



Patient Rights

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Background

The advent of the "patient rights" movement and associated legislation is a relatively recent phenomenon, having first taken root in the early 1990s. As of January 2002, a divided and partisan 107th Congress of the United States was still grappling with various provisions for a national **PATIENTS' RIGHTS** Law. But all states have enacted some form of health care law addressing "patient rights." The problem remains that there is no uniformity of laws, and the scope of rights afforded patients varies greatly from state to state.

The term "patient" generally refers to a person who is receiving medical treatment and/or who is under medical care. Certain vulnerabilities attach to the status of patient. For this reason, certain laws have been passed at both the national and state levels to protect people's interests which otherwise might be compromised by medical, social, governmental, and/or financial entities. These protective provisions may be in the form of passive guarantees, or they may spring into effect as a result of some affirmative act on an individual's part, such as the [EXECUTION](#) of a legal document.

Generally speaking, the rights of a patient fall into a few main categories: the right to autonomy and self-determination (which includes the related right to withhold or grant [INFORMED CONSENT](#)), the right to privacy concerning medical information, and the right to receive treatment (not be refused treatment). Some hospitals refer to these collectively as a "Patient Bill of Rights," but there is no such "bill of rights" document [PER SE](#), excepting a generally accepted (but not mandated) version prepared by the American Medical Association and frequently used by hospitals.

Right to Autonomy and Self Determination

Considered one of the most important and fundamental of all is patients' right to direct the medical treatment they choose to receive or reject. Patient "autonomy" or self-determination is at the core of all medical decision-making in the United States. It means that patients have the right and ability to make their own choices and decisions about medical care and treatment they receive, as long as those decisions are within the [BOUNDARIES](#) of law. There is a legal presumption that they are fit and competent to make those decisions until a court determines otherwise.

But what happens when they are suddenly incapacitated and unable to express their wishes regarding their medical care? Thanks to a few historical developments, they can now pre-determine the medical care they

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wish to receive in the event that they become incapacitated by mental or physical injury or condition. By making their wishes and directives known to their doctors and others before they might suffer the loss of fitness or competency, they are able to avoid the circumstance of a court being forced to second-guess what is best for them or what their wishes would be. Additionally or in the alternative, patients may delegate to another person the power to make these medical decisions for them, should they lose consciousness or competency in the future.

These two concepts sound redundant but are actually quite different. In the first instance, patients have declared in advance the medical treatment they wish to receive in the event that they can no longer express those wishes (commonly referred to as a "living will"). In the second instance, patients have authorized another person to make those medical decisions for them in the event that they can no longer make themselves (commonly referred to as a "health care proxy," or "durable [POWER OF ATTORNEY](#) for health care.") Additionally, most "living will" documents address medical care and efforts in the event of life-threatening or terminal conditions. Durable powers of attorney generally address medical decision-making in any circumstance where patients are unable or not competent to speak for themselves, whether the condition is temporary or permanent.

The modern trend has been to create a "hybrid" of the above, which combines a declaration of the patients' own wishes with an appointment of a durable power of attorney to make decisions for them (which must be consistent with their declared wishes). Any or all of these legal devices are generally referred to as "advance directives for health care."

The Uniform Health-Care Decisions Act (UHCDA), approved in 1993 by the National Conference of Commissioners on Uniform State Laws, constitutes such a "hybrid" law intended to replace the fragmented and often conflicting laws of each state. Because existing laws (often several within each state) must be separately reviewed and compared to those provisions comprehensively collected under the umbrella Act, [ADOPTION](#) has been slow. As of 2001, only six states had adopted the Act to replace their existing [STATUTORY](#) provisions (Alabama, Delaware, Hawaii, Maine, Mississippi, and New Mexico) but dozens more have modeled their own comprehensive health care acts after the UHCDA.

