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Advance Directive Instruments for Those with Mental Illness

BRUCE J. WINICK*

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I. INTRODUCTION

In an increasingly complex and stressful society, characterized by the erosion of family and community, it is not surprising that mental illness is so prevalent. A recent study estimated that fifty-two million Americans suffer from mental illness each year.¹ This represents more than twenty-eight percent of the adult population, more than one in four.² These statistics are conservative because the researchers counted only people meeting the diagnostic criteria for a mental disorder. Those suffering only from “problems in living,” such as marital problems, were excluded.³ Moreover, while thirty-five million Americans suffer from continuing symptoms, almost nine million (more than five percent of the adult population) develop a problem for the first time each year, and another eight million suffer a relapse of symptoms experienced in a prior

* Copyright 1996 by Bruce J. Winick, Professor of Law, University of Miami School of Law. This Article in somewhat different form will appear as a chapter in the author's forthcoming book, THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW. I would like to acknowledge Paul Sherman for sharing his valuable insights on advance directive instruments, and the helpful comments of Mary Coombs, Clark Freshman, Pat Gudridge, Rob Rosen, and Susan Stefan on an earlier draft of this Article presented at a University of Miami School of Law faculty seminar. I would also like to acknowledge the research assistance of Douglas Stransky and Bill Collins.

1. See Darrel A. Regier et al., *The de Facto U.S. Mental and Addictive Disorders Service System*, 50 ARCHIVES GEN. PSYCHIATRY 85, 88 (1993); see also Daniel Goleman, *Mental Disorders Common, but Few Get Treatment, Study Finds*, N.Y. TIMES, March 17, 1993, at C13 (discussing study by Regier et al.).

2. See Goleman, *supra* note 1, at C13.

3. See Goleman, *supra* note 1, at C13 (reporting on interview with Dr. Regier, principle author of Regier et al., *supra* note 1).

year.⁴ The study also showed that only 28.5% of those suffering from some form of mental illness obtained treatment for their problems.⁵

The prevalence of mental illness suggests the need to reexamine our attitudes about it. We can no longer regard mental illness as affecting only a small minority of people whom we can ignore. The likelihood is high that mental illness will strike a member of our own family, if not ourselves. Understanding this risk should make us all wonder about what we will do if mental illness should befall us or a close family member. Other illnesses, of course, occur frequently. We increasingly worry about cancer, heart disease, and AIDS, and prudent people seek to change their eating, smoking, drinking, and sexual habits to minimize the risk. We also think about what we would do if we or a family member was affected by one of these conditions. Planning for future mental illness is trickier in some ways. Treatment decisions relating to cancer, heart disease, and AIDS are largely left to the individual; the state does not insist on one treatment approach rather than another, or require treatment when it is unwanted.

With mental illness, treatment decisions are frequently made differently. First, the state may insist on psychiatric hospitalization and various forms of mental health treatment on an involuntary basis. Second, when mental illness strikes, individuals may not be able to make their own treatment decisions. Other illnesses, such as cancer, heart disease, and AIDS, usually do not impair cognitive processes, at least not until a fairly final stage. Mental illness, however, sometimes prevents people from engaging in rational decisionmaking about treatment and hospitalization. In such cases, an individual may find that his or her decision-making power has been taken away and placed in the hands of a guardian or other surrogate decisionmaker, such as a judge or administrative body.

The prospect of losing control over the ability to make crucial hospitalization and treatment decisions should we become mentally ill is a frightening one. This prospect, coupled with the high prevalence rate for mental illness, provides a new incentive to think ahead about mental health treatment possibilities, to understand how the law may respond to mental illness, and, if possible, to avoid unpleasant treatment options and secure more desirable alternatives.

The law remains in flux concerning the extent to which those suffering from mental illness may be subjected to involuntary hospitalization and treatment. A movement to abolish or seriously curtail involuntary hospitalization, begun in the 1960's, succeeded in restricting

4. See Goleman, *supra* note 1, at C13.

5. See Regier et al., *supra* note 1, at 90.

civil commitment,⁶ but more recently the pendulum has swung back in the direction of expanding the legal criteria for involuntary hospitalization.⁷ The question of the extent to which mental patients have a right to refuse treatment was first raised in the 1970's.⁸ Although it has drawn much judicial, legislative, and scholarly attention, the issue remains largely unresolved.⁹

In view of these legal uncertainties, how can a prudent person facing the increased possibility of an encounter with mental illness plan for the future? The Supreme Court's landmark "right-to-die" case, *Cruzan v. Director, Missouri Department of Health*,¹⁰ presents an opportunity to view these unresolved legal issues in a new light and to plan for future mental illness. In *Cruzan*, the Court determined that it was constitutionally permissible for a state to require clear and convincing evidence of a patient's desires before terminating life-sustaining medical treatment.¹¹ While upholding this condition on exercise of the "right to die," the Court's opinion suggests that when the patient's intention to discontinue such treatment is clearly expressed in a living will or other advance directive instrument, the patient's right to refuse life-prolonging treatment or nourishment will be constitutionally protected.¹²

By recognizing the ability of patients to make treatment decisions in advance, *Cruzan* introduces a new dimension — time — that allows us to view the right to refuse psychiatric hospitalization and treatment

6. See ALEXANDER D. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 609-18 (1974). Compare, e.g., THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS (5th ed. 1968) (critiquing the concept of mental illness as justification for involuntary hospitalization and treatment) with Paul Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976) (arguing for a return to the use of medical criteria to involuntarily commit people).

7. See, e.g., Mary L. Durham & John Q. La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitments*, 3 YALE L. & POL'Y REV. 395, 398 (1984); John Monahan et al., *Coercion and Commitment: Understanding Involuntary Mental Hospital Admission*, 18 INT'L J.L. & PSYCHIATRY 249, 249 (1995).

8. Bruce J. Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 AM. B. FOUND. RES. J. 769, 811 & nn. 230-31 (citing early right to refuse cases and commentary from the early 1970's).

9. See BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT (forthcoming 1996). Compare *Riggins v. Nevada*, 504 U.S. 127, 136-37 (1992) with *Washington v. Harper*, 494 U.S. 210, 227 (1990).

10. 497 U.S. 261 (1990).

11. See *id.* at 283. The Missouri Supreme Court had rejected the request of parents of a comatose accident victim to withdraw artificial feeding and hydration because "there was no clear and convincing evidence of [the patient's] desire to have life-sustaining treatment withdrawn under such circumstances." *Id.* at 265. The United States Supreme Court determined that the Missouri Supreme Court's clear and convincing evidence requirement furthered the state's interest in preservation of human life, as well as several additional state interests, and that the requirement did not violate the patient's due process rights. See *id.* at 281.

12. See *id.* at 278; see also *infra* note 14 and accompanying text.

differently. *Cruzan* allows us to reframe these issues and creates new possibilities for resolving involuntary hospitalization and right-to-refuse treatment problems. Indeed, in many cases, it allows us to avoid these problems altogether.

Cruzan allows us to view involuntary commitment and treatment refusal issues as opportunities for advance planning, rather than as disputes in need of judicial or administrative resolution. In many cases, the advance planning that these developments permit may enable the individual to exercise control over hospitalization and treatment issues, rendering dispute resolution in these areas unnecessary. Moreover, the possibilities that *Cruzan* creates for advance planning in the area of mental health treatment and hospitalization present new therapeutic opportunities as well.

This Article analyzes how living wills and other advance directive instruments may be used in the mental health context. Part II examines *Cruzan* and the extent to which the Court's endorsement of the living will can and should apply to the use of advance directive instruments, designed to control future hospitalization and treatment, by those with mental illness or who fear they may someday encounter it.¹³ Part III analyzes limits on the legal enforceability of advance directives in this context. It suggests that the state will and should enjoy somewhat wider latitude in regulating advance directives that elect a particular treatment than those that refuse treatment. Although state law will be able to limit the effectiveness of both types of instruments, individuals interested in selecting future treatment in advance will retain a significant ability to do so. This part also analyzes the state's ability to limit the enforceability of advance directives by asserting a police power interest in doing so, compared to a *parens patriae* interest in promoting the individual's welfare. It suggests that the state's police power interest in protecting the safety of others will trump the individual's interest in advance decision-making, but that the state's *parens patriae* interest rarely will do so. Part III then analyzes the distinction between advance instruction directives, through which the individual specifies particular treatment choices, and health-care proxies and durable powers of attorney, by which the individual designates a relative or friend to make decisions on his or her behalf during any future period of incompetence. It suggests that the state will give a greater degree of effectiveness to the former and

13. As used herein, "advance directive instruments" is a general term that includes both health-care instruction directives, and health-care proxies and powers of attorney. This is consistent with common usage. See, e.g., Unif. Health-Care Decisions Act § 1(1), 9 U.L.A. 222 (Supp. 1996) ("'Advance health-care directive' means an individual instruction or a power of attorney for health care."). For the distinction between advance directives and health-care instruction directives and health-care proxies or durable powers of attorney, see *infra* Part III.C.

may impose limits on the ability of a proxy decisionmaker to act on behalf of the incompetent individual.

Part IV analyzes the therapeutic value of advance directive instruments in the mental health context. Planning for future problems may help to avoid them. Moreover, when treatment proves necessary, having planned for it in advance can increase its therapeutic efficacy. Part V discusses the revocation and amendment of advance directive instruments. It proposes a method by which "irrevocable" advance directive instruments can be judicially or administratively changed when unforeseeable circumstances arise.

The Article concludes that advance directive instruments can be a useful means of planning for mental illness and of avoiding disputes concerning hospitalization and treatment. The avoidance of hearings, either judicial or administrative, to resolve these controversies would produce considerable fiscal and administrative savings. It also could prevent diversion of scarce clinical resources from treatment to dispute resolution. In addition, it would avoid the patient dissatisfaction that results when patients lose such hearings and that sometimes produces a psychological reactance that undermines the chances for successful treatment. Even apart from these considerations, however, the law should facilitate the use of advance directive instruments because they both promote individual autonomy and present significant therapeutic potential.

II. ADVANCE DIRECTIVE INSTRUMENTS AND THOSE WITH MENTAL ILLNESS

Cruzan and its state court counterparts¹⁴ have recognized that a patient enjoys a constitutionally-protected liberty interest in making his or her own future health-care decisions.¹⁵ Although these cases

14. See, e.g., *New Mark v. Williams*, 588 A.2d 1108, 1116 (Del. 1991); *In re Dubreuil*, 629 So. 2d 819, 828 (Fla. 1993); *In re Guardianship of Browning*, 568 So. 2d 4, 10 (Fla. 1990); *In re Guardianship of Doe*, 583 N.E.2d 1263, 1267 (Mass.), cert. denied sub nom. *Doe v. Gross*, 503 U.S. 950 (1992); *Gleason v. Abrams*, 593 A.2d 1232, 1234 (N.J. Super. Ct. App. Div. 1991); *Grace Plaza of Great Neck, Inc. v. Elbaum*, 623 N.E.2d 513, 514 (N.Y. 1993); *McKay v. Bergsted*, 801 P.2d 617, 622 (Nev. 1990); *In re Guardianship of L.W.*, 482 N.W.2d 60, 65 (Wis. 1992); LAWRENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-11 (2d ed. 1988).

A number of courts have recognized the right to refuse life-sustaining treatment based on common law. See *In re Doe*, 418 S.E.2d 3, 6 (Ga. 1992); *In re Estate of Greenspan*, 558 N.E.2d 1194, 1201 (Ill. 1990); *Mack v. Mack*, 618 A.2d 744, 755-56 (Md. 1993); *In re Rosebush*, 491 N.W.2d 633, 635-36 (Mich. Ct. App. 1992).

15. *Cruzan*, 497 U.S. at 278. The Court noted that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," and was willing to assume, "for purposes of this case, . . . that the United States Constitution would grant a competent person a constitutionally protected right to refuse life sustaining hydration and nutrition." *Id.* at 278-79; see also *id.* at 289 (O'Connor, J.,

involved the right of a terminally ill patient to discontinue life-prolonging treatment or nourishment, their language and rationale suggest that the right includes a broad liberty interest in accepting or refusing treatment that extends to the mental health context.¹⁶ Moreover, these cases indicate that individuals have a constitutional right to make health-care decisions not only when they are competent, but also when they are incompetent, as long as they indicated in advance the manner in which they wished their right to be exercised or other evidence exists concerning what their wishes would have been.¹⁷ Surrogates traditionally exercised an incompetent person's right to make health-care decisions. Recent legal developments suggest that such surrogate decisionmaking should reflect the patient's values, rather than some objective view of the best interests of the patient.¹⁸ Under *Cruzan*, patients are given an opportunity to express their desires about future treatment.¹⁹ Depending

concurring). The *Cruzan* Court cited three earlier decisions involving psychiatric patients to support the right to refuse treatment: *Washington v. Harper*, 494 U.S. 210 (1990), *Vitek v. Jones*, 445 U.S. 480 (1980), and *Parham v. J. R.*, 442 U.S. 584 (1979). See *id.* at 278. In *Harper*, the Court recognized that mentally ill, convicted prisoners possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." 494 U.S. at 221-22, quoted in *Cruzan*, 497 U.S. at 278. The *Cruzan* Court cited *Vitek* for the proposition that a prisoner's "transfer to a mental hospital coupled with mandatory behavior modification implicated liberty interests." *Cruzan*, 497 U.S. at 278. Finally, quoting *Parham*, the Court noted that "a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment." *Id.* at 278-79 (quoting *Parham*, 442 U.S. at 600).

