

MENTAL HEALTH ADVANCE DIRECTIVES: A FALSE SENSE OF AUTONOMY FOR THE NATION'S AGING POPULATION

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Currently, one in four American adults suffer from mental illness each year. Experts predict that the number of people over sixty-five with psychiatric disorders will reach fifteen million in 2030. Treatment of such illnesses can have serious side effects, which makes it necessary to have the informed consent of the patient before administering treatment. In this note, Elizabeth Rosenfeld examines the effectiveness of mental health advance directives, which have become more popular over the past ten years, in solving the problem of informed consent among the mentally impaired. Thus far, Illinois is among ten states which have enacted such legislation in an effort to resolve conflicts regarding mental health treatment. Ms. Rosenfeld argues that while the theory behind these statutes of ensuring that the patient's wishes are met without resorting to the courts may be positive, the actual value of mental health advance directives is questionable. In reaching this conclusion, Ms. Rosenfeld explores the movement behind the enactment of the Illinois Mental Health Treatment Preference Act, as well as the issues that have arisen since it became law in 1996. She then

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concludes that the main problem with mental health advance directives is that they protect health care providers rather than patients. Therefore, she argues that the patient must become the Acts' primary concern, or the Acts must be abolished.

I. Introduction

What would you do if Lucille Austwick¹ were your mother? In 1993, this eighty-one-year-old woman was diagnosed with chronic depression and dementia.² According to her doctors, this condition leads to withdrawal from others, paranoia, suspicion, forgetfulness, impaired judgment, and the inability to distinguish right and wrong.³ The treatment recommended by her doctors was electroconvulsive therapy (ECT), "a procedure in which an electrical stimulus is used to induce a cerebral seizure."⁴ But Lucille refused to accept medication, nutrition, and hydration.⁵ She said, "I am wise enough to make [the] decision for myself. I don't need anybody to make the decision for me."⁶ Despite Lucille's refusal, her best interests became the focus of two years of litigation, as courts assigned her a public guardian and then disputed the use of ECT.⁷ On appeal, the court held that the determination that ECT was in Lucille's best interests was manifestly erroneous.⁸

In 1996, the year following this confusing and controversial case, the Illinois Legislature enacted the Mental Health Treatment Preference Declaration Act⁹ (Act) to deal with such disputes before they arise. To date, Illinois and nine other states offer mental health ad-

1. See *In re Estate of Austwick*, 656 N.E.2d 779 (Ill. App. Ct. 1995).

2. See *id.* at 781; see also *infra* notes 58–65 and accompanying text (discussing these illnesses).

3. See *Austwick*, 656 N.E.2d at 781.

4. *Id.* ECT is one of the treatments that a principle may request or refuse under the Illinois' Mental Health Treatment Preference Declaration Act enacted in 1996. See generally 755 ILL. COMP. STAT. 43/1-115 (West 1998).

5. See *Austwick*, 656 N.E.2d at 781; see also *infra* notes 26–48 and accompanying text (discussing the constitutional grounds for refusal of medical treatment).

6. *Austwick*, 656 N.E.2d at 782.

7. See *id.*; see also note 18 and accompanying text (discussing the process of guardianship).

8. See *In re Estate of Austwick*, 656 N.E.2d 779, 786 (Ill. App. Ct. 1995). "Best interests" determinations can be made by a surrogate decisionmaker. See *infra* note 19 and accompanying text.

9. 755 ILL. COMP. STAT. 43/1-115.

vance directives to their citizens.¹⁰ In theory, such legislation resolves conflicts regarding mental health treatment without resorting to the courts.¹¹ Acting as a very specific advance directive, a mental health advance directive ensures the patient's expression of her wishes so that health professionals can act accordingly.¹²

The Illinois Act serves as a model—for better or worse—of one state's mental health advance directive.¹³ This note argues that statutes like the Illinois Act afford no real legal protection, but, at most, offer only a psychological benefit of questionable value. First, this note examines the Constitutional basis for general advance directives, the purposes behind a directive specific to mental health, and the influences behind this particular Act. Second, this note sorts through many difficult and unresolved issues pertaining to mental health advance directives. Third, this note concludes that the problematic areas surrounding mental health advance directives are so numerous that such laws ought to be repealed.

II. Background: The Origins of The Mental Health Treatment Preference Declaration Act

A. The Need for Advance Directives

Ten years ago, living wills and advance directives were quite uncommon.¹⁴ The long-standing doctrine of informed consent pro-

10. See ALASKA STAT. § 47.30.950–980 (Michie 2000); HAW. REV. STAT. ANN. § 327F (Michie 2000); IDAHO CODE §§ 66-601 to -613 (2000); 755 ILL. COMP. STAT. 43/1-115 (West 1998); MINN. STAT. ANN. § 253B.03(6)(d) (West 1998 & Supp. 2000); N.C. GEN. STAT. §§ 122C-71 to -77 (1999); OKLA. STAT. ANN. tit. 43A, §§ 11-101 to -113 (West Supp. 2001); OR. REV. STAT. § 127.700–737 (1999); TEX. CIV. PRAC. & REM. CODE ANN. §§ 137.001–.011 (West Supp. 2000); UTAH CODE ANN. §§ 62A-12-501 to -504 (2000).

11. See *infra* Part II.

12. See *infra* notes 71–81 and accompanying text. *But see* discussion *infra* Part III.B.4 (explaining why providers might not comply with the patient's express wishes).

13. Illinois has the most comprehensive directive of this type. See *infra* notes 82–86 and accompanying text (describing the many choices a patient may make under the Illinois Act); *cf.* ALASKA STAT. § 47.30.950–980; HAW. REV. STAT. ANN. § 327F; IDAHO CODE §§ 66-601 to -613; MINN. STAT. ANN. § 253B.03(6)(d); N.C. GEN. STAT. §§ 122C-71 to -77; OKLA. STAT. ANN. tit. 43A, §§ 11-101 to -113; OR. REV. STAT. § 127.700–737; TEX. CIV. PRAC. & REM. CODE ANN. §§ 137.001–.011; UTAH CODE ANN. §§ 62A-12-501 to -504.

14. See generally LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 25–44 (2d ed. 1999). It is commonly stated that the Supreme Court's

vides that competent patients are entitled to make their own health decisions.¹⁵ Accordingly, all persons are presumed competent to consent to or refuse treatment,¹⁶ and doctors must respect competent patients' refusals of treatment.¹⁷ If doctors or loved ones want to override a patient's refusal on the basis of competency, they have to seek a guardianship arrangement.¹⁸ In those cases where incompetence is legally determined, consent or refusal of medical treatment may be made on the patient's behalf.

The decision to treat an incapacitated person can be justified under two legal standards.¹⁹ Under the standard of "best interests," a surrogate decisionmaker weighs the benefits and risks of the treatment to decide what is in the best interests of the patient.²⁰ The standard of "substituted judgment" asks the surrogate to consider what the patient would choose, were the patient able to make this decision.²¹ The court must also balance the patient's best interests against the interests of the State in preserving life.²² This amount of judicial involvement consumes great quantities of personal and judicial resources and offers little in the way of certainty.

An early case examining consent to mental health treatment is *In re Guardianship of Roe*.²³ In *Roe*, the Massachusetts Supreme Court considered its ability to force antipsychotic drug treatment on incapaci-

decision in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), marked the beginning of the advance directive era.

15. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914). Judge Cardozo's famous rule states: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body[.]" *Id.*

16. See generally *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978). See also FROLIK & KAPLAN, *supra* note 14, at 23. But see *infra* note 87, for a comment regarding the less presumptive standard afforded to elderly patients.

17. See *Lane*, 376 N.E.2d at 1234 (holding that the patient fully appreciated the consequences of her decision).

18. See generally FROLIK & KAPLAN, *supra* note 14, at 224-28.

19. See DONALD H. J. HERMANN, *MENTAL HEALTH AND DISABILITY LAW IN A NUTSHELL* 187 (West 1997).

20. See *id.* This approach is seriously limited in that many risks and benefits cannot be calculated objectively.

21. See *id.* This standard relies on statements the patient made previously about being in such a condition. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 271 (1990). It requires forward thinking on the part of the patient. Moreover, one's thoughts concerning treatment may change drastically once the need for such treatment arises.