Of course, advance directives are useless unless individuals provide copies of them to their doctors and their families or attorneys-in-fact, while they are still competent and before any incapacitation arises. Otherwise, medical personnel cannot effect their wishes if they are not made aware of them. Importantly, individuals should also keep a copy at their residence, in the event an ambulance is called on their behalf if a medical emergency arises. Without direction, ambulance personnel may initiate life-sustaining procedures that are contrary to their wishes. This is often the case for terminally ill patients who choose home hospice care and have not made other persons aware of their advance directives (even though their treating physicians may be aware of them).

One more note: if individuals do not execute an advance directive in any form, many states have passed "surrogate consent acts" which mandate the priority of surrogates permitted to make decisions about their care, should they be incapacitated.

History

In 1990, the U. S. Supreme Court decided one of the most important cases of the century, with farreaching consequences for all citizens, when it ruled that every person had a fundamental right of self determination with regard to refusing life-sustaining medical treatment. In the case of *Cruzan v. Commissioner, Missouri Department of Health*, 497 U.S. 261 (1990), the issue centered around who had the right to decide to remove a permanently brain-damaged and comatose patient from life-support systems, in the absence of the patient's own ability to express that determination. (The case included family [TESTIMONY](#) expressing what they felt

the patient's wishes would have been.)

In *Cruzan*, the family of comatose Nancy Cruzan, an automobile accident victim, requested that she be removed from life support systems and be allowed to die naturally. The hospital refused to withdraw the life support equipment. Cruzan remained on life support in an irreversible coma for the next nine years, while the case went through several appeals. Following the Supreme Court's decision, Cruzan's life support equipment was discontinued and she died naturally thirteen days later.

The horror of that scenario, combined with the high court's recognition of a constitutional right of self determination, led to a flurry of state enactments of various laws permitting living wills or advance directives for health care. However, state laws vary considerably, and it is imperative that individuals first research the laws of their state or consult an attorney before attempting to create any of these legal documents. That said, many state offices or private organizations provide pre-printed forms that comply with state laws, so it is not always necessary to consult legal [COUNSEL](#).

Living Wills

A [LIVING WILL](#) is a form of advance directive that provides specific instructions to health care providers about patient wishes to receive or refrain from receiving life-sustaining medical care in the event of a life-threatening illness, injury, or incapacitation. The document only has effect in the event that individuals are physically and/or mentally incapable of expressing their wishes at the time. Doctors and medical personnel are generally bound to adhere to the wishes patients have articulated in their living will, even if those wishes are contrary to those of the family or loved ones, and even if those wishes are inconsistent with those of the doctors or medical personnel.

Although a majority of states have living will statutes, they vary greatly in how far the law will permit individuals to dictate the extent of life-sustaining treatment they may refuse to receive. On one end of the spectrum are those states which only permit people to refuse "artificial means" of sustaining life (such as heart-lung machines, respirators, etc.) all the way to the other end of the spectrum, where less than a handful of states permit individuals to request artificial means to accelerate the timing of their death (such as Oregon's Death With Dignity Act, or other "right to die" initiatives).

Durable Powers or Attorney

Sometimes referred to as a "health care proxy," the more common term for the appointment of a surrogate decision-maker is the creation of a "durable power of attorney." By placing the word "durable" in front of a regular power of attorney, individuals create an "enduring" power for their appointed "attorney-in-fact" that survives and continues in effect, even if they become incapacitated or lose competency. A durable power of attorney for health care decisions can be worded so that it takes effect only under conditions in which where individuals are unable to competently express their own wishes, or it may be worded to have immediate and continuous effect, whether or not they are incapacitated.

The Patient Self-Determination Act (PSDA) of 1990

In 1990, Congress passed The Patient Self-Determination Act (PSDA) 42 U.S.C. Section 1395 et seq., a federal law which requires health care providers (that are recipients of federal Medicaid/Medicare funds) to inform all adult patients of their right to accept or refuse medical treatment, and their right to execute an advance directive. This law had particular impact upon nursing homes and assisted living facilities, because it required them to request each /patient resident if an advance directive was in effect, and if not, if he or she desired one.