16. See *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986); *In re Rosa M.*, 597 N.Y.S.2d 544, 545 (Sup. Ct. 1991); JUDITH C. AHRONHEIM ET AL., *ETHICS IN CLINICAL PRACTICE* 16-19 (1994); Lester J. Perling, Comment, *Health Care Advance Directives: Implications for Florida Mental Health Patients*, 48 U. MIAMI L. REV. 193, 206 (1993). This conclusion is also supported by the *Cruzan* Court's reliance on cases from the mental health context in reaching its conclusion that the Constitution protects a liberty interest in refusing treatment. See cases cited *supra* note 14.

17. See *Cruzan*, 497 U.S. at 271 (stating that "an incompetent person retains the same rights as a competent individual 'because the value of human dignity extends to both,'" and adopting a substituted judgment standard under which courts must determine what the incompetent person's decision would have been under the circumstances) (quoting Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 427, 431, 434 (Mass. 1977)); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 612 (N.Y. 1988); *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1982); *In re Rosa M.*, 597 N.Y.S.2d at 545.

18. See AHRONHEIM ET AL., *supra* note 15, at 17-18; ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISIONMAKING* 350-57 (1989) (reviewing the moral and ethical arguments supporting the use of advance directives and surrogate decisionmaking); see also Alison Patrucco Barnes, *Florida Guardianship and the Elderly: The Paradoxical Right to Unwanted Assistance*, 40 U. FLA. L. REV. 949, 988 (1988); Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy Decision Making for Incompetent Patients*, 267 JAMA 2067, 2071 (1992); Thomas G. Gutheil & Paul S. Appelbaum, *The Substituted Judgment Approach: Its Difficulties and Paradoxes in Mental Health Settings*, 13 L. MED. & HEALTH CARE 61, 64 (1985); Robert M. Wettstein & Loren H. Roth, *The Psychiatrist as Legal Guardian*, 145 AM. J. PSYCHIATRY 600, 604 (1988).

19. In *Cruzan*, the Court upheld the constitutionality of Missouri's requirement that, for an advance directive instrument to be effective, there must be clear and convincing evidence of the

on the clarity of their expression, these preferences will bind treatment providers or, in the case of health-care proxies, bind the surrogate or provide strong guidance for the exercise of surrogate decisionmaking.

As a result of these developments, patients are empowered to make advance decisions concerning health-care needs that may arise when they are incapacitated. They may do so either orally or in writing, pursuant to health-care proxies, living wills, or other advance directive instruments. As long as there is clear and convincing evidence concerning the patient's desires, *Cruzan* implies that the patient may choose in advance to discontinue life-prolonging treatment or nourishment that may be provided in the future.²⁰

Cruzan also implies that the state's interest in prolonging life, however important it may be, will not outweigh a patient's clearly expressed desire to discontinue life-support treatment or nourishment. Although the Court recognized a constitutionally protected liberty interest in refusing treatment that it assumed would apply in the "right to die" context,²¹ the Court did not address whether this liberty interest was "fundamental," thereby requiring strict scrutiny of government attempts to abridge it. The Court upheld the constitutionality of Missouri's requirement of clear and convincing evidence supporting a patient's desire to refuse life-sustaining treatment or nourishment.²² The state's interest in prolonging life was found to be sufficiently important to justify a clear and convincing evidence standard.²³ This standard, however, is merely a procedural requirement for exercise of the liberty interest assumed by the Court to be protected by due process. Such a standard still allows

patient's desire to refuse life-sustaining treatment or nourishment if she were in a vegetative state. See *Cruzan*, 497 U.S. at 283. The *Cruzan* Court, however, declined to determine whether a state might be required to defer to the decision of a surrogate appointed by the patient even if the patient's wishes were clearly expressed. See *id.* at 287 n.12; see also *id.* at 289 (O'Connor, J., concurring) (expressing view that duty to defer to surrogate "may well be constitutionally required"). Nancy Cruzan had not left any written instructions regarding her care in the event of incompetency, and the Missouri Supreme Court had found testimony concerning her oral statements on the issue to be insufficiently clear to establish her intentions. See *id.* at 268. In addition, Cruzan had not, either orally or in writing, appointed a surrogate decisionmaker. As a result, the case presented no occasion for the Court to consider the question.

20. See ARTHUR S. BERGER, *DYING & DEATH IN LAW & MEDICINE* 113-16 (1993); ALAN MEISEL, *THE RIGHT TO DIE* 316-21 (1989); BARBARA A. WEINER & ROBERT M. WETTSTEIN, *LEGAL ISSUES IN MENTAL HEALTH CARE* 299 (1993); John W. Parry, *The Court's Role in Decisionmaking Involving Incompetent Refusals of Life-Sustaining Care and Psychiatric Medications*, 14 *MENTAL & PHYSICAL DISABILITY L. REP.* 468, 474 (1990); Perling, *supra* note 15, at 205, 219; Gary N. Sales, *The Health Care Proxy for Mental Illness: Can it Work and Should We Want it To?*, 21 *BULL. AM. ACAD. PSYCHIATRY & L.* 161, 162-63 (1993).

21. See *supra* note 15.

22. See *Cruzan*, 497 U.S. at 283; see also *supra* note 11 and accompanying text.

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

the right to be exercised, and does not substantially burden it; the standard merely requires that exercise of the right be clearly expressed.

There is no suggestion in the Court's opinion that, as a matter of substantive due process, the state's interest in prolonging life could be invoked to justify a total infringement on the patient's right to decline treatment. Indeed, language in several more recent Supreme Court opinions seems to suggest that the right to refuse treatment, assumed to exist in *Cruzan*, may be fundamental. For example, in its 1992 decision in *Foucha v. Louisiana*,²⁴ the Court labeled the liberty interest in avoiding involuntary psychiatric hospitalization fundamental. In *Riggins v. Nevada*,²⁵ the Court, in dicta, suggested the need for a strict scrutiny approach to measuring the constitutionality of involuntary administration of antipsychotic medication in the criminal pretrial and trial context. Thus, if an individual objects to hospitalization or intrusive treatment through an advance directive instrument, the liberty interest asserted may be considered a fundamental constitutional right, requiring strict judicial scrutiny of state attempts to invade it.²⁶ In other words, the liberty interest in using advance directive instruments that the Court recognized in *Cruzan* takes on new importance when viewed in the light of these two more recent decisions. These developments suggest that the Constitution leaves decisions regarding medical treatment and hospitalization presumptively to the individual, rather than the state.

This principle should also apply to advance decisionmaking concerning treatment that is not life prolonging. *Cruzan* suggests that a patient possesses a due process right to choose whether to accept or reject medical treatment. Thus, a competent expression of the patient's desires should be respected even if the patient is incapacitated and the state asserts a *parens patriae* interest in promoting and protecting the patient's best interests.²⁷ The patient's clearly expressed interest in choosing whether to discontinue life-sustaining treatment or nourish-

24. 504 U.S. 71, 80, 86 (1992).

25. 504 U.S. 127, 133, 136 (1992); see Bruce J. Winick, *New Directions in the Right to Refuse Mental Health Treatment*, 2 WM. & MARY BILL RTS. J. 205, 225 (1993).

26. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374, 388 (1978) (stating that if a requirement upheld by a state "significantly interferes with the exercise of a fundamental right, it cannot be imposed unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests.").

27. Under their historic *parens patriae* power, state's may act in the best interest of those incapacitated by age or mental illness. See *Mills v. Rogers*, 457 U.S. 291, 296 (1982); see also JOEL FEINBERG, *HARM TO SELF* 6 (1986) (analyzing *parens patriae* power); Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 Hous. L. REV. 15, 16 & n.3 (1991) [hereinafter *Competency for Treatment*] (discussing scope of government's *parens patriae* power); Bruce J. Winick, *Legal Limitations on Correctional Therapy and Research*, 65 MINN. L. REV. 331, 374 (1981) (examining government's *parens patriae* power to make decisions for those who are unable to make decisions for themselves); Note,

ment, which *Cruzan* suggested would be superior to the state's *parens patriae* interest in prolonging life, would seem as strong or stronger than the state's *parens patriae* interest in administering treatment to a patient whose life is not at risk. Given the finality of death, honoring a patient's decision to discontinue life-sustaining treatment would totally frustrate the state interest in preserving life. By contrast, honoring a patient's decision to reject treatment that is not itself necessary to keep the patient alive still leaves open other ways in which the state may attempt to achieve its *parens patriae* interest in promoting individual health, including future attempts by the state to persuade or induce the patient to accept treatment thought to be beneficial.²⁸ As a constitutional matter, competent patients are more entitled to make decisions concerning their own health than the state is.²⁹ The state's *parens patriae* interest, however, might allow the state to insist on treatment for an incompetent patient who has not expressed a previous competent desire concerning treatment, if a surrogate decisionmaker believes such treatment is in the patient's best interest. But when a patient expressed a preference while he was competent, the state's *parens patriae* interests generally would seem insufficient to outweigh the patient's prior judgment about his or her own best interests.³⁰

Developments in the Law: Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1207-22 (1974) [hereinafter *Civil Commitment*].

28. Because the advance directive instrument ordinarily will not become effective until the individual becomes incompetent. The question may be raised whether the individual would be competent to change his mind about treatment. Competence, of course, is more a normative than a descriptive concept, and can be defined differently for different purposes. I have previously argued that competency to assent to treatment, particularly treatment in accordance with the recommendation of a clinician having a fiduciary duty to the patient, should require less in the way of decisionmaking ability than competency to object to treatment. See Winick, *Competency for Treatment*, *supra* note 27; see also *infra* text accompanying note 118. Competence is difficult to assess and fluctuates over time. When an individual whose competence is in doubt seeks to assent to treatment his clinician recommended and the individual previously assented to the treatment in an advance directive instrument, we can treat the instrument as controlling without ascertaining competence. When an instrument rejects treatment, however, if the individual subsequently agrees to treatment, we may conclude that he possesses sufficient competence to change his mind. Even if he is only barely competent, his present choice should take precedence over his former choice expressed in the instrument. When, on the other hand, he continues objecting to treatment, we should respect his refusal without assessing his competence, because, even if he is incompetent, his prior objection is legally effective.

29. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 67-70 (1979); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1755-71 (1992).

30. See Winick, *Competency for Treatment*, *supra* note 27, at 19 (noting that, although mental illness may impair competency, mentally ill persons often have a significant capacity for rational thought); see also ALAN A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 102 (DHEW Pub. No. (ADM) 76-176, 1976); THOMAS S. SZASZ, *THE THERAPEUTIC STATE: PSYCHIATRY IN THE MIRROR OF CURRENT EVENTS* 99 (1984); Perling, *supra* note 15, at 195; Thomas S. Szasz, *The Psychiatric Will: A New Mechanism for Protecting Persons Against*

There is one troubling exception to this general approach. Although a competent patient is presumptively better able to identify his or her best interests than is the state, the patient may be unable to anticipate changes in circumstances that might occur when the patient is incompetent. Incompetence—cognitive impairment caused by physical trauma, organic brain disorder, or mental illness—may be long lasting. During a period of incompetence, treatment options not available when the patient executed an advance directive instrument may arise that would clearly be in the patient's best interest. Because the patient is incompetent, the state would be unable to persuade or induce the patient to change his or her mind and accept such a treatment. In this circumstance, the state's ability to assess the patient's best interest may be superior to that of the patient, even though the patient was competent at the time he or she made the directive.

Some commentators argue that this dilemma should render advance directive instruments ineffective once the patient becomes incompetent.³¹ In my view, however, this response goes too far. In the many cases in which treatment options have not materially changed, the patient's prior expression of preference should be respected even if the state or a surrogate decisionmaker thinks that another treatment would be best for the patient. However, in those cases in which treatment options or other circumstances have changed in a way that could not reasonably have been foreseen, there are ways of dealing with the problem that would not compromise the instrument's effectiveness altogether. I discuss these approaches in Part V, which deals with amendment and revocation of advance directive instruments.³²

The foregoing analysis of *Cruzan* and its implications suggests that advance determinations concerning hospitalization and treatment made by mental patients during periods of competency generally should be enforceable.³³ Although *Cruzan* did not deal with the mentally ill's abil-

"Psychosis" and Psychiatry, 37 AM. PSYCHOLOGIST 762, 766-67 (1982); Bruce J. Winick, *Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and a Response to Professor Bonnie*, 85 J. CRIM. L. & CRIMINOLOGY 571, 585 (1995).

