Doing Away with Dogmatic Medical Directives

BY CASEY FRANK

"Plans are worthless, but planning is everything."
—President (and General) Dwight D. Eisenhower[1]

When I started practicing, I had a 40-page program for advance medical planning, addressing every conceivable contingency, each provision crafted in consultation with a physician board-certified in both geriatrics and family medicine. This pleased my clients and was remunerative. However, the estates I've planned recently have had a one-page description of the health care agents and their contact information, including social media. Clients were then counseled to have ongoing conversations with trusted decision-makers regarding future medical care. This could include writing down values and preferences, but never in a statutorily defined document requiring that everyone "shall comply."

This is a call for lawyers to stop doing something we do regularly (and do very well): create documents. In planning for future medical decisions, documentary mandates make an illusory promise. This is because it is unrealistic to memorialize treatment decisions to be made at an unknown time in the future, in unpredictable medical circumstances, to be implemented by clinicians who are now strangers.

This is also a call for lawyers to do something we don't do regularly enough: look outside the legal office to the end users of medical plans. If we listen to the clinical professionals who are making treatment decisions in the moment, we will reach a different conclusion about the value of finely crafted medical directives.

Why Medical Directives Are Different

Decades ago, advance directives arose from a fear of medical technology. People did not want to exist "hooked up to machines," which led to end-of-life decisions then called "pulling the plug."[2] The floodgates of proliferation opened in 1991 with passage of the US Patient Self-Determination Act.[3] This legislation incentivized the medical industry to promote written directives and to measure success by the number of directives produced. But "not everything that can be counted, counts."[4]

The problem with this approach is that medical directives are not like other legal planning documents. For example, a will may be introduced in subsequent legal proceedings, such as probate. But we fall into a trap if we attempt to craft medical directives designed as trial briefs. That impetus is understandable, as Professor George Gopen put it: "A lawyer writes worrying about 'an opposing counsel who, fully cognizant of what the author intended, will spare no pains to demonstrate that it might not, indeed cannot, mean that very thing.'"[5] This adversarial thinking is not a good way to plan for the intimate issue of caring for the sick.

Instead of compiling compulsory documents, lawyers should counsel their clients to use a person-centric approach, to create an ongoing conversation between clients and their decision-makers: health care agents, proxies, and guardians (and other protective fiduciaries). They are legally established, authorized to make every treatment decision, and best positioned to provide in-the-moment guidance, reflecting evolving personal preferences and the inexorable increase in medical options.

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Medical directives are carried out in clinical settings, and it is to those end users we must pay attention. We should direct our clients to communicate with clinicians informally in natural language unaffected by lawyerly wordsmithing—in any form that is readily readable by the intended audience. The personal approach gets frustrated and often derailed by the compilation of documents.

Dr. Sean Morrison, a national leader in palliative medicine, recently summarized the futility of the mandatory approach, concluding that it "does not improve end-of-life care, nor does its documentation serve as a reliable and valid quality indicator of an end-of-life discussion."[6]

The Lawyer's Dual Role in Medical Planning

It is estimated that between 49% to 76% of persons do medical planning with lawyers (compared with only 6% to 7% with physicians).[7] In assuming the role of medical planning gatekeepers, we must be both advocate and counselor.

Lawyer as Advocate

The Colorado Rules of Professional Conduct (Rules) teach us that "[t]he advocate has a duty to use legal procedure for the fullest benefit of the client's cause."[8] We first seek the intent of the law.[9] Medical planning laws are appropriately intended to protect personal treatment preferences, to provide informed consent in the future when we cannot competently make or communicate our choices.

We then ask how to make laws work better. For example, the medical durable power of attorney statute (MDPOA) provides for appointment of a health care agent.[10] Added value based on our professional judgment and experience leads us to add a back-up agent, even if not legally required.

Naturally, we also care how a law is incorporated into our practice. A regular option is to combine medical and estate planning, as recommended by the American Bar Association (ABA).[11] This seems logical, since both involve planning for future contingencies. The problem is that lawyers lack rudimentary medical skills, and as a result they cannot know if treatment choices in documents they help write are rooted in reality.