Euthanasia and the "Right to Die" Movement

There is a medical, legal, and ethical distinction between directing the cessation of life-sustaining medical care or treatment, and directing the initiation of medical technique or treatment that accelerates the onset of death. In all but less than a handful of states, "patient rights" do not include the right to choose euthanasia and/or physician-assisted suicide, and these remain patently illegal. In those few states that permit such initiatives, it is imperative that individuals seek legal counsel prior to committing to such a directive, so that they can fully appreciate the ramifications of their decision upon such factors as life insurance benefits exclusions, health care insurance coverage, the right to change their minds, the possibility of failed initiatives, religious considerations, etc.

In the 1997 U. S. Supreme Court case of *Washington v. Glucksberg*, 117 S. Ct. 2258, the nation's highest court concluded that the "right to die" is not a constitutional right, and that a person's right to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment to the U. S. Constitution. The Court cited a state's legitimate government interest in prohibiting intentional killing and preserving human life, among other stated interests. States are, therefore, free to enact laws that treat such assisted suicides as crimes.

Informed Consent

Directly related to people's right to make decisions about their medical care is the fact that their ability to make such decisions may be limited by the amount of information they have received regarding their choices or alternatives. Therefore, virtually all states have recognized, either by express [STATUTE](#) or [COMMON LAW](#), their right to receive information about their medical condition and treatment choices, in plain language terms that they can understand, and in sufficient amounts such that they are able to make an "informed" decision about their health care.

People have a right to know what their diagnosis is, and the doctor generally cannot refrain from advising them of the true nature of their condition. A doctor may temporarily withhold some information if the doctor believes in [GOOD FAITH](#) that their condition will be substantially worsened by the knowledge of their diagnosis (referred to as "therapeutic privilege"). Also, doctors may have privilege to withhold certain diagnoses or records of mental conditions, if the disclosure of such information would create a risk of harm to patients or others. Although patients generally have a right to review their medical records, doctors may substitute "summary reports" or summary statements under circumstances of limited disclosure.

Before individuals consent to any treatment for a condition, they should receive, at a minimum, an explanation of their health problem, the treatment options available to them (including any standard treatments not available through their particular health care provider), the pros and cons of the various treatment choices, and the expected prognosis or consequence associated with each. If they have received this information, any consent to treatment that they subsequently give will be presumed to be an "informed consent."

During medical emergencies, doctors are not required to obtain permission to save individuals' lives or end the emergency, in the absence of any advance directive from patients notified them of. Also, patient consent for routine treatments or procedures such as having blood drawn or providing a urine sample, is presumed by the fact that the patients have solicited a medical [ASSESSMENT](#) and diagnosis from their doctors. On the other hand, their consent cannot be "informed" if they are intoxicated, under chemical influence of drugs or medicine, or (sometimes) in extreme pain or quasi-conscious; the law will presume that their judgment or consent was impaired under those circumstances. A doctor who fails to obtain an informed consent for non-emergency treatment or care may be charged with a criminal offense.

If individuals are incapacitated and have executed an advance directive, their attorneys in fact must consent to their treatment (durable power of attorney) and/or the health care provider must treat them in a manner consistent with their declared wishes (living will).

Right to Privacy

The fundamental right to privacy, guaranteed by the Fifth and Fourteenth Amendments to the U. S. Constitution, protects against unwarranted invasions of privacy by federal or state entities, or arms thereof. As early as in **ROE v. Wade**, 410 U.S. 113 (1973), the U. S. Supreme Court acknowledged that the doctor-patient relationship is one which evokes constitutional rights of privacy and confidentiality. But even that right is not absolute and must be weighed against the state or federal interest at stake.

