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## Legal Considerations for Family Caregivers

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David speaks and writes extensively on Elder Law and on Special Needs Law issues. Many of his publications are available on his website at [www.mcguffey.net](http://www.mcguffey.net).

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## **Consent to Health Decisions, Right to Refuse Treatment, Health Privacy and Advance Directives**

The right to self-determination is a bedrock legal principle, and is usually expressed either by consenting to treatment or by refusing treatment.<sup>1</sup> As the Court found in the *Quinlan* case, decisions concerning life and death are where medicine, law and theology converge. Medicine takes the view that treatment is appropriate if it will cure, but a physician may refuse to treat in futile situations. Theology varies depending on beliefs, and the right to hold particular religious belief is absolute; however conduct in pursuit of those beliefs is sometimes limited.<sup>2</sup> The law seeks to protect individual liberty, but plays a protective role (*parens patrie*) when a surrogate makes decisions for someone else, or where an individual attempts to accelerate death. When a surrogate makes decisions because the patient failed to plan in advance, the surrogate's decision might be second-guessed, as happened in the *Schiavo* case.

The treatment decisions of a patient with capacity (other than to commit suicide) to consent to treatment or to refuse treatment are generally absolute. Ideally, the patient plans for the future by appointing a health surrogate and by documenting end-of-life treatment preferences in an advance directive. The advance directive would then be used when the patient cannot make or communicate his or her own decisions.

The phrase "advance directive" refers to any document used to make health care decisions in advance. It generally includes healthcare powers or attorney, living wills, Do-Not-Resuscitate (DNR) orders, and the Physician Order on Life Sustaining Treatment (POLST). There is also a statute appointing a default health agent, which is where we begin.

### **Georgia Medical Consent Law (O.C.G.A. § 31-9-1 et seq.)**

Without authority to act, a decision is ineffective. Only someone with authority to act can consent to treatment, or refuse treatment. If the patient cannot make decisions for himself or herself, Georgia law gives default authority to certain classes of individuals. Those individuals may or may not share your values, and they may or may not get along, so reliance on this statute is not recommended.

Georgia's default medical and surgical consent statute provides that, in addition to other persons authorized by law, the following persons are authorized and empowered to

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<sup>1</sup> In *Cruzan, infra*, the U.S. Supreme Court held that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment.... The informed consent doctrine has become firmly entrenched in American tort law."

<sup>2</sup> *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, at 35 (1976) (citing among other cases *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964)).

consent, either orally or otherwise, to any surgical or medical treatment or procedures not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician:

(1) Any adult, for himself or herself, whether by living will, advance directive for health care, or otherwise;

(1.1) Any person authorized to give such consent for the adult under an advance directive for health care or durable power of attorney for health care under Chapter 32 of this title;

(2) In the absence or unavailability of a person authorized pursuant to paragraph (1.1) of this subsection, any married person for his or her spouse;

(3) In the absence or unavailability of a living spouse, any parent, whether an adult or a minor, for his or her minor child;

(4) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his or her care; and any guardian, for his or her ward;

(5) Any female, regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth;

(6) Upon the inability of any adult to consent for himself or herself and in the absence of any person to consent under paragraphs (1.1) through (5) of this subsection, the following persons in the following order of priority:

(A) Any adult child for his or her parents;

(B) Any parent for his or her adult child;

(C) Any adult for his or her brother or sister;

(D) Any grandparent for his or her grandchild;

(E) Any adult grandchild for his or her grandparent; or

(F) Any adult niece, nephew, aunt, or uncle of the patient who is related to the patient in the first degree; or

(7) Upon the inability of any adult to consent for himself or herself and in the absence of any person to consent under paragraphs (1.1) through (6) of this subsection, an adult friend of the patient.

Persons acting under this statute must act in good faith to consent to procedures the patient would have authorized.

If a physician determines that an individual is unable to make health care decisions for himself or herself, that determination must be noted in the medical record after an examination. The note should indicate that the adult "lacks sufficient understanding or capacity to make significant responsible decisions" regarding his or her medical treatment or the ability to communicate by any means such decisions.

The above does not alter a person's right to refuse treatment if the patient is 18 years of age or older. O.C.G.A. § 31-9-7.

## **Informed Consent and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

“Informed consent is the process by which the treating health care provider discloses appropriate information to a competent patient so that the patient may make a voluntary choice to accept or refuse treatment. (Appelbaum, 2007). It originates from the legal and ethical right the patient has to direct what happens to her body and from the ethical duty of the physician to involve the patient in her health care.”<sup>3</sup> However, “informed” consent implies that information was shared; since the implementation of the HIPAA privacy rule, securing health care information is sometimes problematic.

HIPAA<sup>4</sup> was adopted to ensure health insurance coverage after leaving an employer and to provide for standards for facilitating healthcare related electronic transactions. While enacting these changes, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress mandated adoption of federal privacy protections for certain individually identifiable health information.<sup>5</sup>

The federal statute is enabling legislation; it is not the privacy rule. *See* 42 U.S.C. § 1320d et seq.<sup>6</sup> The HIPAA regulations are found in Title 45 of the Code of Federal Regulations, Parts 160, 162 and 164. Specifically, the privacy rule (also called the security rule) is found at 45 C.F.R. Part 164, Subpart E (§ 164.500 through 164.534). Security standards are at 164.302 through 164.318. Requirements relating to a covered entity’s duty following improper use or disclosure of protected health information are at 45 C.F.R. 164.400 through 164.414.

Generally speaking, covered entities and business associates may not use or disclose protected health information, except as permitted or required under the rule.<sup>7</sup> *See* 45 C.F.R. § 164.502(a). The Privacy Rule:

- gives patients more control over their health information;
- sets boundaries on the use and release of health records;
- establishes appropriate safeguards that the majority of health-care providers and others must achieve to protect the privacy of health information;
- holds violators accountable with civil and criminal penalties that can be imposed if they violate patients' privacy rights;

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<sup>3</sup> J. Bord, *Informed Consent*, <https://depts.washington.edu/bioethx/topics/consent.html>. Georgia’s informed consent statute is found at O.C.G.A. § 31-9-6.1. Georgia’s rule is limited and only requires disclosure of risks in the six areas covered by the statute. *See Blotner v. Doreika*, 285 Ga. 481 (2009).

<sup>4</sup> A more detailed paper on HIPAA is available at <http://www.mcguiffey.net/pdf/HIPAA%202014%20-%20What%20You%20Need%20to%20Know.pdf>.

<sup>5</sup> The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. [http://www.hhs.gov/ocr/privacy/hipaa/faq/privacy\\_rule\\_general\\_topics/188.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/privacy_rule_general_topics/188.html).

<sup>6</sup> Section 1320d-1 provides “The Secretary shall establish specifications for implementing each of the standards adopted under this part.”

<sup>7</sup> Subpart C of Part 160 relates to compliance and enforcement by the Secretary.

- strikes a balance when public health responsibilities support disclosure of certain forms of data;
- enables patients to make informed choices based on how individual health information may be used;
- enables patients to find out how their information may be used and what disclosures of their information have been made;
- generally limits release of information to the minimum reasonably needed for the purpose of the disclosure;
- generally gives patients the right to obtain a copy of their own health records and request corrections; and
- empowers individuals to control certain uses and disclosures of their health information.

The privacy rule applies uniformly to most protected health information. Psychotherapy notes are the primary exception. If information relates to an individual's past, present or future physical or mental health condition or payment for treatment of the condition, and if it contains information that identifies or provides a reasonable basis for believing the individual could be identified, then the privacy rule probably applies.

A covered entity is required to disclose protected health information to the patient when the patient requests information. See § 164.524 or § 164.528. A covered entity must, except as provided in paragraphs (g)(3)<sup>8</sup> and (g)(5)<sup>9</sup> of 164.502, treat a personal representative as the individual for purposes of this subchapter.<sup>10</sup> This means a person with power to make health care decisions has a right to the information necessary to make those decisions.

A covered entity may disclose limited information to a person involved in the individual's care. The information disclosed must be directly related to that person's involvement with the patient's care or payment for care. A covered entity may also disclose information necessary to identify or notify a personal representative or other person responsible for the individual's care. If the patient is present and has capacity, the covered entity must obtain consent, provide the patient with an opportunity to object, or reasonably infer under the circumstances that the patient does not object. Section 164.510(b).<sup>11</sup> In situations where the patient is not present, lacks capacity, or if

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<sup>8</sup> Subsection (g)(3) relates to unemancipated minors.

<sup>9</sup> Subsection (g)(5) provides that a covered entity may elect to not treat a person as a personal representative if there is a reasonable belief the person abused the patient or that doing so would endanger the patient.

<sup>10</sup> O.C.G.A. § 31-32-1, et.seq., the Georgia Advance Directive for Health Care Act, establishes a means for appointing a health agent who would be authorized to receive PHI. The statutory form is found at O.C.G.A. § 31-32-4, but variations are permitted. Other forms, such as Five Wishes and Critical Conditions, are acceptable so long as they include the required statutory elements. See also O.C.G.A. § 31-33-2(a)(2).

<sup>11</sup> The provider may ask the patient's permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to

there is an emergency, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the patient and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the patient's health care. 45 C.F.R. § 164.510(b)(3).

Except as otherwise permitted or required (such as a disclosure to the health decision-maker), a covered entity may not use or disclose protected health information without an authorization that is valid under section 164.508. When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, its use or disclosure of protected health information must be consistent with the terms of the authorization.<sup>12</sup> For families, this means family members who are not involved with the health care decision-making process may still obtain information regarding the patient's care if the requesting individual has a properly structured HIPAA release.

