

PENNSYLVANIA AIDS LAW REPORT

Funded by a grant from the Lawyer Trust Account Board

Issue No. 3
May 1994

A PUBLICATION OF THE AIDS LAW PROJECT OF PENNSYLVANIA
1211 Chestnut Street, Suite 1200, Philadelphia, PA 19107 (215) 587-9377

In This Issue ...

... our major article covers issues involved in documenting client decisions regarding the sensitive issues of disability and death. There is no single term that adequately describes this area of legal practice. The major article draws on subjects including probate and inheritance tax law, estate planning, agency law, and legal and practical aspects of health care, insurance, and public benefits in order to provide a full overview of the topic.

Based on client inquiries here at the AIDS Law Project, we know that this is one of the most needed areas of legal service. And contrary to what many legal practitioners may think, the need for this planning and decisionmaking is no less pressing and important for low-income clients than it is for clients with substantial wealth. In many ways, the issues are even more crucial for low-income clients with HIV disease, since they already may have lost control over so many other aspects of their lives. Here is an important opportunity for volunteer lawyers to make a significant difference in the lives of their clients in an area of practice in which many attorneys are more than adequately experienced. If you wish to volunteer, or if you know an attorney who may be interested in volunteering, please call us: (215) 587-9377.

Also in this issue, you'll find the second part of our Litigation Docket.

If you didn't receive either or both of the first two issues of the *Pennsylvania AIDS Law Report*, copies are available. Our first issue covered Act 148, Pennsylvania's Confidentiality of HIV-Related Information Act, and included several forms to help ensure compliance with the law. The second issue covered nondiscrimination standards in regard to HIV/AIDS, and included a listing of state and federal standards in a summary chart format for easy reference. The second issue also presented part one of our litigation docket. To request back issues of the *Pennsylvania AIDS Law Report*, or to be added to our mailing list for future issues, please call.

§§§

Documenting Personal Decisions

Introduction

One of the basic legal services for persons with HIV disease is that of documenting the client's decisions regarding health care and/or financial issues in advance of decisional incapacity or death. Although such issues are relevant to everyone regardless of HIV status, for clients with HIV disease, they can take on a special urgency. Legal services in this area fall into several related categories which will be reviewed in turn in this article: decisionmaking regarding provision of health care, by advance health care directive or living will; appointment of a surrogate decisionmaker, by a power of attorney, which addresses health care or financial decisionmaking; and post-mortem planning, usually involving execution of a will or alternatives to wills.

This article considers the personal decisionmaking issues from the perspective of low-income clients with limited assets, who are likely to look to legal service or volunteer attorneys for assistance. Clients with more significant income and assets present many of the same issues, but those clients should be able to obtain for-fee legal services to address potentially more complex issues, particularly in regard to estate planning. Those issues are beyond the scope of this article.

Even though these services are provided routinely by legal professionals, and may in some instances be provided without the involvement of an attorney, there may be significant barriers to obtaining such services. Such planning involves consideration of circumstances — loss of decisional capacity or death — that few, if any of us, wish to confront. Because of denial about the potential for disability or death, many clients with HIV disease may delay or avoid consideration of such issues. Similarly, social service and health care professionals may feel uncomfortable raising such issues with their clients. Raising these issues may be viewed as putting emphasis on the client's potential loss of control, resulting from his or her illness, as well as the fact that service providers' power over the disease is limited.

It is important to emphasize the positive in terms of living with HIV. Although incapacity and death issues cannot be avoided, persons with HIV disease should understand that the law provides them with significant decisionmaking power that only they can exercise. Exercising that power may protect loved ones by resolving potential conflicts before they occur, and alleviate much of the distress family or other loved ones may experience in caring for the client during a period of illness. Some of the planning may protect

(continued on page 2)

Documenting Personal Decisions (continued from page 1)

loved ones in the event of the client's death. Clients should understand that by failing to address these issues they face the risk that decisions will be made on their behalf by others without regard to their own wishes. Clients and their loved ones should also understand that such planning should be undertaken while the client has the mental and physical capability to do so. Delay or postponement exposes the client to the risk that decisions are documented, if at all, under circumstances that are potentially subject to challenge and disputed interpretation because of lack of certainty regarding the client's decisionmaking capacity.

Many clients may need the support of compassionate social service or health professionals in responding to these issues. Form documents can be provided to the client to review to de-mystify the process. Review of these issues should be a routine part of case management services, typically at the point of client intake, although service providers should of course use their own judgment in deciding when and how to raise these issues with clients. A "Personal Decisionmaking Checklist" is printed on page 13. Individuals who counsel clients about these issues should consider having their own advance medical directives, wills, or powers of attorney prepared, which will provide them with first-hand experience regarding the decisionmaking process. Although, as noted below, federal law requires certain institutional health care providers to inform patients about their right to have advance health care directives, all providers should routinely review such issues with their clients. Also, attorneys representing clients with HIV disease in litigation should determine whether the client has executed a durable power of attorney and will naming an executor. In the event of the client's death or decisional incapacity, the litigation may be continued by the attorney-in-fact or executor of the client's estate.¹

In cases where a client has not yet documented any decisions in these areas, but wishes to do so, health care and social service providers should be prepared to provide a referral to an HIV-sensitive attorney. Ideally, clients should always have access to attorneys to prepare these documents. This is particularly true in the cases of powers of attorney dealing with financial issues and wills, which often need to be individually drafted to meet the specific needs of individual clients. Other documents, however, such as health care powers of attorney and advance health care directives can be effectively completed without the assistance of attorneys, when attorneys are not available to assist clients.

Advance Health Care Directives

An advance health care directive, frequently referred to as a living will, was recognized as legally valid in Pennsylvania by the state legislature's adoption of the Advance Directive for Health Care Act in 1992.² The goal of the Pennsylvania statute is to minimize uncertainty and the potential for dispute regarding

health care decisionmaking by allowing a competent, adult individual to clearly express his or her wishes with respect to health care in advance of the need to make a decision regarding such care.