For example, in *Whalen v. Roe*, 429 U.S. 589 (1977), a group of physicians joined patients in a lawsuit challenging the constitutionality of a New York statute that required physicians to report to state authorities the identities of patients receiving Schedule II drugs (controlled substances). The physicians alleged that such information was protected by the doctor-patient confidentiality, while the patients alleged that such disclosure was an invasion of their constitutional right to privacy. The Supreme Court did not disagree with the lower court's finding that "the intimate nature of a patient's concern about his bodily ills and the medication he takes—are protected by the constitutional right to privacy." However, the high court concluded (after balancing the state's interests) that "Requiring such disclosures to representatives of the State having responsibility for the health of the community, does not automatically amount to an impermissible invasion of privacy."

There are a few key points to remember about the privacy or confidentiality of medical information:

- Generally, what is considered private is information that is learned or gained by a doctor, during or as a result of a doctor's communications with patients, or [EXAMINATION](#) of them, or medical assessment of them. The privacy extends to documents and forms, whether completed by them or their health care providers, that are contained in their personal medical records.
- The scope of the duty of doctor-patient confidentiality, as well as the existence of a doctor-patient legal privilege, varies from state to state. No federal law governs doctor-patient confidentiality or privilege.
- The duty to maintain the privacy of one's own medical information continues even after individuals stop seeing or treating with the health care provider.
- The right to privacy of medical information is not absolute. Doctors may divulge or disclose personal information, against patients' will, under very limited circumstances. Some exceptions include the duty to warn police or third persons of a patient's threats of harm, or the duty to report to health authorities the fact of sexually transmitted or communicable diseases, including HIV or AIDS status. In many states, health care providers are required to report treatments of gunshot or stab wounds and suspected incidence of child abuse.

The Right to Treatment

If individuals do not carry health insurance, they are still entitled to hospital emergency care, including labor and delivery care, regardless of their ability to pay. The federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395, which is a separate section of the more comprehensive 1985 Consolidated Omnibus Reconciliation Act (COBRA), mandates minimum standards for emergency care by hospital emergency rooms. The law requires that all patients who present with an emergency medical condition must receive treatment to the extent that their emergency condition is medically "stabilized,"

irrespective of their ability to pay for such treatment.

An emergency medical condition is defined under federal law as one that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in the following:

- Placing the health of the individual (or unborn child) in serious jeopardy
- The serious impairment of a bodily function
- The serious dysfunction of any bodily function or part
- The inadequate time to effect a safe transfer of a pregnant woman to another hospital before delivery, or, that the transfer may pose a threat to the health or safety of the woman or unborn child

The law goes on to define "stabilization" as meaning "that no material deterioration of the condition is likely within reasonable medical probability to result from or occur during the transfer of the patient from a facility" (or discharge).

However, once the emergency is over and a patient's condition is stabilized, the patient can be discharged and refused further treatment by private hospitals and most public hospitals. If the individual seeks routine medical care or schedule a doctor's appointment for non-emergency medical problems, doctors have a general right to refuse treatment if they have no insurance or any other means of paying for the provided care.

There are numerous protections for HIV-positive and AIDS patients that prohibit hospitals and facilities from refusing treatment if the facility's staff has the appropriate training and resources. However, most private physicians and dentists are under ethical but not legal obligations to provide treatment.

Individuals also have a [LEGAL RIGHT](#) to not be released prematurely from a hospital. If they are advised to vacate their hospital room because of a standardized "appropriate length of stay" generally approved for their specific condition, they have the right to appeal that discharge if they believe that they are not well enough to leave. They should consult both their doctors and a hospital patient representative for procedural information regarding an appeal. However, the policy generally works in a way that makes them liable for payment of excess hospital stays if they should lose the appeal.

Individuals have the right to refuse treatment and leave a hospital at any time, assuming that they are mentally competent. The hospital may ask them to sign a document releasing it from liability if their medical condition worsens as a result of their refusal to accept the recommended treatment.