### **Temporary Health Care Placement Decision Maker for an Adult Act (O.C.G.A. § 31-36A-1 et seq.)**

An attending physician, treating physician, or other physician licensed according to the laws of the State of Georgia, after having personally examined an adult, may certify in the adult's medical records the following: (1) The adult is unable to consent for himself or herself; and (2) It is the physician's belief that it is in the adult's best interest to be discharged from a hospital, institution, medical center, or other health care institution providing health or personal care for treatment of any type of physical or mental condition and to be transferred to or admitted to an alternative facility or placement, including, but not limited to, nursing facilities, assisted living communities, personal care homes, rehabilitation facilities, and home and community based programs. After the certification is made anyone listed in O.C.G.A. § 31-36A-6(a) (which includes most relatives), may consent to a transfer, admission or discharge that is believed to be in the patient's best interests. The authorization to give consent for transfer, admission, or discharge is limited solely to the transfer, admission, or discharge decision and responsibilities associated with that decision, including providing assistance with financial assistance applications. It does not include the power or authority to perform any other acts on behalf of the adult.

If someone is available to consent to the admission, transfer or discharge, then any interested person including the health care facility, may petition the probate court of a health care placement transfer, admission or discharge order. If granted, the order shall authorize the petitioner or the petitioner's designee to do all things necessary to accomplish the discharge from a hospital, institution, medical center, or other health

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agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made. <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidancepdf.pdf>.

<sup>12</sup> 45 C.F.R. § 164.508(a)(1).



care institution and the transfer to or admission to the recommended facility or placement.

### **Involuntary Hospitalization and Treatment of Involuntary Patients**

The procedure commonly referred to as a “1013”<sup>13</sup> is governed by O.C.G.A. Title 37, Chapter 3 (§ 37-3-41 et seq). The procedure applies to individuals who present a substantial risk of imminent harm to himself, herself or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis; and Who is in need of involuntary inpatient treatment.

Any physician (or psychologist, clinical social worker, licensed professional counselor, or clinical nurse specialist in psychiatric/mental health) within Georgia may execute a certificate stating that he has personally examined a person within the preceding 48 hours and found that, based upon observations set forth in the certificate, the person appears to be a mentally ill person requiring involuntary treatment. This certificate is the 1013. A physician's certificate shall expire seven days after it is executed. Any peace officer, within 72 hours after receiving such certificate, shall make diligent efforts to take into custody the person named in the certificate and to deliver him forthwith to the nearest available emergency receiving facility serving the county in which the patient is found, where he shall be received for examination. A court may also issue an order to deliver an individual for examination, and a peace officer may deliver an individual who has committed a crime for examination.

Unless a physician examines the patient and determines that the patient is mentally ill and requires hospitalization, he or she must be discharged within 48 hours. If the examining physician certifies (on Form 1014) that the patient may be mentally ill, requiring involuntary treatment, and that treatment is consistent with good medical practice, then the patient may be transported to an evaluating facility. Notice must be given to the patient and his representative and the patient is informed of his or her rights on Form 1015. Involuntary hospitalization may only continue for five days (excluding Saturdays and Sundays) without a court order, although the patient may transfer to voluntary and remain (on Form 1012). A petition, verified by the chief medical officer and supported by two physicians must be filed if involuntary hospitalization continues. A hearing on the petition for involuntary hospitalization beyond the initial five day period must take place no sooner than seven and not later than 12 days after the petition is filed with the court. If the court at a hearing concludes that the patient is a mentally ill person requiring involuntary treatment, it shall make

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<sup>13</sup> It is called a “1013” because Form 1013 is completed by the assessing physician (or other health care professional). The form is at <http://www.djj.state.ga.us/Policies/DJJPolicies/Chapter12/Attachments/DJJ12.23AttachmentA.pdf>.

findings of fact and conclusions of law in support of that conclusion as part of its final order. The court may order involuntary hospitalization for a period of up to six months.

**Georgia Advance Directive for Health Care Act (O.C.G.A. § 31-32-1 et seq.)**

Georgia's law relating to advance directives changed, effective July 1, 2007. Prior to 2007, Georgia residents frequently executed a health care advance directive and a living will. The new law combines the old forms into a single document known as an Advance Directive for Health Care. Old documents, however, were not invalidated by the new law if executed prior to July 1, 2007. *See* O.C.G.A. § 31-32-3.<sup>14</sup>

Initially, the patient is always in charge of his or her care. "A health care agent shall not have the authority to make a particular health care decision different from or contrary to the declarant's decision, if any, if the declarant is able to understand the general nature of the health care procedure being consented to or refused, as determined by the declarant's attending physician based on such physician's good faith judgment." O.C.G.A. § 31-32-7(a). In that regard, the health agent has the following powers:

- (1) The health care agent is authorized to consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment, or procedures relating to the physical or mental health of the declarant, including any medication program, surgical procedures, life-sustaining procedures, or provision of nourishment or hydration for the declarant, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;
- (2) The health care agent is authorized to admit the declarant to or discharge the declarant from any health care facility;
- (3) The health care agent is authorized to contract for any health care facility or service in the name of and on behalf of the declarant and to bind the declarant to pay for all such services, and the health care agent shall not be personally liable for any services or care contracted for or on behalf of the declarant;
- (4) At the declarant's expense and subject to reasonable rules of the health care provider to prevent disruption of the declarant's health care, the health care agent shall have the same right the declarant has to examine and copy and consent to disclosure of all the declarant's medical records that the health care agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other

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<sup>14</sup> Former O.C.G.A. § 31-36-1 through 31-36-13, relating to Durable Powers of Attorney for Health Care, were repealed and replaced by the new statute.

medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, health care facility, or other health care provider, notwithstanding the provisions of any statute or other rule of law to the contrary; and

(5) Unless otherwise provided, the health care agent is authorized to direct that an autopsy of the declarant's body be made; to make an anatomical gift of any part or all of the declarant's body pursuant to Article 6 of Chapter 5 of Title 44, the "Georgia Revised Uniform Anatomical Gift Act"; and to direct the final disposition of the declarant's body, including funeral arrangements, burial, or cremation.

Although other forms that comply with the law are valid,<sup>15</sup> the legislature approved a statutory form (O.C.G.A. § 31-32-4). That form and the statute incorporate the following defined terms (O.C.G.A. § 31-32-2):

(1) "Advance directive for health care" means a written document voluntarily executed by a declarant in accordance with the requirements of Code Section 31-32-5.

(3) "Declarant" means a person who has executed an advance directive for health care authorized by this chapter.

(4) "Durable power of attorney for health care" means a written document voluntarily executed by an individual creating a health care agency in accordance with Chapter 36 of this title, as such chapter existed on and before June 30, 2007.

(5) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for a declarant's physical or mental health or personal care.

(6) "Health care agent" means a person appointed by a declarant to act for and on behalf of the declarant to make decisions related to consent, refusal, or withdrawal of any type of health care and decisions related to autopsy, anatomical gifts, and final disposition of a declarant's body when a declarant is unable or chooses not to make health care decisions for himself or herself. The term "health care agent" shall include any back-up or successor agent appointed by the declarant.

(9) "Life-sustaining procedures" means medications, machines, or other

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<sup>15</sup> For example, we frequently modify the document to include language prohibiting blood transfusions for Jehovah's Witnesses. We have also changed the language to make statements affirmative rather than negative, and have reversed some default provisions to make them "opt out" rather than "opt in."

medical procedures or interventions which, when applied to a declarant in a terminal condition or in a state of permanent unconsciousness, could in reasonable medical judgment keep the declarant alive but cannot cure the declarant and where, in the judgment of the attending physician and a second physician, death will occur without such procedures or interventions. The term "life-sustaining procedures" shall not include the provision of nourishment or hydration but a declarant may direct the withholding or withdrawal of the provision of nourishment or hydration in an advance directive for health care. The term "life-sustaining procedures" shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

(10) "Living will" means a written document voluntarily executed by an individual directing the withholding or withdrawal of life-sustaining procedures when an individual is in a terminal condition, coma, or persistent vegetative state in accordance with this chapter, as such chapter existed on and before June 30, 2007.

(12) "Provision of nourishment or hydration" means the provision of nutrition or fluids by tube or other medical means.

(13) "State of permanent unconsciousness" means an incurable or irreversible condition in which the declarant is not aware of himself or herself or his or her environment and in which the declarant is showing no behavioral response to his or her environment.

(14) "Terminal condition" means an incurable or irreversible condition which would result in the declarant's death in a relatively short period of time.

Any person of sound mind who is emancipated or who is over 18 years of age may execute an advance directive. The document must either be signed in front of a notary, or must be executed in front of two witnesses.

The following persons may not serve as witnesses: (1) the health agent who will serve; (2) anyone who would knowingly inherit anything, or who would knowingly benefit financially from the declarant's death; or (3) anyone who is directly involved in the declarant's health care. See O.C.G.A. § 31-32-5(c).

A copy is valid and has the same effect as an original. The document may be amended at any time, so long as it is executed properly. It may also be revoked by executing a new advance directive, by obliterating the original, by a written revocation, or by an oral revocation in front of a witness.

Unless the advance directive expressly provides otherwise, marriage revokes the appointment of any health agent other than the spouse. Similarly, divorce revokes the appointment of the former spouse as health agent.

Appointment of a guardian does not revoke an advance directive.<sup>16</sup> Absent an order of the probate court or superior court having jurisdiction directing a guardian of the person to exercise the powers of the declarant under an advance directive for health care which survives disability, incapacity, or incompetency, the guardian of the person has no power, duty, or liability with respect to any health care matters covered by the advance directive for health care.

