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David M. English
University of Missouri School of Law, englishda@missouri.edu

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The Uniform Health-Care Decisions Act and its Progress in the States

By David M. English

Over the past decade, planning for health care decision making through the making of an advance directive has become a routine part of personal counseling. Public interest in the subject has been fueled by well-publicized cases such as Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990). In response to this interest, most states authorize their citizens to make at least one form of advance directive: all states statutorily authorize powers of attorney for health care, and all but Massachusetts, Michigan and New York authorize living wills.

State legislation has been a mixed blessing. Although intended to facilitate the making of advance directives, many of the statutes may actually inhibit their use. The execution requirements are often detailed. Restrictions on the types of treatment that may be withheld or withdrawn are common.

There is little uniformity. The result is a system of fragmented, incomplete and often inconsistent legislation, both among states and within single states.

In 1993, the Uniform Law Commissioners approved the Uniform Health-Care Decisions Act (UHCDA) in order to bring order to the existing chaos. (The text of the UHCDA is available at www.nccusl.org.) Unfortunately, the Commissioners waited too long to act. By the time the UHCDA was
approved, nearly all states had passed legislation governing advance directives. Convincing states to revisit existing legislation is not easy. Interest declines in expending further political capital on what may seem to some to be only modest improvements. Consequently, the UHCDA has achieved only a limited success, picking up but one or two enactments a year. The UHCDA is currently in effect in six states: California, Cal. Prob. Code §§ 4600-4805; Delaware, Del. Code Ann. tit. 16, §§ 2501-2517; Hawaii, Haw. Rev. Stat. §§ 327E-1 to 327E-16; Maine, Me. Rev. Stat. Ann. tit. 18-A, §§ 5-801 to 5-817; Mississippi, Miss. Code Ann. §§ 41-41-201 to 41-41-229; and New Mexico, N.M. Stat. Ann. §§ 24-7A-1 to 24-7A-18.

The overall objective of the UHCDA is to encourage the making and enforcement of advance health care directives and to provide a means for making health care decisions for those who have failed to plan. The UHCDA accomplishes these objectives by

- making the UHCDA comprehensive, combining in one place topics that are related but that have often been addressed by separate statutes;
- removing the hurdles to the making of advance directives and the limitations on the topics an advance directive can address;
- establishing a system for decision making by surrogates for those who have failed to plan; and
- providing a mechanism for the enforcement of advance directives.

Comprehensive Scope

Most states recognize living wills, powers of attorney for health care and a decision making role for the families of those who have failed to make advance directives. But the statutes that address these subjects often create inconsistencies within a state’s own law. The UHCDA avoids these inconsistencies by covering all of these topics within one statute. Under the UHCDA, any adult or emancipated minor may give an “advance health-care directive,” which refers to either a “power of attorney for health care” or “individual instruction.” The UHCDA deliberately avoids the term “living will,” because the drafters concluded that the term “individual instruction” is more accurate. If an individual fails to execute a power of attorney for health care or if the agent is not available, the UHCDA authorizes health care decisions to be made by a “surrogate” to be selected from a priority list.

All six states that have enacted the UHCDA include its provisions on individual instructions and powers of attorney, albeit with numerous (mostly small) modifications. All of these states, except California, contain comprehensive provisions on decision making by surrogates.

Topics Not Addressed

Although comprehensive, the UHCDA does not address all conceivable issues. The UHCDA is limited to health care decision making for adults and emancipated minors. The Commissioners concluded that covering the full range of health care decision making for unemancipated minors, including the effect of differing parental and custodial arrangements and levels of maturity, would have made the Act unwieldy.

A topic generating enormous publicity in recent years is physician-assisted suicide. The UHCDA does not expressly prohibit physician-assisted suicide, but it does recognize that other state statutes may prohibit the practice. The consensus to date is that physician-assisted suicide, if it is to be allowed at all, requires the enactment of special legislation, such as that in effect in Oregon. Or. Rev. Stat. §§ 127.800 to 127.995.

A topic not generating as much discussion but ultimately far more important is the problem of the “friendless patient”—the individual who has no family or friends available to act on his or her behalf. The UHCDA does not address this topic, nor is it adequately addressed in any of the states that have enacted the UHCDA. This leaves the decisions for friendless patients to be made largely in default by health care providers without any guidance or safeguards. A need remains for a procedure to make routine and critical health care decisions for friendless patients outside of court but with appropriate safeguards.