In Pennsylvania, this legislation now recognizes the patient's right to choose or reject, in advance, certain health care options in the event that the patient: (1) is incompetent and (2) is either permanently unconscious or has a terminal condition. The law defines incompetency as "lack of sufficient capacity for a person to make or communicate decisions concerning himself." Permanent unconsciousness is defined as a "medical condition that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity to interact with the environment." A terminal condition is defined as "[a]n incurable and irreversible medical condition in an advanced state caused by ... disease ... which will, in the opinion of the attending physician, to a reasonable degree of medical certainty, result in death regardless of the continued application of life-sustaining treatment." Accordingly, the circumstances in which the advance directive is valid are limited and very specific. The advance directive may also specify what treatments or procedures the patient consents to or refuses. The advance directive may name a surrogate decisionmaker in addition to specifying consent or refusal for care or treatment. FORM 1, accompanying this article, is a standard advance health care directive.³ Because of the limited application of the advance directive, clients should also execute a durable health care power of attorney, discussed below.

This discussion addresses advance directives only within the context of the Pennsylvania statute. Individuals who executed an advance health care directive prior to the effective date of the Pennsylvania statute (April 16, 1992) should have the advance directive reviewed to determine whether it conforms to the current law, or they should simply execute a new advance directive. If there is any doubt regarding the effectiveness of an earlier advance directive, an advance directive that conforms to the law should be executed. Advance directives that do not conform to the law (e.g., were executed without the necessary formalities, such as being signed without the required two witnesses), may nevertheless be upheld in the courts and honored by health care providers, but individuals should rely on such documents only on advice of an attorney. In general, individuals with advance directives should review them approximately every two years or so, and date and initial them upon reviewing them.

The Pennsylvania law provides that in the absence of an advance health care directive that conforms to the statutory requirements, there is no presumption as to the intent of the patient to consent to or to refuse initiation, continuation, or termination of life-sustaining treatment. Thus, failure to execute a directive is not to be viewed as evidence of an intent not to

(continued on page 5)

AIDS Law Project Case Docket Update

Part II

*A listing of currently pending or recently resolved litigation matters
sponsored by the AIDS Law Project of Pennsylvania*

The AIDS Law Project of Pennsylvania provides a wide range of legal services to people with HIV and AIDS, or others affected by the AIDS epidemic. In 1993 over 1500 people contacted the AIDS Law Project for legal assistance. We help clients with a variety of legal issues including wills and advance directives; problems obtaining insurance benefits; debt problems or public assistance; inadequate medical care in the prisons and discrimination in employment, medical services and education.

In some matters Law Project staff refer clients to members of our attorney referral panel. Before referring a client to a cooperating attorney, a Law Project attorney reviews the case and refers only to lawyers who have volunteered to accept such cases. When necessary, the Law Project staff or volunteer attorneys provide immediate, emergency bedside assistance in a hospital, hospice, or a person's home.

In 1993 the Law Project established the Adoption, Foster Care and Custody Assistance Project which offers free legal services and advice at four Philadelphia hospitals and health clinics to help parents with HIV and AIDS plan for the future welfare of their children. Through this program, the pressing needs of families with HIV and protection of the family structure in the event of the parent's or caregiver's death is addressed as part of comprehensive family services.

In those cases which have the potential for law reform the Law Project will sponsor individual representation in an effort to make a significant contribution to the development of case law involving the civil liberties of people with HIV/AIDS.

As noted below, AIDS Law Project "cooperating attorneys" represent our clients, along with AIDS Law Project staff, on a pro bono basis. If no cooperating attorney is listed for the case, it is being handled directly by AIDS Law Project staff without assistance of private, volunteer attorneys. As is common in litigation of cases involving HIV issues, a pseudonym (typically, "Doc") is used to protect the identity of the client with AIDS/HIV. These cases represent approximately half of the cases currently under AIDS Law Project sponsorship. The other half were summarized in the Pennsylvania AIDS Law Report (March, 1993, Docket Part I).

Discrimination in Services

1. ***The Dental Cases***, Pennsylvania Human Relations Commission and Philadelphia Court of Common Pleas. **CASES SETTLED and PENDING.** In a joint project with the ACLU of Pennsylvania, the AIDS Law Project filed a series of complaints with the Pennsylvania Human Relations Commission in 1990 against Philadelphia-area dentists for

refusing to provide services to persons with HIV infection. In each case, the complainant made an appointment with a dentist for routine services; subsequently, the complainant disclosed his HIV status, with the result that the dentist then refused to provide services on the basis of the complainant's HIV status. Although discrimination by dental professionals is now covered by the Americans with Disabilities Act of 1990 (ADA), these cases were filed under the Pennsylvania Human Relations Act, prior to the effective date of the ADA. In October 1993, all but one of the cases was settled. In settling the cases, the dentists agreed not to discriminate in the future, to post a notice in clear view in their offices that they do not discriminate on the basis of disability and/or infectious disease status, and to provide continuing infection control training for their staff. In announcing the settlement, attorneys for the complainants were critical of the Pennsylvania Human Relations Commission's handling of the cases, since the complaints were pending for 14 months before a finding of probable cause was made, and, after pending for 3 years, the cases had not yet been scheduled for a public hearing.

The one remaining case has been filed in the Philadelphia Court of Common Pleas (*Hardy v. Branca*). Under the Human Relations Act, that case is now being litigated without regard to the prior proceedings before the Human Relations Commission. The complainants before the Human Relations Commission and the remaining plaintiff in Common Pleas Court are represented by Valerie J. Flocco and Alan K. Maesaka of Morgan, Lewis & Bockius, Philadelphia, and Scott Burris, Assistant Professor of Law, Temple University School of Law, on behalf of the ACLU of Pennsylvania.

2. ***Wey v. Evangelical Community Hospital***, U.S. District Court, Middle District of Pennsylvania.

