

AN ANALYSIS OF THE CONVENTION ON THE INTERNATIONAL PROTECTION OF ADULTS

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The Draft Hague Convention on the International Protection of Adults was released in 1996, with the intent of protecting the dignity of elderly persons traveling abroad by determining which state—that of their permanent residence, or that in which they were currently located—exercised jurisdiction over them in the case of illness or insufficiency. In her Note, Aimee Fagan argues that the elderly person’s dignity is preserved when his previously arranged requests for medical treatment are fulfilled. This Note thus examines the Convention’s ability to enforce the advance medical directives of the elderly abroad. While praising its goals, Ms. Fagan asserts that numerous exceptions within the Convention—allowing for local laws to govern the medical treatment of elderly patients, regardless of the patients’ wishes—undermine the purpose of advance directives and render them meaningless. Ms. Fagan concludes by suggesting that if the Convention cannot find a way to effectuate the preferred medical destiny of the elderly away from home, it simply should not attempt to enforce advance directives at all.

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I. Introduction

On October 1, 1998, United Nations Secretary General Kofi Annan, speaking at a gathering at the United Nations (“UN”) headquarters in New York, announced that the year 1999 would be the International Year of Older Persons.¹ The coming months would be devoted to the promotion of the United Nations Principles for Older Persons (“Principles”),² adopted in 1991, establishing a framework for the basic human rights of the elderly.³ These principles, Annan announced, would guide the events and activities planned by the UN and its agencies, informing the direction of policies among the UN member nations to promote the health and welfare of the world’s elderly.⁴ Annan emphasized that this ambitious initiative would necessitate international cooperation.⁵ Achievement of the United Nations’ goals would require a “mixture of practicality and persistence, and [a] sense of common purpose.”⁶

To that formidable list, Annan should have added the need for a new body of international law. The United Nations Principles for Older Persons recognize the need for treaties to implement its broad policy goals.⁷ However, such treaties will require extraordinary feats

1. Secretary General Kofi Annan, Address at the Opening Ceremony of the International Year of Older Persons (Oct. 1, 1998), at <http://www.un.org/esa/socdev/iyop/iyopsgsm.htm> [hereinafter Address by Secretary General Annan].

2. *United Nations Principles for Older Persons*, G.A. Res. 46, U.N. GAOR, 74th Sess., U.N. Doc. A/Res/46/91 (1991), available at <http://www.un.org/esa/socdev/iyoppop.htm> (last modified Mar. 14, 2000) [hereinafter *UN Principles*].

3. *Id.* The Principles contain eighteen points relating to independence, participation, care, self-fulfillment, and dignity. *Id.* The genesis of the Principles can be found in the International Plan of Action on Ageing, the first international agreement on the subject. See U.N. GAOR, 51st Sess., U.N. Doc. A/Res/37/51 (1982). Sometimes called the Vienna Plan, the International Plan of Action on Ageing addressed a broad spectrum of concerns of the elderly, including nutrition, consumer protection, health care, social welfare, income security, and housing. United Nations, Div. for Soc. Policy & Dev., *Foreword to the International Plan of Action on Ageing*, available at <http://www.un.org/esa/socdev/ageing/ageipaa.htm> (last visited Aug. 20, 2002). It was endorsed by the United Nations General Assembly in 1982. U.N. GAOR, 51st Sess., U.N. Doc. A/Res/37/51 (1982).

4. Address by Secretary General Annan, *supra* note 1.

5. *Id.*

6. *Id.*

7. See Conceptual and Operational Frameworks for the United Nations Principles for Older Persons (Sept. 5, 1998), at <http://www.un.org/esa/socdev/iyop/iyopreco.htm> (last visited Aug. 20, 2002) (suggesting “[t]he international community of experts, practitioners and policy makers develop clear guidelines supporting lifelong individual development . . . and the integration of ageing into government policies, which may involve multisectoral policy adjustments”).

of draftsmanship to accomplish the mandate of the Principles without alienating the intended signatories or sacrificing the expansive spirit of the undertaking. The Principles may set the finish line for international elderly rights, but they do not chart its course, and the vicissitudes of forging international understandings in the field of human rights are particularly heightened when the subject of those rights is the elderly. A recent illustration of this difficulty is provided by the Draft Hague Convention on the International Protection of Adults (“Convention”).⁸ The Convention was intended to protect the interests of adults who, by choice, accident, or circumstance, find themselves residing outside their countries of origin and suffering an incapacity or “insufficiency of their personal faculties.”⁹ The Convention aims to shield these vulnerable members of society by determining which state—that of their citizenship or of their current residence—may assert jurisdiction over them.¹⁰ While, on its face, the Convention may seem to settle relatively benign issues of choice of law, in reality it implicates—and ultimately fails to resolve—the most heated and controversial subjects of international human rights—the right to medical care, the right to refuse such care, and the right to die.