This contrasts with estate planning, where we are alert for discord. If a client wants to bequeath land owned on Mars, we know better and will intervene. But if a client wants to enshrine in documents an unworkable belief about medical treatment, we are ill-suited to respond intelligently, as we have no competence to do so.

It is far better if we counsel our clients to rely primarily on informed agents, proxies, and guardians, avoiding legalized documentary mandates. This duty emerges from the other great branch of professional responsibility.

Lawyer as Counselor

The Rules also acknowledge our role as counselor, stating that advice "couched in narrow legal terms may be of little value to a client."[12] With regard to medical planning, the Rules recognize that it "often involves unpleasant facts and alternatives that a client may be disinclined to confront."[13] A client who wants to only create written medical mandates while avoiding the appointment of a health care agent who is kept informed is disserved by our acquiescence to such a plan.

With documentary mandates, the governing statutes, regulations, and forms are written in language the average person does not use. The forms are not user friendly and demand strict compliance with a treatment decision without human review. Each form directive uses some version of the same statutory language, that all concerned "shall comply." (See accompanying table.) This approach is so drastic that it provokes countermeasures like witnesses, clinical pre-approval, added electronic affidavits, and notarization. Such countermeasures increase costs, discourage revision, and reduce the directive's practical value.

In addition, written directives aren't a bilateral contract; they lack the benefit of negotiation and fulfillment by those who create and perform them. Directives are a breed apart: surrogates decide how to interpret them, not the parties writing them; unknown medical professionals implement them, though unaware of the concerns driving their creation. They are conclusory, not explanatory, and can't be quizzed. They can lie dormant for years or be needed in a second, and their rigid approach is not well suited to addressing these different contingencies.

It is virtually impossible to determine a medical directive's validity from the four corners of the document, because the creator can fire a health care agent, a proxy, or a designated beneficiary; veto any specific decision; or revoke a directive completely—at any time, orally, in writing, for any reason or no reason, and without notice.[14] Consequently, a medical directive can never be considered settled once and for all.

It is hard to imagine any treatment mandate that complies with its enabling statute and addresses all the medical treatment options that might be available when applied. Such a form would yield little in reliable prospective guidance. It would be like attempting to create a parenting plan at the beginning of a marriage, for children not born. What competent family law practitioner would ever consider doing so?

What the Data Show

That is why the data consistently fail to reveal a substantial benefit to society by advance care

STATUTORY "SHALL COMPLY" LANGUAGE

Living wills	If a living will complies with its stated formalities "the attending physician *shall then withdraw or withhold* all life-sustaining procedures or artificial nutrition and hydration pursuant to the terms of the declaration." CRS § 15-18-107 (emphasis added).
CPR directives	"Emergency medical service personnel, health care providers, and health care facilities *shall comply* with a person's CPR directive that is apparent and immediately available." CRS § 15-18.6-104(1) (emphasis added).
MDPOA	"Each health care provider and health care facility *shall, in good faith, comply,* in respective order, with the wishes of the principal, the terms of an advance medical directive, or the decision of an agent acting pursuant to an advance medical directive." CRS § 15-14-508(2) (emphasis added).
MOST	Everyone involved "*shall comply* with an adult's executed medical orders for scope of treatment form." CRS § 15-18.7-104(1)(a) (emphasis added).
BHOST	Everyone involved "*shall comply* with an adult's executed behavioral health orders form." CRS § 15-18.7-205(1)(a) (emphasis added).