This federal lawsuit, as initially commenced, included HIV discrimination claims against the defendant Hospital. As explained below, those claims were subsequently abandoned, and the case was tried, albeit unsuccessfully, on other claims not involving the HIV status of the plaintiff. In July 1991, plaintiff sought treatment at Evangelical Community Hospital for leg injuries he suffered in a bicycling accident. He informed the Hospital's staff that he was HIV positive. The emergency room physician then diagnosed the plaintiff's injuries as a severe fracture and ankle dislocation, and recommended surgery. But instead of treating plaintiff at the Hospital in preparation for the surgery, the physician referred the plaintiff to another medical facility where the plaintiff had previously received medical care relating to his

(continued on page 4)

Case Docket Update, Part II (continued from page 3)

HIV infection. Although the travel time to the other facility was approximately 1.5 hours by car, and it was then 1:25 AM, plaintiff and his wife felt they had no choice but to drive to the other facility. They were not informed that the plaintiff could have obtained ambulance transportation, without charge, as a Medical Assistance patient. He then went to the other facility in his own car, driven by his wife, arriving after 3:00 AM. The federal court complaint against the Hospital alleged HIV discrimination under the Section 504 of the Rehabilitation Act, 29 U.S.C. 794, as well as claims under the federal Anti-Dumping Act, 42 U.S.C. 1395dd, and the Hill-Burton Act, 42 U.S.C. 291. The Anti-Dumping Act prohibits hospitals with emergency departments from refusing to treat patients requiring emergency services or from referring such patients to other facilities without first stabilizing the patient's condition. The Hill-Burton Act prohibits hospitals from refusing to provide services on the basis that the patient is unable to pay for the services. In this case, the Hospital conceded that it was covered by both the Anti-Dumping Act and the Hill-Burton Act. As a result of pre-trial discovery, plaintiff learned that the Hospital was able to document its provision of services to other patients known by it to be HIV infected. Because of this fact, and the fact that there was no direct evidence that the plaintiff's referral was based on his HIV status, the Rehabilitation Act discrimination claim was dismissed by the plaintiff. Thus, at trial, plaintiff's case did not present any issues of HIV discrimination, but instead involved the other two federal statutory claims. After trial of the case in July 1993, Judge James F. McClure, Jr., found in favor of the defendant in an opinion issued September 21, 1993. In resolving issues that turned largely on assessment of the credibility of the witnesses and the weight to be given to their testimony, Judge McClure found that the Hospital was not liable under the Anti-Dumping Statute because the plaintiff had validly consented to the transfer. In regard to the Hill-Burton claim, the Judge concluded that provision of ambulance services was not a service provided by the Hospital and the Hospital staff had no duty to inform the plaintiff that they could obtain ambulance services that would accept Medical Assistance payment for the service.

Lead counsel on this case was Roberta Mueller, Staff Attorney with Keystone Legal Services, of Lewisburg, Pennsylvania, on behalf of the Pennsylvania Health Law Project.

3. Haraczka v. Montgomery County Geriatric and Rehabilitation Center, Administrative complaint with U.S. Department of Health and Human Services, Office for Civil Rights.

SUCCESSFUL DISPOSITION. This administrative complaint under Section 504 of the Rehabilitation Act was brought on behalf of a HIV-infected man who was denied admission to a nursing home because of his HIV status.

Subsequent to the filing of the complaint, the nursing home agreed to accept the complainant's application for admission, and the complaint was resolved on that basis.

4. Paziora v. Dental Care Associates, Pennsylvania Human Relations Commission.

SUCCESSFUL SETTLEMENT. This case involves a claim of illegal discrimination by a dental office which refused to provide dental care to a patient because of her HIV infection. As a result of the complaint, Dental Care Associates, which operates several dental offices in central Pennsylvania, agreed to mandatory staff training on dental care and HIV transmission, adopted a written HIV nondiscrimination policy, and agreed to provide dental treatment in a nondiscriminatory manner to patients with HIV/AIDS.

Discrimination in Employment

5. Herrero v. Computer Learning Center and Administrative Management Group, Pennsylvania Human Relations Commission.

PENDING CASE. This case involves claims of discrimination under the Pennsylvania Human Relations Act for an employer's termination of an HIV-infected employee from employment as a result of the employee's disclosure of HIV illness in the course of seeking reimbursement for medical services under the employer's health benefits program. Additionally, the former employee is challenging the employer's health benefits lifetime cap of \$15,000 on all HIV-related benefits. The former employee was terminated from employment after submitting claims for medical services pertaining to his HIV illness.

6. Doe v. Southeastern Pennsylvania Transportation Authority (SEPTA), U.S. District Court, Eastern District of Pa.

PENDING CASE. This employment discrimination case involves claims that the defendants, SEPTA and Judith Pierce, a SEPTA manager, unlawfully used confidential information pertaining to the plaintiff's HIV-related drug prescriptions to identify the plaintiff as having HIV illness and further invaded the plaintiff's privacy by disclosing this information to other employees. The defendants also discriminated against him by withholding salary increases. The federal court complaint alleges that SEPTA violated the federal and state constitution, the Americans with Disabilities Act and the related nondiscrimination statutes, and the Pennsylvania Confidentiality of HIV-Related Information Act. The case is scheduled for trial in September 1994. Lead counsel for the plaintiff is AIDS Law Project cooperating attorney, Clifford A. Boardman of Philadelphia.

§§§

Documenting Personal Decisions (continued from page 2)

refuse life-sustaining care. Even if the client's directions fail to meet the standards of the statute, they may be taken as evidence of the client's intentions. In order to have the client's wishes honored, however, it may be necessary to obtain a court ruling to that effect. Executing an advance directive in conformity with the statute will avoid this potential problem.

To be effective, an advance medical directive must be signed in the presence of two witnesses, who also sign the document. Although the law does not prohibit family members or health care providers from being witnesses, it is best if the witnesses have no interest in the client's estate. Similarly, the witnesses to the execution of the advance directive should not be the individual named as surrogate decision-maker. The advance directive need not be notarized to be effective.

The signer must be 18 years of age, or, if under 18, must have been married or have graduated from high school. For other persons under the age of 18 years, parents retain decisionmaking authority. For minor children in the dependency system, for whom no parental decisionmaker is available, court approval is required for health care decisionmaking of this nature.⁴ As a result, advance planning is generally not possible.