If individuals lose mental competency and appear to be a danger to themselves or others, they may be taken to a hospital against their will and held for involuntary "commitment." Most states require an immediate written statement or [AFFIDAVIT](#) affirming the reasons for their involuntary commitment. However, within a short period of time (e.g., 72 hours), most states require a full examination by a medical and psychiatric doctor, a diagnosis, and (within a certain number of days) a [HEARING](#) at which they will have the right to be represented by counsel. The purpose of the hearing is to establish whether there is sufficient information to justify their continued commitment or whether they should be released. Also, their attorneys will advise them as to whether there had been sufficient cause to justify holding them against their will in the first place.

State Provisions

In the following summaries, "DPA" is substituted for "Durable Power of Attorney." The acronym "UHCDA" is substituted for the Uniform Health Care Decisions Act, discussed previously. The reference to "combined

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advance directives" means that both living wills and proxy or power of attorney directives are authorized.

ALABAMA: Alabama has adopted an Act modeled after the UHCDA at Alabama Code of 1975, Sections 22-8A-2 to 11, enacted in 1997 (amended in 2001). Patients must be in a terminal condition or permanently unconscious. The state also has a DPA Act, Section 26-1-2, revised in 1997.

ALASKA: Alaska Statute Section 13.26.332 to .356 (specifically, 13-22.344(l) generally authorizes DPA for health care.

ARIZONA: Arizona has enacted a Comprehensive Health Care Decisions Act under Arizona Revised Statutes Annotated, Section 36-3231, dated 1992 and amended in 1994. All forms of advance directives permitted in the state are covered under Sections 3201 to 3262.

ARKANSAS: Arkansas has a Living Will Declaration Statute, Section 20-17-202 to 214. The 1999 Arkansas Laws Act 1448 (House Bill 1331) created a special DPA for health care.

CALIFORNIA: California **PROBATE** Code, Sections 4600 to 4948 (enacted in 1999) and Sections 4711 to 4727 authorize combined advance directives and a Comprehensive Health Care Decisions Act. There is a limitation on DPA power for civil commitments, electro-convulsive therapy, psycho-surgery, sterilization, and [ABORTION](#).

COLORADO: Colorado law authorizes health care DPA under Revised Statutes, Section 15-14-501 to 509, enacted in 1992. A separate Surrogate Consent Act is at Section 15-18.5-103.

CONNECTICUT: Connecticut authorizes DPA and combined advance directives under General Statutes, Section 1-43 (1993) and Sections 19a-570 to 575 (1993). Reviewed but not amended in 1998.

DELAWARE: Delaware Code Title 16, Sections 2501 to 2517, revised in 1996 and 1998, authorize combined advance directives modeled after the UHCDA.

DISTRICT OF COLUMBIA: D.C. Code Section 21-2210 (1998) covers the DPA for Health Care Act.

FLORIDA: Florida Statutes Annotated, Sections 765-101 to 404 cover the state's Comprehensive Health Care Decisions Act, last amended in 2000.

GEORGIA: Appointment of a Special DPA is authorized under Georgia Code Annotated, Section 31-36-1 to 13 (1990, amended in 1999). It also has a separate Informed Consent statute under Section 31-9-2 (1998). In 1999, the state enacted the "Temporary Health Care Placement Decision Maker for an Adult Act" which basically expands the Informed Consent Statute.

HAWAII: Hawaii Revised Statute Section 327E-1 to 16 covers the state's Comprehensive Health Care Decisions Act, modeled on the UHCDA. (1999, amended in 2000).

IDAHO: Idaho Code 39-4501 to 4509, last amended in 2001, authorizes the appointment of a Special DPA. Section 39-4303 contains the state's Informed Consent statute.

ILLINOIS: (755 Illinois Compiled Statutes 45/1-1 to 4-12, amended in 1999, creates a Special DPA for health care. 755 ILCS 40/25 (1998) addresses the state's Surrogate Consent Act, in the absence of an advance directive.