Eliminating Restrictions

Most power of attorney for health care statutes allow a principal to delegate to an agent the authority to make all health care decisions. The living will statutes are replete with restrictions. The complex definitions of the categories of patients for whom life-sustaining treatment may be withheld or withdrawn and the prohibitions against the withdrawing or withholding of certain forms of treatment have rendered many of these statutes virtual nullities.

The drafters of the UHCDA concluded that the attempts to prescribe statutorily the circumstances when life-sustaining treatment may be withheld or withdrawn are difficult to apply in a clinical setting and provide an appearance of precision where none is possible. Under the UHCDA, there are no specific restrictions. An individual instruction and the authority granted to an agent may extend to any “health-care decision,” a term that is expansively defined to include such matters as approval or disapproval of orders not to resuscitate and directions to provide, withhold or withdraw artificial nutrition and hydration and other forms of health care.

The enacting states are mostly faithful to the text of the UHCDA on this point. Only Delaware restricts the topics that can be addressed in an advance health care directive, providing that an advance health care directive can be applied to withdraw life-sustaining procedures only for patients who are terminally ill or...
requirements has been only a partial written or oral. Individual instruction may be either witnessed or acknowledged. An individual's intent. The UHCDA facilitates the making of advance directives by keeping execution requirements to an absolute minimum. A power of attorney for health care must be written and signed, but it need not be either witnessed or acknowledged. An individual instruction may be either written or oral.

This attempt to eliminate execution requirements has been only a partial success. Concerns about possible fraud and undue influence motivated many state legislatures in their consideration of the UHCDA. Nevertheless, the UHCDA's provisions on oral instructions have been generally accepted, although both Maine and New Mexico have imposed some safeguards. Maine provides that the instruction is valid only if given to the health care provider or person eligible to act as surrogate; New Mexico validates an instruction only if given to the health care provider. Only Delaware omits the provision recognizing oral instructions.

The effort to relax execution requirements for the power of attorney for health care has been less successful. The drafters of the UHCDA concluded that the cumbersome execution requirements found in many state statutes have done little to deter fraud or overreaching. Only New Mexico has followed the UHCDA without change. The other states have generally retained the execution requirements under prior law. But even here surface appearances do not reflect the full reality. Most of the states have enacted without change the UHCDA provision on oral designation of surrogates, which in practical effect is the same as allowing for the oral appointments of agents.

The UHCDA's combined advance directives form consists of four parts: appointment of agent, instructions, organ and tissue donation and designation of primary physician. The power of attorney appears first on the form to ensure that it comes to the attention of the casual reader, since the appointment of an agent is usually more helpful in the making of health care decisions than is the giving of instructions.

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The Statutory Form

Statutory forms provide a number of benefits. Because the form is standard and widely available, individuals who would otherwise be reluctant to pay to have a form prepared are more likely to execute an advance directive. The availability of an officially sanctioned form will reduce the reluctance of health care providers to honor a directive. Through continued use of the form, it is hoped that health care providers will become more familiar with its provisions and make more informed decisions.

Nearly all living will statutes contain statutory forms, as do most of the power of attorney for health care enactments. Signing separate power of attorney and living will forms can lead to complications: execution requirements may differ, and forms can be inconsistent. Issues can arise as to how to coordinate the two documents. Did the creator intend the agent to be bound by the wishes expressed in the living will, or did the creator...
categories of care for which an individual is most likely to have special wishes. This section includes optional provisions relating to withdrawing or withholding treatment, supplying artificial nutrition and hydration and providing pain relief. An individual may merely designate an agent and leave the instructions part of the form blank. This allows the agent maximum flexibility to respond to the principal’s current health care needs.

Adopting language suggested by the Uniform Anatomical Gift Act, the form includes space for the individual to express an intent to make an organ or tissue donation. The drafting committee assumed that a donation designation on an advance health care directive is more likely to come to light than an organ donor card. Because health care providers usually refuse to honor a donation document unless the donor’s family concurs, practitioners should always encourage donors to discuss their wishes with their families.

Finally, the form provides space for an individual to designate a “primary” physician. The UHCDA specifically avoids use of the term “attending physician,” which could refer to the physician currently providing treatment to the individual and not the physician whom the individual would select. Among the functions of a patient’s primary physician is the determination of the patient’s capacity to make health care decisions. Drafting forms is an art, not a science, and there is always room for improvement. In many small ways, New Mexico’s form is more “user friendly” than the UHCDA form. The other states have largely enacted the form without significant change, except for conforming the form to match other modifications that they have made to the UHCDA, such as the addition of execution requirements. Perhaps from a concern that providing for organ and tissue donation might deter some individuals from making advance directives, both Mississippi and New Mexico dropped the subject from their forms, although New Mexico later added it back.