In order to validly execute an advance directive, the client must be, in the terms of the statute, of "sound mind." The statute does not further define this term, nor have the courts interpreted it. In some cases, clients with HIV disease suffer from AIDS-related dementia or other conditions that may impair mental function. In preparing advance directives for clients, if there is any question regarding the client's ability to understand the advance directive or to communicate his or her wishes, the directive should be prepared under the supervision of an attorney, who should then document the opinion of medical professionals regarding the client's mental status. If the decisional incapacity is too severe, the client may not be capable of executing a valid advance directive. In the case of clients without a valid advance directive, but who lack the necessary capacity to execute one, health care decisionmaking authority is vested in the person appointed by the court as the guardian of the person for the client.⁵

After executing an advance health care directive, the individual should give a copy to his or her physician or other health care provider, who is then required to include it in their patient's medical record. Copies should also be given to the client's medical attorney-in-fact, if the client has one, or to members of the client's family who are likely to be involved in providing health care for the client. If the attending physician believes that he or she will be unable to comply with the directive, the physician is required to advise the patient of that fact at that time. The advance directive is operative when a copy is given to the individual's attending physician and after the individual is then determined by the attending physician, and a second, consulting physician, to be incompetent and in a terminal condition or in a state of permanent unconsciousness.

An individual can revoke an advance directive at any time and in any manner by communicating the revocation to the attending physician or other health care provider. The physician is then required to make the revocation a part of the patient's medical record.

In many hospitals, physicians follow the practice of noting, after obtaining the patient's consent or that of the patient's family, that a patient with a terminal, irreversible illness should not be resuscitated after an episode of cardiac or respiratory failure. Such "do no resuscitate" (or "DNR") orders do not conform to the statutory requirements of an advance directive; completion of an advance directive that includes such a provision (as does FORM 1) alleviate the need for the patient's or family's decision at that point regarding the entry of the DNR order.

The Pennsylvania advance directive law also provides that the withholding or withdrawal of life-sustaining treatment in accordance with a patient's advance directive does not constitute suicide or homicide. As a result, a patient's death resulting from the directions in the advance directive cannot be ruled a suicide by a life insurer in seeking to avoid paying the benefits from a policy of life insurance. Nor could a health care professional be prosecuted for assisting suicide in acting in accordance with a valid advance directive.⁶

Finally, the Pennsylvania advance directive law provides a pregnancy exception. If the client is pregnant, the statute provides that life-sustaining treatment, nutrition and hydration must be provided, regardless of an advance directive to the contrary, unless her attending physician and an obstetrician certify that the life-sustaining treatment, nutrition and hydration will: (1) not maintain the client in such a way as to permit the continuing development and live birth of the unborn child; (2) will be physically harmful to the client; or (3) would cause pain to the client which cannot be alleviated by medication. These statutory limitations on a pregnant woman's decisionmaking authority have not been reviewed by the courts in Pennsylvania. Clients who may have concerns regarding the pregnancy limitation should seek advice from their own attorneys regarding its application. In any event, the pregnancy exception should not deter women from executing advance health care directives.

Institutional health care providers who receive Medicare and/or Medicaid funding are required by federal law to furnish patients with information about Pennsylvania's advance health care directive law. This federal law, the Patient Self-Determination Act,⁷ also requires institutions to maintain written policies and procedures concerning advance directives and to document whether or not the patient has executed an advance directive. As a practical matter, however, most institutions will not assist a patient in actually preparing an advance health care directive, so referral to an attorney may nevertheless be necessary. As noted above, under Pennsylvania law, the attending physician at an institution is required to include the

(continued on page 6)

Documenting Personal Decisions (continued from page 5)

advance directive in the patient's records. The federal law also requires institutions to ensure that they comply with the Pennsylvania advance directive law and that they not discriminate against patients based on whether or not the patient has executed an advance directive.

Power of Attorney

A power of attorney is a document in which the client (usually referred to as the "principal" in the document itself) names another person (the attorney-in-fact) to act on his or her behalf. This is technically termed an "agency" relationship, with the individual who is named as the attorney-in-fact acting as the agent of the principal, who is delegating the authority to act. For example, a gay client (the principal) may wish to name his lover (the attorney-in-fact) on a power of attorney; this will enable the client's lover to exercise decisionmaking authority on his lover's behalf, much as a (legally) married spouse may make decisions on behalf of his or her spouse.

The authority or powers granted to the attorney-in-fact can be as broad or as limited as the client wishes. Typically, a power of attorney may be limited to health care decisionmaking (FORM 2, a health care power of attorney), or financial issues (a financial power of attorney), or without any limitation (a general power of attorney). Because of the potentially broad authority that an attorney-in-fact may be granted, the client should select the attorney-in-fact with great care and review with an attorney the precise authority that the power of attorney grants to the attorney-in-fact.⁸ More than one attorney-in-fact may be appointed on a power of attorney, although this may be cumbersome if both signatures are required for certain transactions. Alternative attorneys-in-fact may also be named to serve if the first-named cannot do so.

Powers of attorney executed on or after December 16, 1992, are "durable" in effect unless the power of attorney document specifies otherwise. A durable power of attorney continues to be valid when the principal is decisionally incapacitated (e.g., is unconscious).⁹ In most cases, the primary purpose of the power of attorney is to protect the client in the event of incapacity, and thus a non-durable power of attorney is of no effect in that situation. If the client is able to make decisions on his or her own behalf, the client's own decision will override that of the attorney-in-fact; in the event of a conflict between the client and the attorney-in-fact, the client can simply revoke the power of attorney. A client may choose to execute a health care power of attorney, which will allow the attorney-in-fact to make decisions only concerning health care for the client (see FORM 2). The medical power of attorney should be consistent with the client's advance health care directive, and should reference the advance directive. Unlike an advance directive, however, the power of attorney can only authorize the initiation of health care or treatment; it cannot authorize the termination or withdrawal of care or treatment.¹⁰

Accordingly, clients should have both a power of attorney and an advance directive.

Powers of attorney are effective upon being signed, unless specified otherwise in the power of attorney. A power of attorney may be drafted to be effective only upon the principal's becoming incapacitated, as certified by two physicians, or some other future event (a "springing" power of attorney). Alternatively, a power of attorney, when prepared by an attorney, may be retained by the attorney, and then provided to the attorney-in-fact once the attorney has determined that the attorney-in-fact needs to act pursuant to it as a result of the principal's incapacity. A power of attorney can be revoked by giving written notice to the attorney-in-fact. Notice to client's physician, or other appropriate service provider, may also be appropriate in the event of revocation or other change in the provisions of a power of attorney.