LEGAL AUTHORITY FOR MEDICAL TREATMENT DECISIONS

Patient Autonomy	Informed consent	Prior approval required for all medical treatment; this is a fundamental right. *Cruzan v. Director, MDH*, 497 U.S. 261, 279 (1990); *Gorab v. Zook*, 943 P.2d 423, 427 (Colo. 1997) ("A physician must obtain informed consent, whether express or implied, from the patient."). The standard is reasonableness.[1]
Professional Practice Acts	Colorado Medical Practice Act (1899)	Defines physician professional standards of care. CRS §§ 12-240-101 et seq.
	Nurse and Nurse Aide Practice Act (1957)	Defines nursing professional standards of care. CRS §§ 12-255-101 et seq.
	Mental Health Practice Act (1988)	Defines six professions' standards of care. CRS §§ 12-45-101 et seq.
Personal Surrogacy Laws (Most Flexible)	Guardian (1887[2])	Court-appointed decision maker; often used if there's no one else. CRS § 15-14-301, Appointment and status of guardian.
	Health care agent (MDPOA) (1992)	Someone a person identifies to make treatment decisions for that person. CRS §§ 15-14-503 to -509, Patient Autonomy Act. Authorized by MDPOA, CRS § 15-14-506, Medical durable power of attorney.
	Proxy decision-maker (1992)	Flexible procedure that can generate a decision maker for a person if there has been no planning in advance by that person. CRS § 15-18.5-101.
	Designated beneficiary (2009)	Enacted before same-sex marriage was legalized to allow authorized decision makers from nontraditional roles; is less flexible when recorded with the County Clerk and Recorder. CRS §§ 15-22-101 et seq., Colorado Designated Beneficiary Agreement Act.
Personal Surrogacy Laws (Most Restrictive)	Living will (1985)	Document that states at what point to stop life-sustaining treatment. CRS §§ 15-18-101 et seq., Colorado Medical Treatment Decision Act.
	CPR directive (1992)	Directive not to restore cardiac function or to support breathing in the event of cardiac or respiratory arrest or malfunction. CRS §§ 15-18.6-101 to -108, Directive Relating to Cardiopulmonary Resuscitation.
	Medical jewelry and tattoos (1992)	A form of CPR directive through jewelry and tattoos, per 6 CCR 1015-2(3.1.2)(a), www.coloradosos.gov. The jewelry itself is available online without restriction.
	Medical orders for scope of treatment (MOST) (2010)	Medical orders that your provider uses to tell another provider what treatments you want. CRS §§ 15-18.7-101 to -110. In other states, this document type may be called an eMOST, MOLST, POLST, or TELP.
	Behavioral health orders for scope of treatment (BHOST) (2020)	Controls treatment decisions for the adult who provided the instruction; prohibits revocation without the approval of two witnesses who are strangers to the patient.[3] CRS §§ 15-18.7-201 to -207. Also called a "psychiatric advance directive."
	Advance Directives Registry (2021)	A centralized online site to access medical plans.[4] CRS §§ 25-54-101 to -102.

NOTES

1. Colorado views patients and providers as cooperative allies in reaching informed consent, both acting according to norms. The standard is to "act consistently with the standards required of the medical profession in the community, while a specialist must treat the patient in accordance with the standard of a reasonable physician practicing in that specialty." *In re P.W.*, 2016 CO 6, n.5 (2016). It is negligent failure to inform when a "reasonable person in the same or similar circumstances as the Plaintiff would not have consented . . . if given the information required for informed consent." CJI-Civ. 15:10(3).

2. *Fillmore v. Wells*, 10 Colo. 228 (Colo. 1887) (The facts of this early case arose in 1875 over payment for services as a guardian, a year before Colorado was admitted to the United States).

3. Also known as a "Ulysses" contract, this type of advance directive effectively creates an irrevocable mandate to control mentally ill persons against their will.

4. The Colorado State Board of Health has announced that it will allow individuals to access the registry. It was not yet online as of this publication.

planning through the production of documentary mandates. A 2020 systemic review analyzed the advance medical directives of neurocritically ill patients, using 25 studies representing 35,717 patients. The authors concluded that "the quality of evidence regarding the[] effects [of advance medical directives] on critical care remains weak and the risk of bias high."[15]

An even more damning conclusion was drawn by Dr. Morrison: "A 2018 review of 80 systematic reviews (including 1600 original articles) found no evidence that ACP [advance care planning] was associated with influencing medical decision making at the end of life, enhancing the likelihood of goal-concordant care, or improving patients' or families' perceptions of the quality of care received."[16] Systematic reviews are the gold standard of epidemiology (the study of studies) and bring science closest to consensus.

This dismal return for all the effort exposes the damaging fallacy that mandates are better than nothing. The harm was summarized by Dr. Morrison: "Encouraging the belief that ACP is essential to good end-of-life care meaningfully detracts from other initiatives." The effort and expense invested in documents delays and displaces person-to-person communication.