22. See HERMANN, *supra* note 19 at 271; see also *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

23. 421 N.E.2d 40 (Mass. 1981).

tated patients.²⁴ The court held that the substituted judgment standard could be used to determine that the patient would have consented to the treatment.²⁵

Nine years later, in the landmark case *Cruzan v. Missouri Department of Health*, the Supreme Court considered whether a patient has a constitutional right to refuse medical treatment such that a hospital is required to withdraw treatment.²⁶ In that case, the parents of a young woman in a persistent vegetative state sought permission to *refuse* treatment on their daughter's behalf.²⁷ The Supreme Court granted certiorari to decide whether the Constitution provides a patient the right to die.²⁸ While it never answered that specific question, the Court did articulate three important holdings. First, a competent person can refuse medical treatment.²⁹ Second, a state can require clear and convincing evidence that the patient wants to terminate treatment.³⁰ Third, a state may prevent family members from making a decision on the patient's behalf.³¹ Following the *Cruzan* decision, every state developed law in the area of advance directives and living wills.³² These documents are intended to outline a person's medical wishes and bypass the uncertainties of litigation.

Although the Court in *Cruzan* suggested a Fourteenth Amendment fundamental right for a competent person to refuse treatment, the Court did not specifically address whether a right exists for an institutionalized mentally incompetent person to refuse treatment.³³ Courts must look to *Rennie v. Klein*³⁴ or *Rogers v. Okin*³⁵ to answer this question. In *Rennie*, the United States Court of Appeals for the Third Circuit limited a patient's right to refuse treatment.³⁶ A patient may only make such a determination absent an emergency or a situation in which the patient poses a threat to himself or others.³⁷ This approach

24. See HERMANN, *supra* note 19, at 187.

25. See *In re Guardianship of Roe*, 421 N.E.2d at 60.

26. See *Cruzan*, 497 U.S. at 277.

27. See *id.* at 267–68. A right to *refuse* treatment on someone's behalf is accorded less legal certainty than a right to *consent* to treatment for that person.

28. See *id.* at 265.

29. See *id.* at 270.

30. See *id.* at 284.

31. See *id.*

32. See FROLIK & KAPLAN, *supra* note 14, at 29.

33. See HERMANN, *supra* note 19, at 189.

34. 720 F.2d 266 (3d Cir. 1983).

35. 634 F.2d 650 (1st Cir. 1980).

36. See *Rennie v. Klein*, 720 F.2d 266, 269–70 (3d Cir. 1983).

37. See *id.*

emphasizes the role of professional judgment.³⁸ In *Rogers*, the First Circuit Court of Appeals held that institutionalized patients have a right to privacy.³⁹ Accordingly, it held that a patient's refusal may only be overcome by an emergency or after finding a guardian who consents to treatment.⁴⁰ This approach places ultimate authority in the hands of the court rather than with mental health professionals.⁴¹ Despite the apparent divergence in these approaches, both arrive at the conclusion that an emergency situation may trump a patient's request. The *Rogers* court defined "emergency" broadly, so that virtually any situation before a court could be so classified.⁴² The effect of these decisions is that patients may not refuse treatment when they are being treated for mental illness.

Another approach used by those seeking greater patient autonomy is a First Amendment argument to control one's treatment. Under the freedom of religion clause, a competent patient may base his refusal of treatment on religious grounds.⁴³ Also, an institutionalized mentally ill patient may refuse treatment after a court considers certain factors.⁴⁴ Courts normally examine the consequences of the refusal of treatment, whether the patient has previously refused such treatment on religious grounds prior to becoming incompetent, and whether the patient "adhered to the tenets of his faith before becoming incompetent."⁴⁵

Along these same lines, courts have also considered a First Amendment freedom of thought argument regarding the refusal of treatment.⁴⁶ The District Court in *Rogers* articulated: "[W]hatever powers the Constitution has granted our government, involuntary

38. See *id.*; see also HERMANN, *supra* note 19, at 192.

39. See *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980).

40. See *id.* at 661.

41. See HERMANN, *supra* note 19, at 192. Who is better equipped to make these medical decisions? Are these really questions of medical certainty, or are they simply questions of patient autonomy and a right to informed consent?

42. See *Rogers*, 634 F.2d at 659. The First Circuit rejected the district court's definition of "emergency" as "circumstances in which a failure to (forcibly medicate) would bring about a substantial likelihood of physical harm to the patient or others." Instead, the appellate court chose to broaden the definition to "also include situations in which the immediate administration of drugs is reasonably believed to be necessary to prevent further deterioration in the patient's mental health." See *id.* at 659-60.

43. See HERMANN, *supra* note 19, at 195.

44. See *id.*

45. *Id.*

46. See *id.* at 195-96.

mind control is not one of them, absent extraordinary circumstances . . . medically sound treatment of a mental disease is not, itself, an extraordinary circumstance warranting an unsanctioned intrusion on the integrity of a human being.”⁴⁷ Although arguments in support of a “fundamental right to freedom of thought” often fail under a strict scrutiny approach in which the State has a compelling interest in preventing harm to these patients, psychiatry remains an imprecise science and should not override an individual’s interest in mind control.⁴⁸

Cases involving mental health treatment reveal, at best, a grueling, uncertain approach to articulating and enforcing a patient’s interests. In reaction to these difficult decisions, many states now afford the elderly an opportunity to arrange for substituted decisionmaking prior to the onset of incompetence, thus minimizing the need for court intervention.

B. Mental Health Advance Directives for the Elderly

More than one in four adult Americans suffer from mental illness each year.⁴⁹ This prevalence suggests the need for heightened awareness of medical options. Treatments for mental illness are not without side effects. Side effects of ECT⁵⁰ include “fractures, memory loss, confusion, delirium, and, in rare cases, death.”⁵¹ “[S]ide effects of psychotropic drugs include tardive dyskinesia, an involuntary movement of limbs, tongue, and mouth; drowsiness; dizziness; dry mouth; loss of sexual desire; apathy; depression; and bowel dysfunction.”⁵²

Given such dire consequences, informed consent is especially critical. Advance directives can be used to elicit patients’ desires while the patients are competent. Patients can authorize certain treatments while avoiding unwanted treatment. Mental health directives also overcome “disease-induced refusal.”⁵³ With mental illness

47. *Rogers v. Okin*, 478 F. Supp. 1342, 1367 (Mass. Dist. Ct. 1979).

48. HERMANN, *supra* note 19, at 196.

49. See Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57, 57 (1996).

50. See *supra* note 4 and accompanying text.

51. *In re Estate of Austwick*, 656 N.E.2d 779, 781 (Ill. App. Ct. 1995).

52. *Id.* at 783.

53. Roberto Cuca, *Ulysses in Minnesota: First Steps Toward A Self-Binding Psychiatric Advance Directive Statute*, 78 CORNELL L. REV. 1152, 1153 (1993).

in particular, the disease itself may be the reason that the patient refuses treatment—a directive “serves as a record of the patient’s pre-incompetent consent.”⁵⁴ The directives are often termed “Ulysses directives,” derived from *The Odyssey*, in which Ulysses orders his men to lash him to the mast and not release him despite what he may say while he is under the spell of the Sirens.⁵⁵ Mental health advance directives allow competent people to contemplate what care they receive in the event of incompetence.⁵⁶

Mental health advance directives are particularly important to the country’s aging population. Approximately six million elderly people were afflicted with mental disorders in 1990.⁵⁷ The elderly do not suffer from severe psychotic or anxiety disorders as often as the general population, but they do suffer from and are at a high risk for depression and dementia.⁵⁸

Many elderly people are afflicted with depression. As many as twenty-five percent of the elderly are clinically depressed at any given time, and at some point during their old age, sixty percent of the elderly suffer depression.⁵⁹ Depression may result from loss of an indi-

54. *Id.* Whether pre-incompetent consent should trump the patient’s refusal is addressed by Nancy K. Rhoden. See Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845 (1990).

