013) (defining "qualified witnesses").

120. *Id.* § 41-41-209.

The form then clarifies that this form requirement is essential only with regard to the Healthcare Proxy.[121]

In addition to extending the validity of the document, the Mississippi Living Will also increases patient discretion in health care. As provided in the Uniform Act, the patient is allowed to provide health care instruction regarding any type of medical care.[122] While other states may constrain the patient's choice to concern only life-sustaining treatment, Mississippi has no such limitation. The open-ended language provided within the sample Mississippi Living Will emphasizes this right as follows:

> Part 2 of this form lets you give specific instructions about *any aspect of your health care*. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.[123]

Moreover, Mississippi advance directives further increase patient access because the Living Will becomes effective upon the moment that the patient cannot speak for herself, unless otherwise stipulated by the patient.[124] While many states require extensive diagnosis and recordation for the directive to take effect, Mississippi law does not mandate such requirements.[125]

Finally, the Mississippi statute imposes a duty of compliance on the health care provider and institution: "[A] health care provider or institution providing care to a patient shall . . . [c]omply with an individual instruction of the patient . . . ."[126] As

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121. MISS. CODE ANN. § 41-41-209 (2013); *id.* § 41-41-205(2) (requiring witnesses or a notary to create a power of attorney).

122. *See id.* § 41-41-203(h)(i)–(iii).

123. *Id.* § 41-41-209 (emphasis added).

124. *Id.* § 41-41-205(1) ("An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises."). By default, the primary physician must determine that the patient is incapacitated, yet this diagnosis may be superseded by written instruction in the advance direction. *Id.* § 41-41-205(6).

125. *See, e.g.*, LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be codified at LA. STAT. ANN. § 40:1151.1(11)) ("'Qualified patient' means a patient diagnosed and certified in writing as having a terminal and irreversible condition by two physicians who have personally examined the patient, one of whom shall be the attending physician.").

126. MISS. CODE ANN. § 41-41-215(4) (2013).

stated in the Uniform Act, this duty of compliance is conditioned on the conscience exception,[127] which if invoked, requires the physician or institution to appropriately transfer the patient to a medical professional willing to comply with the directive.[128] If such procedures are not executed in good faith, the health care provider or institution may be held liable for civil damages of $500, actual damages resulting from the action, or equitable relief by "any court of competent jurisdiction."[129] The preliminary establishment of a duty to comply, without reason for noncompliance, significantly advances the patient's interests and protects her rights by future suit, if necessary.[130]

Nevertheless, Mississippi advance directive legislation is not without error. For instance, physician compliance in Mississippi is contingent on patients' ability to provide medical personnel with copies of their Living Wills. The Mississippi legislature has been unsuccessful in establishing a state registry for such documents, which if created would provide physicians with the ability to readily attain the wishes of even incapacitated patients.[131] Thus while patients' directives may be appropriately executed under the generous requirements of state law, the likelihood of the desires therein being communicated to attending physicians is diminished.

The Mississippi advance directive also does not include a duty to inform the patient of medical planning resources, such as the Living Will, but the statute does take a significant step towards recognizing the importance of the Living Will. The law mandates that "[a] supervising health-care provider who knows of the existence of an advance health-care directive . . . shall

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127. MISS. CODE ANN. § 41-41-215(5), (7) (2013) ("A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. . . .").

128. *Id.* 41-41-215(7)(c).

129. *See id.* §§ 41-41-221(1), -229.

130. If the physician or health care institution is not required to comply with a Living Will and is instead provided broad discretion for compliance, the patient will be at a disadvantage in establishing the legal significance of compliance with her medical instruction. This inclusion only establishes a preliminary duty to comply, if possible.

131. In 2015, the Mississippi legislature proposed an amendment, which would have established a registry for advance directives. This amendment would have required that "any acknowledged advance health-care directive shall be filed in the chancery court and made available on the official state of Mississippi website." H.R. 708, 2015 Leg., Reg. Sess., § 5 (Miss. 2015). Unfortunately, the proposed amendment died in committee. *House Bill 708*, MISS. LEGISLATURE (Feb. 3, 2015, 6:09 PM), http://billstatus.ls.state.ms.us/2015/pdf/history/HB/HB0708.xml.

promptly record its existence in the patient's health-care record."[132] This requirement of recordation imposes a duty on the physician to respect the significance of the patient's instructions and comply with them appropriately under the other provisions of the Mississippi law.

In addition to the Uniform Act on advance directives, Mississippi enacted a statute on the "Physician Order for Sustaining Treatment" (POST) in 2014.[133] Unlike the Living Will, this form of advance medical planning constitutes a medical order, certified by both the physician and the patient, and has several legal requirements for validity, thereby proscribing at will modification or revocation of the document.[134] Still, the Mississippi POST statute mirrors the liberal protection of patient autonomy found in its advance directive law by allowing instruction for any medical treatment, requiring review for accordance with the patient's Living Will, and providing for civil action to remedy noncompliance.[135]

2. TEXAS LEGISLATION ON MEDICAL DIRECTIVES

Unlike Mississippi's statutes, the Texas advance directive statutes were not modeled on the Uniform Act but were instead enacted as state-specific legislation in 1999.[136] Incorporating a combination of expanded patient autonomy and intensive requirements, Texas's advance directive law exemplifies a middle ground between Mississippi's Uniform Act and Louisiana's legislation. The law's purpose of protecting the patient's right to execute health care instruction is apparent, yet the narrow scope of the Texas legislation drastically limits the validity and accessibility of such a significant resource.

At its outset, the Texas law allows any "competent adult . . .

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132. MISS. CODE ANN. § 41-41-215(2) (2013).

133. *See* Mississippi Physician Order for Sustaining Treatment (POST) Act, ch. 470, 2014-2 Miss. Laws Adv. Sh. 538 (LexisNexis) (codified at MISS. CODE ANN. §§ 41-41-301 to -303 (Supp. 2015)).

134. *See* MISS. CODE ANN. § 41-41-302 (Supp. 2015). A medical order is significant in that the instruction is placed within the patient's medical records immediately and therefore will follow the patient throughout the health care system—upon discharge, transfer, and subsequent intake to institutions. The binding nature of the order requires the physician to execute it. The Living Will does not involve any such requirements and is the patient's responsibility.

135. *See id.* § 41-41-303(2)–(4).