31. Professor Rebecca Dresser is the leading proponent of this view. See Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986) [hereinafter *Life, Death, and Incompetent Patients*]; Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609 (1994) [hereinafter *Missing Persons*]; Rebecca Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425 (1990) [hereinafter *Relitigating*].

32. See *infra* notes 116-17 and accompanying text.

33. See *In re Rosa M.*, 597 N.Y.S.2d 544, 545 (Sup. Ct. 1991) (upholding patient's advance directive refusal of electroconvulsive therapy); Paul S. Appelbaum, *Advance Directives for Psychiatric Treatment*, 42 HOSP. & COMMUNITY PSYCHIATRY 983, 984 (1991); Deborah S. Pinkney, *Advance Directive Could Give Mentally Ill More Treatment Control*, AM. MED. NEWS, Dec. 16, 1991, at 3.

ity to engage in future health-care decisionmaking, mental illness should not be distinguished from physical illness in this regard, at least not when the individual in question is competent at the time the advance directive instrument is executed. Is the existence of mental illness *per se* incompatible with such competence? Although mental illness sometimes impairs competency to process information and make rational decisions, it often does not do so.³⁴ Those who are mentally ill often have a significant capacity for normal and rational thought and behavior.³⁵ Mental illness, even a severe mental illness like schizophrenia, simply cannot be equated with incompetence to make rational treatment decisions.³⁶ The due process liberty interest recognized in *Cruzan* therefore should be equally applicable to mental patients and medical patients. It should apply to all "persons," the term used in the Due Process Clauses of both the Fifth and Fourteenth Amendments to describe the beneficiaries of their protection against governmental deprivation.³⁷

34. "The mere presence of psychosis, dementia, mental retardation, or some other form of mental illness or disability is insufficient in itself to constitute incompetence." PAUL S. APPELBAUM & THOMAS G. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 220 (2d ed. 1991); see also AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* xxiii (4th ed. 1994) ("[A]ssignment of a particular diagnosis does not imply a specific level of impairment or disability.").

35. See *Rivers v. Katz*, 495 N.E.2d 337, 341-42 (N.Y. 1986); Stephen J. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 540, 572-77, 632-35 (1978); Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 54 (1989).

36. See Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM. BEHAV. 149, 171 (1995) (comparing treatment decisionmaking of hospitalized mental patients and medically ill patients and non-ill community groups, finding that nearly half of schizophrenic patients and 76% of clinically depressed patients performed in an "'adequate' range . . . across all decision-making measures," and that a significant portion performed at or about the mean for persons without mental illness); Karen McKinnon et al., *Rivers in Practice: Clinicians' Assessments of Patients' Decision-Making Capacity*, 40 HOSP. & COMMUNITY PSYCHIATRY 1159, 1159 (1989) ("Clinical evidence suggests that despite alterations in thinking and mood, psychiatric patients are not automatically less capable than others of making health care decisions."); David A. Soskis, *Schizophrenic and Medical Inpatients as Informed Drug Consumers*, 35 ARCHIVES GEN. PSYCHIATRY 645, 645 (1978) (finding individuals with schizophrenia to be more aware of risks and side effects of their medications than medical patients, but medical patients to be more informed about the name and dose of their medication and of their diagnosis); David A. Soskis & Richard L. Jaffe, *Communicating with Patients About Anti-Psychotic Drugs*, 20 COMPREHENSIVE PSYCHIATRY 126 (1970) (understanding in both groups equal); Barbara Stanley, *Informed Consent in Treatment and Research*, in *HANDBOOK OF FORENSIC PSYCHOLOGY* 63, 77-78 (Irving B. Weiner & Allen K. Hess eds., 1987) (reviewing studies finding little difference between psychiatric and medical patients' comprehension of consent information); Barbara Stanley et al., *Preliminary Findings on Psychiatric Patients as Research Participants: A Population at Risk?*, 138 AM. J. PSYCHIATRY 669, 671 (1981) (finding no differences between mental and medical patients' willingness to expose themselves to high-risk, hypothetical studies); see also Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL., PUB. POL'Y & L. 137, 140 (1996) (discussing study by Grisso & Appelbaum, *supra*).

37. U.S. CONST. amends. V, XIV; see *Plyler v. Doe*, 457 U.S. 202, 210 (1982) (construing

Both those suffering from mental illness and those suffering from life-threatening medical conditions may exercise this liberty interest when they are competent, even though they may be incompetent when their choice is given effect. *Cruzan's* deference to state law concerning the degree of clarity required to render advance directive instruments enforceable³⁸ suggests that states will enjoy wide latitude in defining competency for this purpose³⁹ and in deciding on the procedures necessary for its determination. Within these limits, however, the constitutional right to engage in advance treatment decisionmaking, recognized in *Cruzan*, should apply with equal force to individuals with mental illness.

In light of *Cruzan's* implications, both patients with mental illness who have been restored to competency through hospitalization or treatment, and those who have never been incompetent, should be encouraged to determine in advance how they would like to be treated during future periods of incompetency. For example, those who had a positive hospital experience, but were subjected to involuntary commitment proceedings that they found to be demeaning, might agree in advance to voluntary hospitalization should they again experience severe

"persons" broadly). For Supreme Court recognition that persons with mental illness have a constitutionally-protected liberty interest in refusing unwanted mental health treatment, see *Riggins v. Nevada*, 504 U.S. 127, 133-34 (1992); *Washington v. Harper*, 494 U.S. 210, 221-22 (1990).

38. See *supra* note 10 and accompanying text.

39. For an analysis of differing standards for determining a patient's competency to make treatment decisions, see THOMAS GRISSO, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* (1986); Winick, *Competency for Treatment*, *supra* note 27. Virtually all states employ a statutory presumption in favor of competence, applicable even to mental patients committed to psychiatric hospitals under the *parens patriae* power because they are incompetent to appreciate their need for hospitalization. See SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 375, 406-07 tbl.7.2 (3d ed. 1985); Catherine E. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447, 471-72 nn.87-88 (1990); Winick, *Competency for Treatment*, *supra* note 27, at 22-23 & n.19, 35-37. As a result, individuals executing advance directive instruments should be presumed to be competent to do so. See *In re Rosa M.*, 597 N.Y.S.2d 544, 545 (Sup. Ct. 1991) (presuming involuntarily committed civil patient who received electroconvulsive therapy is competent to execute advance directive). In view of our society's historic commitment to principles of individual autonomy, see Winick, *Competency for Treatment*, *supra* note 27, at 35-37; Winick, *supra* note 29, it would seem unlikely that states would depart from the general presumption of competency in the case of the advance directive instrument. See Unif. Health-Care Decisions Act § 11(b), 9 U.L.A. 243 (Supp. 1996) (applying a presumption in favor of competency to execute an advance directive instrument; OR. REV. STAT. § 127.575 (1995) (presuming instrument is valid). When competency is presumed, the burden falls on those who are questioning the advance directive instrument's validity on the basis that the individual who executed it was incompetent at the time. In defining incompetency, our commitment to the principle of autonomy calls for a narrow definition that respects individual self-determination in all cases but those in which the decision made is clearly the product of mental illness. See Winick, *supra* note 29, at 1732-35.

symptoms.⁴⁰ Similarly, those who strongly disliked a particular medication or other treatment, such as electroconvulsive therapy, might insist that they never again be subjected to it, or that a specified alternative treatment be used instead.⁴¹ To satisfy the clear and convincing evidence standard approved in *Cruzan*, which some states may apply in the mental health context, patients should be encouraged to express their desires clearly and in writing.⁴² In addition, they may wish to designate an appropriate health-care surrogate or proxy to assist in effectuating their desires. Some patients, particularly those whose competence to execute an advance directive instrument is in question, may wish to have their execution of the written instrument witnessed or even videotaped, and to recite for the witnesses or the tape the reasons for their choices. In the absence of an expressed desire, a state's *parens patriae* civil commitment statute or involuntary treatment authority presumably would prevail, should the patient become incompetent, allowing the state to determine what the patient would have wished if he or she was competent.

In this sense, the advance health-care directive bears a strong analogy to the last will and testament.⁴³ Just as individuals have the ability to dispose of their property upon death by making a will expressing their intentions, patients may control future health-care treatment through the use of advance directive instruments. When a competent individual executes a will, his or her estate will be disposed of in accordance with the

40. See Steven K. Hoge, *The Patient Self-Determination Act and Psychiatric Care*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 577, 583-84 (1994); Marilyn K. Rosenson & Agnes M. Kasten, *Another View of Autonomy: Arranging for Consent in Advance*, 17 SCHIZOPHRENIA BULL. 1 (1991).

41. See *Rosa M.*, 597 N.Y.S.2d at 544 (upholding advance directive by patient who previously experienced electroconvulsive therapy and executed advance directive stating "I am withdrawing my consent to electroconvulsive therapy and am refusing any more treatments with this procedure.").

42. One court has defined the clear and convincing evidence standard in the context of advance directive instruments as follows:

[T]he "clear and convincing" evidence standard requires proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented. As a threshold matter, the trier of fact must be convinced, as far as is humanly possible, that the strength of the individual's beliefs and the durability of the individual's commitment to those beliefs makes a recent change of heart unlikely. The persistence of the individual's statements, the seriousness with which those statements were made and the inferences, if any, that may be drawn from the surrounding circumstances are among the factors which should be considered.

In re Westchester County Med. Ctr., 531 N.E.2d 607, 613 (N.Y. 1988) (citation omitted). For criticism of the clear and convincing evidence standard in the advance directive context on the basis that it is almost impossible to satisfy, see Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988).

43. See MEISEL, *supra* note 20, at 312-13; see also SZASZ, *supra* note 30, at 91-92.

will's directions, even if the individual subsequently becomes incompetent to execute or amend the will. Absent a will, state law on intestate succession applies. In the mental health context, by analogy, the state's *parens patriae* hospitalization or treatment law and practice should prevail in the absence of an advance directive concerning hospitalization or treatment. When patients express their desires in such instruments, however, they generally should be effective in determining future hospitalization or treatment during subsequent periods of incompetency. State *parens patriae* hospitalization or treatment law can thus be seen as a default rule that applies only in the absence of a clearly expressed advance directive.

III. LIMITS ON ENFORCEABILITY

A. *The Distinction Between Advance Directives Electing Treatment and Those Rejecting It*

The analogy to the last will and testament also suggests that while many provisions in the advance health care directive will be enforceable, some will not be. Just as provisions in a will that violate public policy will not be enforced,⁴⁴ provisions in an advance directive should be ineffective to the extent they seek, for example, to elect drugs that are unlawful or unapproved by the Food and Drug Administration, treatments that exceed the patient's financial resources, or treatment modalities that are banned by the professional ethics of the practitioner in question. Although an individual's right to refuse treatment that the state wishes to impose may be fundamental,⁴⁵ the right to obtain a particular treatment that the state forbids may not be entitled to as much constitutional protection.⁴⁶ As a result, the state may enjoy wider latitude in regulating directive instruments that elect certain forms of treatment than those that reject a particular form of treatment. Current statutes and case law dealing with advance directives do not draw this distinction, but there may be good reasons for doing so, and the distinction may already be reflected in existing practice.

Both tort law principles and professional ethics require that the treating clinician obtain the patient's informed consent.⁴⁷ To satisfy this

44. See WILLIAM M. MCGOVERN, JR. ET AL., *WILLS, TRUSTS AND ESTATES* 86-93 (1988).

45. See *supra* notes 24-26 and accompanying text.

46. See *United States v. Richardson*, 588 F.2d 1235 (9th Cir. 1978), *cert. denied*, 440 U.S. 947 (1979) (rejecting challenge to ban on Laetrile, a drug sought by some cancer patients); *cf. DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989) (distinguishing negative liberties from positive liberties and suggesting greater constitutional protection for the former); Isaiah Berlin, *Two Concepts of Liberty*, in *FOUR ESSAYS ON LIBERTY* 118 (1969) (distinguishing positive and negative liberty).