55. The reference to Ulysses comes from the following passage of *The Odyssey*:

Listen to what I say, and God himself shall help you remember. First you will meet the Sirens, who cast a spell on every man who goes their way. Whoso draws near unwarned and hears the Sirens’ voices, by him no wife or little child shall ever stand, glad at his coming home; for the Sirens cast a spell of penetrating song, sitting within a meadow. But by their side is a great heap of rotting human bones; fragments of skin are shriveling on them. Therefore sail on, and stop your comrades’ ears with sweet wax kneaded soft, that none of the rest may hear. As for yourself, if you desire to listen, see that they bind you hand and foot on the swift ship, upright upon the mast-block,—round the mast let the rope’s ends be wound,—that so with pleasure you may hear the Sirens’ song. But if you should entreat your men and bid them set you free, let them thereat with still more fetters bind you fast.

HOMER, *THE ODYSSEY* 505 (George H. Palmer trans., 1886).

In a medical situation, “[t]he Ulysses contract is intended to allow a physician to ignore the treatment refusals of an incompetent patient when the patient’s illness is the source of the refusals.” See Cuca, *supra* note 53, at 1163–64.

56. See Cuca, *supra* note 53, at 1162–63.

57. See Bruce Bower, *Warning on Elderly Mental Health*, SCI. NEWS, Sept. 18, 1999, at 189.

58. See Linda F. Smith, *Representing the Elderly Client and Addressing the Question of Competence*, 14 J. CONTEMP. L. 61, 68 (1988).

59. See *id.* at 69.

vidual's physical vitality,⁶⁰ loss of a spouse, or an inability to live independently.⁶¹ However, just as treatment proves successful for younger patients of depression, treatment is also effective for depressed elderly patients.⁶²

In addition to depression, many elderly people suffer from dementia. Defined as chronic degenerative diseases involving progressive deterioration of all intellectual functions, forms of dementia affect as many as twenty percent of the over-eighty population in the general community and seventy percent of nursing home residents.⁶³ The two most common dementias are Alzheimer's,⁶⁴ a general deterioration of the brain, and multi-infarct dementia, which involves death of brain tissue as a result of a stroke.⁶⁵

With the elderly population growing,⁶⁶ experts predict that the number of people over age sixty-five with psychiatric disorders will reach fifteen million in 2030.⁶⁷ The predicted "crisis in geriatric mental health"⁶⁸ is a culmination of several factors. University of California, San Diego, psychiatrist Dilip Jeste attributes this alarming increase to a greater number of aging mentally ill young adults, more late-life mental ailments resulting from prescription drugs, and continued substance abuse of some baby boomers.⁶⁹ An alarming 275 percent jump in psychiatrically ill elderly is forecast from 1970 to 2030.⁷⁰ Consequently, now is the time for baby boomers to consider the treatments for mental illness and execute advance directives detailing their wishes.

60. *See id.* at 62.

61. *See id.* at 69.

62. *See id.*

63. *See id.* at 70.

64. *See id.*

65. *See id.* at 71.

66. *See* Arlene S. Kanter, *Abandoned But Not Forgotten: The Illegal Confinement of Elderly People in State Psychiatric Institutions*, 19 N.Y.U. REV. L. & SOC. CHANGE 273, 274 (1991/1992).

67. *See Rise in Mental Illness Expected for Elderly*, S.F. CHRON., Sept. 26, 1999, at 21A.

68. *Id.*

69. *See id.*

70. *See id.*

C. The Movement Behind the Illinois Mental Health Treatment Preference Declaration Act

Like other states,⁷¹ Illinois enacted an advance directive statute to deal specifically with mental health treatment. At the time the bill was introduced, Illinois allowed living wills⁷² and a power of attorney for health care,⁷³ but it wanted to create legislation similar to that already in place in the state of Oregon.⁷⁴ The original intent of the Illinois statute, as articulated by Representative Krause, was to make “a piece of legislation that goes a long way to help us make our own determination [sic] as they relate in the field of health services.”⁷⁵

This idea of greater autonomy to control one’s own destiny garnered much support in the Illinois House of Representatives. Outside supporters of the Act included the Alliance for the Mentally Ill of Illinois, the Department of Mental Health and Developmental Disabilities, the Illinois State Medical Society, and the Illinois Association of Community Mental Health Agencies.⁷⁶ By a sweeping majority, the eighty-ninth General Assembly enacted the Act, which went into effect on June 1, 1996.⁷⁷

The Act allows any adult of “sound mind” to explicitly declare her preferences regarding mental health treatment.⁷⁸ The Act grants the principal the option to consent to or refuse three types of treatment: electroconvulsive therapy (ECT), psychotropic medication, or admission to a mental health facility for up to seventeen days.⁷⁹ Addi-

71. See sources cited *supra* note 10.

72. See Illinois Living Will Act, 755 ILL. COMP. STAT. 35/1-10 (West 1998).

73. See Powers of Attorney for Health Care Law, 755 ILL. COMP. STAT. ANN. 45/4-1 to 4-12 (West 1996 & Supp. 1997).

74. See S. Transcript, 89th Gen. Assem. (Ill. 1995) [hereinafter S. Transcript] (referring to OR. REV. STAT. §§ 127.700-.735 (1999)).

75. *Id.*

76. See *id.*

77. See Roger R. Clayton et al., *Survey of Illinois Law: Health Care Law*, 22 S. ILL. U. L.J. 939, 939-55 (1998).

78. 755 ILL. COMP. STAT. 43/10(1) (West 1996) states: “An adult of sound mind may make a declaration of preferences or instructions regarding mental health treatment. The preferences or instructions may include consent to or refusal of mental health treatment.” The determination that someone is “of sound mind” is addressed in Part III.A.

79. See 755 ILL. COMP. STAT. 43/5(7) (West 1996) states: “‘Mental health treatment’ means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a mental health facility for a period not to exceed 17 days for care or treatment of mental illness.” Although this portion of the Act specifies a seventeen-day duration, the provider’s incentive under Medicare is to exhaust the patient’s 190-day reserve. See *infra* notes 142-44 and accompanying text.

tionally, the Act permits the designation of an attorney-in-fact.⁸⁰ The designee may execute these written preferences or, in the absence of such direction, act in the best interests of the principal.⁸¹ Through these avenues, the Illinois legislators hoped to give clarity, certainty, and force to the principal's preferences.⁸²

III. Analysis

The Act attempts to accomplish many objectives. The form of declaration included in the Act highlights these details.⁸³ With respect to each of the treatment types—psychotropic medications, ECT, and admission to facilities—the Act prompts a declaration of assent or refusal and any conditions or limitations desired by the principal.⁸⁴ The principal may then select a physician to determine capacity and may provide additional references or instructions.⁸⁵ Next, the principal may appoint an attorney-in-fact to make decisions and an alternative person in case of refusal, inability, or revocation.⁸⁶ Finally, the form allows for revocation, in full or in part, if a physician certifies that the principal is capable of making such a revocation.⁸⁷ Because the objectives are now somewhat obscured, each of these aspects deserves closer consideration.

80. 755 ILL. COMP. STAT. 43/15 (West Supp. 2000) states:

A declaration may designate a competent adult to act as attorney-in-fact to make decisions about mental health treatment. An alternative attorney-in-fact may also be designated to act as attorney-in-fact if the original designee is unable to act at any time. An attorney-in-fact who has accepted the appointment in writing may make decisions about mental health treatment on behalf of the principal only when the principal is incapable. The decisions must be consistent with any desires the principal has expressed in the declaration.