FORM 2 is a sample power of attorney for the purposes of health care decisionmaking only (although no witnesses are required for execution of a valid power of attorney, the form provides spaces for two witnesses to sign). Neither witness should be the person named as the attorney-in-fact. Although powers of attorney need not, in general, have a notarized acknowledgment to be valid, powers of attorney that contain authorization to transfer real estate or to engage in financial transactions should be acknowledged before a notary public. The FORM 2 power of attorney includes provisions relating to hospital visitation, access to medical records, and related provisions that may be important particularly if the situation involves a non-marital relationship (e.g., a gay couple or other non-marital relationship), and the relationship may not be given recognition by an institutional provider unless it is documented by the power of attorney. Although the FORM 2 power of attorney is effective upon execution, many of the decisions on the client's behalf could only be made in the event that the client lacks the decisional capacity to make those decisions. In regard to visitation during a hospitalization when visitation is restricted, or access to the client's hospital physicians for consultation, the client may indicate who is to have such access in the hospital's admission documents, pursuant to the Patient Bill of Rights,¹¹ in addition to making that designation on the power of attorney.

The health care power of attorney should be provided to the client's physician, and, of course, it should be reviewed with the attorney-in-fact so the attorney-in-fact understands his or her responsibilities in regard to decisionmaking on the client's behalf.

An attorney-in-fact owes a fiduciary duty to the principal/client, and as a result may be required to account for the handling of any funds or property entrusted to his or her care pursuant to a power of attorney that provides authority over

(continued on page 7)

Documenting Personal Decisions (continued from page 6)

financial or related matters. An attorney-in-fact should maintain records of income and expenses involving the client's funds.

Although powers of attorney sometimes include provisions authorizing the attorney-in-fact to undertake actions after the client's death (e.g., collecting personal property from a hospital, arranging for funeral services, etc. — see FORM 2, para. 3), the power of attorney ceases to be effective upon the death of the client. Although such provisions in powers of attorney may be honored, the client should understand that it is the executor named in the client's will who has authority to undertake such actions. In many cases, the client will name the same person as the attorney-in-fact and as the executor in the will. Issues related to wills are discussed more fully below.

Financial institutions such as banks frequently prefer that customers utilize the institution's own form power of attorney, even though an appropriately drafted and executed power of attorney is valid for banking transactions. If the attorney-in-fact may need to engage in financial transactions, the client's bank or other financial institution should be contacted and the appropriate power-of-attorney forms executed in order to avoid any problem with bank personnel who are unfamiliar with powers of attorney other than the form used by their institution. As noted below, joint ownership of an account may also be considered as a means of providing access. Also, the client can designate an attorney-in-fact to receive social security benefits (SSDI/SSI benefits) by designating the attorney-in-fact as a representative payee on the appropriate Social Security Administration form (SSA-11-BK). The Social Security Administration, however, is not required to accept the client's designation on the power of attorney or the Social Security Administration form.

Wills and Intestacy

A will is a document that directs the distribution of property upon the signer's death and may cover related post-mortem issues. Until death occurs, the will has no legal effect and may be amended or revoked. Having a validly executed will frequently avoids disputes over the division and disposition of property that might otherwise arise. Even if a client does not have a great deal of property to be distributed, it may be a good idea to have a will. Gifts of specific items (family heirlooms or other items of sentimental, if not monetary, value) can be made to any beneficiary of the client's choice, such as family members and friends, as well as to charitable organizations. Also, a will covers property that the client is not even aware of owning, or property that the client acquires after executing the will, or even funds that are obtained after the client's death as a result of any claims the client may have commenced during his or her lifetime. Note, however, that in regard to social security benefits (SSDI or SSI), the Social Security Act, not the client's will, controls the limited circumstances in which benefits are

recoverable in the event that the client dies while the disability benefit claim is pending.¹²

In the will, the client can name an executor — the person who has authority to handle the estate (e.g., collecting any property, obtaining funds from bank accounts, and ensuring that they are distributed as directed in the will). The executor does not take on the debts or other obligations of the client by being named as executor in the will.

The executor also has authority to make funeral/burial arrangements. A will should not, however, contain directions concerning such arrangements. Since the will is rarely consulted before the funeral arrangements are made, these instructions should be stated in a separate letter to be consulted in the event of the client's death. Copies should be given to the executor and, if appropriate, to the client's family. Although not legally binding, such instructions, when left with the person named as executor of the estate, provide the best means of assuring that the client's wishes are respected.

The will should be prepared and executed in the state where the client intends to reside permanently. To be valid in Pennsylvania, the will needs to be in writing (oral wills are generally unenforceable), bearing the client's signature at the end. Frequently, however, witnesses are used for the signing, with the signatures notarized, with the result that the will is more easily admitted to probate. Because of the potential complexity in preparing even a basic will, it should be prepared by an attorney.

For clients with minor children, a will can address several important issues. A will can include a nomination of a guardian for minor children. Although a court is not bound by the client's directions regarding the choice of guardian, the nomination may be an important factor in a court's decision regarding placement of children.¹³ For clients with any significant assets, including proceeds from life insurance, a trustee can be named to hold the property for the benefit of the minor children. The trustee appointment, which does not require court approval, is frequently preferable to court supervision of the assets in cases where no such appointment by will has been made.

Upon the death of a married client, the client's surviving spouse has the right to claim against the estate, even if the will excludes the surviving spouse from having any share in the estate.¹³ Planning for such clients may thus involve consideration of initiating divorce proceedings.

One issue in the context of HIV disease which arises with wills, as well as with living wills and powers of attorney, is incapacity. On occasion disputes have arisen regarding the validity of wills executed by clients who are alleged to have suffered from AIDS-related dementia. As noted above in reference to execution of an advance medical directive and power of attorney, if there is any question regarding the client's capacity to sign the will, the attorney supervising the signing

(continued on page 12)

FORM 1
ADVANCE HEALTH CARE DIRECTIVE

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged by the administration of life-sustaining treatment under the circumstances set forth below, and I do hereby declare:

1. If, at any time I should have an incurable condition, caused by injury, disease, or illness, and certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and who have determined that my death is imminent whether or not medical treatment, including life-sustaining procedures, is utilized, and where the application of medical treatment, including life-sustaining procedures, would only serve to artificially prolong the dying process; or

2. If at any time I should be diagnosed to have suffered extensive, irreparable brain damage resulting in permanent unconsciousness as certified by two physicians who have personally examined me, one of whom shall be my attending physician, and who have determined that life-sustaining procedures will serve only to preserve me in a permanent unconscious existence with no reasonable chance of a return to a cognitive, sapient state; I then direct that such medical treatment, including life-sustaining procedures, be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedures deemed ordinary and basic to my comfort and care. This treatment shall be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment. Specifically, if I am in the condition described above, I direct that the following treatments be administered according to my wishes as stated below:

I () do () do not want cardiac resuscitation.