47. See, e.g., PAUL S. APPELBAUM ET AL., *INFORMED CONSENT* 23 (1987); RUTH R. FADEN &

requirement, the clinician must disclose to the patient the risks and benefits of the treatment in question and alternative treatments, and the patient must provide a competent consent.⁴⁸ Only in some cases will the same clinician who counseled the patient at the time the advance directive was executed also be involved in the patient's treatment at a later time when the patient is incompetent. This raises several serious problems. A treating clinician who has never previously been involved with the patient might be reluctant to administer the treatment selected in the advance directive. Even if the treating clinician believes the treatment is clinically appropriate, he or she will not have made the necessary disclosure to the patient concerning risks, benefits, and alternatives, and as a result, may feel vulnerable to a tort suit or ethics charges.⁴⁹ Moreover, even if the treating clinician fully disclosed to the patient when the patient executed the directive instrument, material facts concerning risks, benefits, and alternative therapies may have changed, raising serious questions concerning the validity of the prior consent.

These are problems that will not arise in cases in which the advance directive instrument seeks to decline a specified treatment rather than elect one. The arguments in favor of the enforceability of advance directives denying treatment may therefore be considerably more compelling. Because advance directives denying treatment are likely to have greater constitutional protection, states will enjoy considerably wider latitude in regulating advance directives that elect rather than reject treatment. Indeed, because the liberty interest in electing a particular treatment, although protected by due process,⁵⁰ probably will not be considered fundamental, state regulation will presumably be tested only under the minimal scrutiny of the rational basis standard. Thus, a state statute permitting clinicians to refuse to provide treatment elected in an advance directive instrument if they concluded it would be therapeutically inappropriate, inconsistent with professional ethics, or in violation of the requirements of informed consent,⁵¹ would probably survive con-

TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 23 (1986); Charles L. Sprung & Bruce J. Winick, *Informed Consent in Theory and Practice: Legal and Medical Perspectives on the Informed Consent Doctrine and a Proposed Reconceptualization*, 17 CRITICAL CARE MED. 1346 (1989).

48. See sources cited *supra* notes 24-26.

49. This concern will be alleviated by increasingly common statutory provisions immunizing providers from tort liability or charges of unethical conduct for complying with patients' directives. See *infra* note 52.

50. See *supra* note 46 and accompanying text.

51. See, e.g., Unif. Health-Care Decisions Act § 7, 9 U.L.A. 239 (Supp. 1996):

(e) A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the institution which is expressly

stitutional challenge. Similarly, a statute immunizing clinicians from liability for violation of the informed consent requirement when, in good faith, they provide treatment to an incompetent patient in accordance with his or her advance directive⁵² would also seem constitutional. Although statutes such as these would vest clinicians with a considerable degree of discretion, given the complex clinical and ethical issues that varied circumstances are likely to create, such discretion appears more appropriate and cost efficient than a system relying on administrative or judicial decisionmaking. Even when a competent patient seeks treatment, clinicians may refuse to provide it if they feel it to be clinically inappropriate or unethical under the circumstances. Advance directives should not change this feature of clinical practice.

If immunizing statutes such as these are adopted, as we should anticipate they will be in view of the political power that the professional groups affected usually enjoy at the state legislative level, they will facilitate the use of advance directive instruments for those with mental illness. Obviously, clinicians will feel most comfortable honoring an advance directive electing a particular treatment when they have had a long-standing relationship with the patient and have developed the advance directive with him or her. When the patient is unknown to the clinician, the clinician's willingness to comply with an advance selection of treatment will vary with the clinician's assessment of its clinical appropriateness in light of alternative therapies. To ensure that his or her interests and preferences are promoted, it may be advisable for the patient to supplement his or her advance directive instrument with health-care proxies to trusted friends or relatives. These designees can not only advocate the patient's interests and preferences, but also provide an additional informed consent as the patient's surrogate, alleviating many of the clinician's concerns, including those relating to potential liability.

B. *The Distinction Between the State's Police Power and Its Parens Patriae Power*

The above discussion suggests a number of limitations on the

based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient. (f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

52. Most state statutes, including those dealing explicitly with advance directives for persons with mental illness, provide for such immunity. See, e.g., HAW. REV. STAT. ANN. § 327F-13 (Michie 1994); OKLA. STAT. tit. 43A, § 11-112 (1995); OR. REV. STAT. § 127.555(3) (1995).

enforceability of advance directive instruments that elect a particular treatment. Those seeking to reject a particular form of treatment or treatment altogether, however, will enjoy a higher degree of enforceability. When the rejected treatment is sufficiently intrusive that the patient's right to reject it is deemed fundamental,⁵³ the advance directive will generally be upheld as long as the state interest in providing treatment is grounded solely in its *parens patriae* power. Absent a court order revoking or amending it,⁵⁴ an advance directive executed while the patient was in a competent state should be respected, just as under *Cruzan*, a living will declining life-prolonging treatment or nourishment would be.

By contrast, an advance directive would not control in instances in which the state's interest in hospitalization or treatment is grounded in its police power,⁵⁵ rather than its *parens patriae* power. Just as a will provision that violated public policy would be unenforceable,⁵⁶ a mental health advance directive refusing the hospitalization or treatment required to prevent the patient's suicide or harm to others would be unenforceable. The subordination of the patient's liberty interest in engaging in future mental health-care decisionmaking to the state's police power is no different than the state's interest in public health or safety overriding the desire of a patient suffering from infectious tuberculosis who refuses treatment or quarantine,⁵⁷ or the desire of an individual who refuses compulsory vaccination designed to prevent the spread of an epidemic.⁵⁸ The autonomy justification for respecting and enforcing advance mental health directives is insufficient to outweigh

53. See *supra* notes 24-26 and accompanying text.

54. See *infra* Part V.

55. See *Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (suggesting that state's police power interest in preventing harm to other inmates or staff in a jail and in restoring and maintaining a defendant's competency to stand trial would justify forced antipsychotic medication that was medically appropriate and the least intrusive means of accomplishing these goals); *Washington v. Harper*, 494 U.S. 210, 227 (1990) (upholding state's authority to forcibly administer antipsychotic drugs to a prisoner to protect safety of other prisoners and prison staff); *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983) (en banc); *Rogers v. Okin*, 634 F.2d 650, 656 (1st Cir. 1980) (en banc), *vacated and remanded on other grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). The state's police power interest in preventing suicide is a traditional justification for civil commitment. See, e.g., *In re Guardianship of Hedin*, 528 N.W.2d 567, 572 (Iowa 1995); *Rodriguez v. City of New York*, 861 F. Supp. 1173, 1184 (S.D.N.Y. 1994); *Civil Commitment*, *supra* note 27, at 1222-45 (analyzing police power and the basis for involuntary hospitalization).

56. See MCGOVERN ET AL., *supra* note 44, at 86-93.

57. The state possesses a limited quarantine power under which those with tuberculosis may be hospitalized to protect the public health. See, e.g., FLA. STAT. § 392.56 (1995); N.Y. PUB. HEALTH LAW § 2120 (McKinney 1996).

58. See *Jacobson v. Massachusetts*, 197 U.S. 11, 29 (1905) (holding that state's police power interest in preventing epidemic outweighed competent individual's asserted right to refuse compulsory vaccination for smallpox).

the state's interest in protecting those who the patient could harm. Just as the state would be able to hospitalize or treat dangerous, although competent mental patients over their present objections,⁵⁹ the state would be able to hospitalize or treat mental patients who are both dangerous and incompetent over the objections they expressed in the past.

Thus, in the future, the right to refuse treatment question may, in part, be answered through the use of advance directive instruments. Statutory commitment or involuntary treatment laws applied to accomplish state police power interests will prevail over patient choices made in such instruments. However, when applied in the *parens patriae* context, these laws generally will prevail only in the absence of such instruments.

C. *The Distinction Between Instruction Directives and Health-Care Proxies*

Individuals may engage in advance health-care decisionmaking in two different ways. First, they may execute advance directive instruments (what I shall call "instruction directives"), specifying in detail how particular health-care decisions shall be made in the event of future incompetence.⁶⁰ Second, they may execute health-care proxies, a type of durable power of attorney in which they designate another person to act on their behalf in the event of future incompetence.⁶¹ Should these

59. See *Washington v. Harper*, 494 U.S. 210 (1990) (holding that state's police power interest in protecting other prisoners and staff outweighed competent prisoner's desire not to take antipsychotic medication); *Civil Commitment*, *supra* note 27, at 1222-28 (analyzing state's police power as a justification for involuntary hospitalization). Under this analysis — a police power interest, but not a *parens patriae* interest, would trump an individual's advance directive instrument refusing hospitalization or treatment — the individual's advance refusal would prevail only when the state's justification for the involuntary intervention is grounded exclusively in its *parens patriae* power.

The state's rationale for involuntary hospitalization and treatment does not always fall neatly into either the police power or the *parens patriae* categories. Sometimes a patient's situation invokes both justifications.

60. See, e.g., Unif. Health-Care Decisions Act § 2(a), 9 U.L.A. 224 (Supp. 1996) ("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."). "Every state now has legislation authorizing the use of some sort of advance health-care directive. All but a few states authorize what is typically known as a living will." *Id.* at prefatory note, 9 U.L.A. 220.

61. See, e.g., Unif. Health-Care Decisions Act § 2(b), 9 U.L.A. 224-25:

An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the principal is receiving care.

two mechanisms be treated differently by the law?⁶² Although both should be legally effective ways⁶³ of engaging in future health-care decisionmaking, to some extent they deserve different treatment, and the state will have somewhat more latitude in regulating the latter than the former.

An individual may exercise his or her liberty interest in making health-care decisions through either mechanism.⁶⁴ In the instruction directive, the individual specifies what should be done, whereas in the health-care proxy, the individual delegates this authority to another. When the individual specifies what should be done in the event of future incompetence, there is certainty concerning how the individual desires to exercise his or her right. On the other hand, when the individual appoints a designee to engage in surrogate decisionmaking, there is far less certainty concerning whether the surrogate's decisions accurately reflect the individual's desires. Except in situations in which a designee provides guidance to the surrogate concerning how to act in specified circumstances,⁶⁵ a health-care proxy does not insure that the surrogate decisionmaker will decide the way the individual would have. Even though the individual designated a close friend or relative presumed to understand the individual's preferences as surrogate, the surrogate may not truly understand the individual's preferences or may decide to pursue his own view of the individual's best interest. Moreover, there may be a conflict of interest between the surrogate and the individual. For example, if the surrogate resides with a mentally ill individual, the distressing behavioral symptoms of mental illness may dispose the surrogate to prefer hospitalization, even if it is not in the individual's best interests.⁶⁶ Thus, the state will have a legitimate interest in policing the health-care proxy process to ensure against conflicts of interest and other abuses.⁶⁷ When the individual has clearly articulated a choice in the

"Nearly all states have statutes authorizing the use of powers of attorney for health care." *Id.* at prefatory note, 9 U.L.A. 220.

62. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 287 n.12 (1990) (suggesting that states treat the two mechanisms differently) (dictum); *People v. Eulo*, 472 N.E.2d 286, 296 (N.Y. 1984) (stating that the right to decline life-preserving treatment is personal, and, while the individual may exercise it through an advance directive instrument or when he otherwise clearly makes his wishes known, it may not be exercised on his behalf by a third party) (dictum); see also *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 612 n.2 (N.Y. 1988) (citing statement in *Eulo*, but noting that it was subsequently overruled by statute).

63. See *Cruzan*, 497 U.S. at 289-90 (O'Connor, J., concurring).

64. See *supra* note 15 and accompanying text.

65. See, e.g., FLA. STAT. § 765.205(1)(a) (1995).

66. See *Parham v. J.R.*, 442 U.S. 584, 632 (1979) (Brennan, J., dissenting).

67. See *Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 (Ct. App. 1983) (requiring that there be no evidence that family members acting as surrogate decisionmakers "were motivated in their decisions by anything other than love and concern" for the patient); *John F. Kennedy Mem'l*

matter, however, these state interests are absent.

When an individual has not articulated his or her preferences, the state may have good reason to scrutinize proxy decisionmaking. This is particularly true when the intervention in question—hospitalization or intrusive treatment—can have a dramatic effect on the individual's welfare. Deference to individual autonomy may make us reluctant to interfere with an individual's own choice, even when we suspect it is imprudent or foolish.⁶⁸ But when the individual's surrogate seeks to do something that we suspect is not truly in the individual's best interest, an added degree of scrutiny seems appropriate, particularly if the intervention in question seems seriously detrimental. Although both advanced directive instruments and health-care proxies are mechanisms for exercising the liberty interest in health-care decisionmaking, the latter may be subject to a higher degree of governmental regulation, limitation, and oversight.⁶⁹

Moreover, the instruction directive is a more basic assertion of the right to make personal health-care decisions⁷⁰ and, hence, is subject to a higher degree of constitutional protection. There are certain constitutional rights that individuals may not delegate to others. For example, a citizen may exercise the right to vote, but a citizen may not delegate his or her vote to others. An adult may decide to marry or divorce, but a power of attorney delegating that authority to another would be unenforceable. A woman has a protected liberty interest in deciding whether

Hosp. v. Bludworth, 452 So. 2d 921, 926-27 (Fla. 1984) (noting that "evidence of [surrogate decisionmaker's] wrongful motives . . . may require judicial intervention"); Judith Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 JAMA 229, 232-33 (1987); see, e.g., N.M. STAT. ANN. § 24-7-8.1 (Michie 1995) (requiring that patient's family act "in good faith."); Unif. Health-Care Decisions Act § 5(i), 9 U.L.A. 235 (Supp. 1996) (disqualifying employees of long-term residential centers from being proxies). Professor Rhoden has suggested that all proxy decisionmakers are inevitably influenced by their own interests and values. Rhoden, *supra* note 42, at 392. Because these interests and values might differ from those of the patient, proxy decisionmaking must be scrutinized in a way that does not arise when the individual himself has provided an instruction directive. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 287 n.12 (1990):

The differences between the choice made by a competent person to refuse medical treatment, and the choice made for an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class.