81. *See id.*; *see also* 755 ILL. COMP. STAT. 43/30(4) (West 1996), which states:

In exercising authority under the declaration, the attorney-in-fact has a duty to act consistently with the desires of the principal as expressed in the declaration. If the principal's desires are not expressed in the declaration and not otherwise known by the attorney-in-fact, the attorney-in-fact has a duty to act in what the attorney-in-fact in good faith believes to be the best interests of the principal.

82. *See* S. Transcript, *supra* note 74.

83. *See* 755 ILL. COMP. STAT. 43/75 (West 1996).

84. *See id.*

85. *See id.*

86. *See id.*

87. *See id.*

A. Ambiguity Surrounding Invocation

An adjudicated incompetent loses more rights than the typical prisoner. An accused murderer enjoys a presumption of innocence as well as a heavy state burden to prove guilt beyond a reasonable doubt. The elderly, on the other hand, are not always presumed competent, and the burden of proof is universally less strict. If the elderly person wishes to contest the appointment of a guardian, the process is necessarily an adversarial one⁸⁸

The declaration can be invoked when either two physicians or a court determines that the principal lacks the capacity to make decisions concerning treatment.⁸⁹ In the declaration, the principal may select one of these two physicians to make this determination.⁹⁰ The Act is not clear regarding how capacity will be determined. Perhaps mental health advance directives will adopt a competency standard from another area of law.⁹¹

Capacity is central to many legal issues. For example, one's ability to render competent authority is critical to conveying property,⁹² to creating a valid will,⁹³ or to giving informed consent to medical care.⁹⁴ Capacity is also a large component of juvenile jurisprudence for everything from consent to medical experimentation⁹⁵ to the use of the death penalty in the juvenile justice system.⁹⁶ The fundamental as-

88. Mark D. Andrews, *The Elderly in Guardianship: A Crisis of Constitutional Proportions*, 5 *ELDER L.J.* 75, 93-94 (1997).

89. 755 ILL. COMP. STAT. 43/5(5) (West 1996) states: "'Incapable' means that, in the opinion of 2 physicians or the court, a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions." See also 755 ILL. COMP. STAT. 43/25 (West 1996), which states: "The attending physician shall act in accordance with an operative declaration when the principal has been found to be incapable."

90. See 755 ILL. COMP. STAT. 43/75 (West 1996).

91. The mental health advance directive in Texas provides:

"Incapacitated" means that, in the opinion of the court in a guardianship proceeding under Chapter XIII, Texas Probate Code, or in a medication hearing under Section 574.106, Health and Safety Code, a person lacks the ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, and lacks the ability to make mental health treatment decisions because of impairment.

TEX. CIV. PRAC. & REM. CODE ANN. § 137.001(6) (West Supp. 2000). Can a determination be made without a hearing or court's opinion?

92. See FROLIK & KAPLAN, *supra* note 14, at 250.

93. See *id.* at 23.

94. See *id.*

95. See Dennis H. Langer, *Medical Research Involving Children*, 36 *BAYLOR L. REV.* 1, 9 (1984).

96. See *Stanford v. Kentucky*, 492 U.S. 361, 374 (1989).

pects of judging the competency of minors are actual ability to understand and the ability to make a voluntary decision.⁹⁷ At the other end of this area of law is determining the capacity of impaired adults. These persons, for reasons of age and mental illness, may be thought of as incompetent. The legal presumption is that all adults are competent absent a strong showing to the contrary.⁹⁸

The issue of capacity is particularly important in the context of this Act, since the principal must be competent to make a declaration,⁹⁹ and she must be incompetent to invoke the declaration.¹⁰⁰ The presumption of competency allows the principal to articulate her preferences, yet incompetence cannot be presumed in the same way to invoke the declaration. Thus, a determination of incompetence is needed to invoke a declaration. Tests for competency include: (1) whether a patient is able to express a decision; (2) whether a patient actually understands the treatment and the alternatives to treatment; (3) whether a patient appreciates the implications of alternative choices; and (4) whether the decision is one that reasonable people would make.¹⁰¹ Because a test for this determination is not articulated in the Act, health care providers need clear standards for judging incompetence.¹⁰²

B. Limits on Enforceability

In light of the many potential conflicts of interest and practical obstacles, directives established under the Act may not provide the strength they purport to give patients.

97. See Langer, *supra* note 95, at 8.

98. See FROLIK & KAPLAN, *supra* note 14, at 225.

99. 755 ILL. COMP. STAT. 43/10(1) (West 1996) states: "An adult of sound mind may make a declaration of preferences or instructions regarding mental health treatment."

100. 755 ILL. COMP. STAT. 43/25 (West 1996) states: "The attending physician shall continue to obtain the principal's informed consent to all mental health treatment decisions if the principal is capable of providing informed consent or refusal."

101. See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 24 (1991).

102. Embedded in this problem is the issue of portability. Because competency standards vary from state to state, these directives may not be enforceable out of state. See *infra* Part III.B.3 for a discussion of other aspects of access and portability not addressed by the Act.

1. CONFLICTS OF INTEREST

When the declaration is invoked, the principal's preferences are supposed to be followed unless there is a contradictory court order¹⁰³ or an emergency situation.¹⁰⁴ Although these exceptions may seem to be narrow at first glance, the reality is that nearly any situation involving incapacity and mental treatment can fall within one of these two categories.¹⁰⁵ Certainly Lucille's daughter would seek a court order and argue that her mother's situation is an emergency. There is almost always a compelling argument that someone's life or health will be endangered without necessary treatment.¹⁰⁶

Another potential limit on the enforceability of a declaration is conflict between an agent named under the Act¹⁰⁷ and an agent named as the durable power of attorney for health care.¹⁰⁸ According to the language of the Illinois Power of Attorney Act, it supersedes all other statutes to the extent that those statutes are in conflict with it.¹⁰⁹ One solution to this conflict is to allow the person named under the Act to

103. See 755 ILL. COMP. STAT. 43/45(a) (West 1998).

104. 755 ILL. COMP. STAT. 43/45(1)(b) states: "The physician or provider may subject the principal to mental health treatment in a manner contrary to the principal's wishes as expressed in a declaration for mental health treatment only: . . . (b) In cases of emergency endangering life or health." See also OR. REV. STAT. § 127.720 (1999); UTAH CODE ANN. § 62A-12-503(2)(b) (2000).

105. See 405 ILL. COMP. STAT. 5/2-107 (West 1999) (providing refusal of treatment except where there is imminent danger to oneself or others). More often than not, refusal of treatment results in some harm to oneself. Are we supposed to look at physical danger? Emotional danger? A person who receives treatment to which she does not consent may suffer emotional harm. On the other hand, her loved ones may suffer emotional harm if she does not undergo the treatment—which may constitute danger to others.

106. See *supra* note 32 and accompanying text. The Texas mental health advance directive statute states that a physician may ignore a declaration "in case of an emergency when the principal's instructions have not been effective in reducing the severity of the behavior that has caused the emergency." TEX. CIV. PRAC. & REM. CODE ANN. § 137.008(a)(2) (West 2001). This means that a doctor may ignore a principal's refusal of treatment whenever that refusal increases the severity of the behavior. Also, the execution of a declaration may hinge on the definition of "emergency."

107. 755 ILL. COMP. STAT. 43/15 (West 1998).

108. See Rebecca J. O'Neill, *Surrogate Health Care Decisions for Adults in Illinois—Answers to the Legal Questions That Health Care Providers Face on a Daily Basis*, 29 LOY. U. CHI. L.J. 411, 441 (1998).