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Surrogates

Despite the wider and highly recommended use of powers of attorney for health care, families continue to play an important role in making health care decisions for incapacitated relatives. Even if they do, interpretation is often necessary.

The UHCDA’s initial priority list is rather standard, beginning with the spouse, followed in order by an adult child, a parent and an adult sibling. Those lower on the list are eligible to act when a predecessor is unwilling or unavailable. Unlike the statutes in most states, the UHCDA then creates a bottom level priority for the "close friend," although distant relatives and domestic partners can also fit within this category. The UHCDA defines a "close friend" as a person who has exhibited special care and concern for the patient and who is familiar with the patient’s personal values.

The states enacting the UHCDA have not hesitated to modify the priority list. Delaware expressly disqualifies the spouse if there has been a complaint of domestic abuse. Hawaii rejects the priority list altogether, opting instead to select the surrogate based on the consensus of the interested persons, who are defined to include all of the persons who might have been eligible to act as surrogate under the UHCDA as originally written. Maine and New Mexico add various other relatives to the list. More significantly, New Mexico
also creates an express priority for a domestic partner.

Orally Designated Surrogates

The UHCDA does not specifically use the term “domestic partner,” but an attempt to address issues arising from such relationships led to perhaps the most innovative and successful feature of the Uniform Act. Instead of granting domestic partners a specific priority, the Commissioners elected to make it easier for any patient to designate a nonrelative to make health care decisions. The “orally designated surrogate” appears as the type of decision maker first on the priority list of surrogates. The orally designated surrogate does not have quite the status of an agent appointed under a written power of attorney; hence the use of the different term. Although the Commissioners by the use of this term indicated a preference for written powers of attorney, they also recognized that many individuals simply will fail to prepare the necessary documents. Furthermore, the Commissioners recognized that oral designations occur with some frequency in practice. The ease with which oral designations can be made creates a significant risk of miscommunication, however. To provide some reliability of proof, an individual may orally designate a surrogate only by personally informing the individual’s supervising health care provider. In turn, the UHCDA obligates the health care provider to record the designation in the individual’s health care record.

All of the states that have enacted the UHCDA included the oral surrogate provision. It is the most successful of the UHCDA’s innovations. Only Delaware has made the making of an appointment more difficult by requiring that the patient’s oral designation be communicated not only to the supervising health care provider but also to a witness who is someone other than the designated surrogate. California added language to clarify that an oral designation of a surrogate continues only during the course of treatment or illness or stay in the health care institution.

Enforcement

Effectuating a patient’s right to self-determination requires assurance that the patient’s views and the decisions of those acting for the patient will be respected and enforced. The UHCDA contains a series of provisions designed to enhance this possibility. The UHCDA requires providers to honor a patient’s instructions about health care and to comply with a reasonable interpretation of those instructions and with a health care decision made by the patient’s agent, guardian or surrogate. A health care provider may decline to act only for “reasons of conscience” or if the requested treatment would be “medically ineffective.” In either case, a health care provider or institution must assist in the patient’s transfer to another health care provider or facility where compliance will be assured, if one can be found.

The UHCDA provides certain immunities to induce compliance. An individual’s agent or surrogate is typically an uncompensated volunteer and therefore is not held to the onerous standards of general fiduciary law. An individual acting as a patient’s agent or surrogate is not subject to civil or criminal liability for health care decisions made in good faith. To encourage health care providers to comply, the UHCDA generally exempts from liability health care providers acting in good faith and in accordance with generally accepted health care standards. The UHCDA protects providers who (1) comply with a health care decision of a person apparently having authority to make a decision for a patient, (2) decline to comply with the decision of a person based on a belief that the person lacks authority, and (3) assume that the directive was valid when made and has not been revoked or terminated.

The provisions of the UHCDA on enforcement of advance directives have been enacted without significant changes. The most important revisions concern the obligation to provide continuing care upon declination of a health care decision for reasons of conscience or on the basis that the care would be medically ineffective. Recognizing that no other facility may be willing to accept the patient, California has specified that the obligation of the declining facility to provide continuing care does not mean unlimited compliance with the patient request but only that the facility continue pain relief and other palliative care. Maine provides that the obligation to provide continuing care terminates on final order of court regarding the disputed health care decision. California, Delaware and New Mexico fix a gap in the immunities section of the UHCDA by providing protection from liability to a provider or institution declining to provide care as authorized by the Act.