68. See Winick, *Competency for Treatment*, *supra* note 27, at 21 & n.17.

69. See *Cruzan*, 497 U.S. at 287 n.12.

70. See *id.* Nancy Rhoden would go further. In her view, instruction directives are the *only* way in which the right to engage in treatment decisionmaking can be exercised. Unless the patient has provided specific instructions to the designated proxy decisionmaker, Rhoden argues that the decisionmaker is not truly exercising the patient's liberty interest, but only his or her own conception of how the patient would have or should have chosen. See Rhoden, *supra* note 42, at 381-82, 385-94.

to have an abortion, but she cannot delegate that authority to a surrogate decisionmaker.⁷¹ In the criminal justice process, although defense counsel may waive a variety of constitutional and trial-related rights on the defendant's behalf,⁷² counsel may not make a decision about certain fundamental constitutional rights. Only the defendant may decide whether to plead guilty, to waive jury trial, to attend trial, and to testify at trial.⁷³ Similarly, individuals may enjoy greater latitude in making personal health-care decisions through an advance directive instrument than through delegating power to a proxy decisionmaker; and the legislature will possess greater authority to regulate health-care proxies than advance directive instruments.

Do the above examples, prohibiting the delegation of certain personal rights to others, suggest that health-care decisions may not be delegated to a proxy? Courts have not yet addressed this question,⁷⁴ but such delegations are increasingly allowed permitting such delegations in this context. Indeed, the reasons for doing so are convincing, and the situations in which delegation of decisionmaking is prohibited are distinguishable. With respect to the right to vote, there are political reasons, including the wish to avoid an economic market in votes, that explain why that right should not be delegable. Likewise, decisions about marriage, divorce, and abortion are so personal and intimate and have such a profound effect on the individual's life that the law may require the individual to make the decision personally and not delegate it to another. While health-care decisions also are personal and intimate, and may

71. *E.g.*, FLA. STAT. § 765.113(1) (1995); OR. REV. STAT. § 127.540(5) (1995).

72. *See* *Morris v. Slappy*, 461 U.S. 1 (1983); *Jones v. Barnes*, 463 U.S. 745, 751 (1983); *Wainwright v. Sykes*, 433 U.S. 72, 91 n.14 (1977); *Estelle v. Williams*, 425 U.S. 501, 512 (1976); *id.* at 514-15 (Powell, J., concurring); *Faretta v. California*, 422 U.S. 806, 820 (1975); *Henry v. Mississippi*, 379 U.S. 443, 451-52 (1965); *United States ex rel. Brown v. Warden*, 417 F. Supp. 970, 972-73 (N.D. Ill. 1976) (collecting cases); 2 WAYNE R. LAFAVE & JEROLD H. ISRAEL, *CRIMINAL PROCEDURE* § 11.6, at 501-06 (1985); Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 959-63 (1985).

73. *See* *Jones*, 463 U.S. at 751 (dictum) ("[T]he accused has the ultimate authority to make certain fundamental decisions regarding the case, as to whether to plead guilty, waive a jury, testify in his or her own behalf, or take an appeal . . ."); *Sykes*, 433 U.S. at 93 n.1 (Burger, C.J., concurring); ABA STANDARDS FOR CRIMINAL JUSTICE § 4-5.2(a) (1993); LAFAVE & ISRAEL, *supra* note 72, § 11.6, at 502-03; Winick, *Reforming Incompetency*, *supra* note 30, at 576; Winick, *supra* note 72, at 959 n.181; *see, e.g.*, *Rock v. Arkansas*, 483 U.S. 44, 52-53 (1987) (decision to testify); *Brookhart v. Janis*, 384 U.S. 1, 7-8 (1966) (decision to plead guilty); *Adams v. United States ex rel. McCann*, 317 U.S. 269, 275 (1942) (decision to waive jury trial). *See generally* Timothy P. O'Neill, *Vindicating the Defendant's Constitutional Right to Testify at a Criminal Trial: The Need for an On-The-Record Waiver*, 51 U. PITT. L. REV. 809 (1990) (contending that the fundamental nature of the right to testify necessitates a personal, on-the-record waiver of that right at trial).

74. *See* *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 287 n.12 (1990) (raising the question but not deciding it).

have profound effects on the individual's life, the arguments in favor of allowing delegation in this area are strong.

Our traditions reflect a wide range of permissible decisionmaking by others in the area of health care. For example, parents make health-care decisions for their minor children.⁷⁵ Families have traditionally enjoyed an important role in health-care decisionmaking for ill, adult family members.⁷⁶ While the individual retains the authority to make decisions on his own behalf, the individual frequently is allowed to designate a spouse or other close family member to exercise the individual's decisionmaking authority in the event illness destroys the individual's competence.⁷⁷ State laws recognize the general validity of health-care proxies.⁷⁸ Even in the absence of a formal health-care proxy, physicians will frequently consult close family members about treatment decisions when the individual's ability to make them is reduced.⁷⁹

These health-care proxy decisionmaking traditions reflect ill individuals' need for decisionmaking assistance, and the reasonableness of appointing family members or friends to provide that assistance. When illness strikes, treatment decisions frequently must be made before the individual is fully capable of making them. The right to make health-care decisions—to elect or refuse treatment—sometimes must be exercised through or with the assistance of another. When illness impairs the ability to make decisions, delegation of health-care decisionmaking authority to a trusted friend or relative is far preferable to decisionmaking by the government.

The traditional use of health-care proxy decisionmaking, reflected in legal and medical practice, suggests that states will not attempt to

75. See *Parham v. J.R.*, 442 U.S. 584 (1979) (relying on parents' traditional authority to make health-care decisions for their minor children in upholding parents' ability to admit children to mental hospitals and mental retardation facilities).

76. See generally *Areen*, *supra* note 67 (discussing the medical custom of physicians relying on families to make medical decisions when the patient cannot speak for himself).

77. See *Cruzan*, 497 U.S. at 290 (O'Connor, J., concurring) ("Delegating the authority to make medical decisions to a family member or friend is becoming a common method of planning for the future."); *Areen*, *supra* note 67, at 230 (discussing medical practice and judicial and statutory authorizations for families to make termination of life-prolonging treatment decisions for incompetent patients).

78. See, e.g., ARK. CODE ANN. § 20-17-202 (Michie 1995); DEL. CODE ANN. tit. 16, § 2502 (1995); FLA. STAT. § 765.303 (1995); IDAHO CODE § 39-4504 (Supp. 1995); IND. CODE ANN. § 16-36-4-13(g)(2) (West Supp. 1996); IOWA CODE § 144A.7(1)(a) (1995); LA. REV. STAT. ANN. §§ 40:1299.58.1-3(C) (West 1992); MINN. STAT. § 145B.01-.17 (Supp. 1995); TEX. HEALTH & SAFETY CODE ANN. § 672.003(d) (West 1996); UTAH CODE ANN. §§ 75-2-1105, 1106 (Supp. 1995); VA. CODE ANN. § 54.1-2986 (Michie 1995); WASH. REV. CODE ANN. § 7.70.065(1)(b) (West 1992); WYO. STAT. ANN. § 35-22-102 (1995).

79. See *Areen*, *supra* note 67, at 229.

prevent delegation of this authority to another in the mental health treatment context. State legislatures, however, may seek to regulate it more closely than health-care instruction directives, in which individuals specify what should be done in the event of future incompetence. The state, for example, may wish to prohibit surrogate decisionmakers from electing certain types of experimental treatment, such as psychosurgery,⁸⁰ or certain types of controversial treatment, such as electroconvulsive therapy.⁸¹ States may also limit surrogates' ability to civilly commit individuals to psychiatric hospitals.⁸² In addition, states may prohibit individuals with conflicts of interest from exercising health-care proxies, and impose fiduciary duties on individuals accepting such appointments. Moreover, in the case of some treatments, legislatures may require that health-care proxies not only name an individual as surrogate decisionmakers, but also provide standards channeling the surrogates' exercise of discretion. Such a limitation on surrogate discretion is not unusual in American jurisprudence. In the law of agency, for example, courts have sometimes reacted with skepticism when a general power of attorney is relied upon as authorization to dispose of significant property or to enter into a guarantee.⁸³ Courts construe corporate bylaw provisions granting officers broad authority similarly.⁸⁴ Courts often require more specificity in the instrument to permit the inference that the principle intended his or her agent to exercise the power in question.⁸⁵ Simi-

80. See e.g., FLA. STAT. § 765.113(1) (1995); OR. REV. STAT. § 127.540(3) (1995).

81. See e.g., FLA. STAT. § 765.113(1) (1995); OR. REV. STAT. § 127.540(2) (1995).

82. See e.g., FLA. STAT. § 765.113(1) (1995); OR. REV. STAT. § 127.540(1) (1995).

83. See Bruce J. Winick, *Forfeiture of Attorneys' Fees Under RICO and CCE and the Right to Counsel of Choice: The Constitutional Dilemma and How to Avoid It*, 43 U. MIAMI L. REV. 765, 861 n.470 (1989); see, e.g., *Chicago Title Ins. Co. v. Progressive Hous., Inc.*, 453 F. Supp. 1103, 1106-07 (D. Colo. 1978) (Holding the general power of attorney insufficient to authorize an agent to execute a guaranty agreement binding the principal, the court noted that "representatives, [dealing with the agent] as persons of ordinary prudence in business matters, should have perused the instrument granting [the agent] a general power of attorney and should have insisted upon more than was furnished by him as evidence of his authority to enter into the specific transaction."); *Gittings, Neiman-Marcus, Inc. v. Estes*, 440 S.W.2d 90, 93 (Tex. Civ. App. 1969) (dictum) (noting that a broad power of attorney authorizing an agent "to sell, transfer and convey all lands that I may have in the said State of Texas, and generally to do and to perform all acts and deeds for me and in my name concerning any and all property that I now own in said State of Texas" was insufficient to authorize the agent to barter or exchange the principal's land).

84. See Winick, *supra* note 83, at 861 n.470; see, e.g., *General Overseas Films, Ltd. v. Robin Int'l, Inc.*, 542 F. Supp. 684, 691-92 (S.D.N.Y. 1982), *aff'd*, 718 F.2d 1085 (2d Cir. 1983). In *General Overseas Films, Ltd.*, the court held that a bylaw provision granting a treasurer "power on behalf of the Company to sign checks, notes, drafts, bills of exchange and other evidences of indebtedness" did not authorize him to execute a guaranty binding the corporation. *Id.* at 691. "[S]uch a contract is unusual and extraordinary and so not normally within the powers accruing to an agent by implication, however general the character of the agency; ordinarily the power exists only if expressly given." *Id.* at 692 (quoting 2A C.J.S. *Agency* § 181 (1979)).

85. Demands for specificity can be seen as examples of "the policy of clear statement." HENRY M. HART, JR. & ALBERT SACKS, *THE LEGAL PROCESS* 1205-10 (William N. Eskridge, Jr. &

larly, when administrative agencies rely upon a broad and general legislative delegation for the authority to intrude upon fundamental constitutional rights, courts often insist upon a more explicit statutory authorization.⁸⁶

The requirement that a clear statement of authority exist when serious consequences might ensue suggests that individuals should be as specific as possible in the health-care proxy, either permitting or prohibiting certain treatment options or providing general standards to guide the surrogate's decisionmaking. Such a limited health-care proxy can be seen as a hybrid of the instruction directive and the traditionally unlimited health-care proxy.⁸⁷ It will perhaps be the most enforceable instrument for two reasons. First, courts will feel confident about the individual's intentions and will, therefore, be more willing to defer to them when they are confirmed by the individual's trusted designee. Second, treatment providers might feel more comfortable with a process that involves a surrogate, that is, another human being with whom to share the difficult dilemmas that these situations may present.