If a health agent exercises the authority granted in an advance directive, the health agent must act with due care for the benefit of the patient in accordance with the terms of the advance directive. "A health care agent shall exercise granted powers in such manner as the health care agent deems consistent with the intentions and desires of the declarant. If a declarant's intentions and desires are unclear, the health care agent shall act in the declarant's best interest considering the benefits, burdens, and risks of the declarant's circumstances and treatment options." O.C.G.A. § 31-32-7(b).

The federal Patient Self-Determination Act requires most health care institutions, but not individual doctors, give patients upon admission a summary of their health care decision-making rights and the facility's policies regarding recognition of those rights. It requires the institution to ask whether the patient has an advance directive and document that the patient does or does not have one. However, the facility cannot require the patient to execute an advance directive, and cannot discriminate based on whether there is or is not an advance directive.

### **Do Not Resuscitate Orders (O.C.G.A. § 31-39-1 et seq.)**

Georgia law defines a candidate for nonresuscitation as meaning a patient who, based on a determination to a reasonable degree of medical certainty by an attending physician with the concurrence of another physician:

(A) Has a medical condition which can reasonably be expected to result in the imminent death of the patient;

(B) Is in a noncognitive state with no reasonable possibility of regaining cognitive functions; or

(C) Is a person for whom cardiopulmonary resuscitation would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time so that the patient will likely

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<sup>16</sup> See also O.C.G.A. § 31-32-14(e).

experience repeated need for cardiopulmonary resuscitation over a short period of time or that such resuscitation would be otherwise medically futile.

Generally, every patient is presumed to have capacity to consent, and is presumed to consent, to cardiopulmonary resuscitation in the event of cardiac or respiratory arrest, unless there is consent or authorization for the issuance of an order not to resuscitate. O.C.G.A. § 31-39-3(a). Consent does not presume administration of CPR because it is not required if it would be futile.

Any written order issued by the attending physician using the term "do not resuscitate," "DNR," "order not to resuscitate," "do not attempt resuscitation," "DNAR," "no code," "allow natural death," "AND," "order to allow natural death," or substantially similar language in the patient's chart shall constitute a legally sufficient order and shall authorize a physician, health care professional, nurse, physician assistant, caregiver, or emergency medical technician to withhold or withdraw cardiopulmonary resuscitation. Such an order shall remain effective, whether or not the patient is receiving treatment from or is a resident of a health care facility, until the order is canceled as provided in Code Section 31-39-5 or until consent for such order is revoked as provided in Code Section 31-39-6, whichever occurs earlier. An attending physician who has issued such an order and who transfers care of the patient to another physician shall inform the receiving physician and the health care facility, if applicable, of the order.

An adult may consent to a DNR for himself or herself,<sup>17</sup> and an authorized person may also consent. Authorized persons, in order of priority, are: (a) Any agent under a durable power of attorney for health care or health care agent under an advance directive for health care appointed pursuant to Chapter 32 of this title; (b) A spouse; (c) A guardian over the person appointed pursuant to the provisions of Code Section 29-4-1; (d) A son or daughter 18 years of age or older; (e) A parent; or (f) A brother or sister 18 years of age or older. Where such authorized person is an agent under a durable power of attorney for health care or a health care agent under an advance directive for health care appointed pursuant to Chapter 32 of this title or where a Physician Orders for Life-Sustaining Treatment form with a code status of "do not resuscitate" or its equivalent has been executed in accordance with Code Section 31-1-14 by an authorized person who is an agent under a durable power of attorney for health care or a health care agent under an advance directive for health care appointed pursuant to Chapter 32 of this title, the attending physician may issue an order not to resuscitate a candidate for nonresuscitation pursuant to the requirements of this chapter without the concurrence of another physician, notwithstanding the provisions of paragraph (4) of Code Section 31-39-2.

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<sup>17</sup> If an adult patient with capacity has not consented to the DNR, or if he or she regains capacity and does not consent, then the DNR must be cancelled. O.C.G.A. § 31-39-5(c) and § 31-39-6.

The DNR statute does not impair or supersede any legal right to withhold or withdraw treatment, if done so lawfully. Also, it does not impair or prevent any court's authority to issue an order not to resuscitate.

### **Physician Order for Life Sustaining Treatment (O.C.G.A. § 31-1-14)**

A POLST form<sup>18</sup> is a legally sufficient medical order that health care providers and health care facilities may use in accordance with their policies and procedures regarding end of life care. A POLST order remains effective unless the order is revoked by the attending physician upon the consent of the patient or the patient's authorized person. An attending physician who has issued such an order and who transfers care of the patient to another physician must inform the receiving physician and the health care facility, if applicable, of the order. Review of the POLST form is recommended at care transitions, and such review should be specified on the form.

POLST forms for DNR and for other interventions signed by the patient and attending physician may be implemented without restriction. If the POLST form is signed by anyone other than the patient, then DNR provisions may only be implemented if the patient is a candidate for nonresuscitation, and other provisions withdrawing treatment may only be implemented if the patient has a terminal illness or is in a state of permanent unconsciousness.

The key feature of POLST forms is that they are portable. They may travel with the patient across care settings and are valid in any health care facility in which the patient who is the subject of such form is being treated; health care facilities may impose additional requirements regarding a patient's end of life care decisions, so long as notice is given to the patient as required by the federal Patient Self-Determination Act and similar laws. A health care facility and a health care provider, in its discretion, may rely upon a POLST form as legally valid consent by the patient to the terms therein.

In the event there are any directions in a patient's previously executed living will, advance directive for health care, durable power of attorney for health care, do not resuscitate order, or other legally authorized instrument that conflict with the directions in a POLST form, the most recent instrument will take precedence to the extent of the conflict.

### **Consent and Right to Refuse Treatment in a Nursing Home**

Nursing home residents have the right to direct their care, and have the right to refuse treatment. Federal law provides as follows:<sup>19</sup>

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<sup>18</sup> POLST forms are available at <http://www.gapolst.org/>.

<sup>19</sup> A more detailed paper on this topic is at [http://www.mcguiffey.net/pdf/Getting\\_Your\\_Loved\\_Ones\\_the\\_Care\\_They\\_Deserve\\_2016.pdf](http://www.mcguiffey.net/pdf/Getting_Your_Loved_Ones_the_Care_They_Deserve_2016.pdf).

42 U.S.C. § 1396r(c)(1)(A)(i)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

42 C.F.R. § 483.10(b)(3)

The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

### **End-of-Life and the Right to Refuse Treatment: Quinlan through Schiavo**

The cases below make clear the importance of making health decisions and communicating them. Too often, decisions are put off, sometimes because people fear an advance directive is a license to kill; if individuals took time to examine the document, they would find that its simply an expression of individual values, whether that means extending life for as long as possible or allowing natural death to occur.

Others do not want to pay legal fees. That excuse is nonsense because the statutory form is available for free.<sup>20</sup>

The result of indecision can be as tragic for a family as the initial event placing a family at that crossroad. William Colby, the lawyer who represented the Cruzan family, describes that family's experience as follows:

As a father, I can't imagine getting the phone call in the night from the state trooper. But to then layer on top of that call, years of your child not emerging from unconsciousness, facing and making the unbelievably horrific decision, even though you think it's right, to remove a feeding tube, and then having to fight a highly public, highly contentious three-year legal battle to implement that decision. And then when you ultimately win, what you "win" is ten days of watching your child die.<sup>21</sup>

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<sup>20</sup> Most Georgia law schools have the form posted. It is also available at [http://aging.dhr.georgia.gov/sites/aging.dhs.georgia.gov/files/imported/DHR-DAS/DHR-DAS\\_Publications/GEORGIA%20ADVANCE%20DIRECTIVE%20FOR%20HEALTH%20CARE-10.pdf](http://aging.dhr.georgia.gov/sites/aging.dhs.georgia.gov/files/imported/DHR-DAS/DHR-DAS_Publications/GEORGIA%20ADVANCE%20DIRECTIVE%20FOR%20HEALTH%20CARE-10.pdf).

<sup>21</sup> W. Colby, *From Quinlan to Cruzan to Schiavo: What Have We Learned*, 37 Loyola L.J. 279, 287 (2006), <http://www.luc.edu/media/lucedu/law/students/publications/llj/pdfs/colby.pdf>.



Expressing your values, whatever they are, will limit the heartache Mr. Colby described. Everyone over the age of 18 should have an advance directive. Life is fragile, but medical care has improved to the point where most deaths are the result of a decision regarding medical treatment: respirators turned off, medicines not started, dialysis stopped, feeding tubes clamped.<sup>22</sup> The question is who makes these emotional decisions when the patient has not executed an advance directive, and whether the decision will cause family strife. Colby then poses the following scenario:

But consider one side of that sad case that never received much media attention. There was a time, before her cardiac arrest, when Terri and Michael Schiavo and Bob and Mary Schindler lived together, took vacations together, had meals together. What if just once she had talked with her parents and husband together for two minutes, for a minute, about Nancy Cruzan? Would she have saved these people she cared about all of this incredible strife that we saw played out on the public stage? We don't know. But I think there are families now who are being saved from that kind of family debate and dispute by Terri Schiavo, because they're talking. That talk is a gift.<sup>23</sup>

In re Quinlan, 355 A.2d 647 (N.J.) cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976)

On the night of April 15, 1975, for reasons that were unclear, Karen Quinlan ceased breathing for at least two 15 minute periods.<sup>24</sup> Mouth-to-mouth resuscitation was in effective. She was taken to the hospital where she was unresponsive even to deep pain. A neurologist and other expert physicians who examined her characterized Karen as being in a "chronic persistent vegetative state." One expert witness defined this as a "subject who remains with the capacity to maintain the vegetative parts of neurological function but who ... no longer has any cognitive function."