The current pandemic brought the dichotomy into sharp relief, as Dr. Morrison further noted: "In addition, the presence of an advance directive can inhibit current discussions about goals of care; this occurred in overwhelmed hospitals during the COVID-19 pandemic when treatment decisions were made according to written documents rather than discussions with patients or their surrogate."[17]

Unresolved Conflicts

Surrogacy laws also contradict one another, because they weren't designed as an integrated system. The oldest surrogacy law, guardianship, pre-dates Colorado statehood. The most recent, behavioral health orders for scope of treatment (BHOST), went into effect in 2020.[18] No medical decision-making statute has ever been repealed. There is no corollary to the sunset reviews that require regulatory agencies to be reevaluated to see if they "have outlived their usefulness" and to avoid the proliferation of rules.[19] Here are some unresolved conflicts:

- According to the 2010 law establishing medical orders for scope of treatment (MOST), a health care agent explicitly appointed through the 1992 MDPOA cannot revise CPR instructions.[20] MOST is incompatible with the unfettered authority granted to an agent, who is intended to stand in the shoes of the patient, comprehensively able to make any decision the patient could make.[21]

Humane conversations about surrogacy should be centered on the individual's unique circumstances in the moment of need, rather than being driven by complicated forms from the past.

- The CPR statute states that emergency personnel "shall comply with a person's CPR directive that is apparent and immediately available."[22] The directive's primacy is unconditional. But the interpretive Colorado Code of Regulations states: "Any document or item of information or instruction that clearly communicates the individual's wishes or intent regarding CPR may be regarded as valid and the individual's wishes honored."[23] Emergency responders cannot be reasonably expected to decide in the field which authority controls.
- BHOST prohibits revocation without the approval of two witnesses who are strangers to the patient.[24] This is the opposite of the 1992 proxy statute, which puts trust in one who has "a close relationship with the patient."[25] BHOST is also a profound departure from the prime privilege granted families and intimate friends throughout civil society.
- The "designated beneficiary" was created in 2009, before same-sex marriage was available, to make "existing laws relating to health care . . . available to more persons."[26] That included naming a proxy.[27] However, this requires recording with a clerk and recorder. This diverges from the 1992 proxy statute requiring neither documentation nor recording. To determine if someone has a recorded designated beneficiary proxy, one must make a Colorado Open Records Act request of all 63 county clerks and recorders. It cannot be done online.

Hyper-Rationalism

What tempts lawyers and their clients into dogmatic medical planning is the hope that the chaotic drama of human life can be organized into predictable categories, such as quality-of-life versus quantity-of-life. In this, the legal community is not alone. This tendency is also found in many other areas of society.

Gail Sheehy's *Passages: Predictable Crises of Adult Life*, organizing life as a developmental ladder from youthful individuation to mature self-acceptance, with five more predictable crises of adulthood in between, sold 5 million copies.[28] Psychiatrist Elisabeth Kübler-Ross codified the phases of terminally ill patients into denial, anger, bargaining, depression, and acceptance.[29] Eventually, the "notion that these five stages occur in a linear progression has since become a kind of modern myth of how people ought to cope with dying."[30]

Analogously, "smart cities" promoters insist that adding high-tech structure to urban design will eliminate chaos and crime, and cure the ills of society. These promises have been repeatedly unfulfilled, as best explained

by Professor Shannon Mattern: "When you take messy ambiguous dimensions of human nature and try to find ways to algorithmicize them, there is always a failure there, something that slips through the cracks."[31]

It is a vain hope that medical planning can be settled by statutory categories and special forms. Even more elusive is the hope to enshrine all that in mandatory documents that give only conclusions. This conflicts with the unqualified freedom-of-choice championed by informed consent, and personal autonomy, as supported in the Colorado Patient Autonomy Act.[32]

The Better Way: Personal Surrogate Decision-Making

Humane conversations about surrogacy should be centered on the individual's unique circumstances in the moment of need, rather than being driven by complicated forms from the past. Person-centered medical surrogacy more realistically reflects the nuances and uncertainties of life and illness. It is simpler and less expensive, and still legally grounded.