The legislature may place certain treatment choices beyond the authority of a surrogate when the individual has failed to either specify them in the health-care proxy or specify appropriate standards governing their choice. However, in general, it should give effect to such proxy instruments. To the extent that the individual is able to think ahead about the particular treatment choices that might arise, the individual should specify his or her wishes in as much detail as possible in a health-care directive instrument. By making their intentions clear, individuals can avoid the possibility that courts will deny effectiveness to their health-care proxies based on concern about whether they would have made the same choice that their surrogate elects. While the legislature

Philip P. Frickey eds., 1994); see also ALEXANDER M. BICKEL, *THE LEAST DANGEROUS BRANCH: THE SUPREME COURT AT THE BAR OF POLITICS* 156-69 (1962); WINICK, *supra* note 83, at 839-43 & 841 n.375.

86. *E.g.*, *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 308-09 (1978) (opinion of Powell, J., stating judgment of the Court); *Hampton v. Mow Sun Wong*, 426 U.S. 88, 105-14 (1976); *United States v. Robel*, 389 U.S. 258, 275-76 (1967) (Brennan, J., concurring); *Greene v. McElroy*, 360 U.S. 474, 507-08 (1959); *Kent v. Dulles*, 357 U.S. 116, 129-30 (1958); see JAMES D. FREEDMAN, *CRISIS AND LEGITIMACY: THE ADMINISTRATIVE PROCESS AND AMERICAN GOVERNMENT* 83-85 (1978); LOUIS L. JAFFE, *JUDICIAL CONTROL OF ADMINISTRATIVE ACTION* 72-73 (abr. ed. 1965); BERNARD SCHWARTZ, *ADMINISTRATIVE LAW* § 2.9, at 49-50 (2d ed. 1984); TRIBE, *supra* note 14 § 5-17, at 365-66; Richard B. Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1669, 1680-81 (1975); Winick, *supra* note 83, at 853-64; *cf.* *City of Lakewood v. Plain Dealer Pub. Co.*, 486 U.S. 750, 756-57 (1988) (holding that the delegation of power to restrict First Amendment rights requires more than broad legislative directives to guide the restricting authority); *Shuttlesworth v. City of Birmingham*, 394 U.S. 147, 150-51 (1969) (same).

87. See Hoge, *supra* note 40, at 578.

may possess greater leeway in regulating health-care proxies, both proxies and more specific health-care instruction directives should generally be given effect in the mental health area.

IV. THE THERAPEUTIC VALUE OF ADVANCE DIRECTIVE INSTRUMENTS

In addition to avoiding the need for formal resolution of treatment disputes and promoting autonomy values, the use of advance directive instruments in the mental health context may have significant therapeutic value. Merely contemplating the possibility of mental illness and mental health treatment may cause some patients to take preventative measures that may avoid the problem. Staring into the abyss of mental illness may give people a clearer view of their present reality and an incentive to change it when appropriate and possible, or to find better ways of coping with it. It may also provoke people who suspect that their problems might escalate to obtain treatment early, before their condition gets out of hand. For some people, a little counseling may go a long way, helping them to confront and resolve problems before they become too serious.

People who previously have experienced mental illness may avoid a recurrence of their problems by advance planning. Such planning will cause them to reflect upon their desires in light of the hospitalization or treatment they have already experienced and to take responsibility for future decisionmaking. When patients have strong feelings about treatment issues, their feelings generally should be respected. To the extent patients do not have strong feelings, they can either leave their affairs to the state, which will appoint a surrogate under its *parens patriae* power, or designate a surrogate or proxy who is known to them and more capable than the state of representing their interests and preferences. The assurance that an individual's strongly held feelings will be respected can bring a measure of ease that can have beneficial effects; the concern that such choices will be ignored can provoke stress, fear, and anxiety that may exacerbate the individual's mental illness.

The very process of advance planning can have a number of positive therapeutic effects. Particularly for mental patients, who frequently are infantilized by the treatment they receive in mental hospitals, assuming responsibility for decisions vitally affecting them would be empowering and have predictable beneficial effects.⁸⁸ Indeed, the very process

88. A persistent criticism of mental hospitals is that, by taking over virtually all aspects of patients' lives, they foster dependency, incompetency, learned helplessness, and a form of institutional personality that is inconsistent with community readjustment. See ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* 3-74 (1961); Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for*

of making decisions about the future might well have an impact on the patient's future behavior and condition, that is, it may diminish the chances of future incompetency.

The process of preparing an advance directive instrument also can provide an important therapeutic opportunity that creative clinicians can exploit. Preparing the instrument will focus the patient's attention on future goals and how to attain them. The goal-setting effect—the finding that the setting of concrete goals itself helps to bring about their achievement—can be harnessed through the process of planning and preparing the instrument.⁸⁹ Because the patient's goals will be clearly set forth in writing and executed by the patient with a high degree of formality in the presence of witnesses, the advance directive instrument can be a particularly effective means of achieving the benefits of goal setting. Therapists should become involved in preparing the instrument because the process itself will provide an opportunity to engage the patient and to eliminate potential resistance to treatment in a context that, precisely because it involves the future, may be less threatening to the patient than the process of treatment decisionmaking concerning a present problem.

An advance directive can function as an important safety valve for the right-to-refuse-treatment issue. Patients who feel strongly about determining the course of their treatment or about a specific treatment or intervention will have the option of making advance decisions that in general will effectuate their wishes. If they are able to do so in a way that the law will honor, this will provide a degree of predictability that can reduce stress and anxiety that might otherwise be devastating. Being able to plan in advance about important matters, with the assurance that those plans generally will be respected and effectuated, brings a measure of ease that can permit the patient to pursue happiness and the blessings of liberty in a way that the anxiety and fear produced by uncer-

Mental Health Law, 1 PSYCHOL., PUB. POL'Y & L. 6, 19 & n.81 (1995); see also *id.* at 13-23 (analyzing negative effects on performance, motivation, and mood of labeling mental patients as incompetent). By contrast, allowing patients to exercise self-determination and control over important aspects of their lives, can improve their self-esteem and effective functioning. See Winick, *supra* note 29, at 1755-71 (discussing the psychological value of choice).

89. Cf. Donald J. Campbell, *The Effects of Goal-Contingent Payment on the Performance of a Complex Task*, 37 PERSONNEL PSYCHOL. 23, 23 (1984); Edward L. Deci & Richard M. Ryan, *The Empirical Exploration of Intrinsic Motivational Processes*, 13 ADVANCES EXPERIMENTAL SOC. PSYCHOL. 39, 58-61 (1980); Vandra L. Huber, *Comparison of Monetary Reinforcers and Goal Setting as Learning Incentives*, 56 PSYCHOL. REP. 223 (1985); Daniel S. Kirschenbaum & Randall C. Flanery, *Toward a Psychology of Behavioral Contracting*, 4 CLINICAL PSYCHOL. REV. 598, 603-09 (1984); Edwin A. Locke et al., *Goal Setting and Task Performance 1969-1980*, 90 PSYCHOL. BULL. 125, 125-31 (1981); James R. Terborg & Howard E. Miller, *Motivation, Behavior, and Performance: A Closer Examination of Goal Setting and Monetary Incentives*, 63 J. APPLIED PSYCHOL. 29, 30-31 (1978).

tainty in such matters might well prevent. Patients may thereby be liberated to maximize their potential for a healthy adjustment to life. Dealing with such an important matter in an effective way also predictably will allow the patient to experience feelings of self-esteem and self-efficacy that can increase their decisionmaking capacity and their ability to perform in their chosen endeavors.⁹⁰

Acting and being treated as self-determining individuals with a significant measure of authority over their own fate, instead of as powerless and incompetent victims of forces beyond their understanding and control, can be therapeutically advantageous to mentally ill patients.⁹¹ Restoration of mental patients to as high a degree of community functioning as possible should be a significant goal of any sensible system of mental hospitalization and treatment. This goal will be furthered by allowing patients to exercise their decisionmaking capacity. By contrast, paternalistic treatment can foster feelings of incompetency, reinforcing expectations that might keep such patients from emerging from the shadow of the psychiatric sick role.⁹²

Moreover, recognizing that patients have the power to direct the future course of their treatment will make psychiatrists and other clinicians negotiate with the patients about treatment, increasing the likelihood that the patients will be treated with dignity and respect,⁹³ rather than paternalistically.⁹⁴ Patients who are able to choose a course of treatment in advance are likely to feel better about the treatment and are more willing to comply with it, which can help to maximize the potential for therapeutic success.⁹⁵ Even for those patients whose feelings about future treatment are not strong enough to lead them to execute an advance directive, the opportunity to do so, even though foregone, may lead to greater acceptance of any therapeutic intervention subsequently imposed by the state pursuant to its *parens patriae* power. Similarly, failure by the individual to deal with the matter through an advance

90. See Winick, *supra* note 88, at 13 & n.49.

91. See Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 17 INT'L J.L. & PSYCHIATRY 99 (1994); *Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1643-55 (1990).

92. See JOHN S. STRAUSS & WILLIAM T. CARPENTER, JR., SCHIZOPHRENIA 128-29 (1981); Donald N. Bersoff, *Autonomy for Vulnerable Populations: The Supreme Court's Reckless Disregard for Self-Determination and Social Science*, 37 VILL. L. REV. 1569, 1571 (1992); Phil Fennell, *Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder*, 17 J. L. & SOC'Y 29, 29 (1990); Winick, *supra* note 88, at 8, 12-13; see also JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 2 (1984).

93. See Winick, *supra* note 91, at 111-12, 114.

94. See *id.* at 111-12.

95. See *id.* at 115-16; see also KATZ, *supra* note 92, at 102-03; DONALD MEICHENBAUM & DENNIS C. TURK, *FACILITATING TREATMENT ADHERENCE: A PRACTITIONER'S GUIDEBOOK* 63, 71-76, 84-85 (1987).

directive, when that option is made available to him or her, may decrease the individual's potential for subsequent resentment and psychological reactance to a course of treatment later imposed through surrogate decisionmaking.⁹⁶ Psychological reactance is at its highest when individuals feel that their decisionmaking authority has unfairly been intruded upon.⁹⁷ Being reminded that they had the ability to make other arrangements, but neglected to do so, may help to diffuse such negative reactions.

Thus, having the opportunity to engage in advance planning concerning hospitalization and treatment may have significant therapeutic benefits. The ability to be self-determining—to plan for the future, to envision future contingencies and bring about those that are desired and avoid those that are undesired, to set goals and see them achieved—is an important aspect of mental health and self-esteem. Those suffering from mental illness too frequently lack or have been denied this opportunity. Such denial exacerbates their illness and intensifies feelings of powerlessness, dependence, incompetence, and depression.

An additional therapeutic opportunity is presented if the hospital, treatment facility, or therapist obtains the information set forth in the advance directive instrument. It often may be difficult to obtain information from or about a highly disturbed patient, particularly if the patient is incompetent. The advance directive can supply the provider with important information about the patient, the patient's treatment history, and the patient's treatment preferences and dislikes. This information can be invaluable in the proper diagnosis of the patient's condition and in devising an appropriate treatment plan.

Another advantage of advance directive instruments is their potential for avoiding formal adjudications of incompetency. Such adjudications are a form of deviance labeling that can produce seriously detrimental social consequences and psychological damage.⁹⁸ They are often a prerequisite for exercise of the state's *parens patriae* power.⁹⁹

96. See SHARON S. BREHM & JACK W. BREHM, *PSYCHOLOGICAL REACTANCE: A THEORY OF FREEDOM AND CONTROL* 301 (1981).

97. See Nancy S. Bennett et al., *Inclusion, Motivation, and Good Faith: The Morality of Coercion in Mental Hospital Admission*, 11 *BEHAV. SCI. & L.* 295, 297-99 (1993); Steven K. Hoge et al., *Patient, Family, and Staff Perceptions of Coercion in Mental Hospital Admission: An Exploratory Study*, 11 *BEHAV. SCI. & L.* 281 (1993); John Monahan et al., *Coercion to Inpatient Treatment: Initial Results and Implications for Assertive Treatment in the Community*, in *COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW* 13, 24, 27 (Deborah L. Dennis & John Monahan eds., 1996); Monahan et al., *supra* note 7, at 252-53.

98. See generally Winick, *supra* note 88 (describing antitherapeutic social and psychological effects of incompetency labeling).