136. Advance Directives Act, ch. 450, 1999 Tex. Gen. Laws 2835 (1999) (codified as amended at TEX. HEALTH & SAFETY CODE ANN. §§ 166.001-.166 (West 2010 & Supp. 2015)).

at any time [to] execute a written directive," which must be signed by the patient in the presence of two witnesses or with the acknowledgment of a notary public.[137] If two parties witness the document, specific criteria must be satisfied in order for the Living Will to be valid:

> (1) Each witness must be a competent adult; and
>
> (2) at least one of the witnesses must be a person who is not:
>
> (A) a person designated by the declarant to make a health care or treatment decision;
>
> (B) a person related to the declarant by blood or marriage;
>
> (C) a person entitled to any part of the declarant's estate after the declarant's death under a will or codicil executed by the declarant or by operation of law;
>
> (D) the attending physician;
>
> (E) an employee of the attending physician;
>
> (F) an employee of a health care facility in which the declarant is a patient if the employee is providing direct patient care to the declarant or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
>
> (G) a person who, at the time the written advance directive is executed or, if the directive is a nonwritten directive issued under this chapter, at the time the nonwritten directive is issued, has a claim against any part of the declarant's estate after the declarant's death.[138]

Unlike the Mississippi statutes, the validity of the Texas Living Will is contingent upon the sufficiency of form, regardless of the patient's expressed treatment preferences.[139] Consequently, patients unfamiliar with the formal requirements for the Living Will begin their execution of this document at a disadvantage.

Though the Texas advance directive requires specific form, it provides the patient with discretion in health care treatment. After directing the patient to indicate whether life-sustaining treatment should be administered or withheld under particular

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137. TEX. HEALTH & SAFETY CODE ANN. § 166.032(a)–(b-1) (West Supp. 2015).
138. *Id.* § 166.003.
139. *Compare id.* § 166.032(b)–(b-1) *with* MISS. CODE ANN. § 41-41-205(1) (2013).

circumstances, the law then provides for the designation of "additional requests."[140] The sample Living Will Form instructs: "After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc."[141] The statute does emphasize, however, that life-sustaining treatments will not be performed on hospice patients.[142] While this disclosure may seem obvious to those familiar with the nature of hospice care,[143] the Texas statute takes special consideration to indicate to patients that exceptions to compliance with the Living Will exist.

In contrast to the liberal discretion provided to the patient, the Texas Living Will is only accessible to a narrow subset of patients. Under Texas legislation, a "qualified patient" is defined as "a patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician."[144] Thus, the patient who has neither been diagnosed with a terminal condition nor irreversible illness, but who is incapacitated, will not be able to rely on her advance directive. Such an incapacitated patient does not meet the preliminary definition of "qualified" under Texas law.

However, the Texas definition of the "qualified patient" is unique in that it distinguishes between the notions "terminal" and "irreversible."[145] The former is defined as an incurable condition "that according to reasonable medical judgment will produce death within six months, even with available life-

140. TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West Supp. 2015); *see id.* § 166.032(c) (authorizing a patient to give "directions other than those provided by Section 166.033").

141. *Id.* § 166.033.

142. *Id.*; *see also Hospice Care*, NAT'L HOSPICE & PALLIATIVE CARE ORG., http://www.nhpco.org/about/hospice-care (last updated July 23, 2015) ("At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. . . . Hospice focuses on caring, not curing and in most cases care is provided in the patient's home.").

143. Hospice, by nature, concerns treatment for a patient with a terminal illness. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.002(13) (West Supp. 2015) (creating a presumption that a person receiving hospice care has a terminal condition).

144. TEX. HEALTH & SAFETY CODE ANN. § 166.031(2) (West 2010).

145. *Compare id.* § 166.031(2) ("a patient with a terminal *or* irreversible condition" (emphasis added)) *with* LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1(11)) ("a patient diagnosed and certified in writing as having a terminal *and* irreversible condition" (emphasis added)).

sustaining treatment."[146] Irreversible condition, on the other hand, is defined as "a condition . . . (1) that may be treated, but is never cured or eliminated; (2) that leaves a person unable to care for or make decisions for the person's own self; and (3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal."[147] The Texas statute explains, "Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced."[148] Therefore, the advance directive law encourages the patient to distinguish between these two conditions in executing a Living Will because the circumstances of each may appear at different instances. Along with its hospice disclosure, Texas's clarification of these conditions enables the patient to make informed decisions concerning his future medical care and supports the autonomy of the patient in making such decisions.

If a qualified patient has accurately stipulated medical instructions under the above provisions, the final concern is whether the physician or health care institution will comply with the executed Living Will. Despite the narrow circumstances under which it is effective, the Texas advance directive law employs various safeguards to ensure physician compliance with the patient's desires. While the statute does not impose a duty to inquire about the existence of a Living Will, the Texas legislation does require the health care provider to inform the patient of her right to execute a Living Will, as well as the medical institution's policies regarding advance directives.[149] Furthermore, a physician who has been notified of an executed directive must "make the directive part of the declarant's medical record."[150] The physician must then "provide for the declarant's certification as a qualified patient on diagnosis of a terminal or irreversible condition."[151] If qualified, the physician must act in accordance

146. TEX. HEALTH & SAFETY CODE ANN. § 166.002(13) (West Supp. 2015).

147. *Id.* § 166.002(9).

148. *Id.* § 166.033.

149. *See id.* § 166.004(c) ("[T]he health care provider shall provide written notice to an individual of the [institution's] written policies . . . . The notice must be provided at the earlier of: (1) the time the individual is admitted to receive services from the health care provider; or (2) the time the health care provider begins providing care to the individual."). The statute, however, does not require the health care provider to offer instructions on executing an advance directive.

150. *Id.* § 166.032(d).

151. TEX. HEALTH & SAFETY CODE ANN. § 166.040 (West 2010).

with the patient's expressed desires.[152]

If the physician refuses to comply with a patient's medical instructions, the Texas advance directive statutes promulgate specific procedures to be followed, which include: (1) review of the physician's refusal by an ethics or medical committee of which "the physician may not be a member;" (2) informing the representative of the incapacitated patient, who is "entitled . . . to attend the review meeting," of the noncompliance review procedures; and (3) if the physician, patient, or representative does not agree with the decision of the board, "the physician shall make a reasonable effort to transfer the patient to a physician who is willing to comply with the advance directive."[153] The Texas statutes include a sample statement explaining the patient's right to transfer, which shall be given to the patient or representative in substantially the same form as the legislation.[154] Moreover, Texas law mandates that the Department of State Health Services "maintain a registry listing the identity of and contact information for health care providers" who are willing to comply with the patient's medical instructions.[155] Providing the most detailed state procedures for the transfer of a patient, the Texas law on advance directive ensures that, if at all possible, the patient's medical instructions will be respected.[156]

Once a reasonable opportunity for transfer has elapsed, the patient or patient's representative may pursue legal remedy if unsatisfied with the results of the ethics board or transfer procedures.[157] In addition, a medical professional who does not comply with a valid Living Will in accordance with the above procedures is "subject to review and disciplinary action by the appropriate medical licensing board."[158]

While these advance directive statutes hinder access for those without a proper diagnosis or available witnesses, the Texas legislature has ensured accountability for compliance. Due

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152. TEX. HEALTH & SAFETY CODE ANN. § 166.038(c) (West 2010).

153. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a)–(b), (d) (West Supp. 2015).

154. *See id.* § 166.052(b).

155. *Id.* § 166.053.

156. For information on other state-specific noncompliance procedures, see *Noncompliance with Advance Directives*, PATIENTS RTS. COUNCIL (2007) http://www.patientsrightscouncil.org/site/wpcontent/uploads/2012/05/Noncomplianc_chart_05_10_-12.pdf.

157. TEX. HEALTH & SAFETY CODE ANN. § 166.051 (West 2010).

158. *Id.* § 166.045(b).

to the rigid procedures and duties imposed on the attending physician, health care institution, and medical review board, each party involved has a role in protecting the interests of the incapacitated patient. Regardless of these safeguards, patients outside the reach of qualification remain without access to the Living Will and therefore at the mercy of physician discretion.

III. LOUISIANA'S LIVING WILL AND ITS NEED FOR CHANGE

Remaining largely unaltered since its enactment in 1985, the Louisiana advance directive statute functions as rigid law in an area of health care that is uncertain and requires flexibility.[159] End-of-life medical technology continues to advance throughout the United States, especially within the burgeoning health industry in Louisiana, as the elderly population simultaneously increases.[160] In order to prudently respond to this dilemma, states must propose current and innovative legislation for the benefit of their aging citizens. Emphasis on advance medical planning is a tangible method of ensuring that patients and health care professionals alike make responsible decisions in treatment.

However, Louisiana has fallen behind in acting as a proponent for patients in advance directive law. Though one of the earlier states to pass state legislation on advance planning, Louisiana since has made very few substantive changes to its statutes.[161] Moreover, legislative attempts at innovation have proven ineffective in overcoming the boundaries of advance directive law.[162] For these reasons, the Louisiana legislature should reconsider its advance directive statutes in various areas, evaluate alternatives that may be borrowed from the Uniform Act and Texas law, and amend its legislation to better serve those citizens most vulnerable—incapacitated patients.

This section discusses Louisiana's advance directive

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159. Thaddeus Mason Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMEDICAL L. 213, 234 (2013) ("Clinicians sometimes refuse to comply with an advance directive, because they are unsure whether the triggering event has obtained.").

160. *See* Kusmin, *supra* note 22, at 93; Maron, *supra* note 67, at 178.

161. *See* LA. STAT. ANN. §§ 40:1299.58.1–.10 (2008 & Supp. 2015) (to be recodified at LA. STAT. ANN. §§ 40:1151-51.9)); Henry R. Glick, *The Right to Die: State Policymaking and the Elderly*, 5 J. AGING STUD. 283, 289 (1991).

162. *See infra* text accompanying notes 189–202.

legislation, evaluating the most outmoded areas. In particular, Subsection A first assesses the complexities associated with rigid form requirements in end-of-life care. Next, Subsection B discusses the fiction of patient access to advance directives, an allegedly simple process that actually disqualifies a majority of patients from eligibility. Subsection C then considers the issues of medical professionals' noncompliance with advance directives and the lack of incentives to comply within the Louisiana advance directive statutes. Finally, Subsection D illustrates the need for further education on advance planning in order to increase the impact of such an essential resource for patient autonomy.

A. EFFECT OF INVALIDITY AND THE FORM REQUIREMENT

Consider the opening hypothetical, where Karen constructed a document titled "Karen's Living Will," obtained witnessing signatures from her husband and neighbor, and filed the instrument with the Louisiana Secretary of State. While Karen's efforts may have appeared diligent, the execution of "Karen's Living Will" fell short of validity under Louisiana advance directive law.[163] Strict requirements for particular aspects of the law, in combination with leniency for others, create an ambiguous list of requirements for an advance directive to be considered valid in Louisiana. Though Karen may have indicated her wishes and made an effort to record them, her advance directive may not be honored due to the absence of two disinterested witnesses.

Louisiana Revised Statute § 40:1151.2 explicitly states that the Living Will "may, but need not, be in the [provided] illustrative form."[164] However, the Living Will does have a *form requirement*—the signature of two witnesses.[165] The statute then defines "witness" as "a competent adult who is not related to the declarant or qualified patient, whichever is applicable, by blood or marriage and who would not be entitled to any portion of the estate of the person from whom life-sustaining procedures are to be withheld or withdrawn upon his decease."[166]

Finding these two witnesses may be an exceptionally difficult task, as each witness must be neither related to the

163. Note that Karen's spouse witnessed her Living Will. This section discusses how such a witness is ineligible as witness under Louisiana legislation.

164. LA. STAT. ANN. § 40:1299.58.3(C)(1) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(C)(1)).

165. *Id.* § 40:1299.58.3(A)(2) (to be recodified at LA. STAT. ANN. § 40:1151.2(A)(2)).

166. LA. STAT. ANN. § 40:1299.58.2(15) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.1(15)).

patient by blood or marriage nor entitled to any portion of the patient's estate.[167] Without widespread awareness of the advance directive's utility, the demographic currently utilizing this resource is the elderly and ill population.[168] Those individuals closest to the patient when determining end-of-life care are likely to be exactly those whom the statute disqualifies.[169] Additionally, the patient without extensive social networks, also common in the elderly population, may be without recourse as a result of this requirement for disinterested witnessing.[170] Finally, those patients unaware of this strict requirement, like Karen, may ask a spouse or close relative to witness the document, which would invalidate its effect.[171]

In particular, Louisiana also should reevaluate its form requirement for the execution of a Living Will in relation to other provisions within its legislation. For instance, the requirement of two disinterested witnesses is in conflict with the state's advance directive law. A "qualified patient" who has not previously executed a living will may have one executed on her behalf by a third party.[172] The determination of who will be the third party is made according to the following priority: (1) the patient's tutor or curator, if previously appointed, (2) the named Healthcare Proxy, if assigned, (3) the patient's spouse not judicially separated, (4) an adult child of the patient, (5) the patient's parents, (6) the patient's siblings, (7) other ascendants or descendants of the patient.[173]

Thus, while the requirements for two disinterested witnesses

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167. *See* Kusmin, *supra* note 22, at 95 ("Where both relatives and health care professionals are disqualified from witnessing, it is difficult for patients to execute a directive during a physician visit, and the opportunity to promote end of life discussions between doctors and patients is lost.").