Karen's parents sought to terminate mechanical life support and allow her natural death to occur. The State opposed those efforts. The case was eventually appealed to the New Jersey Supreme Court, where it found that developments in medical technology have obfuscated the use of the traditional definition of death. Historically, death was measured from the time the heart stopped. However, because modern resuscitative and supportive measure may restore heart function, death is now determined by showing "brain death." In Karen's case, although there was severe brain damage, she was not brain dead.

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<sup>22</sup> Colby, *supra*, at 295.

<sup>23</sup> Colby, at 296.

<sup>24</sup> [https://www.uta.edu/philosophy/faculty/burgess-jackson/In%20re%20Quinlan,%2070%20N.J.%2010,%20355%20A.2d%20647%20\(1976\).pdf](https://www.uta.edu/philosophy/faculty/burgess-jackson/In%20re%20Quinlan,%2070%20N.J.%2010,%20355%20A.2d%20647%20(1976).pdf).

In analyzing the case, the Court turned to the right of privacy. “Here a loving parent, *qua* parent and raising the rights of his incompetent and profoundly damaged daughter, probably irreversibly doomed to no more than a biologically vegetative remnant of life, is before the court. He seeks authorization to abandon specialized technological procedures which can only maintain for a time a body having no potential for resumption or continuance of other than a “vegetative” existence.”

In addressing the State’s interest in protecting life, the Court found that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest.

“[I]f Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. ... We have no hesitancy in deciding ... that no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life.” Although Karen could make this choice in a hypothetical sense, her reality was that she lacked capacity to express herself and would never regain that capacity. “The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications ... as to whether she would exercise it in these circumstances.” The Court noted that “substituted judgment” is routinely used to protect individuals with disabilities, and that it could be used to determine what Karen would have chosen if she had capacity.

Ultimately, the Court found that life support could be discontinued if the guardian and Karen’s family concurred, and if the attending physician and the hospital ethics committee agreed there is no reasonable possibility that Karen would ever emerge from her present comatose condition to a cognitive, sapient state.

Cruzan v. Dir. Mo. Dep’t of Health, 497 U.S. 261 (1990)

On the night of January 11, 1983, Nancy Cruzan lost control of her car while driving in Missouri.<sup>25</sup> The vehicle overturned, and she was found lying face down in a ditch without detectable respiratory or cardiac function. Although paramedics restored her breathing and heartbeat at the accident site, she suffered permanent brain damage because she was deprived of oxygen for an estimated 12 to 14 minutes.

After it became apparent Nancy would never recover, her parents asked the hospital to remove Nancy’s feeding and hydration tubes. When the hospital refused, they went to court for an order authorizing discontinuance of artificial nutrition and hydration. The

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<sup>25</sup> <https://supreme.justia.com/cases/federal/us/497/261/case.html>.

trial court granted the petition, finding that a person in Nancy's condition had a fundamental right under the State and Federal Constitutions to refuse or direct the withdrawal of "death prolonging procedures, and finding that Nancy had expressed herself during a conversation with a friend, saying she would not want to live unless she could do so at least half-way normal.

The Missouri Supreme Court reversed. It declined to read a broad right of privacy into the State Constitution which would "support the right of a person to refuse medical treatment in every circumstance," and expressed doubt as to whether such a right existed under the United States Constitution. The court found that Missouri policy was in favor of life, and that oral statements made to a friend were unreliable for the purpose of determining Nancy's intent.

The case was appealed to the Supreme Court and a decision was rendered on June 25, 1990. The Court first noted that informed consent is a firmly established right in America. It then found that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."

The *Quinlan* case was reviewed, with the U.S. Supreme Court finding few right-to-die cases prior to it, but 54 reported decisions from 1976 through 1988. "After Quinlan, however, most courts have based a right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right." A decision from Massachusetts reasoned "that an incompetent person retains the same rights as a competent individual 'because the value of human dignity extends to both,' the court adopted a 'substituted judgment' standard whereby courts were to determine what an incompetent individual's decision would have been under the circumstances." The Massachusetts court found the State's interest in preserving life is greatest when an affliction is curable, but is lessened when the issue is not whether, but when, for how long, and at what cost a life may be briefly extended.<sup>26</sup>

The cases reviewed by the U.S. Supreme Court "demonstrate[d] the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones." The decisions used a variety of justifications for the conclusions they reached. The U.S. Supreme Court found that the question in Nancy's case was whether the U.S. Constitution prohibits Missouri from choosing the rule of decision which it did.

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<sup>26</sup> Although States may adopt a substituted judgment rule, the Supreme Court held that nothing in the U.S. Constitution requires states to repose judgment on refusal to treat decisions with anyone but the patient.

Prior rulings indicated the individuals have a liberty interest in refusing certain treatment, but the court found that withdrawal of life sustaining treatment would have dramatic consequences, which justified weighing it against the state interest in preserving life. In Nancy's case, the issue was whether a procedural requirement that Nancy's wishes be proven by clear and convincing evidence was permissible. The Supreme Court held that Missouri could require clear and convincing evidence. "An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction."

### The Terri Schiavo Case

"The *Schiavo* case differed from the *Quinlan* and *Cruzan* cases by involving settled law rather than breaking new legal ground on the right-to-die issue. The case instead involved a dispute between family members over what Schiavo's wishes would have been for such a situation."<sup>27</sup>

Theresa Marie Schindler ("Terri") was born on December 3, 1963, and lived with or near her parents in Pennsylvania until she married Michael Schiavo on November 10, 1984. Michael and Theresa moved to Florida in 1986. Terri and Michael were happily married and both were employed. They had no children.<sup>28</sup>

On February 25, 1990, their lives changed. Terri, age 27, suffered a cardiac arrest as a result of a potassium imbalance. Michael called 911, and Terri was rushed to the hospital. She never regained consciousness.<sup>29</sup>

Michael and Terri's parents got along during the first three years after this tragedy. In 1993, they stopped speaking.

From 1990 through the time of her death, Terri lived in a nursing home. She was fed and hydrated by tube, and staff changed her diapers. The evidence appeared to be overwhelming that Terri was in a persistent vegetative state. By mid 1996, CAT scans of Terri's brain showed an abnormal structure.

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<sup>27</sup> Wikipedia, *Terri Schiavo Case*,  
[https://en.wikipedia.org/wiki/Terri\\_Schiavo\\_case#Legal\\_cases\\_1992.E2.80.932002](https://en.wikipedia.org/wiki/Terri_Schiavo_case#Legal_cases_1992.E2.80.932002)

<sup>28</sup> <https://casetext.com/case/bush-v-schiavo-4>.

<sup>29</sup> *In re Guardianship of Theresa Marie Schiavo*, Appeal No. 2D00-1269 (Fla. App. 2<sup>nd</sup> Dist. Jan. 24, 2001) ("Schiavo I"), at <http://abstractappeal.com/schiavo/2dcaorder01-01.txt>.

Michael was appointed as Terri's guardian. In May, 1998, Michael petitioned the court to authorize discontinuance of life support. The Schindlers, Terri's parents, opposed his motion.

Under Florida law (and Georgia law), a surrogate should ordinarily look to a living will or other evidence to determine the patient's treatment preferences. Terri, however, had no advance directive and there was no written evidence concerning her end-of-life wishes. The litigation centered on the parties' disagreement concerning what Terri would have wanted. Michael allegedly believed Terri would not want to live in a persistent vegetative state, while her parents allegedly believed Terri might recover and would want to fight for life.<sup>30</sup> Legal presumptions aided Terri's parents. "[A] surrogate decision-maker should err on the side of life.... In cases of doubt, [the court assumes] that a patient would choose to defend life in exercising his or her right of privacy."<sup>31</sup>

The testimony established that Terri was very young and very healthy when tragedy struck. She had not prepared a will, much less a living will. She had been raised in the Catholic faith, but did not regularly attend mass or have a religious advisor who could assist the court in weighing her religious attitudes about life-support methods. Her statements to her friends and family about the dying process were few and they were oral. Nevertheless, those statements, along with other evidence about Terri, gave the trial court a sufficient basis to make this decision for her.

The question for the Court was whether Terri, not after a few weeks in a coma, but after ten years in a persistent vegetative state that has robbed her of most of her cerebrum and all but the most instinctive of neurological functions, with no hope of a medical cure but with sufficient money and strength of body to live indefinitely, would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives. The Court found there was clear and convincing evidence that Terri would not want to live in a persistent vegetative state and affirmed the trial court's decision to permit discontinuation of life support. Terri's feeding tube was removed on April 24, 2001.

That, however, did not end the *Schiavo* case. The Schindlers filed a new case arguing that Michael sought to terminate life support because he would inherit her malpractice settlement under Florida's intestacy law. They also cited "new evidence" of Terri's wishes. The feeding tube was reinserted on April 26, 2001. The litigation continued with a second, third and fourth trip to the Florida Court of Appeals. On the third trip to the Court of Appeals, the court remanded the case to the trial court for a hearing regarding a new treatment would improve Terri's condition. The court found no evidence that it

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<sup>30</sup> Some accounts indicate Terri's parents believed Terri was stable and that Michael wasn't allowing Terri's natural death, but rather, that he was accelerating her death (e.g., killing her).