109. See 755 ILL. COMP. STAT. 45/4-11 (West 1998); see also HAW. REV. STAT. ANN. § 327F-16 (Michie 2000); OKLA. STAT. ANN. tit. 43A, § 11-106(E)(III) (West Supp. 2001); TEX. CIV. PRAC. & REM. CODE ANN. § 137.009 (West 2001). But see ALASKA STAT. § 47.30.970 (Michie 1998) (asking the principal to choose whether an attorney-in-fact appointed under a mental health declaration should jointly or separately from an attorney-in-fact appointed under a general power-of-attorney).

make all of the decisions pertaining to the principal's mental health.¹¹⁰ However, the Act designates only a limited number of treatments, and many mental health decisions are outside this scope.¹¹¹ One thing is clear: the principal must anticipate this potential conflict and explicitly state her agent's limitations in her health care preference instruments so that these conflicts are avoided.¹¹²

2. STATE INTERESTS

The state's *parens patriae* power allows it to act in ways which preserve mainstream values.¹¹³ In most cases, the state does not want people to refuse medical treatment.¹¹⁴ Medicine is generally viewed as necessary to promoting health and life, and the state has an interest in the preservation of all life.¹¹⁵ For many, to allow refusal of these services would be to denounce the importance of medicine and devalue life.¹¹⁶ The high value society places on medicine allows the state to override refusal preferences made explicit by a principal in her declaration.¹¹⁷

The state has a significant *parens patriae* interest in providing medicine to persons who, because of serious mental illness, lack the capacity to make rational decisions regarding their need for medication.¹¹⁸ This interest may be sufficient to overcome an individual's interest in refusing electroconvulsive shock therapy. The Mental Health and Developmental Disabilities Code¹¹⁹ states:

No recipient of services shall be subjected to electro-convulsive therapy, or to any unusual, hazardous, or experimental services or psychosurgery, without his written or informed consent. If the recipient is a minor or is under guardianship, such recipient's parent or guardian is authorized, only with the approval of the court, to provide informed consent for participation of the ward

110. See O'Neill, *supra* note 108, at 441.

111. See *id.*

112. See *id.* at 442. Avoiding these conflicts before they arise requires a tremendous amount of foresight on the part of the principle.

113. See, e.g., O'Connor v. Donaldson, 422 U.S. 563, 573-74 (1975) (discussing traditional justifications for statutes permitting involuntary commitment advanced by states).

114. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990).

115. See *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997).

116. See *id.*

117. See *id.*

118. See *In re Branning*, 674 N.E.2d 463, 468 (Ill. App. Ct. 1996).

119. 405 ILL. COMP. STAT. 5/2-110 (West 1994).

in any such services which the guardian deems to be in the best interests of the ward.¹²⁰

Under this Code, Lucille's daughter could very well convince a court that the state's interest was at stake in forcing treatment on her mother.

The effect of this *parens patriae* on the Act is unclear. The state may override an individual's refusal of treatment if that individual is incompetent.¹²¹ The state may not force treatment on a person who is able to make rational decisions *and* presents no danger to herself or others.¹²² While the principal is presumed to be competent when she makes these decisions, the declaration may fail if the court finds imminent danger in refusal of treatment.¹²³ Thus, the Act would be ineffective. Professor Winick of University of Miami School of Law denounces this possibility:

Such paternalism frustrates the value we place on autonomy and self determination, but does so on the ground of beneficence. The justification traditionally has been thought to be that the injury caused by denying the individual's autonomy would be exceeded by the harm produced by honoring the choices of those who are incompetent.¹²⁴

Because the Supreme Court has not recognized a constitutional right that would require hospitals to withdraw treatment,¹²⁵ states may limit the enforceability of these advance directives.

3. PRACTICAL LIMITS: ACCESS AND PORTABILITY

When a court reviews a petition seeking involuntary administration of psychotropic medication, the petitioner must show that a good faith effort has been made to determine whether the patient has executed a power of attorney for health care or a declaration made under this Act.¹²⁶ That is the only guarantee that the principal's declaration

120. *Id.*

121. See *In re C.E.*, 641 N.E.2d 345, 353 (Ill. App. Ct. 1994).

122. See *In re Estate of Greenspan*, 558 N.E.2d 1194, 1201 (Ill. App. Ct. 1990) (citing *In re Longeway*, 549 N.E.2d 292, 296-97 (1989)).

123. See *Rogers v. Okin*, 634 F.2d 650, 658-59 (1st Cir. 1980).

124. Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 28 (1995).

125. See *supra* notes 17-30 and accompanying text. If the Court recognized the right to refuse treatment, as it framed the issue in *Cruzan*, then declarations made under the Act would stand firm when confronted by State opposition.

126. See *In re Janet S.*, 712 N.E.2d 422, 423 (Ill. App. Ct. 1999) (holding that the state's failure to allege that it had made a good-faith effort to determine whether the patient had executed a power of attorney for health care or a declaration under the Act constituted reversible error). The Mental Health and Developmental Dis-

will be accessed at all; however, it is not a guarantee that the preferences will be enforced as intended. Moreover, when a state articulates that a mental health advance directive “shall become part of the principal’s medical records,”¹²⁷ where is the declaration actually located?

The concern surrounding access applies generally to advance directives. There is no one central registry for these instruments, and this leads to problems in locating and enforcing the patient’s wishes. To combat this problem, a bill was recently introduced in the Senate which seeks to secure access to advance directives, as well as afford portability of these directives when a patient is transferred from one health care provider to another.¹²⁸ The only guarantee of access made explicit in the Act is that the declaration is to become part of the patient’s medical records.¹²⁹

4. THE BIGGEST BARRIER: HEALTH CARE PROVIDERS

Providers may stand in the way of enforcement for reasons of either professional autonomy or financial incentive. There are many instances in which a physician will disagree with a mental health advance directive—the patient’s dictate may contrast squarely with the physician’s professional judgment. Additionally, there will be instances in which financial considerations influence the provider’s decision to administer or discontinue treatment.

If a physician does not wish to comply with the declaration, he can act on his own independent medical judgment and withdraw from treating the principal.¹³⁰ People who wish to execute advance

abilities Code requires this good-faith attempt. *See* 405 ILL. COMP. STAT. 5/2-107.1(a)(1) (West Supp. 1997); *see also Janet S.*, 712 N.E.2d at 423.

127. *E.g.*, HAW. REV. STAT. ANN. § 327F-6 (Michie 2000); MINN. STAT. ANN. § 253B.03(6d)(d) (West 1998 & Supp. 2000); OR. REV. STAT. § 127.717 (1999); UTAH CODE ANN. § 62A-12-503(1) (2000). *But see* OKLA. STAT. ANN. tit. 43A, § 11-108 (West Supp. 2001) (requiring that the declarant or the declarant’s agent present the declaration to the attending physician).

128. *See* S. 628, 106th Cong. (1999). Such a system could allow these legal instruments to travel with the patient from doctor to doctor and from hospital to hospital.

129. 755 ILL. COMP. STAT. 43/40 states: “Upon being presented with a declaration, a physician or other provider shall make the declaration a part of the principal’s medical record.” In practice, medical records are often so cluttered that the declaration could easily be overlooked or lost in transit. A common registry system might solve this problem. *See supra* notes 125–28 and accompanying text.

130.

When acting under authority of a declaration, a physician or provider must comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and

directives need to consider potential conflicts between the patient and the caregiver.¹³¹

The Act furnishes physicians and providers immunity from criminal prosecution, civil liability, and professional disciplinary action, regardless of whether they respected an advance directive of an attorney-in-fact.¹³² It also absolves the attorney-in-fact of liability with regard to any cost of treatment, criminal prosecution, civil liability, or professional disciplinary action.¹³³ Representative Krause defended this limitation of liability, noting that it requires medical providers to act in good faith and does not excuse willful misconduct or gross neg-

applicable law. If the physician or other provider is unwilling at any time to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with the exercise of independent medical judgment and must promptly notify the principal and the attorney-in-fact and document the notification in the principal's medical record.

755 ILL. COMP. STAT. 43/40 (West 1996).

Because the physician may abandon the patient and the patient's wishes, the declaration is useless in such a case. *See also* MINN. STAT. ANN. § 253B.03(5d)(c) (West 1998 & Supp. 2000), which states: "The physician or provider must comply with [the declaration] to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law." A physician could simply state that the patient's wishes are inconsistent with "reasonable medical practice."

131. The Act allows the patient to select a physician, which should encourage communication between the doctor and the patient. In other cases, however, a patient will not see a mental health specialist until the need arises, at which point it may be too late for such discussion.