99. See *supra* note 27 and accompanying text.

Individuals anticipating a future period in which their decisionmaking capacity may be impaired may execute a formal instrument directing how decisions will be made on their behalf in such an event or select a trusted friend or relative to serve as a surrogate decisionmaker on their behalf. An individual with mental illness may experience fluctuating periods of impairment. Execution of either an instruction directive instrument or a health-care proxy can avoid the necessity of a judicial assessment of his or her competence. When the individual has executed an instruction directive, that directive will not take effect until and unless the individual becomes incompetent. However, as long as the individual is able to articulate a present wish that is consistent with the choice he or she articulated in the advance directive, no need would exist to determine his or her competence. If the individual was presently competent, his or her present choice would be honored; if the individual was incompetent, the choice expressed in the instruction directive would be honored. Because the same choice would be honored in either event, an adjudication of competency would be unnecessary. Similarly, when the individual has executed a health-care proxy designating a surrogate decisionmaker to act on his or her behalf in the event of incompetence, if the surrogate seeks to make a treatment decision that is identical to the one that the individual is presently expressing, a formal determination of competence would also be unnecessary. Thus, advance health-care planning through the use of instruction directives or health-care proxies can avoid the need for state coercion and incompetency adjudication, with its accompanying adverse labeling effects.¹⁰⁰

Thus, the use of advance directives can have many therapeutic advantages for mentally ill individuals. It can help to avoid mental health problems and can facilitate the treatment of those that occur. In many cases it can render unnecessary a formal adjudication of incompetence, thus avoiding the negative effects of incompetency labeling. Hence, permitting mentally ill individuals to use advance directive instruments not only promotes liberty, but can be seen as an example of therapeutic jurisprudence.¹⁰¹

100. See Phyllis Solomon, *Research on the Coercion of Persons with Severe Mental Illness*, in *COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW* 129, 142-43 (Deborah L. Dennis & John Monahan eds., 1996); Winick, *supra* note 88, at 39.

101. See generally DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991) (analyzing and illustrating law's role as a therapeutic agent); BRUCE J. WINICK, *THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW* (forthcoming 1997); *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (David B. Wexler & Bruce J. Winick eds., 1996) (illustrating application of therapeutic jurisprudence to a wide spectrum of legal issues and containing commentary on this emerging approach to legal policy analysis). For recent symposia on therapeutic jurisprudence, see *Special Theme, Therapeutic Jurisprudence*, 1 *PSYCHOL., PUB. POL'Y & L.* 1 (1995); Symposium, *Therapeutic*

V. REVOCATION AND AMENDMENT OF ADVANCE DIRECTIVE INSTRUMENTS

Perhaps the most intriguing problem with the use of advance directives in the mental health context arises when patients, who have executed advance directives, either in favor of or against hospitalization or a particular treatment, later seek to change their minds.¹⁰² Obviously, if the change of mind occurs during a period of competency, the advance directive instrument may be revoked or revised. Revocation may be written, oral, or by physical destruction of the document.¹⁰³ Revision may be accomplished by amendment or execution of a superseding instrument.

Should it be possible for an individual to enter into an irrevocable instrument? "Irrevocable," in this context, should be distinguished from "durable." A durable power of attorney or health care-proxy is a grant of authority to a surrogate that will survive the grantor's becoming incompetent.¹⁰⁴ By comparison, an irrevocable instrument may not be changed, even when the individual is competent. While people rarely wish to bind themselves in ways that prevent them from changing their minds, the advance directive for mental health care may present a situation in which some people wish to do precisely this.

Irrevocability, however, raises some troubling problems. Although many individuals who execute advance directive instruments may never expect to change them, time and experience sometimes bring new insight that will make some wish to reevaluate the matter. Those who fear that relatives or others may pressure them to revoke the instrument, particularly one electing against hospitalization or treatment, may wish to make them irrevocable. Ulysses, for example, entered into such a contract when he ordered himself lashed to the mast because he knew the sweet song of the sirens would otherwise be irresistible and would lure him into treacherous waters.¹⁰⁵ Whether the waters awaiting those individuals accepting mental hospitalization or mental health treatment are as treacherous is a matter on which those who previously have experienced them will differ. Most people will not wish to tie their

Jurisprudence: Restructuring Mental Disability Law, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993); Symposium, *Therapeutic Jurisprudence: Bridging the Gap from Theory to Practice*, 20 New Eng. J. on Crim. & Civ. Confinement 243-344 (1994).

102. See, e.g., JON ELSTER, *ULYSSES AND THE SIRENS: STUDIES IN RATIONALITY AND IRRATIONALITY* 38-47 (rev. ed. 1984); Audrey Macklin, *Bound to Freedom: The Ulysses Contract and the Psychiatric Will*, 45 TORONTO FAC. L. REV. 37 (1987). See generally Rosenson & Kasten, *supra* note 40; Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777 (1982).

103. See, e.g., FLA. STAT. § 765.104(1) (1995).

104. See *supra* note 61.

105. HOMER, *THE ODYSSEY* 214 (Robert Fitzgerald trans., 1963).

hands in this manner, preferring instead to preserve their options. However, others who have had very negative hospitalization or treatment experiences, will wish to nail the door shut. Should the law permit them to do so? While they may be foolish to foreclose their options in this way, isn't the essence of freedom the right to make foolish choices?

Although our law's strong commitment to individual autonomy would favor leaving this matter, like many other matters dealing with individual health, to the individual, there is a paradox here. Permitting irrevocable, present choices compromises the making of choices in the future. Freedom to enter into an irrevocable arrangement inevitably conflicts with freedom to change one's mind. Autonomy principles thus also support protecting the ability to make different choices in the future. Even marriage and baptism into a particular religion—pledged to last forever at the time—are not made absolutely irrevocable. People change their minds about many things that they never thought they would, and so the law permits divorce and religious conversion. Even the Constitution can be amended. Thus, although the law may appropriately allow people to make irrevocable advance directives that will survive their becoming incompetent, it should be reluctant to deny them the opportunity, while competent, to change their minds. People should be allowed to lock the door and hide the key, but not to throw it away.

One way to resolve this dilemma is to permit an "irrevocable" advance directive instrument to be revoked or amended with judicial or administrative approval when the individual is competent. Such approval could be by application, with only the most cursory review, much like the procedure for changing a name.¹⁰⁶ The approval procedure would function essentially as a check against coercion and changes by obviously incompetent people who are being manipulated by others. Only those individuals electing to execute such limited "irrevocable" instruments would need to go through this procedure; those who executed advance directives that were not made "irrevocable" would be permitted to amend or revoke them at will.

Allowing this modified form of irrevocability would accommodate the conflicting autonomy concerns while also serving therapeutic ends. Inevitably, modes of mental hospitalization and treatment will improve. Our knowledge about the causes and treatment of mental illness is rapidly developing,¹⁰⁷ and new types of medication and other treatment,

106. A majority of states have enacted statutes prescribing the method by which an individual may change his name. *See, e.g.*, FLA. STAT. § 68.07 (1995). Generally, the individual files an application with the appropriate court, which, unless there is a substantial reason to deny it, makes an order granting the request.

107. *See* Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSCHOL., PUB. POL'Y & L. 534, 564-65 (1995).

more effective and with less adverse effects, hopefully will be developed. It would be a pity to allow the dead hand of a patient who had a negative experience with an outmoded form of treatment to deny him or her the opportunity to benefit from a new or newly improved treatment, particularly if the patient wishes to try it and can make a competent decision to do so. An iron-clad, irrevocable advance directive instrument would have the antitherapeutic effect of foreclosing potentially beneficial treatment options. This therapeutic consideration, although not dispositive, argues for either free irrevocability of advance directives or the modified form of irrevocability suggested earlier.

Therefore, allowing patients to opt for either free revocability or a limited form of revocability subject to judicial or administrative scrutiny would seem to be a sensible approach. The limited revocability (or modified irrevocability) option could have the added advantage of serving as a useful hedge against coercion. The dialogue between the family and a family member who suffers from mental illness, as well as that between mental health professionals and the patient, sometimes crosses the line between persuasion and coercion.¹⁰⁸ When a patient with strong feelings against a particular mental health intervention has been brow-beaten into submission, the judicial or administrative check may allow the patient to resist such pressures. This procedure may also have therapeutic value. Patients who feel unfairly pressured into accepting treatment they really wish to refuse will not do as well as those who feel they have been persuaded to accept a treatment that is in their best interests.¹⁰⁹ Although people sometimes need to be convinced to do things that are in their best interest, coercing them into doing so may backfire.¹¹⁰ By reducing the potential for coercion, the judicial or administrative approval process may allow patients to experience persuasion, rather than compulsion, producing potentially positive therapeutic effects.

Individuals contemplating advanced directive instruments thus could be given the option either of electing an instrument that is freely revocable or one that would require judicial or administrative approval for revocation or modification. Those electing the latter presumably would anticipate that their advance directive would remain unchanged, but in the event they later thought otherwise, they could affect a change, although only with judicial or administrative approval. Those opting for the former would not need to obtain any approval for revocation or mod-

108. See Janet A. Gilboy & John R. Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 Nw. U. L. REV. 429 (1971) (describing coercion in the voluntary hospital admission process); Monahan et al., *supra* note 7, at 251.

109. See Monahan et al., *supra* note 97, at 2.

110. See generally BREHM & BREHM, *supra* note 96.

ification, but could simply revoke their prior directives or execute superseding instruments. This would be similar to the way individuals who change their minds about dispositions made in a will may act. As long as they are still competent, they may revoke or amend their wills as often as they like.

Regardless of whether an individual selects the free or limited revocability option, the question remains: If the individual's change of mind occurs during a period of questionable competency or of incompetency, how should the law respond? Under general principles, an incompetent individual would be unable to revoke or revise a previously executed advance directive instrument.¹¹¹ But should the individual be bound to a prior decision that may no longer be in his or her best interest? Perhaps this is an area in which the state's present ability to ascertain an individual's best interest is superior to the individual's preference at the time the advance directive instrument was executed.

This problem has led some commentators to suggest that advance directives have only limited effectiveness. For example, Professor Rebecca Dresser criticizes advance directive instruments on the ground that honoring them precludes any reconsideration of patients' earlier choices, even when those choices are detrimental to the patients' current interests.¹¹² Dresser would consider patients' present interests more worthy of protection than their previous preferences. In effect, she prefers considerations of beneficence to the value of protecting patient autonomy in the making of future decisions.

Professor Nancy Rhoden, on the other hand, has criticized Dresser's position on the basis that it insufficiently values patient autonomy and precludes the use of living wills and other advance directive instruments.¹¹³ Professor Rhoden endorses the use of advance directive instruments. She argues that decisionmaking relying on such instruments, the patient's prior values and preferences gleaned from conversations with others, and family discretion is superior to an "objective" determination of the patient's present best interests.

I prefer Rhoden's position to Dresser's, but I think there is an area in which Dresser's criticism of the advance directive instrument is appropriate. When treatment circumstances have changed in a way that could not reasonably have been anticipated, there may be reason to prefer the patient's present interests to a past instruction declining treat-

111. See OR. REV. STAT. § 127.545 (1)(b) (1995) (prohibiting incompetent individuals from revoking advance directive instruments).

112. See Dresser, *Missing Persons*, *supra* note 31, at 112; Dresser, *Relitigating*, *supra* note 31, at 431, 433.

113. See Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845, 846 (1990); Rhoden, *supra* note 42, at 411-16.

ment. In what follows, I suggest a way of solving this dilemma without denying general enforceability to advance directives.

If the patient envisioned the new circumstances at the time he or she executed the instrument, the instrument provides the best evidence of how he or she would wish to be treated should the anticipated circumstances materialize. In the absence of a police power interest sufficient to trump the individual's prior expression of choice,¹¹⁴ that expression—assuming the individual was competent when he or she made it, of course—should be respected, regardless of whether it would be inconsistent with the individual's best interests. There are a good many things that competent people choose to do that are objectively not in their best interests. People engage in risky behavior, like sky diving, cigarette smoking, and buying derivatives, which may be detrimental to their safety, health, or financial well-being. We do not, however, interfere with their choices on the basis of beneficence. Deference for individual autonomy mandates respect for competent decisions, even if they are thought to be unwise or imprudent.¹¹⁵ There may be reason to treat differently situations in which an individual, because of present incompetence, cannot change his mind. But to do so would deny the individual's ability to make the decision for himself while in a competent state. As long as the individual can anticipate the future consequences of his decision, we should not substitute our judgment for his own, even if we are convinced that we are right and he is wrong.

If, on the other hand, the individual did not anticipate the changed circumstances—the development of a new form of treatment or a means of eliminating the adverse side effects of an old form of treatment, perhaps—there may be good reason not to respect the individual's previously expressed direction. Indeed, if we are satisfied that had the individual anticipated the changed circumstance, he or she would have wished to modify the original direction in a particular way, then that modification should be made. Careful drafting of advance directive instruments that anticipate possible changes in circumstances and express the individual's wishes in the event they occur would deal with many of these problems. Lawyers and health-care professionals assisting patients in the preparation of these instruments should thus help patients anticipate various changes that might occur and decide how to deal with them should they materialize.