<sup>31</sup> *Schiavo I.*

would. On the fourth trip to the Court of Appeals, the court offered its empathy to the Schindlers. However, the court held “this case is not about the aspirations that loving parents have for their children. It is about Theresa Schiavo's right to make her own decision, independent of her parents and independent of her husband.” The court then affirmed the trial court’s decision to discontinue life support. Terri’s feeding tube and hydration tube were then removed on October 15, 2003.

On October 21, 2003, the Florida legislature enacted “Terri’s Law” and Florida’s governor issued an executive order requiring that the feeding tube and hydration tube be reinserted. Michael filed an action for declaratory judgment, seeking a ruling that the law was unconstitutional.<sup>32</sup> When that case reached the Florida Supreme Court, the court held that Terri’s Law was unconstitutional because it purported to allow the legislature and governor to overrule a final judicial order.

### **Doctors Hospital of Augusta v. Alicea, 2016 Ga. LEXIS 448 (2016)**

On July 5, 2016, the Georgia Supreme Court decided *Doctors Hospital of Augusta v. Alicea*, 2016 Ga. LEXIS 448 (2016).<sup>33</sup> There, the Court affirmed lower court decisions denying a motion for summary judgment. As part of its decision, the Court interpreted the Georgia Advanced Directive Act, O.C.G.A. § 31-32-1 et seq., holding that it is the will of the patient or her designated agent, and not the will of the health care provider, that controls health decisions. *Alicea* is the most recent Georgia case reviewing the right to refuse treatment.

On November 12, 2009, Bucilla Stephenson executed an advance directive naming Jacqueline Alicea, her granddaughter, as health agent. Stephenson was 89 years old at the time. The advance directive specified that Alicea was authorized to make health care decisions for Stephenson in accordance with what Alicea determined Stephenson’s best interest. The advance directive also said: “My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.”

Stephenson repeatedly told her family that she was ready to go when the good Lord called her. “When it’s my time, it’s my time, don’t prolong it.” Stephenson specifically told her agent she did not want to rely on a machine to live, including a ventilator. Another family member had died on a ventilator, with Alicea making the decision to remove life support and Stephenson had not wanted to put her granddaughter through that decision-making process again.

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<sup>32</sup> *Bush v. Schiavo*, 885 So.2d 321 (Fla. 2004).

<sup>33</sup> <http://www.gasupreme.us/wp-content/uploads/2016/07/s15g1571.pdf>.

Two years passed before Stephenson's health declined. She was taken to the hospital around February 28, 2012 when Alicea thought Stephenson was having a stroke. Alicea brought Stephenson's advance directive with her.

Numerous tests were performed, with Alicea inquiring about her grandmother's condition. At each juncture, Alicea indicated that her grandmother did not want to be intubated and did not want to be placed on a ventilator. At least one doctor charted that Alicea was to be contacted before CPR was performed and before Stephenson was intubated.

On Monday, March 5, 2012, a physician requested consent for a surgical thoracentesis, which was a procedure to drain fluid from Stephenson's lung cavity. The physician had not read Stephenson's advance directive or the progress notes charted by the other physician. He did not inform Alicea that the procedure required intubation or the use of a ventilator. If he had provided that information, then Alicea would not have consented to the surgery. During the surgery, the physician discovered that much of Stephenson's right lung was necrotic (dead) and removed approximately two-thirds of the lung. Stephenson was extubated in the recovery room. Alicea was not informed that her grandmother had been intubated and placed on a ventilator for the procedure.

Two days later, Stephenson experienced respiratory distress during early morning hours. Around 4am, nursing staff called the physician. The physician made the decision to place Stephenson on a ventilator. When the nursing staff questioned whether to call Alicea first, the physician rebuffed them saying "I'm not going to call her at six o'clock in the morning and scare the hell out of her. I'll wait till, you know, she wakes up and then I'm going to call her and tell her what happened." No effort was made to contact Alicea before Stephenson was intubated.

Around 8am that morning, Alicea's husband stopped by the hospital and discovered Stephenson was on a ventilator. He called his wife, who immediately came to the hospital demanding to know why her instructions were disregarded. It took the nursing staff approximately 15 to 20 minutes to locate a copy of the advance directive in Stephenson's file and, when they did, one nurse remarked "Boy, somebody really messed up."

On March 14, Stephenson's kidney's began shutting down. A new physician recommended taking Stephenson off of the ventilator, which was done. Comfort measures were provided and Stephenson died three days later, on March 17, 2012.

On May 14, 2013, Alicea filed a lawsuit against the hospital and the physician who intubated Stephenson, and who placed her on the ventilator. The lawsuit alleged that Stephenson was caused unnecessary pain and suffering, contrary to her advance directive for health care and the specific directions of Alicea, her designated health care agent. The complaint alleged breach of agreement, professional and ordinary negligence, medical battery, intentional infliction of emotional distress, and breach of

fiduciary duty. When discovery concluded, the defendants filed a motion for summary judgment, alleging they were immune from civil prosecution because the immunity provisions in the Advanced Directive Act protected them.

The trial court rejected the defendants' arguments and denied the motion for summary judgment. The defendants appealed. The Court of Appeals also rejected the defendants' arguments and affirmed the trial court. The defendants appealed. The Georgia Supreme Court then accepted the defendants' petition for certiorari. On appeal, a unanimous Supreme Court affirmed the trial court and the court of appeals, finding that there is no immunity unless the health care provider acts in good faith to follow the patient's decision, or the decision of her health agent, or unless the provider informs the patient or health agent that it cannot follow the decision on moral grounds and immediately cooperates to facilitate a transfer to a health care provider who will follow the patient's decision.

In reaching its conclusion, the Court examined the statute and the uncodified preface to the 2007 statute. There it stated: "The General Assembly has long recognized the right of the individual to control all aspects of his or her personal care and medical treatment, including the right to insist upon medical treatment, decline medical treatment, or direct that medical treatment be withdrawn." The Court held this means "a clear objective of the Act is to ensure that in making decisions about a patient's health care, it is the will of the patient or her designated agent, and not the will of the health care provider, that controls."

As part of its decision, the Court gave the following instruction regarding how health decisions are made:

The Act then sets forth several rules for how decisions are to be made in caring for a patient with an advance directive. If the patient's attending physician determines in good faith that the patient is able to understand the general nature of the health care procedure being consented to or refused, the patient's own decision about that procedure prevails over contrary instructions by a health care agent. See OCGA § 31-32-7 (a). However,

[w]henever a health care provider believes a declarant is unable to understand the general nature of the health care procedure which the provider deems necessary, the health care provider shall consult with any available health care agent known to the health care provider who then has power to act for the declarant under an advance directive for health care.

OCGA § 31-32-8 (1). In addition, with respect to the withholding or withdrawal of life-sustaining procedures or nourishment and hydration, the health care agent's directions prevail over the patient's written instructions in the advance directive, unless the advance directive specifies otherwise. See OCGA § 31-32-14 (d). The health care agent also has priority over any other person, including a guardian, to



act for the patient in matters covered by the advance directive, unless the directive says otherwise. See OCGA § 31-32-14 (e).

So, was the physician acting in good faith, attempting to follow the patient's wishes as expressed herself or by her health agent? For purposes of the motion for summary judgment, the Court found he was not.

“The health care decision in question is the decision to intubate Stephenson and put her on a ventilator as a life-prolonging measure around 4:00 a.m. on the morning of March 7, 2012. Although there is evidence to the contrary, there is ample evidence that in ordering that procedure, Dr. Catalano was not acting in good faith reliance — in honest dependence — on any decision Alicea had made as Stephenson's health care agent, either to comply with it or to refuse or fail to comply with it and then promptly inform Alicea of his unwillingness. Instead, the evidence would support a finding that Dr. Catalano made the health care decision himself, in the exercise of his own medical and personal judgment. By his own account, when he directed the on-duty doctor to intubate Stephenson, he was not considering the stuff of advance directives and health care agents — “any of the code/no code/do not intubate/resuscitate”; he decided himself “what's right for the patient,” and would check with Alicea later to see if she wanted to “undo” the procedure he was ordering and “pull the tube out.” See footnote 3 above. Dr. Catalano even rebuffed a nurse's question about calling Alicea before ordering the intubation, saying that he would call her later “and tell her what happened.”

The Court declined to comment on the ultimate outcome of the case, or on other disputes among the parties. However, its guidance regarding the use of an advance directive is instructive. The patient or her agent is in charge when making health decisions. Summary Judgment was denied.

## **Financial Powers of Attorney**

A power of attorney creates an agency relationship between a principal (the person giving power) and an agent (the person receiving power), and is governed by O.C.G.A. § 10-6-1 et seq.

The relation of principal and agent arises wherever one person, expressly or by implication, authorizes another to act for him or subsequently ratifies the acts of another in his behalf. An agency relationship authorizing actions that must be taken in writing must also be created in writing. In other words, almost every agency relationship relating to finances must have a written power of attorney or agency agreement.

Any person of sound mind may be appointed as agent. Anything one person may do may be done by an agent, except such personal trusts in which special confidence was placed in the principal. An agent may not delegate authority to act unless specially empowered to do so.

A conditional power of attorney (or “springing power”) is not effective until the specified event occurs. A power of attorney containing a conditional designation becomes effective when the person or persons designated in the power of attorney execute a written declaration under penalty of false swearing that the specified event or contingency has occurred. See O.C.G.A. § 10-6-6.

The agent shall act within the authority granted to him, reasonably interpreted; if he shall exceed or violate his instructions, he does it at his own risk, the principal having the privilege of affirming or dissenting, as his interest may dictate.