II. Background

A. Longevity, Mobility, and International Law

The declaration of the International Year of Older Persons was a reaction by the UN and the international legal community to the sudden cant in the world’s statistics.¹¹ According to the World Health Organization (“WHO”), the population is getting older, and it is doing so rapidly.¹² One in ten people is now sixty years of age or older.¹³ By

8. Convention on the International Protection of Adults, *released for signature* Oct. 2, 1999, 39 I.L.M. 7, available at <http://www.hcch.net/e/conventions/text35e.html> [hereinafter Convention on International Protection of Adults].

9. *Id.* at pmb., para. 1.

10. *Id.* at pmb., para. 2.

11. Address by Secretary General Annan, *supra* note 1.

12. *Contribution from the World Health Organization*, U.N. GAOR, 4th Sess., para. 54, U.N. Doc. A/CONF.157/PC/61/Add.8, 1993 [hereinafter *WHO Contribution*]. The World Health Organization noted, “various forms of ageism may lead, in the event of medical care, to misdiagnosis, inappropriate treatment and unnecessary institutionalization.” *Id.* at para. 55. Because the “health and well-being of the elderly can be assured only through a better understanding of the subtle and pervasive effects of age-related discrimination in all its forms,” the WHO intended

2050, that ratio will climb to one in five.¹⁴ Since 1950, twenty years have been added to the average life span, and in the coming decades, the trend is expected to continue.¹⁵ Moreover, the oldest among the elderly—those eighty years or older—constitute the fastest growing segment of the population.¹⁶ As one UN demographer noted, “if current trends in ageing continue as predicted, a demographic revolution, wherein the proportions of the young and the old will undergo a historic crossover, will be felt in just three generations.”¹⁷ This shift is reflected in the international law context, as the UN and other international organizations grapple with the implications of a larger elderly population.¹⁸ The International Year of Older Persons was thus a bit of a misnomer, as Annan himself conceded that day.¹⁹ “We live in an age to which many labels have been attached,” he admitted, but he would “add one more . . . for our time is also, undeniably, the age of longevity.”²⁰

As the world’s elderly population is growing in numbers, so too, is it becoming more mobile.²¹ The impetus behind the Draft Hague Convention on the International Protection of Adults was in part the practical effect of travel upon the management of their affairs:

Natural movements in population in modern times, and especially the rather high number of people coming to the age of retirement and deciding to spend the last part of their lives in a milder climate, have made practitioners . . . more concerned to

to “participate fully in the development of . . . guidelines” necessary to implement the Principles. *Id.* at paras. 55–56.

13. Population Div. of the Dep’t of Econ. & Soc. Affairs of the United Nations, *The Ageing of the World’s Population* (May 24, 2000), at <http://www.un.org/esa/socdev/ageing/agewpop.htm> (last updated June 11, 2002).

14. *Id.*

15. *Id.*

16. *Id.*

17. Population Div. of Dep’t of Econ. & Soc. Affairs of the United Nations, *Implications of an Ageing Society* (June 7, 2000), at <http://www.un.org/esa/socdev/ageing/ageimpl.htm#Policy> (last updated June 11, 2002).

18. See, e.g., Cynthia Sharp Myers, *Jurisdictional Issues in Interstate and International Guardianships*, ELDER L. REP., Nov. 2000, at 3.

19. Address by Secretary General Annan, *supra* note 1.

20. *Id.*

21. PAUL LAGARDE, HAGUE CONFERENCE ON PRIVATE INTERNATIONAL LAW, EXPLANATORY REPORT FOR THE CONVENTION ON THE INTERNATIONAL PROTECTION OF ADULTS 23–24 (2000), available at <http://www.hcch.net/e/firstvisit/index.htm> (last visited Aug. 20, 2002) [hereinafter EXPLANATORY REPORT].

have at their disposal private international law rules which are certain.²²

Cynthia Sharp Myers wrote, “[o]ur society’s increasing mobility has given rise to a number of legal dilemmas regarding jurisdictional issues in guardianship cases.”²³ The uncertainty as to which law applies often means that “counsel is well advised to master the laws of both the transferring and receiving state.”²⁴ As “the problem of jurisdictional issues in guardianship cases is not confined to the borders of the United States,” with such issues often “aris[ing] at the international level,” the need for an international solution was pressing.²⁵