132. 755 ILL. COMP. STAT. 43/55 (West 1996) states:

A physician who, to a reasonable degree of medical certainty, determines that the principal is capable or incapable of revoking a declaration or a physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the decision or direction of the attorney-in-fact or the validity of the declaration is not subject to criminal prosecution, civil liability, or professional disciplinary action resulting from a subsequent finding of a declaration's invalidity.

See also ALASKA STAT. § 47.30.968 (Michie 1998); HAW. REV. STAT. ANN. § 327F-13; IDAHO CODE § 66-611 (2000); MINN. STAT. ANN. § 253B.03(6d)(f); N.C. GEN. STAT. § 122C-75 (1999); OKLA. STAT. ANN. tit. 43A, § 11-112; OR. REV. STAT. § 127.725; TEX. CIV. PRAC. & REM. CODE ANN. § 137.005 (West Supp. 2000); UTAH CODE ANN. § 62A-12-503(5).

133. 755 ILL. COMP. STAT. 43/30(2) (West 1996) states: "The attorney-in-fact is not, as a result of acting in that capacity, personally liable for the cost of treatment provided to the principal." *See also* OKLA. STAT. ANN. tit. 43A, § 11-112(C); 755 ILL. COMP. STAT. 43/30(5) ("An attorney-in-fact is not subject to criminal prosecution, civil liability or professional disciplinary action for any action taken in good faith pursuant to a declaration for mental health treatment."). If the attorney-in-fact is not financially liable, who is responsible for the cost of treatment outlined in the directive? *See infra* notes 134-46 and accompanying text.

ligence.¹³⁴ The standard of good faith is particularly ambiguous in this context, because it may refer to a good faith belief on the part of the doctor that he is acting in accordance with the principal's preferences *or* that he is acting within the scope of his independent professional judgment. Either justification would likely present itself in court, leaving no meaningful protection that declarations under the Act will be executed in the way they were intended.

The Advance Planning and Compassionate Care Act of 1999 is also aimed at solving the problem of enforceability.¹³⁵ Using this statute, legislators hope to study the aspect of immunity for health care providers who follow the instructions in an individual's advance directive.¹³⁶ The issue of liability is certainly relevant to enforcing these directives, as are the incentives for HMOs and hospitals to administer or cease treatment.¹³⁷

Financial incentives certainly affect the way in which all providers make medical decisions. Because people who may choose to execute these directives have a variety of insurance situations, it is necessary to look separately at each payment systems' incentives.

Mental health care operates under the same structures as the larger health care system, although it is funded differently. Generally, mental health care has been subject to lower reimbursement rates and greater restrictions than other types of health care services.¹³⁸ On several levels, the government is taking steps toward undoing this discrimination and establishing parity between mental health and physical health insurance coverage.¹³⁹

134. See S. Transcript, *supra* note 74. One would certainly hope that gross negligence would not be protected under the Act. State malpractice guidelines must still apply to ensure proper treatment.

135. See S. 628, 106th Cong. (1999).

136. See *id.*

137. Many people argue that HMOs and hospitals will promote treatment against a principal's wishes not only for reasons of liability, but also for financial reasons. In a North Carolina case, a nursing home secured payment for services specifically refused by the patient's advance directive. See *First Healthcare Corp. v. Rettinger*, 456 S.E.2d 347, 350-51 (N.C. App. 1995).

138. See Kanter, *supra* note 66, at 295.

139. See Louann Yeates, *Insurance Generally: Prohibit Disparate Insurance Coverage Between Physical Disorders and Mental Health Disorders Under Certain Conditions*, 15 GA. ST. U. L. REV. 170, 171 (1998); see also Susan Stefan, *The Americans with Disabilities Act and Mental Health Law: Issues for the Twenty-first Century*, 10 J. CONTEMP. LEGAL ISSUES 131, 162-63 (1999) (examining challenges made under Title II of the ADA because Medicaid and Medicare are both government programs pointing to "carve-outs" for mental health care as a form of discrimination against this vulnerable population).

Managed care organizations, which control the health care of the American population to a large degree, may influence doctors' decisions to administer mental health treatments. Under a capitation model, a provider may have incentives to perform screening and preventative testing, yet may be discouraged from referring patients to specialists. Under such a system, a primary care physician may be rewarded for prescribing psychotropic medications rather than sending a patient to a mental health specialist. Most in-patient hospitalizations are reimbursed prior to treatment.¹⁴⁰ Under "prospective payment," a hospital is paid based on the patient's diagnosis, rather than actual cost, which creates an incentive to use less funds than it receives.¹⁴¹ This system illustrates how financial considerations may cloud a physician's professional judgment, though it is not the system that covers most elderly individuals.

Most elderly patients receive health benefits from Medicare and/or Medicaid. Medicare, like most other third-party payers, reimburses mental health services at a rate lower than physical health services.¹⁴² Medicare Part B usually pays eighty percent of the "reasonable" charges associated with treatment, but for the treatment of mental, psychoneurotic, and personality disorders, it pays only fifty percent of "reasonable" charges.¹⁴³ The patient is then left to pay the remaining fifty percent.¹⁴⁴ Also, Medicare imposes a 190-day lifetime maximum on mental health hospitalizations for each patient.¹⁴⁵ The incentive for physicians is to "recruit" patients whose benefits have not expired under this limit and to "dump" patients whose treatment is no longer reimbursed.¹⁴⁶

The elderly poor who suffer from mental illnesses suffer under both the Medicare and Medicaid systems. In their situations, both government systems are supposed to cover mental health treatment, using Medicaid funds to pay Medicare Part B premiums.¹⁴⁷ Recently,

140. See ROBERT FABRIKANT ET AL., HEALTH CARE FRAUD § 2.10 (2000).

141. See *id.* Moreover, prospective payment of mental health in-patient treatment is not subject to caps, which further encourages physicians to hospitalize these patients at the most expensive diagnosis. See *id.* For a discussion of the fraud consequences, see *infra* notes 175–80 and accompanying text.

142. See FROLIK & KAPLAN, *supra* note 14, at 56.

143. See *id.* at 80–81.

144. See *id.* at 81.

145. See FABRIKANT, *supra* note 140, § 2.10.

146. See *id.*

147. See *Royal Geropsychiatric Servs. Inc. v. Tompkins*, 159 F.3d 238, 240 (6th Cir. 1998).

Royal Geropsychiatric Services v. Tompkins, placed the issue of state co-payment before the Sixth Circuit for review, as providers demanded that the combined payment of these two programs should equal one hundred percent of reasonable costs.¹⁴⁸ Ultimately, the court decided that psychiatrists and psychologists are not “providers of services” as defined under the Medicare Act and that nothing in the Act guaranteed full reimbursement.¹⁴⁹ The net effect of this decision is that providers will not garner the same fees from an elderly poor person as from another patient; the incentive is to cherry-pick a patient whose reimbursement will be greater.

In light of this financial motivation, providers may choose to administer treatment when it is profitable and deny treatment when it will create a financial burden, for either themselves or for the patient. Mental health law is not practiced in a vacuum; such financial considerations must be viewed as potential limits on the enforcement of mental health advance directives.

C. Revocation and Expiration

Declarations are effective until they expire or are revoked.¹⁵⁰ Declarations typically expire in three years.¹⁵¹ This is yet another trap for the unwary, as a principal may draft a declaration and assume that her preferences are set in stone. In light of the growing elderly population of mentally ill people,¹⁵² this concern is especially great. An aging person may detail his declaration at age sixty, when he is of completely sound mind, and he may not need to execute it until age eighty-five. By then, his preferences will have expired under the Act, and he will have no authority over his mental health treatment.

Revocation is an equally risky aspect of the Act. To revoke, the principal can sign a statement of revocation and have it signed by her

148. *See id.* at 243.

149. *Id.* at 243–45.

150. 755 ILL. COMP. STAT. 43/10(2) (West 1998) states: “A declaration for mental health treatment may be invoked within 3 years of its execution unless it is revoked.”