A voluntary agent, without hire or reward (which includes most family members serving as agent), shall be liable only for gross neglect. He or she may, however, be liable for breaching his or her duty to the principal. For example, without express authority, the agent may not purchase the principal’s property, and may not sell his property to the principal. The agent may not personally profit from the principal’s property, and may not dispute the principal’s ownership of property. If an agent commingles his or her own money with that of the principal, and if it cannot be separated, then the whole belongs to the principal. The principal may recover back money paid illegally or by mistake of his agent or goods wrongfully transferred by the agent if the party receiving those items had notice of the agent’s improper conduct. Every agent exceeding the scope of his authority shall be individually liable to the person with whom he deals, and is liable for his own negligence.

If an agent signs merely using the word “agent” then the agent may be liable. The correct form identifies the principal for whom the agent is acting, such as “John Smith, by Mary Smith as Attorney in Fact.”

Agents are required to keep regular accounts (records) with supporting documentation.

An agency relationship is revocable at the will of the principal, and unless the agency is coupled with an interest, it is automatically revoked upon the death of the principal or the agent.<sup>34</sup>

In Georgia, all powers of attorney are presumed to be durable. A written power of attorney, unless expressly providing otherwise, shall not be terminated by the incompetency or incapacity of the principal. The power to act as an attorney in fact for a principal who subsequently becomes incompetent or incapacitated shall remain in force until such time as a conservator or receiver shall be appointed for the principal or until some other judicial proceeding shall terminate the power.

Where an agent is authorized to take action, his or her authority is construed to include all necessary and usual means for effectually executing it.

Principals are bound by the actions of their agents unless the agent exceeds his or her authority. If the agent exceeds his or her authority, the principal must either ratify the entire transaction or repudiate the entire transaction. If the principal ratifies the transaction, it relates back to the original act; a ratification once made cannot be revoked.

A statutory form for Financial Power of Attorney appears at O.C.G.A. § 10-6-142.

In *LeCraw v. LeCraw*, 261 Ga. 98 (1991), the Georgia Supreme Court construed a power of attorney and found that it authorized a continued pattern of gifting.<sup>35</sup> After an audit, the IRS took the position that the power of attorney did not authorize gifting. It did, however, authorize making withdrawals from checking accounts, savings accounts, and did authorize the agent to “do any other thing or perform any other act, not limited to the foregoing, which I might do in person, it being intended that this shall be a general power of attorney.”<sup>36</sup> In finding that the power of attorney authorized gifting, the trial court found that Mrs. LeCraw’s agents were continuing a pattern of gifting designed to minimize her transfer tax liability. It also found that she knew about the gifting by her agents, voiced no objection and that she understood tax planning. After finding virtually no Georgia authority on the matter, the trial court found that the power of attorney authorized the gifts based on Mrs. LeCraw’s intent in creating the agency. On appeal the Georgia Supreme Court agreed. The Supreme Court held:

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<sup>34</sup> This rule is varied for service members. See O.C.G.A. § 10-6-35.

<sup>35</sup> The agent is not absolutely prohibited from using a power of attorney to gift the principal’s assets to himself, but the power to do so must be clearly established. See also O.C.G.A. § 10-6-25 (agent shall not make a profit from his principal’s property).

<sup>36</sup> “Where there is no specific power to sell land in the instrument, broad language authorizing the doing of ‘any and all things that he may deem necessary, or that I might do’ is construed as referring back to the particular things already permitted rather than as authorizing all acts which the agent sees fit to do.” Pindar’s Georgia Real Estate Law and Procedure, Sixth Ed. § 19-50.

Where, as here, the grantor of the power of attorney expresses in that document the desires that her business be transacted by her attorneys-in-fact and that the power of attorney be a general power, and the evidence is undisputed that the actions taken by the attorneys-in-fact, unobjected to by the grantor, continue the grantor's practice of giving monetary gifts to the natural objects of her bounty and affection; that the exercise of the power to make gratuitous transfers by the attorneys-in-fact does not deplete the grantor of the assets necessary for her to live her accustomed life-style; and that the exercise of the power to make gifts to the natural objects of her bounty minimizes the estate transfer tax, a goal the grantor desired, we construe the general power of attorney executed by the grantor to include within it the power to make gratuitous transfers of property to the natural objects of the grantor's bounty.<sup>37</sup>

In *Bradshaw v. McNeill*, 228 Ga. App. 653 (1997), an agent was found to have exceeded her authority under a power of attorney. Carol Bradshaw was sued for fraud and undue influence relating to her conduct on behalf of her aunt, Dorothy Harris, the principal, added Bradshaw to a number of accounts after her husband died. Harris' will devised her estate in equal shares to Bradshaw and McNeill. A month prior to Harris' death, Bradshaw accompanied Harris to an attorney where the remainder interest in Harris' home was deeded to Bradshaw. When Harris was admitted to a nursing home, Bradshaw withdrew funds in Harris' non-joint bank accounts and deposited them into new joint accounts with Bradshaw. Harris died the following day. The power of attorney Bradshaw used authorized her to close out checking or savings accounts and to open new accounts. However, it also specified that any such action was to be taken on behalf of Harris. In light of O.C.G.A. §§ 10-6-1; 10-6-5, which prohibit agents from using a power of attorney to benefit themselves to the detriment of their agent, the Court found that a jury question remained as to whether Bradshaw's conduct was on behalf of Harris. The Court distinguished *LeCraw* where the principal had time and opportunity to ratify the agent's conduct.

In *Keith v. Alexander Underwriters Gen. Agency*, 219 Ga. App. 36 (1995), the Court of Appeals examined a power of attorney which permitted an agent to operate an insurance business. In doing so, it rejected the argument that the agent had authority to file a pro

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<sup>37</sup> The Court's decision is less than clear concerning whether authority exists by virtue of the wording of the power of attorney or because the principal waived objections. See e.g., *Britt v. Albright*, 282 Ga. App. 206 (2006) (where an agent exceeded his authority under a power of attorney, but the principal's subsequent actions ratified his act); *Bradshaw v. McNeill*, 228 Ga. App. 653 (1997) (distinguishing *LeCraw* because the principal; "died without an opportunity to ratify or repudiate the agents actions"); *Jordon v. Stephens*, 221 Ga. App. 8 (1996) (there was evidence that the principal intended for a transfer to occur). Although the Court in *LeCraw* affirmed a finding of authority, it restates the general rule that a power of attorney is subject to a strict construction and that general terms are restricted to constancy with the controlling purpose. See *Wheless, supra* ("Georgia law has historically construed powers of attorney strictly and in light of the four corners of the instrument. ... Regardless of strict construction, however, it is well settled that the agent's authority shall be construed to include all necessary and usual means for effectually executing it").

se action on behalf of his principal. “[A] formal power of attorney is subject to a strict construction,’ and ‘general terms in it are restricted to consistency with the controlling purpose . . .’ [cits.], yet . . . ‘the agent’s authority shall be construed to include all necessary and usual means for effectually executing it.’ *LeCraw v. LeCraw*, 261 Ga. 98, 99 (401 S.E.2d 697) (1991). The power of attorney was patently given to allow Latzak to operate the insurance agency. It contains no specific authority to accept service for her or to represent her in a suit against her. The general terms do not implicate such authority either; the power to make a response in a personal suit would be far beyond what would be needed to operate Keith’s insurance business.”

In *Nat’l Treasury Emples. Union v. Macon-Bibb County Hosp. Auth.*, 230 Ga. App. 448 (1998), the Court of Appeals rejected a claim that the Hospital, as agent, had a duty to know the contents of an insurance contract. The Court noted that the power of attorney in that case was a limited one. It did not purport to assign all of the principal’s rights and benefits.; it simply had authority to complete any forms or releases required to obtain assigned insurance benefits. Since the hospital did not have a general power of attorney, it did not stand in the principal’s shoes.

In *Life Care Ctrs of Am. v. Smith*, 298 Ga. App. 739 (2009), the Court of Appeals held that a power of attorney for health care did not give an agent authority to execute an arbitration agreement. “Although Life Care argues that the power of attorney states that the power granted is intended to be as broad as possible, that broad grant of power is ‘so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care. . . .’ We note that the agreement to arbitrate was optional and it is not contended in this case that in order for Petereit to be admitted to Life Care, Smith was required to sign the agreement to arbitrate.”

## Eligibility for Long-Term Care Medicaid

### Why Medicaid?

Long-term care is expensive. Individuals with chronic conditions frequently think Medicare will pay the cost of long-term care. Those costs range from \$5,000 per month to more than \$8,000 per month. In fact, Medicare is structured like health insurance. While Medicare usually reimburses the cost of *acute* care, it does a poor job of reimbursing the cost of “*custodial*” long-term care.<sup>38</sup> The result is that most individuals who require long-term care will seek Medicaid eligibility.<sup>39</sup> They will either seek Medicaid when they become destitute or they will seek to accelerate eligibility.

### What is Medicaid?

Medicaid, enacted in 1965, is means-tested health coverage for certain individuals who are aged, blind or disabled.<sup>40</sup> It is jointly funded federal-State program, administered by the States. It does not pay cash to a beneficiary. Instead, it pays medical providers for services rendered to eligible participants.

Medicaid does not help everyone who needs assistance paying for healthcare. Coverage is limited to individuals who meet the eligibility criteria for specific classes of assistance. The class of assistance most often sought by individuals relates to nursing home coverage or home health care.

To many, Medicaid is an enigma.<sup>41</sup> The program's complexity surrounding who is eligible, what services are paid for, and how those services are reimbursed and delivered is one source of this confusion. Variability across State Medicaid programs is the rule, not the exception. In recent years, more and more States have implemented a variety of major program changes using special waiver authority. Income eligibility levels, services covered, and the method for and amount of reimbursement for services differ from State to State. Furthermore, Medicaid is a program that is targeted at individuals with low-income, but not all of the poor are eligible, and not all those covered are poor.