168. *See* Jones et al., *supra* note 80, at 5.

169. *See* Kusmin, *supra* note 22, at 115 ("Since relatives and doctors already have a substantial role in guiding the care of a terminally ill patient, it is illogical to disqualify them as witnesses.").

170. *See, e.g.*, KARP & WOOD, *supra* note 25, at 13 (reporting studies estimating that between 3% and 30% of long-term care residents are unbefriended). In turn, one may infer that the elderly experience an absence of persons available to be disinterested witnesses.

171. Kusmin, *supra* note 22, at 113 ("Thus a home-drawn directive will be valid in some states, but not others. The requirement of disinterested witnesses only complicates matters. Attorneys report that many clients who attempt to complete the forms themselves do so incorrectly.").

172. LA. STAT. ANN. § 40:1299.58.5(A)(2) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.4(A)(2)).

173. *Id.*

are indubitably strict, the law grants exactly those ineligible as witnesses the authority to construct a Living Will on behalf of the incapacitated patient—without any input from the patient.[174] This conflict demonstrates that potential policy concerns of undue influence or abuse of power, if present, are insignificant in limiting beneficial input from the incapacitated patient's family members.[175] For these reasons, the form requirement of two disinterested witnesses to the patient's signature should be relaxed.

B. INACCESSIBLE HEALTH CARE INSTRUCTIONS

Due to the narrow language of advance directive statutes, several obstacles may hinder a patient from successfully accessing an advance directive as a proactive medical resource. As the Louisiana law stands, the patient who executes a Living Will and overcomes validity restrictions unfortunately may remain unprotected by her properly executed medical directive. Various circumstances first must occur before the document governs the patient's health care treatment.

Unlike Living Wills in Mississippi and Texas, Louisiana provides a narrow scope of healthcare choices to the patient executing such a document. Rather than explicitly allowing the patient to make choices regarding any aspect of health care, or expressly providing the patient with space to include "additional requests," Louisiana focuses its language strictly on determining whether life-sustaining procedures will be performed or withheld.[176] La. R.S. 40:1151.2 provides, "Any adult person may, at any time, *make a written declaration directing the withholding or withdrawal of life-sustaining procedures* in the event such person should have a terminal and irreversible condition."[177] However, upon close reading of the statute's sample Living Will

174. This contradiction is not unique to Louisiana. *See* Kusmin, *supra* note 22, at 104 ("Most states which disqualify heirs and relatives from serving as witnesses allow those parties to serve as attorneys-in-fact for health care.").

175. *Id.* at 105 ("Since relatives cannot logically be barred from acting as attorney-in-fact for health care, there is nothing to be gained by excluding them from serving as witness to an advance directive.").

176. *Compare* MISS. CODE ANN. § 41-41-209 (2013) (allowing patients to provide instructions about "any aspect of your health care"), TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West Supp. 2015), *and id.* § 166.032(c) (authorizing a patient to give "directions other than those provided by Section 166.033") *with* LA. STAT. ANN. § 40:1299.58.3 (2008) (to be recodified at LA. STAT. ANN. § 1151.2) (authorizing a directive for "withholding or withdrawal of life sustaining procedures").

177. LA. STAT. ANN. § 40:1299.58.3(A)(1) (2008) (to be recodified at LA. STAT. ANN. § 1151.2(A)(1)) (emphasis added).

form, the following text is included: "The declaration may, but need not, be in the following illustrative form and *may include other specific directions including but not limited to a designation of another person to make the treatment decision for the declarant . . . .*"[178] Because the Louisiana statute does not expressly prohibit decisions on other medical treatments, and this text leaves the potential form slightly open-ended, the statute suggests that other instructions are permissible. Still, with no explicit provision for additional medical treatment, the patient is unlikely to understand this possibility without legal guidance.

In addition, Louisiana advance directive law restricts when a Living Will becomes effective. Like Texas, the Louisiana patient must first be considered "qualified."[179] Louisiana Revised Statute § 40:1151.1 requires the following criterion for a patient's condition to be "qualified" and so activate the advance directive: the condition must be "terminal and irreversible"[180] A "terminal and irreversible condition" is defined as "a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death."[181] When dealing with "continual profound comatose" states, the terminal nature of the condition is often uncertain.[182] For this reason, some states—such as Texas—distinguish between the notions "terminal" and "irreversible."[183] Nonetheless, under the Louisiana definition, any level of unconsciousness that does not qualify as reasonably resulting in death does not trigger the effect of an advance directive. As such, Karen's reversible diabetic coma may, or may not, qualify as a sufficient medical condition based on these criteria in Louisiana.

Second, this terminal and irreversible condition must be diagnosed and certified in writing "by two physicians, who have

178. LA. STAT. ANN. § 40:1299.58.3(C)(1) (2008) (to be recodified at LA. STAT. ANN. § 1151.2(C)(1)) (emphasis added).

179. *See* LA. STAT. ANN. § 40:1299.58.7(A) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.6(A)) (emphasis added).

180. *Id.* § 40:1299.58.2(11) (to be recodified at LA. STAT. ANN. § 1151.1(11)).

181. *Id.* § 40:1299.58.2(14) (to be recodified at LA. STAT. ANN. § 1151.1(14)).

182. *See* Pope, *supra* note 159, at 234–35.

183. TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West Supp. 2015) ("Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced.").

personally examined the patient, one of whom shall be the attending physician."[184] In an emergency situation, where a patient becomes incapacitated, two physicians must concur and certify in writing that the patient's condition is likely to produce death. Without this certification, a patient's Living Will—though appropriately executed under Louisiana law—will be ineffective because the patient will not be considered qualified.[185]

In conjunction with its legislation on advance directives, Louisiana, like Mississippi, has enacted a "Physician-Order for Scope of Treatment," referred to as "LaPOST."[186] Unlike the Louisiana Living Will, this document does expressly offer the patient increased discretion in medical decision-making, allowing for determinations on antibiotics and "other instructions."[187] Still, this document is only effective once a patient is diagnosed with a "life-limiting and irreversible condition" that will produce death within six months.[188] Similar to the certification for a Living Will, this requirement of patient qualification continues to limit the effect of patient instruction.