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INDIANA: Indiana Code Section 30-5-1 to 5-10 authorizes a general DPA. Section 16-36-1-1 to 1-14 contains provisions for the Health Care Agency and Surrogate Consent Act.

IOWA: A Special DPA is authorized under Iowa Code Section 144B.1 to B12, enacted in 1991. A separate Living Will Statute is found at Section 144A.7 (1998).

KANSAS: Kansas Statutes Annotated, Sections 58-625 to 632, amended in 1994, create a special DPA for health care.

KENTUCKY: Kentucky Revised Statutes, Sections 33– 311.621 to 643, amended in 1998, provide for a combined advance directive. A separate Living Will Statute is found at Section 311.631 (1999).

LOUISIANA: Louisiana Revised Statutes, 40:1299.58.1 to.10 (1999) provide for a Living Will (with proxy powers addressed in that statute).

MAINE: Maine Revised Statutes, Title 18A, Sections 5-801 to 817 (1995) create a combined advance directive authorization, modeled after the UHCDA.

MARYLAND: Maryland Code Annotated, Chapter: Health-General, Sections 5-601 to 608, (amended in 2000) permit combined advance directives.

MASSACHUSETTS: Mass. Gen. Laws Ann., Ch. 201D (1990) provides for the appointment of a special DPA.

MICHIGAN: MCL 333.3651 to 5661 provides for special DPA, with limitations on powers involving pregnancy.

MINNESOTA: Minnesota Statutes Annotated 145C.01 to.16 (1993) (substantially revised in 1998) provides for a combined advance directive. Section 253B.03(Subd 6b) provides for advance directives involving mental health patients.

MISSISSIPPI: Miss. Code Section 41-41-201 to 229 (1998 replacing 1990 law) provides for an combined advance directive modeled after the UHCDA.

MISSOURI: Mo. Ann. Statutes, Sections 404.700 to 735 and Section 800-870 (1991) create a special DPA and DPA for health care.

MONTANA: Montana Code Annotated, Sections 50-9.101 to 111, and 201 to 206 (1991) combine a Living Will statute with a health care proxy authorization.

NEBRASKA: Nebraska Revised Statutes, Sections 30-3401 to 3434 (amended in 1993) permit the appointment of special DPA for health care. Special limitations on the DPA power for pregnancy, life sustaining procedures, and hydration/nutrition.

NEVADA: Nevada Revised Statutes, Sections 449.800 to 860 provide for special DPA for health care. Section 449.626 (1997) contains the state's Living Will Statute.

NEW HAMPSHIRE: The state provides for a Special DPA under Statute Section 137-J:1 to J:16 (1991, revised in 1993).

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NEW JERSEY: New Jersey provides for combined advance directives under Statute Section 26:2H-53 to 78 (1991).

NEW MEXICO: Statute Sections 24-7A-1 to 16 (1995, amended in 1997) provide for combined advanced directives modeled after the UHCDA.

NEW YORK: N.Y. Public Health Law, Sections 2980 to 2994 (1990) provide for the appointment of a special DPA. Additionally, Section 2695 (1999) adds a specialized Surrogate Consent Statute, for use in "do not resuscitate" (DNR) directives.

NORTH CAROLINA: North Carolina General Statute 32A-15 to 26 (1993, amended in 1998) creates a special authority for DPA. Section 122C-71 to 77 (1997) addresses advance directives for mental health patients. Section 90-322 contains the Living Will Statute.

NORTH DAKOTA: Code Section 23-06.5-01 to 18 (amended in 2001) authorizes a special DPA for health care. There is a separate Informed Consent statute under Section 23-12-13.

OHIO: Ohio Revised Code Sections 1337-11 to 17, (1989, 1991) create authority for a special DPA for health care. A separate Living Will Statute is found at Section 2133.08 (1999).