151. *See id.* “If a declaration for mental health treatment has been invoked and is in effect at the expiration of 3 years after its execution, the declaration remains effective until the principal is no longer incapable.” *Id.*; *see also* ALASKA STAT. § 47.30.950(b) (Michie 1998); OR. REV. STAT. § 127.702(a) (1999); TEX. CIV. PRAC. & REM. CODE ANN. § 137.002(b) (West Supp. 2000).

152. *See supra* notes 66–68 and accompanying text. People aged sixty-five and older are generally considered “elderly.” Therefore, someone may be in this category for twenty years and never think that his declaration has expired.

physician.¹⁵³ But because the principal may not revoke her declaration if she is incompetent, the Act creates an irrevocable directive.¹⁵⁴ Like a living will or durable power of attorney for health care, this declaration is revocable only if the principal is competent.¹⁵⁵

Before the Act was passed, many people feared that it would be too difficult to revoke. Representative Schakowsky voiced the opinion of Equip for Equality, an organization that offers legal services relating to disability law, that requiring a physician to sign the revocation form was too limiting of the rights of the mentally ill.¹⁵⁶ She argued that this obstacle to revocation could take decisions out of the hands of mentally ill people, squarely counter to the goals of the Act.¹⁵⁷

The issue of revocation also highlights one of the many difficulties of advance directives in general: it is impossible for healthy people to anticipate how their attitudes may change with illness.

This problem of "objectivity" has been at the center of much of the legal and philosophical debate surrounding advance directives.¹⁵⁸ At the forefront of this debate have been two noted law professors, Nancy K. Rhoden and Rebecca Dresser.¹⁵⁹ Rhoden advocates living wills, prioritizing the values of competent persons over incompetent

153. 755 ILL. COMP. STAT. 43/50 (West 1996) states:

A declaration may be revoked in whole or in part by written statement at any time by the principal if the principal is not incapable. A written statement of revocation is effective when signed by the principal and a physician and the principal delivers the revocation to the attending physician. The attending physician shall note the revocation as part of the principal's medical record.

154. See Clayton et al., *supra* note 77, at 957. Once declared incompetent, the patient cannot go back on her wishes. This is different from most advance directives, whereby the principal can destroy the instrument at any time.

155. See 755 ILL. COMP. STAT. 35/5 (West 1996); *id.* 45/4-6.

156. See S. Transcript, *supra* note 74. These fears are well founded, and they were never addressed by the Act's proponents.

157. See *id.*

158. See generally Rebecca Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425 (1990); Rhoden, *supra* note 54. Physicians may see "best interests" as the patient's medical interests, while the patient and her family may consider spiritual and emotional consequences. Because medical decisions are so highly personal in nature, outsiders have few "objective" guidelines for making these tough decisions. Moreover, this problem of "objectivity" addresses the difference in considering illness from the standpoint of a healthy person and from that same person's perspective when she falls ill.

159. See Dresser, *supra* note 158, at 427-31.

persons.¹⁶⁰ Dresser argues that an objective standard demonstrates more respect for incompetent patients by ensuring their continued care when they have a significant interest in living. This protects them from harmful treatment decisions they made when they were competent.¹⁶¹ In one law review article, she quoted Thomas Mann's *The Magic Mountain*: "For the sick man was—precisely that, a sick man: with the nature and modified reactions of his state."¹⁶² The debate is especially interesting in the context of mental health treatment, as even an incompetent person may subjectively fear treatment in the same way as Lucille Austwick.

Professor Bruce Winick would like to extend the presumption of competency to people with mental illness because he believes they are "not categorically and inherently more incompetent than physically ill patients."¹⁶³ Indeed, dementia and depression do not equate to incapacity.¹⁶⁴ It is also not uncommon for patients with mental illnesses to experience periods of lucidity alternating with lapses into incompetence.¹⁶⁵ There may be instances where mental illness leads to a patient's refusal of treatment, but this illness should not be incompetence per se. A mentally ill person should have the liberty to conduct a risk-benefit assessment of potential treatments without being bound to an earlier declaration.

IV. Recommendation

Elderly patients are mostly kept. They are kept alive. They are kept drugged and they are kept quiet. One thing they are not kept is involved. For the elderly, the price of this enforced passivity is their dignity, their privacy and very commonly their will to live.¹⁶⁶

160. See Rhoden, *supra* note 54, at 865. More than a medical judgment, this reflects a value placed on rationality and a certain modality of thinking above the feelings of the mentally ill person.

161. See Dresser, *supra* note 158, at 427.

162. Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 609 (1994).

163. Winick, *supra* note 101, at 40.

164. See Smith, *supra* note 58, at 71. Although the standards for determining competence under the Act are a bit sketchy, a finding of mental illness does not automatically rebut the presumption of competence.

165. See Cuca, *supra* note 53, at 1152.

166. SENATE SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1987, S. REP. NO. 291, at 29–30 (1987).

People turn to mental health advance directives to take control of their mental health treatment, but these instruments, as they stand today, provide more symbolic than actual protection.¹⁶⁷ In reality, most mental health directives do not provide any meaningful guarantee that declarations will be followed.¹⁶⁸

A. Back to the Goal—Are We Protecting Providers' Rights or Patients' Rights?

Illinois Representatives supported the Act because it purported to protect patients' rights. However, in light of the limitations on liability, it appears that mental health advance directives may protect health care providers more than consumers.

These directives include liability waivers for important practical reasons. Were it not for the waivers, it is probable that doctors would administer treatment and disregard patients' refusals. As part of a physician's duty under the Hippocratic Oath, he must "never do harm."¹⁶⁹ To deny appropriate treatment would subject the doctor to professional ostracism and possible malpractice claims. For these reasons, providers need these waivers so that they can abide by patients' wishes without such consequences.

A second provision regarding liability is the issue of notice of revocation. Oklahoma's statute waives liability if the provider did not know of the revocation.¹⁷⁰ The Hawaii statute waives liability if the declaration was revoked, unless "the absence of actual notice resulted from the negligence of the health care provider."¹⁷¹ Although the legislative intent points to this negligence standard, Illinois does not go as far as other states in making this clear.¹⁷² In the case of revocation, providers should not be able to hide behind invalid directives.

Because Illinois allows for a sweeping immunity of health care providers, it is possible that the Act protects them more than it does patients. This situation ought to be rectified through the inclusion of more specific limitations on immunity. In particular, immunity should be granted when the patient has expressed a refusal of treat-

167. See Clayton et al., *supra* note 77, at 958.

168. See *supra* Part III.

169. DICTIONARY OF MEDICAL ETHICS 157 (1977).

170. See OKLA. STAT. ANN. tit. 43A, § 11-112 (West 1999).

171. HAW. REV. STAT. ANN. § 327F-13 (Michie 1998).

172. See *supra* note 166 and accompanying text.

ment both before and after the need arises. In this way, a provider may see that the patient's wishes are consistent and that refusal should be honored.¹⁷³

Mental health advance directives make the elderly people who consider executing such declarations subject to fraud and abuse. A health care provider may try to condition insurance, treatment, or discharge on the execution of a declaration. Recognizing this danger, four states have incorporated provisions into their directives that prevent such abuse.¹⁷⁴

In general, the area of mental health is ripe for problems of fraud and abuse. Some of the violations occurring in the domain of mental health mirror those in other areas of medicine: "billing for services not rendered, misrepresenting the services that were provided, kick-backs,"¹⁷⁵ and falsely representing that services provided were necessary.¹⁷⁶ Health care attorneys find that mental health is uniquely prone to certain abuses.¹⁷⁷

The primary reasons for this heightened susceptibility to fraud are that the practice of mental health medicine is highly subjective, difficult to measure quantitatively, and that mental health patients are often unreliable or incredible chroniclers of their treatment.¹⁷⁸ Under the framework of incentives, fraudulent providers are encouraged to falsify mental health admission diagnoses on patients who would otherwise be hospitalized for non-mental health problems.¹⁷⁹ Abusive prescription practices also threaten to encroach on patient autonomy.¹⁸⁰ Under strict rules of patient confidentiality, many abuses go undetected.¹⁸¹ In the context of these looming problems, individuals who seek to outline their mental health treatment preferences must be especially wary. Hopefully, by understanding these dangers, they

173. If the patient expresses, both in a directive and when the directive is invoked, that she refuses treatment, the only reason for going against these wishes is financial.