C. THE CHALLENGE OF NONCOMPLIANCE

Noncompliance with patient medical instruction is a significant issue throughout the United States, yet Louisiana exacerbates this problem by failing to impose a duty on the physician or healthcare institution. Unlike Mississippi and Texas, Louisiana has established a registry for Living Wills, allowing patients to file their medical preferences with the Louisiana Secretary of State for a fee of twenty dollars.[189] Ideally, the existence of a central collection for such documents will allow for an increase in physician access and compliance.[190] However, this initiative is thwarted by the statute's failure to

184. LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.1(11)).

185. *See id.*

186. *See id.* § 40:1299.64.2 (to be recodified at LA. STAT. ANN. § 40:1155.2).

187. *Id.* § 40:1299.64.2(8)(h), (j) (to be recodified at LA. STAT. ANN. § 40:1155.2(8)(h), (j)).

188. *See id.* § 40:1299.64.2(6) (to be recodified at LA. STAT. ANN. § 40:1155.2(6)).

189. LA. STAT. ANN. § 40:1299.58.3(D)(1) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(D)(1)).

190. *See* Hughes, *supra* note 35, at 23 ("One of the critical barriers to the effective use of [advance directives] is the difficulty in ensuring their availability when and where needed. . . . As of mid-2009, twelve states have attempted to ameliorate this problem by enacting statutes that establish a registry where people can store their ADs and they can be accessed by the designated personal representative or health care providers when needed.").

impose a duty on medical professionals to search the registry: "No provision of this Part imposes a duty upon the physician or health care facility to make a search of the registry for the existence of a declaration."[191]

Similarly, physician compliance with LaPOST is futile under the provisions of Louisiana law. The purpose of POST is to ensure compliance by requiring the signature of a physician and inclusion of the document in the patient's medical record.[192] Nevertheless, the law mandates the following: "No provision of this Part imposes a duty upon the physician or health care provider to make a search of whether a patient has executed a LaPOST form."[193] Again, the physician and health care provider are relieved of any proactive duty to search for a previously executed document.

Though these disclaimers may have been promulgated in an effort to preserve medical efficiency, the availability and accessibility of electronic resources has changed. With the emergence of bedside Electronic Medical Records (EMR), as well as ubiquitous Internet access, the burden of imposing a duty to search for these documents in good faith is trivial.[194] Because the patient has a right to provide advance medical instruction—specifically concerning a medical emergency—and this right is protected by federal and Louisiana legislation and jurisprudence, a duty to search for such instruction is critical to preserving this liberty. Instead, Louisiana law establishes that "[i]t shall be the responsibility of the declarant to notify his attending physician that a declaration has been made."[195]

Once the physician has been notified that a Living Will exists, the physician is required to include the document in the patient's medical record.[196] The physician then must also "take necessary steps to provide for written certification of the patient's terminal and irreversible condition, so that the patient may be

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191. LA. STAT. ANN. § 40:1299.58.7(C) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.6(C)).

192. *See* SHAPIRO & KARP, *supra* note 35, at 3–4.

193. LA. STAT. ANN. § 40:1299.58.64.4(B) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1155.4(B)).

194. *Electronic Medical Record Systems*, U.S. DEP'T HEALTH & HUMAN SERVS., http://healthit.ahrq.gov/key-topics/electronic-medical-record-systems (last modified Feb. 2015) (discussing the benefits of EMR).

195. LA. STAT. ANN. § 40:1299.58.3(B)(1) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(B)(1)).

196. *Id.* § 40:1299.58.3(B)(3) (to be recodified at LA. STAT. ANN. § 40:1151.2(B)(3)).

deemed to be a qualified patient . . . ."[197] Despite these affirmative procedures, the physician lacks sufficient motivation to comply at this stage because the physician retains the discretion in implementation.[198] If the attending physician or health care institution refuses to comply with the Living Will of a qualified patient, a "reasonable effort" must be made "to transfer the patient to another physician."[199] Unlike Texas, Louisiana does not establish a process to determine reasonableness, nor does the state maintain a registry of available physicians for compliance.[200]

Finally, Louisiana does not explicitly provide either a penalty or equitable relief for noncompliance. In general, the physician and health care facility are granted immunity from liability under the Living Will statutes.[201] The statute provides that this immunity from liability may be overcome only if a challenger is able to show bad faith on behalf of the physician or health care institution by a preponderance of evidence.[202]

Based on these provisions, the Louisiana law on advance directives provides minimal incentive for the attending medical professionals to comply. Explicitly waiving any duty to search and stipulating narrow avenues for legal recourse, the law insulates the Louisiana health care provider from accountability—despite the life or death circumstances surrounding an incapacitated individual. In order to promote compliance and encourage respect for patient autonomy, the Louisiana legislature must reconsider its law on advance directives, concentrating on the well-established shortcomings of validity, access, noncompliance, and finally, education.

D. IGNORANCE OF THE LIVING WILL

Consider once more the opening hypothetical, where Karen

197. LA. STAT. ANN. § 40:1299.58.7(A) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.6(A)).

198. *See id.* § 40:1299.58.7(B) (to be recodified at LA. STAT. ANN. § 40:1151.6(B)). ("Any attending physician who refuses to comply with the declaration of a qualified patient or declaration otherwise made pursuant to this Part shall make a reasonable effort to transfer the patient to another physician.").

199. *Id.*

200. *Compare id.* § 40:1299.58.7 (to be recodified at LA. STAT. ANN. § 40:1151.6) *with* TEX. HEALTH & SAFETY CODE ANN. § 166.053 (West 2010).

201. LA. STAT. ANN. § 40:1299.58.8 (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.7).

202. *Id.* § 40:1299.58.8(C)(1).

executed a Living Will in an effort to voice her preferences for medical care. This description of a citizen, who has proactively utilized an advance directive without emergency need, is an anomaly.[203] As a whole, Americans remain unaware of the advance directive's existence and function.[204] Although widespread ignorance is the basis of advance directive literature and research, neither state-specific medical planning nor the Uniform Act establish mechanisms for resolving the knowledge gap. Louisiana's advance directive statutes are silent on the issue.

This failure to enact an education requirement is likely the consequence of Congress's legislation in this area. As described above, the Patient Self–Determination Act requires health care institutions to provide information to their patients, physicians, and community about the nature and use of advance directives.[205] Theoretically, if an institution fails to comply with these requirements, the PSDA threatens to withhold Medicare and Medicaid funding.[206] Even if this penalty is currently enforced, the statistics on minimal patient knowledge and rare execution of advance directives illustrate that this method is insufficient.