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<sup>38</sup> Medicare does cover limited long-term care if it is “skilled” and if it is for rehabilitation. Many individuals have heard of Medicare’s “100 day” coverage in a nursing home. This benefit is only available following a qualifying hospital stay if the patient is discharged to a nursing home for skilled therapy for the same condition that required hospitalization. The nursing home admission must occur within 30 days of the hospital discharge. If skilled therapy is terminated, then Medicare coverage terminates. In other words, there is no guarantee that a patient will receive 100 days of coverage. Even if skilled therapy continues, Medicare only reimburses 100% of the first 20 days. The remaining days are subject to a daily copay of \$148 (2013).

<sup>39</sup> While the use of long-term care insurance is growing, at this time most elders do not have long-term care insurance policies.

<sup>40</sup> Medicaid was created in the same legislation creating the Medicare program, P.L. 89-97.

<sup>41</sup> “The Medicaid Act is an enormously complicated program. The system is a web; a tug at one strand pulls on every other. Given this complexity, there are untold ways in which a state plan might fail to comply with the Act and the governing regulations.” *Lewis v. Rendell*, 501 F. Supp.2d 671 (E.D. Pa. 2007). The same, unfortunately, applies to Medicaid planning, balancing estate planning, retirement planning, tax planning and other goals, is an exercise in risk management, not risk avoidance.

For populations like children and families, primary and acute care often are delivered through managed care, while the elderly and disabled typically obtain such care on a fee-for-service basis. Nationwide, Medicaid finances the majority of long-term care services.<sup>42</sup> Such services include, for example, nursing home care and community-based services designed to support the elderly and disabled in their homes. Recently, some States have begun to integrate Medicare and Medicaid financing and/or coordinate acute and long-term care services for these populations.<sup>43</sup>

Like SSI, to gain or maintain eligibility for Medicaid, an applicant must be poor enough under the program eligibility rules. An applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions. Consequently, those standards vary considerably among States, and different standards apply to different population groups within a State. For many of those groups, States have permission under a special provision, Section 1902(r)(2), to use more liberal standards for computing income and resources than are specified within each of the groups' definitions. Most States use Section 1902(r)(2) to ignore or disregard certain types or amounts of income or assets, thereby extending Medicaid to individuals with earnings or assets too high to otherwise qualify under the specified rules for that eligibility pathway.

### **Where can I find “the Rules?”**

The Medicaid statute is found at 42 U.S.C. § 1396 et seq. Two of the sections commonly reviewed by Elder Law Attorneys are 42 U.S.C. §§ 1396p and 1396r-5.

Federal regulations appear at 42 C.F.R. § 435.2 et seq.

The Center for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, published a State Medicaid Manual. Chapter 3 includes significant commentary regarding Medicaid eligibility, but it was not updated following passage of the Deficit Reduction Act of 2005.

The State Plan is the primary document controlling each State's Medicaid program. It must be submitted to and approved by CMS. The State Plan takes precedence over State rules or regulations if there is a conflict.

The Georgia Medicaid manual (MAN3480) is online at:  
<http://odis.dhs.ga.gov/ChooseCategory.aspx?cid=813>.

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<sup>42</sup> Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness, frailty, or a disabling condition. It differs from acute care in that the goal of long-term care is not to cure an illness that is generally of short duration, but to allow an individual to attain and maintain an optimal level of functioning over the long-term.

<sup>43</sup> House Ways and Means Committee Prints, 108-6, 2004 Green Book, Chapter 15, at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108\\_green\\_book&docid=f:wm006\\_15.wais](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_green_book&docid=f:wm006_15.wais).

### **Why Plan for Medicaid?**

Individuals will become eligible for Medicaid when they are poor enough to qualify. Why, one might ask, would they want to plan to accelerate eligibility?

One reason is because the Medicaid benefit is meager. An individual on Medicaid usually has nothing left to fund quality of life goods and services. For example, Medicaid does not fund the cost of cable television or a personal telephone. Anything that would enhance quality of life other than medical care must be paid for by the individual or the individual's family.

Another reason for accelerating Medicaid is protection of a healthy spouse. The Medicaid defaults available to protect the healthy spouse of someone who needs long-term care are meager. For example, the 70 year old healthy spouse of a nursing home resident (known as the "Community Spouse") is entitled to keep \$119,220 (fy2016) in countable assets. If the Community Spouse lives another 20 years, then he or she only has \$5,961 per year, beyond monthly income, to fund expenses like vehicle replacement, a new roof, and assisted living care.

Another principal reason people plan to accelerate Medicaid eligibility is to protect assets. Frequently this reason for Medicaid planning is questioned by fiscal conservatives, but their reasons for doing so are unsound since fiscal conservatives almost uniformly plan to pay the minimum tax possible each April 15<sup>th</sup>. There is no obligation to pay more for any good or service than the law requires; therefore, individuals who plan to accelerate Medicaid eligibility are within their right to do so as long as they comply with the Medicaid rules.

### **Basic eligibility**

Income and resources must be within the eligibility limits. In 2016, the eligibility limits are:

<b>Applicant's Income</b>	<b>Applicant's Resources</b>	<b>Healthy Spouse's Resources</b>
Less than \$2,199	Less than \$2,000	Less than \$119,220

With regard to married couples, all marital assets are examined when determining eligibility. It does not matter which spouse owns the assets.

### **Resource Exemptions**

Not everything counts toward the eligibility limits. Certain resources are exempt, most notably an individual's home. Other exempt resources include furniture and other person property in the home, one vehicle, and a reasonable burial. Unless an asset is exempt, then it counts toward eligibility.



### **Transfer penalties**

If you attempt to artificially impoverish yourself by giving away your resources within 60 months prior to seeking long-term care Medicaid, then a transfer penalty will be imposed. The penalty is a math formula, but can be roughly stated as follows: the value of the gift, divided by the average monthly cost of nursing home care, equals the number of months Medicaid will refuse to make payments.

The transfer penalty is not imposed (meaning the clock does not begin ticking) until the applicant is otherwise eligible. In most cases, this means a full Medicaid application is necessary to prove the individual would have been eligible but for the gift.

### **Estate Recovery**

After a Medicaid recipient dies, the State will file a creditor claim in the decedent's estate. In most cases, the only resource remaining is the home.

## Legal options for developmentally disabled children

### Guardianship and Conservatorship<sup>44</sup>

The primary purpose of a guardianship or conservatorship is to protect a class of citizens who are incapable of fully protecting themselves. Guardianships and conservatorships are court proceedings which, when approved, implement the concept of *parens patriae*. They include “front end” procedures (associated with due process when the petition is considered) and “back end” procedures (associated with guardian oversight).

“Conservatorship proceedings provide a forum for determining whether a person’s ability to remain autonomous has become impaired. Even though these proceedings are intended to promote the best interests of the vulnerable elderly, they carry with them the real possibility of displacing the elderly person’s ability to make even the most basic decisions for themselves and to live their lives unfettered by the control of others. Persons who are the subject of a conservatorship face a substantial loss of freedom, that resembles the loss of freedom following a criminal conviction.” *In re Conservatorship of Groves*, 109 S.W.3d 317, 329 (citations omitted).

In Georgia, the guardianship process is the exclusive method for appointing a guardian other than a guardian ad litem. O.C.G.A. § 29-4-1(b). The conservatorship process is the exclusive means for appointing a conservator, except a conservator for the estate of an individual who is missing or believed to be dead. O.C.G.A. § 29-5-1(b).

A ward has the right to:

- (1) A qualified guardian who acts in the best interest of the ward;
- (2) A guardian who is reasonably accessible to the ward;
- (3) Have the ward’s property utilized to provide adequately for the ward’s support, care, education, health, and welfare;
- (4) Communicate freely and privately with persons other than the guardian, except as otherwise ordered by a court of competent jurisdiction;
- (5) Individually, or through the ward’s representative or legal counsel, bring an action relating to the guardianship, including the right to file a petition alleging that the ward is being unjustly denied a right or privilege granted by this chapter and Chapter 5 of this title and including the right to bring an action to modify or terminate the guardianship pursuant to the provisions of Code Sections 29-4-41 and 29-4-42;
- (6) The least restrictive form of guardianship assistance, taking into consideration the ward’s functional limitations, personal needs, and preferences; and
- (7) Be restored to capacity at the earliest possible time. O.C.G.A. § 29-4-20.

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<sup>44</sup> A longer paper on guardianships, included footnotes deleted from this version, appears at <http://www.mcguiffey.net/pdf/Guardianship%20Litigation%20v7%20February%202015.pdf>.

The appointment of a guardian is not a determination regarding the right of the ward to vote. The appointment of a guardian is not a determination that the ward lacks testamentary capacity. O.C.G.A. § 29-4-20.

In Georgia, the prioritized list is as follows: (1) The person or persons designated in a writing signed by the alleged disabled person; (2) The spouse of the disabled person; (3) Any child of the disabled person; (4) Closest relative or relatives of the disabled person; and (5) Other person or persons. Ultimately, though, there is no right to serve as fiduciary; the Court names the fiduciary if one is appointed. If the court declines to appoint the individual nominated by the ward, good cause must be shown. See M.F. Radford, *Guardianships and Conservatorships in Georgia*, § 4-5 (Chattahoochee Legal Press 2005), § 4-5. If the alleged ward is present, a Georgia court should consider any person suggested by the proposed ward. O.C.G.A. § 29-4-12(d)(6); § 29-5-12(d)(6).