174. See IDAHO CODE § 66-608 (2000); N.C. GEN. STAT. § 122C-73(c) (1999); OR. REV. STAT. § 127.715 (1999); TEX. CIV. PRAC. & REM. CODE ANN. § 137.006 (West Supp. 2000). Note that Illinois does not offer its citizens such protection and that three of these statutes were amended subsequent to 1996.

175. FABRIKANT ET AL., *supra* note 140, § 2.10.

176. *See id.*

177. *See id.*

178. *See id.*

179. *See id.*

180. *See id.*

181. *See id.*

will be encouraged to select trustworthy physicians to execute their directives.

B. Filling in the Gaps and Removing the Traps

Assisting elderly clients in arranging for substituted decision-making is more complex than simply filling in the blanks on a pre-printed form. Clients must fully understand that by executing advance directives they ultimately may be relinquishing control over significant aspects of their lives.¹⁸²

To make a written declaration under a mental health advance directive, an individual is held to the legal standard of informed consent, meaning that she rationally weighs each treatment decision against its known consequences. Such informed consent is also needed to draft a proper declaration under these statutes. If the principal does not fully understand the consequences, she may not reach the ends she desires.

Mental health advance directives are inherently confusing. They combine a Ulysses directive, where the principal may articulate her own wishes, with a surrogate decisionmaker. For example, the Illinois Act allows the principal to consent to or refuse different kinds of treatment, without clearly defining the risks and benefits of each treatment. Further, these declarations sidestep the issue of revocation.

For an elderly person to execute a declaration, she needs a highly trained lawyer who is familiar with the state's directive and its shortcomings. These directives make it too confusing to execute such a document on one's own, which means they cannot be an extension of patient autonomy. Psychiatrists, family members, and attorneys stand to influence the elderly client in each of her decisions. As suggested by Roberto Cuca, there ought to be an anticoercion provision so that such statutes do not "provide a means for physicians to assume control of treatment decisions."¹⁸³

Persons who wish to draft a declaration must understand the following conditions: expiration, revocation, and limits on enforceability. If they are aware of these limitations, they can better appreciate the significance of their declaration. Some conflicts can be avoided through careful planning, such as making clear the standard of inca-

182. Sharon R. Rudy, *Substituted Decision-Making for the Elderly: Living Wills, POAs, and Other Options*, 84 Ill. B.J. 32, 35 (1996).

183. Cuca, *supra* note 53, at 1185.

capacity they wish their doctors to use or what happens when a power of attorney for health care comes in conflict with a person acting under the declaration.

Also, mental health directives contain two major idiosyncrasies worth noting. First, half of the states with these directives make declarations automatically expire three years after the date of execution.¹⁸⁴ This arbitrary expiration presents yet another obstacle for an elderly person who wants to outline her wishes in a declaration. Moreover, no other advance directive contains this type of expiration. A second oddity that can be found in the fine print of these advance directives is that they may only provide very limited “short term inpatient treatment.”¹⁸⁵ States range between granting ten days at the low end¹⁸⁶ to twenty-eight days at the high end.¹⁸⁷ If states cannot articulate valid reasons for the limited duration of declarations and treatments, these illogical constraints should be removed.

With so much of the nation’s population facing old age, it is critical that mental health advance directives be reevaluated. When people are bombarded with legal paperwork regarding their future medical treatment, it may all become confusing. Individuals must decide among a menu of directive instruments: living wills, health care proxies, and written declarations. It is the responsibility of lawmakers to establish clear policies that afford citizens real protection, not simply burdensome paperwork that may never be enforced.

C. Can Mental Health Advance Directives Be Saved?

Many of the problems addressed in Part III reflect flaws in the system as a whole, rather than errors in legislative drafting. One of these overarching problems is the determination of competence. Naming a particular physician to make this determination may not hold up in court. Moreover, the physician’s determination of competence may not hold up in other states. Mental health advance direc-

184. See ALASKA STAT. § 47.30.950 (Michie 1998); 755 ILL. COMP. STAT. 43/10(2) (West 1998); OR. REV. STAT. § 127.702(2) (1999); TEX. CIV. PRAC. & REM. CODE ANN. § 137.002(b) (West Supp. 2001); UTAH CODE ANN. § 62A-12-502(6)(a) (2000).

185. E.g., ALASKA STAT. § 47.30.970 (Michie 2000); IDAHO CODE § 66-613 (2000); 757 ILL. COMP. STAT. 43/5 (7); OR. REV. STAT. § 127.736 (1999); UTAH CODE ANN. § 62A-12-504. Each of these states provides a limit of seventeen days. One wonders whether there is some treatment value associated with seventeen days or whether this designation has been perpetuated without reason.

186. See N.C. GEN. STAT. § 122C-77 (1999).

187. See OKLA. STAT. ANN. tit. 43A, § 11-106 (West Supp. 2001).

tives present a clear need for a universal standard of competence. Until the time comes when states agree about the standards by which to judge competence or capacity, these documents will not be freely transferable from state to state.

A second looming problem is the difficulty in accessing the documents that are made in accordance with state statutes. This problem of access is not unique to mental health advance directives; it also afflicts living wills. The access problem means that a form that is kept in a bank vault or in a kitchen cabinet will never be read or enforced by health care personnel. This problem is compounded when factors such as travel and hospital transfers prompt questions of enforcement in other states. A multitude of variables, including standards of incapacity or incompetence, malpractice liability, and states' recognition of families as healthcare decisionmakers further complicates the issue of portability.

The possible lack of portability raises a due process concern because it remains unclear whether these directives are subject to full faith and credit in other states. If there is a constitutional right to refuse treatment, then no state may deny anyone this right. States will be bound to enforce these directives. At this time, there is no authority to suggest that these directives will be enforced in their state of origin, let alone in other states. Until directives can be registered and are universally recognized, they offer false protection.

The only real merit to mental health advance directives is that they promote consideration of possible mental illness and treatments that can afford the patient/principal an increased sense of participation.¹⁸⁸ The principal may benefit through increased motivation to comply with the treatment.¹⁸⁹ These psychological aspects can make mental health treatment more efficient and perhaps more beneficial. Professor Winick contends that treatments are more successful when patients choose them, rather than when treatment is imposed over objection.¹⁹⁰ He contends that those patients' predictions and expectations concerning the success of their treatments stimulate "feelings of self-efficacy," thus promoting further action and effort to comply.¹⁹¹ To realize these conditions, people who seek these declarations must

188. See Clayton et al., *supra* note 77, at 958.

189. See *id.*

190. See Winick, *supra* note 101, at 81-82.

191. *Id.* at 83.

be educated on the scope and consequences of their decisions. At a minimum, stating one's wishes under a mental health advance directive will serve as a guide for a health care surrogate to follow.

If mental health advance directives do not afford patients any real protection, then they should be repealed. Such action may appear to disregard patient autonomy. However, people are entitled to know whether their medical wishes will be respected at the outset. This is preferable to people expending effort in vain.

V. Conclusion

Mental health advance directives purport to give individuals greater control over the care they receive should they be incapacitated. They allow people to express their desire for or refusal of ECT, psychotropic medication, or admission to a mental health facility. The Illinois Mental Health Treatment Preference Declaration Act attempts to resolve some of these issues, but it fails to deliver a complete solution for patients with recurrent mental illnesses.

These declarations will only hold up if they reinforce a doctor's decision to administer treatment. When the wishes of the doctor and the patient conflict, there is no guarantee that the patient's previously articulated wishes will prevail. Overall, mental health advance directives fall short of their original goal of fostering autonomy.