This solution must be flexible, capable of handling the many facets of these “jurisdictional issues.” Medical progress allows not just physically healthy elderly people to enjoy a greater freedom to travel, but also persons who are ill or near the end of life.²⁶ Their mobility holds further implications for international law. An article in the *Journal of Air Law and Commerce* noted this phenomena:

Until recently, patients upon whom DNR (do-not-resuscitate) orders were issued were so ill that the prospect of them traveling, or even leaving the hospital for that matter, were so slim that most doctors and legislators were not concerned with the transfer of

22. *Id.* at 24. The population projections from the United Nations were a driving force behind the Convention. *Id.* at 23–24. Specifically, “the human life span in the developed States has continued to lengthen, accompanied by a corresponding increase in the illnesses attaching to old age.” *Id.* at 23. Although the drafters acknowledged the growth in the entire world’s elderly population, it was the expected population growth in the developed countries specifically that caught the Convention’s attention. *Id.* at 24. Nearly all of the primary drafters of the Convention—except China—are from countries in Western Europe and North America. *Id.* at 22–23 & n.5. Ironically, it is the elderly population in the Third World nations that is experiencing the most dramatic increases. Contribution from the World Health Organization, *supra* note 12, at para. 54. The WHO estimates “the percentage of the population 65 years of age and over is projected to triple in China and quadruple [in] the Republic of Korea and Malaysia by the year 2025.” *Id.*

23. Myers, *supra* note 18, at 1. The article discusses jurisdictional issues in the field of elder law and includes an analysis of the Convention’s provisions. *Id.* Myers assumed the Convention would “govern cases where the ward is on vacation and an emergency arises where he or she needs protection.” *Id.* at 5.

24. *Id.* at 5.

25. *Id.* at 3.

26. Amanda Christine Dake, Comment, *The Application of “Out-of-Hospital” Do Not Resuscitate Order Legislation to Commercial Airline Travel*, 63 J. AIR L. & COM. 443, 445 (1997). This note discusses the liability of airline crew members in the event that a passenger with a DNR order falls into cardiac or respiratory arrest while on board an airplane. *Id.* at 443. Because of the conflicting state laws on the validity of DNR orders, the author recommends that a “flight attendant should resuscitate first and ask questions later if unclear about any aspect of the situation.” *Id.* at 473.

these DNR orders outside of hospital or nursing home settings. Medical technology and the nature of terminal illnesses, however, have changed. . . . Patients with advanced AIDS and cancer, for example, remain mobile for much of their disease's progression.²⁷

The likelihood of a person with an advance medical directive or living will traveling abroad is therefore increasing.²⁸ International law and elder law will cross paths more often as elderly people migrate, carrying with them legal instructions and the expectation that their wishes will be protected in the event of an emergency.

B. Elderly Rights and International Law

The Secretary General predicted that the issues of the world's elderly population would remain on the UN agenda far beyond 1999.²⁹ The Principles for Older Persons would therefore become the UN's starting point for addressing those issues.³⁰ At the core of the Principles is the concept that the state should recognize and protect "the dignity and worth of the human person."³¹ The document is peppered with the term "dignity," as is every other major human rights treaty and convention which mentions the elderly.³² For instance, Article 25 of the Charter of Fundamental Rights of the European Union³³ "recognizes and respects the rights of the elderly to live a life of dignity and independence and to participate in the social and cultural life."³⁴ Such specialized treatment recognizes "the elderly have distinct human rights, which were not addressed specifically in

27. *Id.* at 446.

28. *Id.*

29. Address by Secretary General Annan, *supra* note 1.

30. *Id.*

31. *UN Principles, supra* note 2.

32. *Id.* "Dignity" is also mentioned at Principle 17: "Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse." *Id.* Under the rubric of health care principles, Principle 14 provides: "Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs, and privacy, and for the right to make decisions about their care and the quality of their lives." *Id.*

33. Charter of the Fundamental Rights of the European Union, 2000 O.J. (C 364) 1-22, available at http://europa.eu.int/comm/justice_home/unit/charte/pdf/texte_en.pdf (last visited Aug. 20, 2002) [hereinafter Charter of Fundamental Rights of the EU].