I () do () do not want mechanical respiration.

I () do () do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I () do () do not want any form of surgery or invasive diagnostic tests.

I () do () do not want antibiotics.

I () do () do not want blood or blood products.

I () do () do not want kidney dialysis.

Other instructions: _____

Should any specific direction in this declaration be held to be invalid, the invalidity shall not offset other directions of this declaration which can be effected without the invalid direction. I realize that it is not possible for me to anticipate the very wide variety of medical decisions, which may need to be made in the future and to provide specific written directions. Accordingly, my Health Care Representative appointed below, shall make all health care decisions on my behalf, including decisions to accept or

FORM 1, continued

withhold or withdraw life-sustaining procedures and fluids and nutrition. My Health Care Representative shall give priority to the Advance Health Care Directive set forth above and may also consider, as appropriate and necessary as evidence of my wishes: my verbal and nonverbal expressions; other reliable sources of information as to my values, preferences and goals, and reliable oral or written statements by me. If this Advance Health Care Directive in conjunction with other evidence of my wishes is not specific to my medical condition and treatment alternatives, then my Health Care Representative shall exercise reasonable judgment to effect my wishes, giving full weight to the terms and spirit of this Advance Health Care Directive and other evidence of my wishes.

Name, address and phone number of Health Care Representative:

Name, address and phone number of substitute Health Care Representative if primary Health Care Representative is unavailable:

I understand that I may revoke this declaration at any time and in any manner without regard to my mental or physical condition. This revocation shall be effective when I communicate it to my attending physician, other health care provider, or a witness to the revocation. In the absence of my ability to give directions regarding the provision of medical care, including the use of life-sustaining procedures, it is my intention that this declaration shall be honored by my family, attorney-in-fact, Health Care Representative, and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of such refusal. This declaration shall remain a statement of my will unless I subsequently revoke it. I understand the full import of this declaration, and I am emotionally and mentally competent to make this decision. This Advance Health Care Directive, consisting of three (3) pages was signed by me, in the presence of the witnesses whose names appear below, on this _____, day of _____, 1994, in _____, Pennsylvania.

Signature

_____, in my presence, signed this declaration. I believe the declarant to be of sound mind. I am at least 18 years of age and am not related to the declarant by blood or marriage, have no claim against any portion of the estate of the declarant according to the laws of intestate, nor am I directly financially responsible for the declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health care facility in which the declarant is or may be a patient.

Witness Signature

Address

Witness Signature

Address

FORM 2
HEALTH CARE POWER OF ATTORNEY

1. I, _____, of _____ do hereby appoint my _____, _____, residing at _____, in _____, as my attorney-in-fact (hereinafter called "attorney") for me and on my behalf and hereby state that this power of attorney shall not be affected by my subsequent disability or incapacity.

2. This power of attorney is specifically limited to health care decisionmaking. Accordingly, my attorney in fact is appointed to exercise any health care power or take any action in regard to the care of my health as I could do myself, which my attorney, in my attorney's sole discretion believes to be in my best interest, including, without being limited to, the powers and actions hereinafter described.

3. To take charge of my person in case of illness or disability of any kind; to authorize my admission to a medical, nursing, residential or similar facility, and to enter into agreements for my care; to consent to surgical or other medical procedures; to remove and place me in such institutions or places as my attorney may deem best for my personal care, comfort, benefit and safety after giving consideration to any wishes I have previously expressed on this subject; to be given full rights to visit me during my period of in-patient care as though my attorney were a member of my immediate family, and to be given the full right to receive me into my attorney's care and custody upon discharge; to be provided access to my confidential medical records and information pertaining to my medical condition, and to be given full right to consult with my attending physician or other health care providers; to receive into my attorney's possession property and effects which may be recovered from my person by any hospital, police agency, or any other person at the time of my illness, disability, or death;

4. I may have, or may choose to execute, an Advance Health Care Directive, which expresses my wishes in regard to the use of life-sustaining procedures to prolong my life. If for any reason my Advance Health Care Directive is determined to be legally invalid, ineffective, or void, I hereby authorize my attorney-in-fact to make all decisions relating to or concerning the promulgation or termination of care, including life-sustaining procedures and care, if in the opinion of two physicians, one of whom is my attending physician, my condition is terminal or one of permanent unconsciousness, and I will never regain the ability to make such a decision. My attorney is not liable for any decision made in regard to this paragraph.

FORM 2, continued

5. If, after execution of this power of attorney, should any incompetency proceedings be commenced regarding my person, I hereby nominate my attorney-in-fact, _____ as the guardian of my person, and I direct that the appointment by any court of any guardian shall be in accordance with this nomination.
6. In the event that _____ is unable to act as my attorney-in-fact, I hereby appoint _____, residing at _____ as my substitute attorney-in-fact.
7. In WITNESS WHEREOF, I _____, have signed my name to this durable power of attorney, consisting of two (2) pages on this _____ day of _____, 1994, in _____, Pennsylvania.

Printed Name

Signature

Witness #1 Signature

Witness #1 Address

Witness #2 Signature

Witness #2 Address

Documenting Personal Decisions (continued from page 7)

should document the facts supporting the client's capacity to execute the will, including contemporaneous medical opinion regarding the client's mental status. Clients should also consider the will alternatives discussed below as other options which would avoid future potential will contests.

If a client dies without a will (referred to as "intestacy"), Pennsylvania law governs the distribution of the client's property to surviving relatives, without regard to the quality or strength of the client's relationship with those relatives.¹⁴ When none of the relatives specified in the statute can be located, the property passes to the Commonwealth.