When changed circumstances were not or could not have been anticipated, how should the law respond? The law of wills provides a useful analogy. Under the *cy pres* doctrine, a court may modify a will

114. See *supra* notes 55-59 and accompanying text.

115. See Winick, *Competency for Treatment*, *supra* note 27, at 21 & n.17.

provision which, in light of unanticipated circumstances, seems inconsistent with the testator's intentions.¹¹⁶ For example, a will provision making a bequest to a now defunct organization or charity (e.g., the League of Nations) may be modified by the probate court to have the bequest go to another organization fulfilling a similar purpose (e.g., the United Nations). Applying a form of the *cy pres* doctrine, courts and administrative bodies can modify advance directive health-care instruments in a similar way.¹¹⁷

In many cases, individuals who change their minds concerning previously executed advance directives will not clearly be either competent or incompetent. How should the law deal with such cases of questionable competence? How should the law define competency in this context and how should it be determined? In attempting to resolve this problem, the distinction between patient assent and objection that I have proposed elsewhere for defining competency may prove useful.¹¹⁸

In cases in which patients of questionable competency attempt to change previously executed advance directive instruments in order to choose therapist-recommended hospitalization or treatment, the law should utilize a low threshold for defining competency and find patients' assent to such an intervention sufficient to revoke prior directives. Unless the patient's assent seems to be the product of hallucinations, delusions, or outright irrationality, it should be accepted. As long as the patient understands at a basic level that he or she has a problem, and clearly and voluntarily chooses a recommended treatment intervention, such as mental hospitalization or customary mental health treatment, that concerned professionals believe to be in the patient's best interest, the patient generally should be considered competent.¹¹⁹ Although impaired

116. See, e.g., *Yale Univ. v. Blumenthal*, 621 A.2d 1304, 1305 (Conn. 1993); *In re Estate of Crawshaw*, 819 P.2d 613, 620 (Kan. 1991); *Franklin Found. v. Attorney Gen.*, 623 N.E.2d 1109, 1114 (Mass. 1993); *In re Estes Estate*, 523 N.W.2d 863, 870 (Mich. Ct. App. 1994); *In re Gonzalez*, 621 A.2d 94, 95-96 (N.J. Super. Ct. Ch. Div. 1992); *In re Will of Coffey*, 590 N.Y.S. 2d 357 (App. Div. 1992); *In re Estate of Wilson*, 451 N.Y.S. 2d 891 (App. Div. 1982); see also MCGOVERN ET AL., *supra* note 44, at 333-38, 534-35, 550.

117. No case thus far appears to apply the *cy pres* doctrine in the advance health-care directive context, perhaps because the use of such directives is still in its early stages.

118. See generally Winick, *Competency for Treatment*, *supra* note 27; Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch*, 14 INT'L J.L. & PSYCHIATRY 169 (1991). I also have suggested use of the distinction between assent and objection in the context of competency to stand trial in the criminal process. Winick, *Reforming Incompetency*, *supra* note 30; Winick, *supra* note 72.

119. This narrow definition was recently recommended by the American Psychiatric Association Task Force on Consent to Voluntary Hospitalization as a test for competency to consent to voluntary hospital admission. AMERICAN PSYCHIATRIC ASS'N, TASK FORCE REP. NO. 34, CONSENT TO VOLUNTARY HOSPITALIZATION 8 (1993); see Bruce J. Winick, *How to Handle Voluntary Hospitalization After Zinermon v. Burch*, 21 ADMIN. & POL'Y MENTAL HEALTH 395, 402-04 (1994).

by mental illness, these patients are able to express a preference that does not on its face seem "crazy" or the product of a pathological delusion. As long as the patient understands that he or she is seeking admission to a psychiatric hospital, that the treatment sought is for mental illness, that care and treatment will be provided, and that release or discontinuation of treatment can occur if the patient again changes his or her mind, the patient should be deemed competent. In this situation, there would be a rebuttable presumption of competency. A formal inquiry into competency would be unnecessary unless the patient's assent appeared to be a product of outright irrationality, delusions, or severe depression.¹²⁰

Accordingly, unless specific evidence suggests that the choice made was the product of mental illness, there should be no need for a procedural determination of competence for an individual to revoke a previously executed directive that rejects a treatment intervention now sought in response to a therapist's recommendation.

This approach—defining competency differentially for assent and objection, and applying a presumption in favor of competency in cases of assent to a therapist's recommendation—would serve both autonomy interests and therapeutic values. Indeed, permitting patients to choose a therapeutic intervention recommended by their therapists would, according to psychological theory, increase the potential that such an intervention would be efficacious.¹²¹ Moreover, when the patient's assent is in response to a therapist's recommendation, there is reasonable assurance that the chosen treatment will succeed in promoting the patient's health, because the therapist owes a fiduciary duty to the patient.

In contrast, when patients change their minds and object to hospitalization or treatment that, in a prior advance directive, they assented to, autonomy values and therapeutic interests may not align as closely and do not support as lenient an approach. From the perspective of autonomy values, two conflicting expressions of autonomy exist—the previous, presumably competent one and the subsequent one of perhaps more dubious competency. Although ordinarily a more recent expression of autonomy is preferred because it more accurately reflects the patient's

120. See Winick, *Competency for Treatment*, *supra* note 27, at 44; Winick, *Reforming Incompetency*, *supra* note 30, at 596-605; see, e.g., *Zinermon v. Burch*, 494 U.S. 113 (1990) (deeming incompetent overtly schizophrenic patient exhibiting delusions and hallucinations who stated that the mental hospital to which he sought admission was "heaven"). Although broad language in the *Zinermon* opinion suggests the need for an inquiry into competence whenever a mentally ill person assents to hospital admission, see *id.* at 133 n.18, this language is dicta, see Winick, *supra* note 118, at 180-81, and should be rejected as unwise and constitutionally unnecessary. See generally *id.*; Winick, *Reforming Incompetency*, *supra* note 30, at 603-04.

121. See generally Winick, *supra* note 91.

current preferences, there may be reason to question whether the patient's present objection is a product of mental illness rather than genuine autonomy. When the objection is to a therapeutic intervention, such as hospitalization or conventional treatment, that is recommended by the patient's therapist, there also may be reason to question whether the objection might be antitherapeutic and inconsistent with the patient's welfare. I do not suggest that all objections to hospitalization or treatment suggest incompetency. Patients who change their minds and reject therapeutic interventions they previously chose in advance directives may be competent to do so, even if their choice is against clinical advice and seems unwise. But the higher potential of harm, particularly if serious, justifies a stricter approach that features a narrower definition of competency and that does not erect as strong a presumption in its favor. When a proposed revocation or amendment of an advance directive instrument presents a serious risk to the individual's welfare, considerations of beneficence may justify an inquiry into competency before the revocation or amendment is deemed effective.

For these reasons, there should be greater scrutiny of the competency of individuals seeking to reject a therapeutic intervention they previously chose in an advance directive instrument than of patients changing their minds in favor of hospitalization or treatment, and a more demanding standard of competency should be employed. The presumption of competence should apply in this inquiry, but the level of evidence required to rebut it should be reduced. If, pursuant to this more demanding standard, the patient is found to be competent, then the patient's presently expressed objection should take precedence over his or her previously expressed assent. On the other hand, if the patient's is found to be incompetent, then the previously expressed assent should take precedence, unless an unanticipated change in circumstances would reasonably have led the patient to choose otherwise had he or she anticipated it.¹²²

One problem with this differential approach between assent and objection is that it might both mask and facilitate coercion. As previously indicated, family members and clinical staff will sometimes pressure the patient to accept hospitalization or treatment that the patient does not want. Patients in a questionable state of competence, or who are incompetent, will be especially vulnerable to these pressures. Requiring that changes from objection to assent be notarized might provide a degree of protection, at least against the most overt forms of coercion. For patients interested in additional protection against coercion, the modified form of "irrevocable" advanced directives previously dis-

122. See *supra* notes 59-94 and accompanying text.

cussed could be selected.¹²³ Such an instrument, as previously indicated, would not be truly irrevocable; rather, it would require judicial or administrative approval for revocation or modification.¹²⁴ This approval process would provide a degree of scrutiny that would diminish the potential for coercion.

VI. CONCLUSION

Although many details concerning the drafting, use, modification, and revocability of advance health-care directives remain to be worked out, these instruments present an exciting new mechanism for dealing with hospital and treatment refusal issues in the mental health area. The importance of these instruments will surely expand in the future. *Cruzan's* endorsement and popularization of the living will has led to statutory acceptance of advance health-care instruments generally.¹²⁵ Although their extension to the context of mental health treatment has not yet been fully accepted and raises problems,¹²⁶ a broad area exists in

123. See *supra* notes 105-10 and accompanying text.

124. See *supra* text accompanying note 106.

125. See, e.g., 42 U.S.C. §§ 1395cc(f) & 1396a(w) (1994). This federal statute, called the Patient Self-Determination Act (the "PSDA"), is an amendment to the Social Security Act, which established the Medicare and Medicaid programs, and applies to entities participating in the Medicare and Medicaid programs. See *id.* Any service provider participating in Medicare or Medicaid is considered an entity. See Hoge, *supra* note 40, at 578. Although some mental health providers and institutions may not realize that the PSDA applies to them, the act covers all service providers delivering Medicaid and Medicare reimbursable services without limitation. See *id.* at 578-79. The PSDA defines advance directives as written instruments, recognized under state law, relating to incapacitated individuals' health care. See 42 U.S.C. § 1395cc(f)(3). The PSDA seeks to facilitate and promote the use of advance directive instruments by requiring covered providers to inform patients about state law concerning such instruments and to educate the public about their use. See Hoge, *supra* note 40, at 579.

For state statutes authorizing use of such advance directive instruments, see, for example, ALA. CODE §§ 22-8A-1 to 22-8A-10 (1996); ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (West 1996); CAL. HEALTH & SAFETY CODE §§ 7185-7194.5 (West 1996); FLA. STAT. ch. 765 (1995); GA. CODE ANN. §§ 31-32-1 to 31-32-12 (1996); 755 ILL. COMP. STAT. ANN. 40/1-55 (West 1992); MINN. STAT. §§ 145B.01-.17 (1993); MO. REV. STAT. §§ 459.010-459.055 (1995). See also MEISEL, *supra* note 20, at 314-19; Perling, *supra* note 16, at 209. Under some of these statutory provisions, hospitals and other service providers are required to ascertain whether a patient has executed a prior advance directive instrument, obtain a copy, and retain it in the patient's file. The PSDA requires covered providers to document in the patient's medical chart whether he or she has executed an advance directive instrument. 42 U.S.C. § 1395(f)(1)(B).

An additional innovation that would facilitate the implementation of the patient's wishes would be a requirement that the state note in its state mental health computer system that a patient has executed an advance directive instrument. When patients are presented at a hospital or other mental health facility, the facility could be required to check the state computer system to ascertain whether the patient has executed an advance directive and to obtain a copy of the instrument.

126. For example, one significant concern is an individual's ability to anticipate future circumstances and account for all contingencies. See Appelbaum, *supra* note 33, at 983. As the use of these instruments becomes more widespread, lawyers and health-care professionals

which the use of such instruments by mental patients would be both constitutionally protected and therapeutically advantageous.¹²⁷

As people become more familiar with mental illness and the potential that they or a close family member may encounter it, the demand for legal mechanisms to deal with future hospitalization and treatment will cause legislatures and courts to facilitate the use of advance directives in the mental health context. Most people execute a will or engage in some kind of estate planning in contemplation of death. While mental illness is not as certain as death, the likelihood that it will affect us is considerable. With one in four adult Americans suffering from mental illness each year—one in twenty encountering it for the first time¹²⁸—planning for this problem is something everyone should consider, particularly in light of current legal uncertainties and pitfalls. Advance directive instruments in this area therefore represent the future direction of mental health law.

experienced in their use can help guide individuals through the process of planning and drafting the instrument. Advance directive instrument forms with optional provisions and riders, and checklists, will be developed to guide individuals preparing them. These forms, of course, will need to be tailored to the patient's circumstances, and changes in treatment modalities may be difficult to foresee, but the process of attempting to do so can have therapeutic value.

127. Some psychiatrists have responded negatively to the use of advance directive instruments in the mental health treatment context. See, e.g., Paul Chodoff & Roger Peele, *The Psychiatric Will of Dr. Szasz*, 13 HASTINGS CTR REP. 11 (1983). However, because these instruments, for the reasons discussed in *supra* Part IV, may have therapeutic value, this negative response is unjustified. See Hoge, *supra* note 40, at 585 (stating that psychiatrists should share the PSDA's goal of promoting patient autonomy). Viewed properly, these instruments can provide an important therapeutic opportunity. Therefore, therapists should welcome, rather than resist them.

128. See *supra* notes 1-4 and accompanying text.