34. *Id.* at art. 25.

the 1948 Universal Declaration of Human Rights or other relevant human rights instruments.”³⁵

Often, the preservation of dignity for the elderly is mentioned in international instruments in the context of a right to social security from the state. The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights provides that “[e]veryone shall have the right to social security protecting him from the consequences of old age and of disability which prevents him, physically or mentally, from securing the means for a dignified and decent existence.”³⁶ The Convention on the Elimination of All Forms of Discrimination Against Women states that social security shall be extended to elderly women on a nondiscriminatory basis, “particularly in cases of retirement, unemployment, sickness, invalidity and old age.”³⁷ The African Charter on Human and Peoples’ Rights similarly stipulates that the “aged and the disabled shall . . . have the right to special measures of protection in keeping with their physical and moral needs.”³⁸

The pattern that emerges suggests that the preservation of dignity is the preeminent group right of the elderly. The treaties reflect this assumption, and the WHO perhaps identified the source of the interest when it noted, “the elderly represent a minority that all of humanity hopes to join, in contrast to other minority groups such as the disabled, refugees and ethnic minorities that remain distinct throughout life.”³⁹ In other words, the “dignity” at stake belongs not only to the elderly of today. There is a broader interest reflected, and if the statistics are accurate, it shall become broader still over the coming decades.

Another evident pattern in the human rights treaties is the pairing of financial and medical protections for the elderly with the preservation of their dignity.⁴⁰ Granted, the sick and poor constitute the

35. *WHO Contribution*, *supra* note 12, at para. 55.

36. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, Nov. 17, 1988, art. 9, 28 I.L.M. 156 (1989).

37. Convention on the Elimination of All Forms of Discrimination Against Women, Sept. 3, 1981, art. 11, para. (1)(e), 1249 U.N.T.S. 13 (1980).

38. African Charter on Human and Peoples’ Rights, Oct. 21, 1986, art. 18, para. 4, 21 I.L.M. 59 (1982).

39. *WHO Contribution*, *supra* note 12, at para. 55.

40. *See, e.g.*, Charter of Fundamental Rights of the EU, *supra* note 33; African Charter on Human and Peoples’ Rights, *supra* note 38.

most deserving subjects of any discussion on international human rights. However, where the elderly are concerned, the treaties often seem to stop there, with the notable exception being the UN Principles.⁴¹ In other human rights treaties mentioning the elderly, the penumbra of elderly rights is defined by adequate state-sponsored medical care and old-age pensions.⁴² Needless to say, most elderly rights groups might object to such a limited concept of society's duties to them, preferring instead that greater attention be given to issues of autonomy and personal liberty.

In determining the scope of elderly rights, the central problem may come down to the imprecise meaning of the term "dignity" in international law. The clamor to preserve the dignity of the elderly may derive much of its fervor from the very fact that it is a nebulous word, allowing each signatory to a treaty to harbor his own ideas of its import.⁴³ It may also lie at the root of the stalled development of elderly rights at social security and state medical coverage.⁴⁴ What preserves "dignity" in one culture may violate the public policies of another. The disagreements, however, are only postponed until the time when the treaty must be enforced, and the various definitions of "dignity" fail to overlap. It is precisely at the controversial edges of its meaning that it may then assume life and death importance.

III. The Convention on the International Protection of Adults

A. Purpose and History of the Convention

The Convention on the International Protection of Adults provides measures to "avoid conflicts between legal systems in respect of jurisdiction, applicable law, recognition and enforcement of measures

41. *WHO Contribution*, *supra* note 12, at para. 55.

42. *See, e.g.*, Universal Declaration of Human Rights, G.A. Res. 217A, U.N. Doc. A/810, art. 25 (1948). Article 25 is the only provision in the Universal Declaration which mentions "old age." *Id.* Interestingly, it is separated from the "right to social security," which is held "indispensable for . . . dignity and the free development of . . . personality." *Id.* at art. 22. Article 25 creates the right "to a standard of living adequate for the health and well-being of himself and his family," which shall include "the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." *Id.* at art. 25.

43. *See supra* notes 33-38.

44. *Id.*

for the protection of adults.”⁴⁵ The Convention applies “to the protection in international situations of adults who, by reason of an impairment or insufficiency of their personal faculties, are not in a position to protect their interests.”⁴⁶ Within the treaty are guidelines for determining jurisdiction and choice of law if an incapacitated person is located in a country which is not his or her habitual residence.⁴⁷ The purpose of the Convention was to avoid or resolve international legal disputes over the care and custody of such persons and their property.⁴⁸

The Convention is a product of the Hague Conference on Private International Law (“Conference”), an intergovernmental organization, consisting of representatives from fifty-six member states, including the United States, most European nations, China, and several South American countries.⁴⁹ Article 1 of its organizing charter states that the Conference’s “purpose . . . is to work for the progressive unification of the rules of private international law.”⁵⁰ The Conference’s “principal method used to achieve this goal consists in the negotiation and drafting of multilateral treaties, which are called Hague Conventions.”⁵¹ The impetus for this particular convention came during the Eighteenth Session of the Conference, held in October 1996.⁵² During that year, the Conference adopted the Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-operation in respect of Parental Responsibility and Measures for the Protection of Children—or the Children’s Convention, as it later came to be called.⁵³ Shortly after its ratification by most members of the Conference, the member

45. Robert Keating, *ABA Delegate’s Report: International Protection of Adults*, COLO. LAW., Feb. 2000, at 35.

46. Convention on International Protection of Adults, *supra* note 8, at art. 1, para. 1. The Convention is not yet in force, but is pending signature by the parties to the drafting convention. *Id.*

47. *Id.* at para. 2.