As a matter of state policy, citizens should not be at a disadvantage because federal legislation has failed in this area. Instead, Louisiana should initiate the process of education within its jurisdiction by enacting the same requirements as the PSDA. Incorporating these requirements into state advance directive law could potentially increase knowledge of advance directive requirements specific to the state, thereby increasing the validity

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203. Pope, *supra* note 159, at 229–30 ("Unfortunately, most Americans have not completed advance directives. Two 2012 surveys show completion rates of just 23% and 24% . . . . Several other recent surveys show similar low completion rates of 35% and 33% . . . ." (footnotes omitted)).

204. Even medical professionals have been shown to inadequately understand the purpose of advance directives. *Id.* at 231 ("[I]n one study of 768 physicians in 34 states, 78% of clinicians misinterpreted advance directives, thinking that the presence of an advance directive automatically means that the patient is DNR.").

205. *See supra* Section II(A)(2).

206. *See* 42 U.S.C. § 1395cc(a)(1)(Q) (2012) (establishing compliance with PSDA requirements for advance directions as a prerequisite to Medicare funding eligibility). While withholding funds could have a significant impact, no evidence was found indicating that the government issued citations under the PSDA, much less levied fines. However, even if the PSDA were properly enforced and consequences established, the ambiguity of the statute still renders its effect futile, and the lack of specificity perpetuates the discretion that currently encumbers advance directives. *See supra* Section(II)(A)(2).

of these documents when executed.[207] Moreover, enacting this requirement at the state level also holds physicians and medical institutions accountable with regard to medical licensing boards, which are responsible for disciplining institutional fault.[208]

IV. PROPOSALS TO AMEND LOUISIANA LAW

Ineffective and underinclusive, the Louisiana Living Will statutes require amendment in four critical areas. Notably, the purpose of the Louisiana law is strong, establishing that "all persons have the fundamental right to control the decisions relating to their own medical care, including the decisions to have life-sustaining procedures withheld or withdrawn in instances where such persons are diagnosed as having a terminal and irreversible condition."[209] However, the restrictions and qualifications imposed upon the proactive patient frustrate the legislature's expressed intent. Instead, the Louisiana Living Will constrains "all persons" to only those qualified[210] under the law. Thus, despite the law's legitimate purpose, legislative amendment is necessary.

Subsection A contends that the Louisiana form requirement for the execution of a valid Living Will should be relaxed when the patient's desires have been made explicit. Subsection B provides that the eligibility of qualified patients should be expanded in an effort to allow greater access to advanced decision-making. In addition, the scope of medical treatment should be broadened to encourage patient instruction concerning a variety of emergency circumstances. Subsection C emphasizes the necessity of a mechanism for physician compliance—removing unreserved discretion and increasing accountability on behalf of the medical provider. Finally, Subsection D argues for the inclusion of an education requirement, thereby placing a duty

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207. Validity would be increased because the incorporation of an education requirement *within* the advance directive legislation would enhance familiarity with state requirements for validity. Thus regulation could also monitor whether health care institutions are accurately informing patients of state law.

208. *See* LA. STAT. ANN. §§ 37:1261–1292 (2007 & Supp. 2015); *see also Investigations*, LA. ST. BOARD MED. EXAMINERS, http://www.lsbme.la.gov/content/investigations (last visited Oct. 2, 2015) ("The Board is responsible for investigating all complaints and disciplining licensees under its jurisdiction who violate the rules and regulations applicable to their profession.").

209. LA. STAT. ANN. § 40:1299.58.1(A)(1) (2008) (to be recodified at LA. STAT. ANN. § 40:1151(A)(1)).

210. LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1(11)) (defining "qualified patient").

on medical providers to inform their patients, staff, and community at large on the importance of executing a Living Will.

A. RELAXING THE FORM REQUIREMENT

The Louisiana Living Will statutes require signatures from two disinterested witnesses.[211] This requirement places an unnecessary obstacle between the patient and the successful execution of enforceable medical instructions because (1) disinterested witnesses may be unavailable and (2) the requirement contradicts the default rule of the patient representative, undermining a concern for undue influence.[212] Louisiana's form requirement for the Living Will should be lowered to require the signature of two witnesses, one of whom must be disinterested, or notarization, stipulated as follows:

> **La. R.S. 40:1151.1 Definitions**[213]
>
> ***
>
> (16) "Witness" means a competent adult.
>
> (a) "Disinterested witness" means a competent adult who is not related to the declarant or qualified patient, whichever is applicable, by blood or marriage and who would not be entitled to any portion of the estate of the declarant or qualified patient.
>
> **La. R.S. 40:1151.2 Making of declaration; notification; illustrative form; registry; issuance of do-not-resuscitate identification bracelets**[214]
>
> ***
>
> (2) Except as provided by Subsection (2)(a), the declarant must sign the directive in the presence of two witnesses who qualify under §1151.1(16), at least one of whom must be a witness who qualifies under §1151.1(16)(a). The witnesses

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211. LA. STAT. ANN. § 40:1299.58.3(A)(2) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(A)(2)).

212. *See infra* Section III(A).

213. The current statute defines "witness" as "a competent adult who is not related to the declarant or qualified patient, whichever is applicable, by blood or marriage and who would not be entitled to any portion of the estate of the person from whom life-sustaining procedures are to be withheld or withdrawn upon his decease." LA. STAT. ANN. § 40:1299.58.2(15) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.1(15)).

214. The current provision requires that "[a] written declaration shall be signed by the declarant in the presence of two witnesses." LA. STAT. ANN. § 40:1299.58.3(A)(2) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(A)(2)).

> must sign the directive.
>
> The declarant, in lieu of signing in the presence of witnesses, may sign the directive and have the signature acknowledged before a notary public. ***
>
> **La. R.S. 40:1151.2(C)**—illustrating a sample Living Will—shall include two options for verification of the patient's directive.[215] Option 1 will provide spaces for the signatures of two witnesses, one of whom must be disinterested. Option 2 will provide a space for the authorization of a notary public.

This amendment would ensure that one disinterested witness (who may be a medical professional under this definition) is present to safeguard against undue influence, while remedying the excessively high standard of validity currently in place. Borrowing the form requirement of Texas's advance directive law, this standard of mixed interest simultaneously protects the safety of the patient and the legitimacy of the document without burdening the patient.[216]

B. EXPANDING PATIENT ACCESS

Furthermore, the Louisiana Living Will is excessively narrow in both its scope and accessibility. As enacted, an executed Living Will is effective only for a "qualified patient," excluding any patient who may be diagnosed with a more ambiguous condition of incapacitation.[217] In addition, an executed Living Will concerns primarily the withholding or withdrawing of life-sustaining procedures, obscuring possible instruction for other desired medical treatment.[218] In order to resolve these deficiencies, the definition of "qualified patient" should refer to any incapacitated patient, and the illustrative Living Will should highlight a broadened scope of medical options, distinguishing between terminal and irreversible illnesses. Therefore, the following amendment should be implemented:

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215. As currently enacted, Louisiana's Living Will Form includes space for the signature of two disinterested witnesses only. LA. STAT. ANN. § 40:1299.58.3(C)) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(C)).

216. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.003 (West Supp. 2015).

217. *See supra* text accompanying notes 179–83.

218. *See supra* text accompanying notes 176–78.

> **La. R.S. 40:1151.1 Definitions**[219]
>
> ***
>
> (11) "Qualified patient" means a patient diagnosed as incapacitated, or unable to make his or her own health care decisions, by the attending physician. ***
>
> **La. R.S. 40:1151-1151.9** shall replace all references to "terminal and irreversible condition" with "incapacitated."[220]

In expanding the definition of "qualified patient," and eliminating the requirement of diagnosis by two physicians, the patient's Living Will becomes immediately enforceable upon incapacitation.[221] With this reform, a patient may stipulate instructions for any instance where she is incapable of vocalizing medical preferences, regardless of a physician's interpretation of the condition as "terminal and irreversible." Moreover, the Louisiana Living Will should be amended to distinguish between the terms "terminal" and "irreversible," for a condition may not be simultaneously qualified as both.[222] The legislation should provide:

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219. "Qualified patient" is currently defined as "a patient diagnosed and certified in writing as having a terminal and irreversible condition by two physicians who have personally examined the patient, one of whom shall be the attending physician." LA. STAT. ANN. § 40:1299.58.2(11) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.1(11)).

220. For example, the statute currently provides, "Any adult person may, at any time, make a written declaration directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a *terminal and irreversible condition*." LA. STAT. ANN. § 40:1299.58.3(A)(1) (2008) (to be recodified at LA. STAT. ANN. § 1151.2(A)(1)) (emphasis added). This provision will be amended to state "in the event such a person should become incapacitated."

221. The Uniform Act provides that the primary care physician by default shall determine whether the patient is incapacitated or the patient-stipulated condition is present. No other qualification is imposed. *See* UNIF. HEALTH-CARE DECISIONS ACT §§ 2(a), (d), 4 pt. 2 (UNIF. LAW COMM'N 1994); *supra* note 96.

222. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West Supp. 2015) ("Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced).

La. R.S. 40:1151.1 Definitions[223]

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(14) "Terminal condition" means an "incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care."

(15) "Irreversible condition" means "a condition, injury, or illness:

(a) that may be treated, but is never cured or eliminated;

(b) that leaves a person unable to care for or make decisions for his person or affairs; and

(c) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal." ***

La. R.S. 40:1151.2(C)—illustrating a sample Living Will—shall include a disclaimer for the patient, instructing the patient to indicate in particular under what circumstances the preferred medical treatment should be withheld or administered (i.e., during general incapacitation, terminal condition, irreversible condition, etc.). The form should also include an example of each scenario.[224]

Finally, the Louisiana Living Will should emphasize the scope of patient discretion by providing a space for "additional requests." Though this amendment would not alter the law, its inclusion of the illustrative form indicates to the patient that stipulations concerning any form of medical care are permitted under Louisiana law. This addition within La. R.S. 40:1151.2(C) should reflect the following and include ample space for

223. Louisiana's current Living Will statute conflates these two conditions, defining "terminal and irreversible condition" as "a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death." LA. STAT. ANN. § 40:1299.58.2(14) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 1151.1(14)). The amended definitions are modeled on Texas's legislation. TEX. HEALTH & SAFETY CODE ANN. § 166.002(9), (13) (West Supp. 2015).

224. For guidance, see the form developed by the Texas Legislature. TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West Supp. 2015).

instruction:

> Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)[225]

These proposed amendments would ensure that the patient is unmistakably stipulating for medical treatment under specific circumstances and is aware of all available options of care. Expanding the definition of "qualified patient," distinguishing between health care conditions, and emphasizing the scope of patient discretion, would transform the Living Will into an instrument that genuinely protects patients when they are most in need.

C. ENSURING PHYSICIAN COMPLIANCE

Another significant change that must be made to the Louisiana Living Will is the establishment of a physician duty to ensure compliance with an appropriately executed Living Will, which may be codified as the following:

> **La. R.S. 40:1151.2** Making of declaration; notification; illustrative form; registry; issuance of do-not-resuscitate identification bracelets[226]
>
> ***
>
> (1) The declarant has a responsibility to notify his attending physician that a declaration has been made.
>
> (2) In the event the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of the declaration.

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225. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West Supp. 2015).

226. The current provisions provide:

> (1) It shall be the responsibility of the declarant to notify his attending physician that a declaration has been made;
>
> (2) In the event the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of the declaration. In addition, the attending physician or health care facility may directly contact the registry to determine the existence of any such declaration.

LA. STAT. ANN. § 1299.58.3(B) (2008) (to be recodified at LA. STAT. ANN. § 40:1151.2(B)).

> (3) In addition, the attending physician or health care facility shall directly contact the registry, as well as the declarant's medical record, to determine the existence of any such declaration. ***
>
> La. R.S. 40:1151.6. Physician, health care provider, certified emergency technician, and certified first responder responsibility[227]
>
> ***
>
> ~~No provision of this Part imposes a duty upon the physician or health care facility to make a search of the registry for the existence of a declaration.~~ ***

This amendment requires the attending physician or health care institution to make a preliminary, good faith search of the Louisiana Living Will Registry and the incapacitated patient's medical record. This duty invigorates existing provisions, such as the establishment of the registry and the duty of the physician to record a Living Will in the patient's medical record. Without this amendment, the filing of a patient's directive may be futile in that no medical professional is required to look for such an instrument prior to treating the patient. Because the Louisiana statutes protect the physician from most liability (unless bad faith or intent can be shown) and provide for a conscience exception thereafter,[228] the physician or health care institution should be required to make a reasonable search.

Following the example of the Texas advance directive law, the Louisiana legislature should also amend these statutes to include a procedure for patient transfer if either the attending physician or the policies of the health care institution invoke the conscience exception. Currently, La. R.S. 40:1151.6(B) and (D) require a physician or health care institution to "make a reasonable effort to transfer the patient."[229] The statute should define a procedure for executing this reasonable transfer, including at minimum the establishment of a compliance review process and a registry list indicating health care providers willing to accept a transfer.[230]

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227. This provision dismissing the physician's duty to search should be deleted.