Joint Owners with Right of Survivorship

One way of avoiding potential will contests, as well as avoiding the cost and time delays associated with probate, is to hold property jointly, with the surviving joint owner retaining the right of possession and full ownership after the other joint owner dies. The property owned in this manner passes to the surviving owner without any need for a will. More than two individuals may own property jointly; in that situation ownership passes to the surviving owner(s) upon the death of an owner or owners. Generally, joint ownership with right of survivorship is used for ownership of real estate by two or more individuals, in which case the deed to the property must explicitly refer to the owners as "joint tenants with right of survivorship." Bank accounts are also frequently owned in this manner, in which case the signature card on record at the bank will set the terms of the joint ownership and establish the right of survivorship.

When deciding to transfer individually held property to jointly owned property with right of survivorship, the client making the transfer must remember that he or she is giving up a portion of ownership interest at the present time in the property transferred (as opposed to making a gift in a will, which only takes effect on the death of the client). Such transfers, in the case of real estate, for example, may result in real estate transfer tax liability. Because of the many subtleties inherent in joint ownership and the consequences that can result from transfer of property, a client considering these issues should consult an attorney.

Finally, although not a form of joint ownership, a client may wish to make outright gifts of property to others during the client's lifetime, as opposed to including such gifts in a will or holding such property jointly with the intended beneficiary. Although such transfers may be subject to inheritance taxes even if made during the client's lifetime,¹⁵ they may be an effective means for a client to dispose of property without the formality of a will and the potential delays and expense of probate. Unless ownership of the item is evidenced by written title (such as automobile ownership) that must be changed to effectuate the gift, such gifts may be accomplished by physical transfer of the item accompanied by an informal writing

evidencing the client's intention to make a gift of the item to the recipient. This will avoid any claim that the transfer was intended as a temporary loan and that the item should therefore be considered part of the estate, subject to the client's will, or, if there is no will, intestacy distribution to surviving relatives, as noted above.

Life Insurance

A client may have a life insurance policy that will, upon the client's death, pay the proceeds to a beneficiary designated with the insurer by the client. Some clients may have obtained relatively small life insurance policies specifically as a means of ensuring that their families are not burdened with the expense of the funeral. Unlike property passing pursuant to a will, life insurance proceeds are paid by the insurer directly to the named beneficiary. If the client names his or her estate as beneficiary, however, the insurance proceeds may be subject to creditor's claims against the estate. Even if the proceeds are part of the estate, however, they are not subject to Pennsylvania inheritance tax.

Many clients with HIV, however, may not be able to purchase life insurance because of screening by insurers, which routinely involves HIV testing or inquiries regarding AIDS, particularly for life insurance policies of any significant size. Before applying for such insurance, clients should determine whether there is any medical underwriting required for the issuance of the policy. Screening by HIV blood testing is lawful in Pennsylvania, although the testing must be preceded by informed and written consent, as required by the Confidentiality of HIV-Related Information Act.¹⁷ HIV positive clients who attempt to purchase life insurance policies should also be aware that any material misrepresentation made on the insurance application could result in the insurer voiding the policy if the misrepresentation is discovered during the two-year contestability period commencing with the effective date of the policy. If a policy is voided on this basis, the insurance premiums previously paid are refunded, but the life insurance proceeds are not paid. As a result, reliance on a policy of insurance to pay debts or funeral expense, or provide for minor children, may be misplaced.

Some persons with life threatening illnesses, including AIDS, have arranged, in effect, to sell their life insurance policies to companies that pay some portion of the value of the death benefit in exchange for being designated as the beneficiary on the policy. Such arrangements (frequently called viatical settlements) may be appropriate in situations when the client's need for the funds while he or she is alive is more important than having the funds available for a beneficiary upon the client's death. Similarly, clients may be able to obtain what are frequently termed "accelerated death benefits"; that is, the insurer will pay the benefit directly to the insured during the insured's life. Such practices may vary from insurer to insurer.

(continued on page 14)

Personal Decisionmaking Checklist

The following checklist is provided primarily to assist social service professionals in reviewing personal decisionmaking with clients as part of intake or needs assessment services. Legal professionals also may wish to integrate these issues into their client interview process. Complete intake/client needs assessment should, of course, cover many other issues, including information about the client's next of kin, persons the client has authorized for contact, etc., as well as other information not included here. Also, discussion of the sensitive issues raised here may be not be appropriate at an initial meeting with the client. Nevertheless, these issues should be routinely reviewed with all clients at an appropriate point in providing social services.

- If the client does not have a power of attorney, has the client been informed about the potential advantages of delegating financial and/or medical decisionmaking authority by means of a power of attorney? If the client has a power of attorney: Date of execution: _____

[If executed before December 16, 1992, does the power of attorney include a durability clause if it is intended to be durable? —If you or the client are uncertain, referral to an attorney for review or revision of the power of attorney may be appropriate.]

Name and address of Attorney(s)-in-fact: _____

Relationship to client: _____

- What authority is granted by the power of attorney (check all that apply):
☐ Valid only when client is incapacitated ☐ Currently valid ☐ General power of attorney
☐ Medical power of attorney, only ☐ Financial power of attorney, only ☐ Other
special or limited powers granted: _____

- Where is the original power of attorney (and who has access to it or copies of it)?

Name and address of attorney or other person who prepared the power of attorney: _____

- Does the client have a representative payee, if receiving social security benefits? If yes list name and address: _____
- Has the attorney-in-fact been provided a copy of the power of attorney or been informed regarding his/her responsibilities as attorney-in-fact?
- If the client does not have an advance health care directive, has the client been informed of his/her right to make decisions regarding continuation or termination of health care in the event of his or her incapacity? If the client has an advance health care directive: Date of execution: _____

[If executed prior to April 14, 1992, does the directive conform to the requirements of the Advance Directive for Health Care Act of 1992? —If you or the client are uncertain, referral to an attorney for review of the directive may be appropriate.]

Name and address of attorney or other person who prepared the directive: _____

- Has a copy of the directive been provided to the client's physician or other health care provider? If so, list name and address of that person : _____
- If the client has a power of attorney including directions concerning health care decisions, has a copy of the directive been provided to the attorney-in-fact?