### **Standby Guardians**

A parent or a guardian (each a “designated individual”) may appoint a standby guardian of a minor. O.C.G.A. § 29-2-10. Upon determination that the designating individual is unable to care for the minor, the standby guardian, without judicial intervention, may assume all rights, duties and responsibilities of guardianship of the minor. The standby guardian must file a notice of standby guardianship with the probate court where the minor lives. A statutory form appears at O.C.G.A. § 29-2-11(c). The form must be signed by the designating individual and two witnesses. Within 120 days from the date of the health determination, the standby guardian must file a petition seeking temporary guardianship; the standby guardianship terminates upon the earlier of 120 days from the date of the health determination, or the death of the designating individual.

### **Special Needs Trusts**

A special needs trust is a unique type of trust disabled individuals may establish to protect otherwise countable resources when seeking eligibility for SSI and Medicaid. Like any other trust, it has a trustee, a beneficiary and trust property. Trusts may be self-settled (with the beneficiary’s assets) pursuant to 42 U.S.C. § 1396p(d)(4)(A) or (d)(4)(C). They may also be established by third parties who want to make provision for a child, grandchild or other relative.

### **Medicaid Waivers for Disabled Individuals**

#### Independent Care Waiver Services Program (ICWP)<sup>45</sup>

The ICWP is a home and community based waiver intended to help adult Medicaid recipients with physical disabilities live in their own homes or in the community instead of a hospital or nursing facility. ICWP services may also be available for persons with traumatic brain injuries (TBI). This program is generally available for recipients

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[https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/49/47/75995826IndependentCareWaiverProgram\\_FY12.pdf](https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/49/47/75995826IndependentCareWaiverProgram_FY12.pdf)

between the ages of 21 and 64. Eligibility criteria appear in Section 2139 of the Georgia ABD Manual.

#### NOW and COMP Waivers<sup>46</sup>

The New Options Waiver (NOW) and the Comprehensive Supports Waiver Program (COMP) are intended to provide home and community-based services for people with intellectual disabilities or developmental disabilities. A diagnosis of developmental disability includes intellectual disability or other related developmental conditions such as cerebral palsy, epilepsy, autism or neurological problems that require a level of care provided in an ICF/ID. Eligibility criteria appear in Section 2132 of the Georgia ABD Manual.

#### Georgia Pediatric Program Waiver (GAPP)<sup>47</sup>

The Georgia Pediatric Program ("GAPP") is a service-delivery model for providing nursing care in the home to medically fragile children.<sup>48</sup> Children must be under the age of 20 years, 11 months and must be medically eligible. The GAPP Waiver program may provide services in medical daycare settings to medically fragile children with multiple system diagnoses who require continuous skilled nursing care, or skilled nursing care in shifts.<sup>49</sup> Children receive services in their homes, communities, and in 'medical' day care settings rather than placing children in a nursing facility or hospital.

In *Moore v. Reese*, 637 F.3d 1220 (11<sup>th</sup> Cir. 2011), the Eleventh Circuit identified six guiding principles special needs advocates should be aware of in appealing GAPP denials. They are:

(1) Georgia is required to provide private duty nursing services to Moore, who meets the EPSDT<sup>50</sup> eligibility requirements, when such services are medically necessary to correct or ameliorate her illness and condition.

*See* 42 U.S.C. § 1396d(r)(5); *Beal*, 432 U.S. at 444, 97 S. Ct. at 2371; *Murray*, 244 F.3d at 809 n.2; *Pittman*, 998 F.2d at 891-92; *Curtis*, 625 F.2d at 651 n.11; 42 C.F.R. § 440.230(d).

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[https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/49/43/92560099NOW\\_COMP\\_FY12.pdf](https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/49/43/92560099NOW_COMP_FY12.pdf)

<sup>47</sup> [http://dch.georgia.gov/sites/dch.georgia.gov/files/GAPP\\_FY14\\_Final.pdf](http://dch.georgia.gov/sites/dch.georgia.gov/files/GAPP_FY14_Final.pdf)

<sup>48</sup> *Moore v. Reese*, 637 F.3d 1220 (11<sup>th</sup> Cir. 2011).

<sup>49</sup> See Section 713, Part II Policies and Procedures for the Georgia Pediatric Program (GAPP Manual), at [http://asiworks.com/sdp/docspdfsgeorgia/policies/comp\\_part\\_ii.pdf](http://asiworks.com/sdp/docspdfsgeorgia/policies/comp_part_ii.pdf).

<sup>50</sup> EPSDT is an acronym for Early and Periodic Screening, Diagnostic, and Treatment. In 1989, Congress amended the Medicaid Act to broaden the categories of services that participating states must provide to Medicaid-eligible children. The 1989 Amendment mandates that participating states provide EPSDT services to all Medicaid-eligible persons under the age of 21. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262-64; 42 U.S.C. § 1396d(a)(4)(B), (r). The goal of the EPSDT program is to provide low-income children with comprehensive health care. The EPSDT program, codified at 42 U.S.C. § 1396d(r), mandates four specific categories of services: screening, vision, dental, and hearing services. 42 U.S.C. § 1396d(r)(1)-(4).

(2) A state Medicaid plan must include "reasonable standards . . . for determining eligibility for and the extent of medical assistance"—here, the extent of private duty nursing services for Moore—and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program. See § 1396a(a)(17); *see also Beal*, 432 U.S. at 444, 97 S. Ct. at 2371; *Rush*, 625 F.2d at 1155.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. *Rush*, 625 F.2d at 1154. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. *Curtis*, 625 F.2d at 652; 42 C.F.R. § 440.230(c). Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose." *Rush*, 625 F.2d at 1156.

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." *Id.* Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive." *Moore I*, 324 F. App'x at 774.

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. CMS Manual § 5122(F) (construing 42 C.F.R. § 440.230). The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. *See Beal*, 432 U.S. at 444-45, 97 S. Ct. at 2371; CMS Manual § 5010(B). However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b); *see also* CMS Manual § 5122(F).

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." 42 C.F.R. § 440.230(d). In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis," and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. *Rush*, 625 F.2d at 1152, 1155.

### Katie Beckett (Deeming) Medicaid Program<sup>51</sup>

This is not a waiver services program, but a category of eligibility for Medicaid assistance. For that reason, it is sometimes referred to as the “Deeming Waiver.”

The Katie Beckett Medicaid Program (KB) permits Georgia to ignore family income for certain children with disabilities. It allows Medicaid benefits to be provided to children 18 years of age or less who qualify as “disabled individuals” under the Social Security Act and who live at home rather than in an institution. These children must meet specific criteria to be covered.<sup>52</sup> Qualification for Katie Beckett Medicaid should not be based on medical diagnosis but rather based on the institutional level of care the child requires. Eligibility criteria appear in Section 2133 of the Georgia ABD Manual.

### **The Olmstead Decision**

The Olmstead case<sup>53</sup> was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated setting appropriate.

The Supreme Court ruled that “Unjustified isolation . . . is properly regarded as discrimination based on disability.” It observed that (a) “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life,” and (b) “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

Under the Court’s decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State’s treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State’s responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

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<sup>51</sup> <https://dch.georgia.gov/tefrakatie-beckett>

<sup>52</sup> See Section 712, GAPP Manual, at

[http://asiworks.com/sdp/docspdfsgeorgia/policies/comp\\_part\\_ii.pdf](http://asiworks.com/sdp/docspdfsgeorgia/policies/comp_part_ii.pdf).

<sup>53</sup> Olmstead v. L.C., 119 S.Ct. 2176 (1999).

Under the ADA, States are obliged to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity.” The Supreme Court indicated that the test as to whether a modification entails “fundamental alteration” of a program takes into account three factors: the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the provision of services affects the ability of the State to meet the needs of others with disabilities.

### **Special Education Laws**

The three most common documents prepared for special education students are the individualized education plan (IEP), the individual health plan (IHP) and the 504 plan. An IEP is a plan developed by a team, to address these learning gaps.

An IEP can also be used when the gap is anticipated, such as with a child who will have difficulty keeping up due to frequent illness and absences, or a child whose hearing impairment, orthopedic impairment, or emotional disturbance necessitates modifications and/or accommodations in the curriculum. An IEP a legally binding document based on the Individuals with Disabilities Education Act (IDEA). A child identified for services under IDEA must meet specific criteria. The degree of regulation is more specific in terms of time frames, parental participation, and formal paperwork requirements.

An IHP is a plan that considers how to deal with what might happen with a student medically while the student is in school. It is designed to address medical issues that do not impact the student’s learning. There is no federal or state protection with an IHP.

Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law which prohibits discrimination against people with disabilities. Section 504 covers the lifespan and safeguards the rights of persons with disabilities in many areas of their lives, including employment, public access to buildings, transportation, and education. To be protected under Section 504, a student must be determined to: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) have a record of such an impairment; or (3) be regarded as having such an impairment. A 504 Plan is a legally binding agreement between the parent(s) and the school district. It is a part of the Americans with Disabilities Act (ADA). Children who have disabilities that do not interfere with their ability to progress in general education are not eligible for special education services, but they may be entitled to the protection provided by a 504 Accommodation Plan. 504 Plans are used widely and for diverse needs. It is developed by a team, including school staff, the parent and the student (if the student is able to participate). Medical professionals may be included if the 504 plan covers medical needs. The plan can include adaptive equipment or assistive technology devices; an aide; assistance with health-related needs; school transportation; or other related services and accommodations.

More information regarding special education, and enforcement of special education rights and plans is available at [www.wrightslaw.com](http://www.wrightslaw.com).