48. EXPLANATORY REPORT, *supra* note 21.

49. Hague Conference on Private International Law, *Frequently Asked Questions Regarding the Hague Conference on Private International Law*, at <http://www.hcch.net/e/faq/faq.html> (last updated June 4, 2002) [hereinafter *FAQs Regarding the Hague Conference*].

50. Statute of the Hague Conference on Private International Law, July 15, 1955, art. 1, 15 U.S.T. 2228, available at <http://www.hcch.net/e/conventions/text01e.html> (last visited Aug. 22, 2002).

51. *FAQs Regarding the Hague Conference*, *supra* note 49.

52. EXPLANATORY REPORT, *supra* note 21, at 22.

53. *Id.*

states began reexamining the issue of the international protection of disabled adults.⁵⁴ At the prompting of the Swiss delegation, the members decided to institute a Special Commission charged with commencing another Draft Convention.⁵⁵

The Children's Convention provided a beginning for the drafters in developing the text of the Convention on the Protection of Adults.⁵⁶ However, it was not a perfect template, and nearly four years of negotiations—between 1996 and the beginning of the Nineteenth Session of the Conference in 2000—ensued before the final draft was completed.⁵⁷ The Convention was first released in October 1999 and is now pending signature and ratification by the member states of the Conference.⁵⁸

The Convention demonstrates the difficulties in addressing the problems of the elderly by codifying protections for them within international treaties. Though pursuing a laudable goal, the Convention misses the mark on the most important of its primary objectives. Rather than injecting a level of certainty into the situation of an incapacitated person who resides abroad, the terms of the Convention fail to adequately clarify which elderly persons are covered, which of their directives may be followed, and where local law may nevertheless supercede the choice of law provisions in the Convention.⁵⁹

54. *Id.*

55. *Id.*

56. *Id.* at 25.

57. *Id.* at 22. The initial outlines of the Convention were prepared by a committee which met in the Hague during April 1997 under the chairmanship of the representative from the Netherlands, Professor Struycken. *Id.* The drafters convened a Special Commission to begin research on the text in June 1997. *Id.* The following September, the writing of the draft convention began, with the cooperation of representatives from the United Kingdom, the United States, Germany, Argentina, Switzerland, France, and China. *Id.* at 22–23. At the negotiations, members of the Special Commission were joined by delegates from thirty Member States of the Conference, along with observers from six other states, two intergovernmental organizations, and three nongovernmental organizations. *Id.* at 22.

58. Convention on International Protection of Adults, *supra* note 8, at art. 53.

59. See *id.* at art. 2 (defining which adults are covered by the Convention only with respect to age, not level of incapacity); see also *id.* at art. 21 (allowing for refusal to honor choice of law if its “application would be manifestly contrary to public policy”).

B. Age and Medical Issues Within the Scope of the Convention

The Convention aims to “determine the State whose authorities have jurisdiction to take measures directed to the protection of the person or property of the adult.”⁶⁰ The drafters of the Convention anticipated that their work would be of significant, if not primary, relevance to the elderly.⁶¹ The *travaux préparatoires*⁶² reveal that the very definition of “incapacity” was crafted with the elderly in mind:

The adults whom the Convention is meant to protect are the physically or mentally incapacitated, who are suffering from an “insufficiency” of their personal faculties, as well as persons usually elderly, suffering from an impairment of the same faculties, in particular persons suffering from Alzheimer’s disease. Although the Commission did not wish to spell this out in the text, to avoid making it pointlessly cumbersome, it accepted that this impairment or this insufficiency could be permanent or temporary, since it necessitates a measure of protection.⁶³

The Convention thus covers a range of ailments, not all of which are either chronic or debilitating.⁶⁴ It may also include an “impairment of faculties” which does not rise to the level of Alzheimer’s disease or dementia, but perhaps is a mere consequence of old age.⁶⁵

The distinction between those “physically or mentally incapacitated” and “persons usually elderly” further indicates that the drafters anticipated a spectrum of impairments for the latter category, without clear-cut diseases and afflictions present in every case. It is not entirely apparent if a physical impairment alone may trigger the Convention in the case of an elderly adult, though the explanatory report stipulates that the impairment itself must “necessitate a measure of protection.”⁶⁶ For elderly adults, as opposed to other adults covered by the Convention, it seems that circumstances, as much as their physical or mental condition, may prove to be pivotal. Situational factors could convert an elderly adult’s slight physical disability into an

60. *Id.* at art. 1(2)(a).