(continued on page 14)

Personal Decisionmaking Checklist (continued from page 14)

- If the client does not have a will, has the client been informed that even if the client does not have significant wealth, important directions can be provided by will (e.g., nomination of guardian for minor children, nomination of executor with authority over funeral arrangements or continuation of claims in litigation, establishment of a trust for minor children, gifts of specific items of property)?
- Has the client provided specific, written directions to the executor or other person regarding funeral arrangements (generally, such directions should be provided other than in the will)? If the client has a will: Date of execution: _____
Name and address of attorney who drafted the will: _____
Name and address of executor (if named in the will): _____
Relationship to client: _____
Location of the original (signed) copy of the will: _____
- Has the executor been advised of his or her nomination in the will and understand his/her responsibilities as executor? _____

§§§

Documenting Personal Decisions (continued from page 12)

Clients seeking viatical settlements or accelerated death benefits should carefully review offers for such settlements and consult an attorney regarding the tax consequences of the transaction. In some cases, the receipt of the cash proceeds from the policy may render the client ineligible for certain public benefit programs based on the client's financial assets, such as Medical Assistance or Social Security SSI benefits.

Guardianship Issues

When a client lacks adequate decisional capacity to handle his or her own affairs, and the individual has not executed a valid durable power of attorney, it may be necessary to petition the local Court of Common Pleas for the appointment of a guardian. An attorney should be consulted in such cases. A power of attorney, even if it is not effective in regard to the issue giving rise to the guardianship proceeding, can include a nomination of a guardian. The client's nomination of a guardian provides the client with an indirect means of assuring that a family member or some other party, who would not be the client's choice, is prevented from taking control over the client's affairs in the event of incompetency.

Endnotes

1. Court rules allow substitution of parties in cases where the plaintiff is incompetent or deceased. *See* Fed. R. Civ. P. 25(a); Fed. R. App. P. 43; Pa. R. Civ. P. 2352(a) and 2354. Pennsylvania law provides for the survival of causes of action in event of the death of the plaintiff. 42 Pa.C.S.A. § 8302 (West 1992). Of course, appropriate steps should be taken to expedite the litigation while the client is competent, or, failing that, to preserve the client's testimony by deposition.
2. 20 Pa.C.S.A. § 5401 (West 1993).
3. Spanish translations of FORM 1 (advance health care directive) and FORM 2 (health care power of attorney) are available upon request from the AIDS Law Project.
4. *See* 35 P.S. § 10101 (West 1993); 55 Pa. Code § 3130.91 (1993).
5. 20 Pa.C.S.A. § 5512.1 (West 1993).
6. The Pennsylvania Crimes Code includes the crime of aiding a suicide if the conduct in aiding the suicide causes

(continued on page 15)

- the suicide or attempted suicide. 18 Pa.C.S.A. § 2505(b) (1993). Attempting suicide on one's self is not a crime.
7. 2 U.S.C. § 1395cc (f) (i) and § 1396a (a) (Supp. 1991); Medicaid and Medicare Programs; Advance Directives, 57 Fed. Reg. 8194 (1992).
 8. Because of the potential for real or perceived conflicts of interest, social service agencies and health care providers should be cautious in allowing staff members to be appointed on a client's power of attorney. Agencies should review their own internal policies on this issue.
 9. 20 Pa.C.S.A. § 5601.1 (West Supp. 1994).
 10. 20 Pa.C.S.A. § 5603(h).
 11. 28 Pa. Code § 103.23 (1993).
 12. Only if the claimant is not survived by a spouse, child, or parent, will SSDI (Title II) back benefits be paid after the claimant's death to the claimant's estate. 42 U.S.C. § 404(d) (1992). SSI (Title XVI) benefits are only paid to the surviving spouse, or parent of a disabled child in the case of a minor claimant, who was living with the claimant at the time of the claimant's death or during the six-month period preceding the month of the claimant's death. 42 U.S.C. § 1383(b)(1)(A).
 13. The applicable Pennsylvania statute provides that "a person competent to make a will, being the sole surviving parent or adopting parent of any unmarried minor child, may appoint a testamentary guardian of such child during his minority" 20 Pa.C.S.A. § 2519 (West 1993). However, a surviving parent's choice of a guardian in a will, while considered by a court, is only one of many such factors to be considered. In re Heym, 19 D. & C.3d 748 (1980).
 14. When a married person domiciled in Pennsylvania dies, their surviving spouse has the right to claim a one-third share of the estate, even though the decedent's will does not include the surviving spouse as a beneficiary. See 20 Pa.C.S.A. § 2202-2207 (West 1992).
 15. 21 Pa.C.S.A. § 2101 (West 1993).
 16. 72 Pa.C.S.A. § 2301 (West 1992). Although inheritance taxes are assessed on a flat percentage basis for property passing by reason of death, few, if any, low-income, limited-asset clients should be concerned with planning for inheritance tax liability since the deduction available for debts, funeral expenses, costs of final illness, and other deductible expenses is likely to exceed the size of the gross estate. Nevertheless, an inheritance tax return is required to be filed by the executor or administrator of the estate even if no tax is due. 72 Pa.C.S.A. § 2484.
 17. 20 Pa.C.S.A. §§ 5511, 5512.2, and 5513.

§§§

Pennsylvania AIDS Law Report

Issue No. 3
May 1994

Pennsylvania AIDS Law Report is a publication of the AIDS Law Project of Pennsylvania, a non-profit public interest law firm providing services to persons with AIDS/HIV and others affected by the epidemic. Publication and distribution made possible by a grant from the Pennsylvania Lawyer Trust Account Board, Alfred J. Azen, Executive Director.

Written and edited by David W. Webber, J.D., with assistance from Edwin J. Greenlee, Ph.D., J.D. and Eric A. Vos, J.D.; layout/design by Vanessa Lowe. For more information, or to be added to the mailing list for this publication, contact the AIDS Law Project at 1211 Chestnut Street Suite 1200, Philadelphia, PA 19107; (215) 587-9377. Comments and questions regarding subjects covered in *Pennsylvania AIDS Law Report* are welcomed.

AIDS Law Project of Pennsylvania Staff

Executive Director

Nan Feyler, Esquire

Director of Education and Policy

David W. Webber, J.D.

Staff Attorneys:

Ronda B. Goldfein

Catherine Hanssens

Yolanda French Lollis

Intake/Legal Advocate

Vanessa L. Lowe

Paralegal

Lolita Kase

Administrative Assistant

Larry Felzer

Intake Staff

Craig Voorhees