OKLAHOMA: Title 63, Sections 3101.1 to 16 (last amended in 1998) provide for combined advance directives. There is a separate statute provision that addresses experimental treatments at Title 63, Section 3102A.

OREGON: Oregon Revised Statute 127-505 to 640 (enacted in 1989, amended in 1993) provides for combined advance directives. Sections 127.700 to 735 address mental health advance directives. Section 127.635 specifically addresses living wills.

PENNSYLVANIA: Pennsylvania has a Living Will statute found at Statute Title 20, Sections 5401 to 5416 (1993). A general DPA (not specific to health care) is permitted under Sections 5601 to 5607.

RHODE ISLAND: Rhode Island General Laws, Sections 23-4:10-1 to 12 (amended in 1998) permit a special DPA for health care decisions.

SOUTH CAROLINA: South Carolina Code Section 62-5-501 to 504 creates a special DPA for health care. Section 44-66-30 (1998) provides separately for the Surrogate Consent Act in the absence of an advance directive.

SOUTH DAKOTA: The state's Codified Laws, Section 34-12C 1 to 8 and Section 59-7-2.1 to 8 (1990) provide for the appointment of a special DPA. There is a separate Surrogate Consent Act under Section 44-66-30 (1998).

TENNESSEE: Tennessee Code Annotated, Sections 34-6-201 to 214 (1990, amended 1991) create the authority for special DPAs.

TEXAS: Texas [Health and Safety] Code, Sections 166.001 to 166.166 (amended in 1999) authorize a special DPA. In 1997, the state enacted its Advance Directive Act under Section 166.039.

UTAH: Utah Code Annotated, Sections 75-2-11-1 to 1118 (amended in 1993) authorizes a special DPA for health care. Since then, it has added its Comprehensive Health Care Decisions Act under Sections 75-2-1105 to 1107 (1998).

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VERMONT: Statute Title 14, Sections 3451 to 3467 (1989) authorize the appointment of a special DPA for health care.

VIRGINIA: Virginia Code Sections 54.1-2981 to 2993 (1992, amended in 2000) provides for combined advance directives, including a version of a comprehensive health care decisions act at Section 54.1-2986.

WASHINGTON: Revised Code Sections 11.94.010 to 900 (1990) provide for general DPA, with limitations on power for electro-convulsive therapy, amputation, and psychiatric surgery. A separate Informed Consent statute is contained under Section 7.70.065 (1998).

WEST VIRGINIA: W. Va. Code Section 16-30-1 to 21 (2000) provide for combined advance directives, but mandate separate documents for living wills and medical powers of attorney.

WISCONSIN: Wisconsin Statutes Annotated, Sections 155.01 to 80 and Section 11.243.07 (6m) (amended 1998) authorize a special DPA.

WYOMING: Wyoming Statutes Annotated, Section 3-5-201 to 214 (specifically Section 3-209) (1991, 1992) authorize appointment of a special DPA. The identical statute is also contained at Section 35-22-105(b) (1998) but is referred to as the Living Will statute.

Additional Resources

"A Few Facts About the Uniform Health-Care Decisions Act." Available at <http://www.alzheimers.org>

"Alzheimer's Disease and Related Dementias: Legal Issues in Care and Treatment, 1994." A Report to Congress of the Advisory Panel on Alzheimer's Disease. Available at <http://www.alzheimers.org>

"Federal Laws in Emergency Medicine." Derlet, Robert, M.D. *eMedicine Journal*, 22 January 2002. Available at <http://www.emedicine.com/emerg/topic860.htm>.

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Law for Dummies. Ventura, John. IDG Books Worldwide, Inc., 1996.

"Surrogate Consent in the Absence of an Advance Directive." American Bar Association, Commission on Legal Problems of the Elderly. July 2001.

The Court TV Cradle-to-grave Legal Survival Guide. Little, Brown and Company, 1995.

Organizations

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The Patient Advocacy List

URL: <http://infonet.welch.jhu.edu/advocacy.html>

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