61. EXPLANATORY REPORT, *supra* note 21, at 27.

62. The *travaux préparatoires* are “materials used in preparing the ultimate form of an agreement or statute, and especially of an international treaty.” BLACK’S LAW DICTIONARY 1505 (7th ed. 1999). They provide a record of deliberations analogous to a legislative history. *Id.*

63. EXPLANATORY REPORT, *supra* note 21, at 27.

64. *Id.*

65. *Id.*

66. *Id.*

“impairment.”⁶⁷ The same affliction could perhaps not be converted to an “insufficiency” in the case of a middle-aged or young adult.⁶⁸

Once an impairment or insufficiency is alleged, the Convention provides the mechanism by which a state may assert measures for the protection of an incapacitated adult.⁶⁹ The treaty first determines which state shall exercise that jurisdiction.⁷⁰ Its default principle gives the country of “habitual residence of the adult . . . jurisdiction to take measures directed to the protection of the adult’s person or property.”⁷¹ This provision follows the precedent set by the Children’s Convention in making “habitual residence the primary jurisdictional standard” and by stipulating that “jurisdiction follows a change in habitual residence.”⁷² However, the state in which the adult is located may gain jurisdiction by way of a number of exceptions to the default

67. *Id.*

68. *Id.* The *travaux préparatoires* noted several attempts to better define the range of ailments constituting an incapacity. *Id.* The drafters “rejected a proposal by the United Kingdom for making it clear that the adult’s incapacity could affect his or her mental faculties or ability to communicate.” *Id.* They preferred, “the court should not be bound by the nature of the incapacity, the first criterion necessarily continuing to be the need for protection resulting from that incapacity.” *Id.* The drafters considered the Convention’s requirement of an “impairment or insufficiency of [the] personal faculties” of the adult a question of fact, capable of being defined on a case by case basis. *Id.* The one explicit exclusion from the definition of incapacity derived from their specification that it must originate within “personal faculties.” *Id.* In other words, “[t]he Convention does not therefore apply to the protection of adult victims of external violence, for example battered wives.” *Id.*

69. Convention on International Protection of Adults, *supra* note 8, at art. 1(1)(a).

70. *Id.*

71. Convention on International Protection of Adults, *supra* note 8, at art. 5(1). The term “habitual residence” was not given a definition in either the Convention or the *travaux préparatoires*. EXPLANATORY REPORT, *supra* note 21, at 39. The drafters believed it should be determined on a case-by-case basis “despite the important legal consequences attaching to it.” *Id.* They concluded it “should remain a factual concept” because “[t]he drawback of providing [a] . . . definition of habitual residence in one convention, would be to cast doubt on the interpretation of this expression in numerous other conventions in which it is used.” *Id.* Similarly, no definition is used to indicate the level of jurisdictional authority that applies to the state in which the incapacitated adult finds him or herself. *See, e.g.*, Convention on International Protection of Adults, *supra* note 8, at art. 8(2)(a) (referring to “the Contracting States whose authorities may be addressed” by the Convention, including states which do not constitute habitual residence but may have claim upon the adult by virtue of nationality, location of property, stipulation by the adult or state of habitual residence of “a person close to the adult prepared to undertake his or her protection”).

72. Gloria F. DeHart, *Introductory Note to the Draft Hague Convention on the International Protection of Adults*, Oct. 2, 1999, 39 I.L.M. 4 (2000).

rule.⁷³ For instance, the state in which the adult is located “ha[s] jurisdiction to take any necessary measures of protection” in emergency situations.⁷⁴ Such states may also exercise jurisdiction “to take measures of a temporary character for the protection of the person of the adult,” provided those measures “have a territorial effect limited to the state in question” and “are compatible with those already taken by the authorities” of the state of habitual residence.⁷⁵

Importantly, this authority over which the two states grapple is extremely broad. It includes “the determination of incapacity and the institution of a protective regime,”⁷⁶ “the placement of the adult in an establishment or other place where protection can be provided,”⁷⁷ and/or “the authorization of a specific intervention for the protection of the person or property of the adult.”⁷⁸ The Convention further pertains to emergency “authorization of a specific intervention for the protection of the person or property of the adult,”⁷⁹ including matters such as “a surgical operation or for the sale of an asset.”⁸⁰ In short, the Convention provides the rules for establishing which state will assert decision-making authority over these adults once they have lost the ability to make such decisions for themselves.⁸¹