Conclusion

The Uniform Health-Care Decisions Act represents a major advance over the existing law in most states. It is comprehensive; it facilitates the giving of advance health care directives; it addresses decision making for those who have failed to plan; and it eliminates many restrictions. The six enactments to date, even with all of the local modifications, remain relatively faithful to the Act’s fundamental premises. In the politically charged arena of health care decision making at the end of life, achieving uniformity in all of the details is not possible. Achieving agreement on fundamental goals is more than sufficient.

David M. English, who was the Reporter for the Uniform Health-Care Decisions Act, is the W.F. Fratcher Missouri Endowed Professor of Law at the University of Missouri-Columbia and a member of the Section’s Council.
National Health Care Decisions Week Participation and Survey Results

Results are in on the RPPT Section-sponsored National Health Care Decisions Week. Developed with grant support from the Health Resources Administration (HRSA) of the U.S. Department of Health and Human Services, this initiative promoted joint bar association and medical organization programs to raise public awareness of advance directives for end-of-life health care decision making, including organ and tissue donation.

Thirty-seven bar associations produced 70 educational programs that were held nationwide and attended by 4,489 members of the public. Participating lawyers donated over 1,100 hours of their time valued at over $100,000. Surveys distributed at approximately half of the program sites revealed the following information:

Health Care Advance Directives

- 73% of respondents did not have health care advance directives before attending the National Health Care Decisions Week program.
- 85% of those without directives reported that they intended to complete directives as a result of the Program, with 77% planning to execute a Health Care Power of Attorney or Appointment of Medical Agent and 63% planning to execute a Living Will declaration.
- 88% of all respondents stated that the program provided new information on the topic of health care advance directives, and 59% stated that the program changed their views on health care advance directives.

Organ and Tissue Donation

- 58% of respondents were not organ and tissue donors prior to attending the National Health Care Decisions Week Program.
- 47% of those who were not organ and tissue donors reported that they intended to become donors as a result of the Program (26% reported that they did not intend to become donors, and the remaining 27% of the previously non-donor group did not respond to this question).
- 70% of all respondents stated that the program provided new information on the topic of organ and tissue donation, and 43% stated that the program changed their views on organ and tissue donation.
Keeping Current—Probate offers a look at selected recent cases, rulings and regulations, literature and legislation. The editors of Probate & Property welcome suggestions and contributions from readers.

**CASES**

- **ADOPTION:** Trust beneficiary has standing to challenge adult adoption. An uncle adopted his life partner. By the adoption, the adoptee became the remainder beneficiary of a trust that would otherwise have passed to the uncle’s niece when the uncle died. In *Rickard v. McKesson*, 774 So.2d 838 (Fla. Dist. Ct. App. 2000), the court held that the niece would have had the right to challenge the adoption had she received notice. The lack of notice amounted to fraud on the court. Accordingly, her action was not barred by the statute of limitations on reopening judgments.

- **BENEFICIARY:** Statute voiding gift to beneficiary who transcribes will narrowly construed. California law invalidates any donative transfer to a “person who has a fiduciary relationship to the transferor” and “who transcribes [the donative instrument] or causes it to be transcribed.” Cal. Prob. Code § 21350. In *Estate of Sweettman*, 102 Cal. Rptr. 2d 457 (Cal. Ct. App. 2000), the court held that the statute applies only to a beneficiary who causes the instrument to be written out in final form and is thus in a position to subvert the donor’s intent.

- **CLASS GIFT:** Gift over on death to children prevents vesting. A decedent left his wife a life estate in the residue of his estate, the remainder to his brothers and sisters and, if any of his siblings predeceased the life tenant, that sibling’s share would pass to the sibling’s children. A brother predeceased the life tenant but was not survived by children. The court in *Martino v. Martino*, 35 S.W.3d 252 (Tex. App. 2000), held that the language creating a gift over prevented absolute vesting of the remainder and thus the brother lost his share of the remainder.

- **DISCLAIMERS:** Disclaimer may not be rescinded or reformed. A son disclaimed his interest in his mother’s estate, assuming it would pass to his brother, the other residuary legatee named in the will. Instead, by virtue of the applicable statute providing that a disclaimant is treated as predeceasing the decedent, the son’s interest passed to his minor children. In *Estate of Fleenor*, 17 P.3d 520 (Or. Ct. App. 2000), the court held that the statutory provision making disclaimers irrevocable prevented the son’s attempt to undo his disclaimer and that the disclaimer could not be reformed into a conveyance to his brother.