This is justified even more fundamentally by informed consent and the constitutional-level privilege of bodily autonomy, which undergird all surrogate appointments. It complements the medical, nursing, and mental health practice acts that allow medical experts to do their best at the moment of need, in collaboration with patients and their surrogates. Providers must respect personal wishes but still adhere to "generally accepted standards of care"[33] as integrated with those preferences.

A health care agent (agent) is someone explicitly recruited by a competent patient and may be a professional employed by the patient. If there is no agent, a proxy, who may be a physician, is chosen by an incapacitated patient's interested persons. The backstop is a guardian appointed by a court in the wide range of court proceedings to protect the vulnerable.[34] A guardian may be a family member or friend, or someone appointed through the Colorado Office of Public Guardianship.[35]

The methods for choosing an agent or a proxy prize clarity over formality and do not require any specialized legal language or forms. In these approaches to inferred medical decision-making (also confusingly known as "substituted judgment"), we see patient rights reach their least expensive and most nimble expression.

It is unrealistic to memorialize fixed treatment decisions in the present, that will be applied at an unknown time in the future, in unpredictable medical circumstances, to be implemented by clinicians who are now likely strangers.

A Heath Care Agent is Best

Patients are best served when they personally recruit and regularly converse with an agent who will most likely closely correspond with the patient. Agents are authorized by the MDPOA law. An MDPOA has few legal formalities and is best seen as a process, not a document, even though someone needs to write it down. That scribe may be the patient, or, for example, the admitting clerk at a hospital.

In Colorado, an agent stands in the shoes of the patient and can make any treatment decision the patient can.[36] This is also true nationally in the US Veterans Health Administration (VHA): "In VHA, a [health care agent] is first in the hierarchy of surrogate decision makers and is authorized to make decisions about all types of health care on the patient's behalf."[37]

Designating an agent is simple, involves minimal expense, and offers nimble changeability. This allows the readiest expression of patient autonomy. But people must also invest in educating their agents. Informal, plain language documents can help guide agents, not as dogmatic authorities but as an essential part of the lifelong conversation that should occur, both orally and in writing, through methods such as social media or paper (i.e., anything but a statutorily defined mandate written in lawyerly language).

There is an uncommon consensus between the medical and legal professions about this most valuable step:

- The ABA states: "The most important legal component of advance care planning is careful selection and appointment of

a health care agent . . . . Advance care planning takes place over a lifetime."[38]

- The American Medical Association states that physicians should counsel their patients to "identify someone they would want to have make decisions on their behalf . . . [and] make their views known to their designated surrogate and to (other) family members or intimates."[39]

Designating an agent does not predetermine the cultural norms of medical decision-making, and patients can be creative in structuring this role. Some patients resist having the sole burden of making treatment decisions for themselves and prefer they be made by a trusted advisor or group. An agent may be an authority or a group spokesperson. Those from diverse cultures and with different world views and mental prototypes can make varied use of the agent role to suit their specific needs.[40]

For example, in one case the author was involved in, a competent, adult patient wanted her husband and her rabbi to make all treatment decisions when she was admitted to a hospital for surgery. After she confirmed this choice directly to her physician, outside the presence of others, this delegation of authority was straightforward. In legal terms, appointing an agent need not be springing (i.e., valid only after the incapacity of the patient). A competent delegation of authority can occur whenever it is preferred.

A Proxy Can Step In

Even if a patient has not identified an agent before becoming incapacitated, a proxy can be named instead.[41] In the hospital setting, the attending physician[42] seeks interested persons to choose a proxy by consensus. There is no legal impediment to appointing a proxy outside a hospital setting for an adult.[43]

The aim is to create an agent retrospectively, by choosing as the proxy "the person who has a close relationship with the patient and who is most likely to be currently informed of the patient's wishes regarding medical treatment decisions."[44]

The pool of potential proxies was increased with the addition of physician proxies. If there are no interested persons available, before resorting to guardianship, an attending physician in a hospital setting may designate as proxy a physician who is not treating the patient, following an independent determination of incapacity.[45]

People can increase the availability of interested persons by educating as many trusted confidantes about their wishes as possible. An agent may grow apart from a person, or be unavailable, so it's best not to depend solely on one person.