By including medical decisions within the grant of jurisdiction, the stakes in these future disputes were raised considerably. Indeed, the subject was hotly debated by the drafters.⁸² Only “after very protracted discussions on the expediency of excluding medical and health matters in their entirety from the scope of the Convention” was a compromise settlement reached.⁸³ The *travaux préparatoires* included the following breakdown of the arguments:

73. Convention on International Protection of Adults, *supra* note 8, at arts. 8(1), 9, 10(1), 11(1).

74. *Id.* at art. 10(1).

75. *Id.* at art. 11(1).

76. *Id.* at art. 3(a).

77. *Id.* at art. 3(e).

78. *Id.* at art. 3(g).

79. *Id.* The Convention does not apply, however, to any “maintenance obligations,” changes in marital status or separation, trusts or succession, social security, “public measures of a general nature in matters of health,” or any measures directly related to asylum, immigration, public safety or penal offenses. *Id.* at art. 4.

80. EXPLANATORY REPORT, *supra* note 21, at 31.

81. Convention on International Protection of Adults, *supra* note 8, at art. 1(1).

82. EXPLANATORY REPORT, *supra* note 21, at 35.

83. *Id.* (emphasis omitted).

[T]hose in favor of excluding medical matters . . . [believed] [i]f those matters were included, [they would be] obliged to recognize, or even implement, individual decisions of a medical nature against their beliefs, such as measures ordering the abortion or sterilization of incapacitated adults. Others were afraid that the medical system might grind to a halt if, before prescribing a course of treatment or carrying out an operation, medical practitioners were obliged, even in non-urgent cases, to obtain the necessary authorization from the competent authorities of another Contracting State at the risk of becoming liable. On the other hand, the opponents of exclusion argued that if medical matters were to be excised from the Convention, it would essentially fail in its aim to protect the sick and elderly and would be reduced to a convention on the property of the adult.⁸⁴

A special committee discussed the merits of “the adoption of rules of jurisdiction specific to medical matters,” considering briefly a proposal to submit “issues of consent and authorization in this field to the authorities and the legal system of the State in which the medical practitioner works.”⁸⁵ In other words, national medical-licensing boards would have been granted the powers of a tribunal, determining the fate of those covered by the Convention.

This parallel system was eventually rejected in favor of a less drastic, more ambiguous approach.⁸⁶ Those in favor and those against the inclusion of medical matters decided to split the differences between them, allowing for certain medical issues to be addressed in the Convention, but also permitting enough leeway for them to be avoided in individual cases as well.⁸⁷ The compromise ended by offering guarantees to neither side of the issue, and the result is a series of conflicting articles in the treaty.⁸⁸ The committee concluded:

84. *Id.*

85. *Id.*; see also T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. LEGAL MED. 481, 481–507 (1995) (discussing the implications of physician-assisted suicide on law, medical ethics, and public policy). Stone and Winslade note the difficulties faced by medical practitioners in reconciling ethical responsibilities with legal mandates. *Id.* at 483. They contend that “[t]he moral and psychological complexity of end-of-life decisions is often compounded rather than clarified by legal interventions.” *Id.* Without clear guidance, doctors are often forced to “assume dual roles of healers and killers.” *Id.* at 496.

86. EXPLANATORY REPORT, *supra* note 21, at 35.

87. *See id.*

88. Compare Convention on International Protection of Adults, *supra* note 8, at art. 4(1)(f) (providing exception to the Convention for health-related matters), and *id.* at art. 10(1) (providing exception to default jurisdiction in “cases of urgency”), with *id.* at art. 5(1) (granting default jurisdiction to the state of habitual residence),

[W]hile medical acts in themselves, which fall within the domain of medical science and are the province of medical practitioners who are not authorities within the meaning of the Convention, fall outside the scope of the Convention, without there being any need to spell this out in the text, on the other hand legal questions concerning the representation of the adult connected with those medical acts (authorisations [sic] or designation of the legal or *ad hoc* representative) are included in the Convention and have to be subject to its general rules, without forming the object of rules of exception.⁸⁹

Medical decisions which are predetermined or designated by power of attorney, living will, or advance medical directive are therefore covered by the Convention, but all other such decisions are governed strictly by local law.⁹⁰ The exception for “public measures of a general nature in matters of health” from the scope of the Convention further emphasizes the split.⁹¹

The schism between the two factions of the Conference was thus permitted to exist, if in less overt form, and thereafter “no [further] reference in the Convention to medical or health matters” was made.⁹² But examination of the articles on emergency measures and guardianship—those most closely related to medical decisions—reveals significant exceptions to the default jurisdictional rule.⁹³ Concurrent and emergency jurisdiction are liberally bestowed, potentially blurring the line between “medical acts . . . outside the scope of the Convention” and “legal questions . . . concerning medical acts.”⁹⁴ The dreaded “rules of exception” for medical decisions have hardly been avoided.