- **FAMILY LIMITED PARTNERSHIPS:** Transfer of assets to an FLP did not constitute a taxable gift. The court in *Estate of Strangi v. Commissioner*, 115 T.C. No. 35 (2000), held that there was no gift when the FLP was formed despite a valuation discount causing the partner to receive an interest that was worth less than the value of the property transferred. The court allowed both an 8% minority discount and a 25% marketability discount. In the similar case of *Knight v. Commissioner*, 115 T.C. No. 36 (2000), a combined 15% discount was allowed.

- **FIDUCIARY RESPONSIBILITY:** Trustee not liable for excessive distributions made at beneficiaries request. The life beneficiary and the sole surviving contingent beneficiary demanded and received distributions from two trusts created by the life beneficiary far in excess of those allowed by the terms of the trusts. After the life beneficiary’s death, the contingent beneficiary sued the trustee for breach of trust. In *Buchbinder v. Bank of America*, 30 S.W.3d 707 (Ark. 2000), the court held that the remaining beneficiary had no cause of action, having procured the very distributions about which the beneficiary was complaining.

- **FORMALITIES:** Constructive trust not available to remedy faulty will execution. A testatrix acknowledged her will but neglected to sign it. The witnesses and the notary signed the instrument. Without the testatrix’s signature, the will cannot be probated, nor can a constructive trust be imposed in favor of the beneficiaries because that would validate an invalid will. *Dalk v. Allen*, 774 So. 2d 787 (Fla. Dist. Ct. App. 2000).

- **GIFT TAX:** Speculative liabilities do not reduce value of gift. The court in *Frank Armstrong, Jr., Trust v. United States*, No. CIT.A.5:99CV00006, 2000 WL 1534714 (W.D. Va. 2000), held that the value of a gift is not reduced by the potential estate tax liability the donee could incur if the
donor died within three years of the gift or by the donee's agreement to pay additional tax on any increases in value determined by the IRS. These amounts were too speculative at the time of the transfer to permit a valuation discount.

• INTERFERENCE WITH EXPECTANCY: Tort of interference with expectancy recognized. Over two strong dissents, the Alabama Supreme Court recognized a right to recover for tortious interference with an expectancy. The plaintiffs alleged that the decedent's husband prevented her from executing her will. Ex parte Batchelor, No. 1991507, 2001 WL 10891 (Ala. 2001).

• JURISDICTION: Federal court has jurisdiction regarding certain probate-related matters. Federal courts lack jurisdiction to probate wills and administer estates. In Dulce v. Dulce, 233 F.3d 143 (2d Cir. 2000), however, the court held that a federal district court has jurisdiction to order the executor to file a will for probate and to determine that a creditor is entitled to share in the estate.

• LAPSE: Reformation to conform to the testator's alleged intent denied. A man's will left his residuary estate to his wife but did not provide for a contingent gift should she predecease him, which she did. Her sisters petitioned for reformation of the will to conform to the husband's alleged intent to leave his property to them should his wife die first. The court in Flannery v. McNamara, 738 N.E.2d 739 (Mass. 2000), held that a will cannot be reformed under such circumstances, rejecting the contrary statement in Restatement (Third) of Property (Donative Transfers) § 12.1.


• POWER OF ATTORNEY: Gifts by agent not recognized. In Christensen v. Commissioner, T.C. Memo. 2000-368, the court did not recognize gifts made under a durable power of attorney because the power did not expressly authorize the gifts. Accordingly, the gifts were included in the donor's gross estate.

• PROFESSIONAL RESPONSIBILITY: Lawyer not liable to individuals not named in any estate planning document. The decedent's nieces and nephews sued his lawyer alleging that the lawyer was negligent in not preparing a new will according to their uncle's instructions, under which they would have been beneficiaries. The court in Beauchamp v. Kemmeter, No. 00-0470, 2000 WL 1863576 (Wis. Ct. App. 2000), held that a lawyer has no duty to individuals who claim to be intended beneficiaries based only on extrinsic evidence.

• PROFESSIONAL RESPONSIBILITY: Lawyers for administrator owe no duty to heir. The father of an intestate decedent alleged that he did not receive his share of the estate and sued the lawyers who represented the administrator. The court dismissed the complaint, holding that lawyers for a personal representative owe their duties only to the client and not to the heirs or beneficiaries of the estate. Jackson v. Furey, No. 98014796S, 2000 WL 1918052 (Conn. Super. Ct. 2000).