Continuing the Conversation

To promote ongoing conversations regarding medical care, practitioners can direct clients to The Conversation Project, an initiative designed to stimulate conversations among (potential) patients, agents, and interested persons about wishes for care through the end of life.[46] Boulder County's Conversation Project does a good job of summing up the benefits:

> Unless your family knows what you want, they are left with the distress of guessing how to best care for you. Starting the conversation is never easy—no one wants to sound gloomy or to upset ourselves or others, but families and health care professionals report that it is a relief when the subject of how we want the end of our life to look is brought into the open and our choices can be honored because of careful forethought and conversation.[47]

This is just one option. The key is not to be sidetracked by imagining that documents will reflect what is best at the moment of need, but instead to keep the conversation going.

Guardians Provide a Backstop

If there is no agent or proxy, a guardian can be appointed by a court. While an agent and a proxy must follow the known wishes of the patient, a guardian reflects the older paradigm, and while considering "the expressed desires and personal values of the ward," decides what is in the patient's best interests.[48]

Guardianship is only one form of protective proceedings than also includes administration of involuntary medication, the right to treatment, civil commitment, mental health holds, state adult and child protective services, and other actions by agencies and courts.

Every expression of patient treatment choices deserves respect, regardless of the form it takes or the method by which it is communicated. An agent or proxy, with a guardian in reserve, minimize encumbrances upon that freedom of expression and should be universally prioritized.

Promotion of personal surrogate medical decision-making is insufficient without pruning away the documentary mandates that dominate the current process of medical surrogacy. That is why reform of customary law practice upstream of moments of medical crisis is needed and can have a huge impact. A good reform would be to add this to every dogmatic advance directive statute: "Regardless of any other language to the contrary, the function of this statute is purely advisory, and must be interpreted in light of present circumstances and best clinical judgment."

Summary of Key Points

As esteemed lawyer and Nobel laureate Elihu Root wisely proclaimed, "About half the practice of a decent lawyer consists in telling would-be clients that they are damned fools and should stop."[49] Lawyers should heed this advice when it comes to medical planning. For example:

- Lawyers should accept that their office is not the best place to memorialize the delicate issues of illness and death. We have no ability to evaluate the cognitive status of clients for whom consequential and technical medical decisions would be enshrined in statutorily defined directives. Decisions rely on the mind-state of your client, such as demeanor, attention-span, memory, mood, intellectual ability, and whether they were on medications that affect thinking.[50]
- Lawyers should stop the futile pursuit of documentary solutions. Even perfect medical directives go stale, as clients' preferences are amended by life experience and emerging medical options. Empirical studies reveal that about one-third of treatment choices change within two years.[51] It is unrealistic to imagine that clients will repeatedly consult with expensive legal advisors and revise documents. Consequently, even superbly crafted documents become eventually unmoored from a client's evolving goals.

- Lawyers should instead counsel clients to invest in a person-centric approach. A lawyer's work product transfers poorly. Whatever documents are created, any understanding is shared between lawyer and client. Even if your client's wishes were perfectly understood and expressed, the meaning to unknown professionals and intimate others in the future will be elusive because they were not present at the creation. Further, lawyers lack medical expertise and don't know if treatment choices in documents are rooted in reality. We can't competently grasp disease, prognosis, comorbidities, and treatment outcomes. If clients have seemingly rational but highly unrealistic beliefs about medical treatment, we are ill-suited to respond intelligently, much less correctively.
- Lawyers should not approach medical planning like trial prep. There, any ignorance is mitigated in court by the Rules of Procedure and Evidence, which ensure that medical information is directly presented by an expert "as the result of extensive experience, training, and education."[52] Drafting medical directives in an office does not take place with those controls. There will be no medical professional at the table, and if there is external information provided, it has the unreliability of hearsay, because there will be no direct assessment possible when documents are the supposed voice of the patient.
- Lawyers must recognize that client competence is less of a concern when naming an agent. Cognitive competence is always situational, depending on the issue is at hand. In In re Estate of Runyon, the court noted that competence to name a personal representative can be adequate even if the testator is incompetent to make more complex property decisions.[53] This is analogous to naming an agent.
- Lawyers have to be good recordkeepers.[54] Paradoxically, this is not beneficial to clients when it comes to written medical mandates. Typically, such records cannot be quickly accessed, though they may be needed at any moment. And when they are available, they can be obsolete, an anchor to the past when decisions need to be made in light of present circumstances. To help ameliorate this dynamic, lawyers should add expiration dates on written directives, even ones appointing an agent. Unfortunately, directives have no expiry date by statute, except for those under the BHOST, which is two years.[55]
- Lawyers must avoid encouraging clients to falsely imagine that because they spent time and money to create written directives, and paperwork exists, the matter is settled. It is ever evolving, and our collaboration in creating this illusion is unethical.