228. *See* LA. STAT. ANN. § 40:1299.58.8(C)(1) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.7(C)(1)); *id.* § 40:1299.58.7(B), (D) (to be recodified at LA. STAT. ANN. § 40:1151.6(B), (D)).

229. *See id.* § 40:1299.58.8(B), (D) (to be recodified at LA. STAT. ANN. § 40:1151.7(B), (D)).

230. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.046(b) (West Supp. 2015); *see*

In order to ensure that the proposed amendments are effective, the Louisiana statutes must enforce accountability for compliance with the promulgated duties of medical professionals and the rights of the patient. Therefore, La. R.S. 40:1151.7(C)[231] should be amended to more succinctly state the following:

> (1) A physician, or a health professional acting under the direction of a physician, is subject to review and disciplinary action by the appropriate licensing board for failing to effectuate a qualified patient's directive in violation of this subchapter or other laws of this state. This subsection does not limit remedies available under other laws of this state.
>
> ***
>
> (3) A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person's appropriate licensing board if the person has complied with the search and transfer procedures outlined in this statute.[232]

The establishment of both reasonable, affirmative duties and defined liability make the parties involved in care responsible for upholding the legislature's intent behind the Living Will. With these amendments, the vast discretion of health care professionals would be restrained, and the patient would be ensured that an executed Living Will would be found if readily available. These amendments also respect the health care provider's concern for efficiency and personal beliefs by allowing for reasonable noncompliance. For these reasons, the proposed changes to the Louisiana statutes do not require absolute enforcement of an advance directive; however, they do mandate a reasonable effort at compliance that the laws, as enacted, dismiss.

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also text accompanying notes 153–58.

231. Louisiana's immunity provisions currently provide:

> (1) . . . [T]he provisions of this Section shall apply to any case in which life-sustaining procedures are withheld or withdrawn unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures did not, in good faith, comply with the provisions of this Part . . .;
>
> (2) [A] declaration made in accordance with this Part shall be presumed to have been made voluntarily.

LA. STAT. ANN. § 40:1299.58.8(C) (Supp. 2015) (to be recodified at LA. STAT. ANN. § 40:1151.7(C)).

232. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.045(b), (d) (West 2010).

D. PROMOTING EDUCATION ON MEDICAL PLANNING

Along with the proposed amendments on validity, access, and compliance, the Louisiana legislature should enact an education requirement for health care institutions and medical professionals. The reformation of the Louisiana Living Will is futile without an increase in public awareness regarding the significance of advance medical planning. Though federal legislation mandates that health care providers must inform patients of advanced planning resources, low public awareness demonstrates that this requirement is insufficient.[233] Within Louisiana, fewer than 7,500 citizens have filed an executed Living Will with the Louisiana Secretary of State—a state with 4.65 million inhabitants.[234]

In order to improve utilization of the Living Will, a separate statute should be passed that requires (1) health care institutions to provide admitted patients with literature on the state-specific Living Will requirements, as well as other components of advance directives, and the institution's policies on advance directives; (2) attending physicians to engage in a dialogue with new patients about executing advance directives, including limitations such as form requirements and the conscience exception; and, (3) medical professionals to distribute information throughout the local communities in Louisiana, in conjunction with other promotional initiatives.[235]

By incorporating these requirements into Louisiana law, education initiatives have the potential to become more effective. Familiarity with state requirements and emphasis on valid execution will bolster the discussion on advance planning between medical providers and patients. Likewise, the establishment of such provisions would allow local medical boards—rather than federal entities—to review compliance with these initiatives, increasing responsibility in this area. Due to the vulnerability of incapacitated patients, and widespread ignorance of advance directives, further implementation of education campaigns has the potential only for positive results.

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233. *See* Rao et al., *supra* note 32, at 68; *see also* Hickey, *supra* note 21, at 456–57.

234. *See Living Will Registry*, LA. SECRETARY ST., http://www.sos.la.gov/OurOffice/PublishedDocuments/LivingWillRegistry.pdf (last visited Oct. 2, 2015).

235. *See, e.g.*, Patient Self-Determination Act, 42 U.S.C. § 1395cc(f) (2012).

V. CONCLUSION

In the United States, an aging population, growing rate of chronic illness, and advancing end–of–life medical technology are simultaneously occurring. Developed to protect the patient from ethical disaster upon convergence of these realities, the Living Will provides a patient with a mechanism for instructing health care professionals on her desired treatments if she becomes incompetent. Despite the significance of this resource, the Living Will has failed in a number of critical areas. Patients are uninformed about the significance of advance directives, the procedures for executing advance directives, and the limited access of these documents within states such as Louisiana. Similarly, physicians nationwide remain unconcerned and noncompliant with the Living Will.

This Comment proposes a solution to this dilemma in Louisiana—amendment of the Louisiana Revised Statutes on advance directives. While previous initiatives have attempted to enhance the Living Will, evidence demonstrates that a greater respect for advance medical planning is needed. Focusing on shortcomings of the Louisiana Living Will, this Comment proposes amendments to the state's legislation to ensure valid execution, expand patient access, increase physician compliance, and strengthen education initiatives.

Foremost, the Louisiana law on advance directives must minimize excessive requirements that hinder—rather than promote—validity of the document. For instance, conflicting law within the statute indicates that certain requirements, such as two disinterested witnesses, lack merit and impede the document's successful execution. Next, Living Will legislation must increase the scope of eligible patients in an effort to provide greater access to advance decision-making. Limiting advance planning resources to patients diagnosed with terminal and irreversible illnesses renders validly executed documents null if the circumstances of the illness are unclear. Also, Louisiana legislation must impose a duty on physicians and medical professionals alike to conduct a good faith search for an incapacitated patient's Living Will. Without this requirement, the patient or patient's representative faces an insurmountable task of combating physician discretion in providing treatment without regard for the patient's desires. Finally, the Louisiana legislature should enact a state-wide requirement that health care professionals inform patients of advanced planning resources

available to them. This requirement would ensure compliance with the federal PSDA, as well as proliferate awareness of Louisiana's specific requirements regarding end–of–life medical planning.

Together, these four amendments would bolster a resource that has been previously recognized by the Louisiana legislature as extraordinarily significant. The Louisiana Revised Statutes on advance directives begin by recognizing this significance and calling for protection of a patient's right to choose medical treatment. To continue to protect the patient's right to autonomy, the Louisiana legislature must consider the discussed proposals and amend Louisiana's legislation on the advance directive.

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