• SHAM TRUSTS: Court disregards sham trusts for tax purposes. Settlors transferred the vast majority of their assets and right to income to a series of trusts. The settlors were the sole trustees and sole beneficiaries of these trusts. The trusts then paid their basic living expenses, such as housing and health care. The court in Muhich v. Commissioner, 238 F.3d 860 (7th Cir. 2001), disregarded these trusts for income tax purposes.

RULINGS AND REGULATIONS

• CHARITABLE REMAINDER UNITRUSTS: Settlors permitted to withdraw prohibited contribution. The transaction did not disqualify the CRUT despite the impermissible contribution. The settlors did, however, pay the tax on the sale and did not take a deduction for the contribution. PLR 200052026.

• ELECTING SMALL BUSINESS TRUSTS: Proposed and temporary regulations issued regarding grantor trusts selecting ESBT status under S corporation rules. T.D. 8915.

• GENERATION-SKIPPING TRANSFER TAX: Final regulations provide guidance on the type of trust modifications that will not affect the exempt status of a trust. T.D. 8912.

• QUALIFIED REVOCABLE TRUSTS: Proposed regulations provide guidance for making a QRT election under Code § 645, the tax treatment of the trust and estate while the election is in effect and rules regarding the termination of the election. Treas. Reg. § 10.6542-9B.
• **Vulture or Ghoul Trusts:** Final regulations address the abusive use of charitable remainder and charitable lead trusts. To obtain a large charitable deduction, a settlor could create a trust in which a charity receives payments until the death of a young person. The young person, however, would be terminally ill so that the charity would actually receive far less than the valuation rules anticipate. The new regulations restrict measuring lives to prevent this and related abuses. T.D. 8926 (charitable remainder trusts); T.D. 8923 (charitable lead trusts).

• **Advance Directives.** Karen L. Schultz & Timothy D. Schultz review the use of the four types of advance directives authorized by Texas law in *Advance Directives: A Primer*, 63 Tex. B.J. 1034 (2000).

• **Disclaimers.** Jeff Y. Bae & David M. Maloney discuss requirements for disclaiming property interests in joint tenancies in *Disclaimers: The Last Line of Defense When Wrestling with Estate Planning Problems*, Tr. & Est. 40 (Nov. 2000).

• **Estate Tax.** Is Treasury Regulation Sec. 25.2702-3(e), Example 5 Valid?, Tr. & Est. 58 (Nov. 2000), offers Christopher P. Bray’s analysis of one of the federal estate and gift tax system’s most challenging provisions.


• **Fiduciaries.** John C. Novograd et al. offer tips for the practitioner in *Private Settlements of Fiduciary Accounts: A Prescription for Achieving Finality*, Tr. & Est. 28 (Nov. 2000).

• **Inter Vivos Trusts.** Dennis M. Patrick explores the recent hype and applauds its demise in *Living Trusts: Snake Oil or Better Than Sliced Bread?*, 27 Wm. Mitchell L. Rev. 1083 (2000).


• **Power of Attorney.** Robert McLeod explores agents’ fiduciary duties in *What Are the Limitations to an Attorney-In-Fact’s Power to Gift and to Change a Dispositive (Estate) Plan?*, 27 Wm. Mitchell L. Rev. 1143 (2000).


• **Spendthrift Trusts.** Karen E. Boxx discusses whether spendthrift trusts have a place in the common law system in *Gray’s Ghost—A Conversation About the Onshore Trust*, 85 Iowa L. Rev. 1195 (2000).

• **Will Contests.** Dennis W. Collins discusses the warning signs and the lawyer’s role in proper planning in *Avoiding a Will Contest—The Impossible Dream?*, 2000 Creighton L. Rev. 7.

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**LITERATURE**

**LEGISLATION**


• **Kansas Provides a Statutory Order of Individuals with Authority to Determine Final Disposition of a Decedent’s Remains.** 2000 Kan. Sess. Laws Ch. 122.

• **Massachusetts Protects Beneficiaries of Structured Settlements.** 2000 Mass. Legis. Serv. Ch. 427.

• **Ohio Requires Certain Statements in Living Wills and Durable Powers of Attorney for Health Care to be in conspicuous Type or Capital Letters.** 2000 Ohio Laws 270.