Conclusion

Encourage your clients to recruit a health care agent and, in case a proxy is needed, to create a group of persons who are informed about their medical planning decisions. Clients should have a lifelong conversation with agents and potential proxies so they remain in the know about the client's current wishes. Consider The Conversation Project or similar resources to facilitate the process. Lastly, the success of your client's personal surrogate decision-making depends on your approach: change your practice to avoid compiling expensive documents with lawyerly language drafted according to statutory mandates. CL

"As I See It" is a forum for expression of ideas on the law, the legal profession, and the administration of justice. The statements and opinions expressed are those of the authors, and no endorsement of these views by the CBA should be inferred.

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NOTES

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2. Institute of Medicine, Committee on Approaching Death: Addressing Key End-of-Life Issues, *Dying in America: Improving Quality and Honoring Individual Preferences Near End of Life* 117 (National Academies Press 2015).
3. 42 USC § 1395cc(f).
4. Bruce Cameron, *Informal Sociology: A Casual Introduction to Sociological Thinking* 13 (Random House 1963).
5. Gopen, *Writing from a Legal Perspective* 335, 340 (West Group 1981).
6. Morrison et al., "What's Wrong With Advance Care Planning?" *J. of Am. Medical Ass'n* 1575–76 (Oct. 8, 2021).
7. Ries et al., "How do lawyers assist their clients with advance care planning? Findings from a cross-sectional survey of lawyers in Alberta," 55(3) *Alberta L. Rev.* (2018); Thorevska et al., "Patients' understanding of advance directives and cardiopulmonary resuscitation," 21(1) *J. Critical Care* (Mar. 2005); Tunzi, "Advance care directives: realities and challenges in central California," 22(3) *J. Clinical Ethics* (fall 2011).
8. Colo. RPC 3.1, cmt. [1].
9. *See* CRS § 2-4-201.
10. CRS § 15-14-500.3(1).
11. ABA Comm'n on Law and Aging, "Advance Directives: Counseling Guide for Lawyers" at 1 (2018).
12. Colo. RPC 2.1, cmt. [2].
13. Colo. RPC 2.1, cmt. [1].
14. "Nothing in this section or in a medical durable power of attorney shall be construed to abrogate or limit any rights of the principal, including the right to revoke an agent's authority or the right to consent to or refuse any proposed medical treatment, and no agent may consent to or refuse medical treatment for a principal over the principal's objection." CRS §

15-14-506(4)(a), 5(d). As to all the other written advance medical directives: "A declaration may be revoked by the declarant orally, in writing, or by burning, tearing, cancelling, obliterating, or destroying said declaration." CRS §§ 15-18-109, 15-18.6-107, and 15-14-506(4)(a).

15. Sutter et al., "Advance Directives in the Neurocritically Ill: A Systematic Review," 48(8) *Critical Care Medicine* 1188 (Aug. 2020).

16. Morrison et al., *supra* note 6 at 1575 (citing Jimenez et al., "Overview of systematic reviews of advance care planning: summary of evidence and global lessons," 56(3) *J. Pain Symptom Management* 436 (Sep. 2018).

17. *Id.* at 1576.

18. CRS §§ 15-18.7-201 et seq.

19. CRS §§ 24-34-104(1)(a), Review of Regulatory Agencies, legislative declaration; 2-3-1203(1)(a), Sunset Review of Advisory Committees, legislative declaration.

20. CRS § 15-18.7-110(3)(b).

21. CRS § 15-14-506(3).

22. CRS § 15-18.6-104(1).

23. CCR 1015-2, 4.2.1.b.

24. CRS § 15-18.7-203(4)(b).

25. CRS § 15-18.5-103(4)(a).

26. CRS § 15-22-102(2)(b)(I).

27. CRS § 15-22-105(3)(f).

28. Sheehy, *Passages: Predictable Crises of Adult Life* 36–45 (Ballantine 2006). Her developmental stages are (1) Pulling up Roots, (2) The Trying Twenties, (3) Passage to the Thirties, (4) But I'm Unique, (5) The Deadline Decade, and (6) Renewal or Resignation.

29. Kübler-Ross, *On Death and Dying* (Macmillan 1969).

30. Corr, "Kübler-Ross and the 'Five Stages' Model in a Sampling of Recent American Textbooks," 82(2) *OMEGA—J. of Death and Dying* 294 (Nov. 2018).

31. Mattern, *A City Is Not a Computer* 51 (Princeton U. 2021). Mattern is a professor of anthropology at the New School for Social Research.

32. CRS §§ 15-14-503 et seq.

33. In the Medical Practice Act, CRS § 12-240-121(1)(j), Unprofessional conduct; the Mental Health Practice Act, CRS § 12-245-224(1)(g)(I), Prohibited activities; and the Nurse Practice Act, CRS § 12-255-120(1), Grounds for discipline.

34. This is under the *parens patrie* authority: the state takes responsibility for those unable to care for themselves, using a need of care basis. This is related to the police power: the state has authority to prevent harm to the community, including the mentally ill themselves, using a dangerousness basis.

35. https://colorado-opg.org.

36. CRS § 15-14-506(3).

37. VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives 3(f)(1) (Dec. 24, 2013).

38. ABA Resolution 103B.

39. AMA Code of Medical Ethics, Ch. 5.1(a)(ii–iii).

40. Schneider, *The Practice of Autonomy* xii (Oxford U. Press 1998).

41. CRS § 15-18.5-103(3). There is one limit on the authority of a proxy, compared to an agent, on the withdrawal of food and water.

42. Attending [Physician], Noun: "Serving as a physician or surgeon on the staff of a hospital or similar health-care facility and having primary responsibility over the treatment of a patient." *Merriam-Webster's Medical Dictionary* (2016).

43. The statute requires the determination of incapacity by any physician, an advance practice nurse, or a court. CRS § 15-18.5-103(1.5)(b). However, the subsequent efforts to designate a proxy can be undertaken by any of them or their designee. "Designee" is a generic term for a person serving as a stand-in for a specific task, allowing great flexibility in the process.

44. CRS § 15-18.5-103(4)(a).

45. CRS § 15-18.5-103(4)(c).

46. Institute for Healthcare Improvement, The Conversation Project, https://theconversationproject.org. There are several other allied movements, including Respecting Choices, https://respectingchoices.org; Death over Dinner, https://deathoverdinner.org; and Coda Alliance, https://codaalliance.org.

47. The Conversation Project in Boulder County, http://theconversationprojectinboulder.org.

48. CRS § 15-14-314(1).

49. Elihu Root, quoted in Jessup 1 *Elihu Root* at 133 (Dodd, Mead & Co. 1938).

50. *See* the Mini Mental Status Examination, in Best Practices in Forensic Mental Health Assessment, in Packer, *Evaluation of Criminal Responsibility* 106 (Oxford U. Press 2009).

51. Fagerlin and Schneider, "Enough: The Failure of the Living Will," 34(2) *Hastings Center Report* at nn. 56–58 (Mar.–Apr. 2004).

52. Expert medical testimony is only admissible as the result of extensive experience, training, and education. That makes it sufficiently reliable, since it is based on accepted, sound, scientific methodology. *See People v. Shreck*, 22 P.3d 68, 77–78 (Colo. 2001), CRE 702 and 403, and CRCP 26.

53. *In re Estate of Runyon*, 343 P.3d 1072, 1077 (Colo.App. 2014).

54. Colo. RPC 1.16A.

55. CRS § 15-18.7-202(3).

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