C. Emergency Authority Under Articles 10 and 11

Article 10 of the Convention creates an exception to the default rule of jurisdiction.⁹⁵ It substitutes the law of the state of the adult’s

and id. at art. 15(1) (allowing for the exercise of “powers of representation” by a designee of the adult).

89. EXPLANATORY REPORT, *supra* note 21, at 35.

90. Convention on International Protection of Adults, *supra* note 8, at arts. 15(1), (3).

91. *Id.* at art. 4(f). The *travaux préparatoires* cites vaccination requirements as an example of a “public measure of a general nature in matters of health.” EXPLANATORY REPORT, *supra* note 21, at 35.

92. EXPLANATORY REPORT, *supra* note 21, at 35–36.

93. *See id.* at 35.

94. *Id.*

95. Convention on International Protection of Adults, *supra* note 8, at art. 10(1).

current residence for the state in which the adult is a permanent resident in “all cases of urgency.”⁹⁶ Article 10 permits “the authorities of any Contracting State in whose territory the adult or property belonging to the adult is present” to “take any necessary measures of protection.”⁹⁷ This permission is only valid: 1) for the duration of the emergency; or 2) until the state of habitual residence has opportunity to intervene independently.⁹⁸ The authority to respond to the emergency thus expires with the emergency itself or with the involvement of the state of habitual residence.⁹⁹ Similarly, any ongoing intervention by that state, such as a course of medical treatment, must cease at that point as well.¹⁰⁰ Those “measures [shall] lapse when the appropriate State with jurisdiction has taken” its own measures for the protection of the adult.¹⁰¹

A situation is considered urgent only where “irreparable harm to the adult or his or her property” might result by waiting for permission from the state of habitual residence.¹⁰² To qualify as a “situation of urgency,”¹⁰³ the harm must therefore not only be sufficiently serious, but also imminent in order to “justify] a derogation from the normal rule.”¹⁰⁴ The exception must “be construed rather strictly,”¹⁰⁵ as in the following example given to illustrate the limitations on Article 10:

In medical matters particularly, Article 10 must not be used as general justification for the jurisdiction of the authorities of the

96. *Id.*

97. *Id.*

98. *Id.* at art. 10(2). Significantly, the Article not only states that the jurisdiction of the intervening state ceases when the emergency ceases, but any “measures taken under the preceding paragraph . . . shall lapse as soon as the authorities which have jurisdiction under Articles 5 to 9 have taken the measures required by the situation.” *Id.* A course of treatment may be instituted in an effort to save the patient’s life, but it will not necessarily be completed. If the emergency has passed and the patient or the patient’s surrogate wishes its discontinuance, the authorities in the state will have no choice but to honor that choice, as they will no longer have jurisdiction to impose those measures. *Id.*

99. *Id.*

100. EXPLANATORY REPORT, *supra* note 21, at 47–48.

101. DeHart, *supra* note 72.

102. EXPLANATORY REPORT, *supra* note 21, at 47.

103. *Id.*

104. *Id.* The “normal rule” referred to by the drafters is presumably embodied within Articles 5 through 12, “establish[ing] habitual residence as the primary jurisdictional standard and jurisdiction follows a change in habitual residence.” DeHart, *supra* note 72.

105. EXPLANATORY REPORT, *supra* note 21, at 47.

State where the adult is present. An example which has been given is termination of the pregnancy of a young incapacitated woman. Although such an operation necessarily has to be performed within a certain time-limit, this is not normally a case of urgency of the kind covered by Article 10.¹⁰⁶

If a medical decision can be postponed for a length of time sufficient to inform the state of habitual residence, that state retains jurisdiction over the adult.¹⁰⁷ This result incurred some resistance among the drafters, many of whom preferred a definition of “urgency” which would have protected the “jurisdiction of the place where the adult is present” under a greater number of circumstances.¹⁰⁸ Deference to the state of habitual residence, however, held sway, and the *travaux préparatoires* ominously noted that “rejection of the proposals to [the opposite] effect cannot justify abuse of jurisdiction in case of urgency.”¹⁰⁹

Taken on its face, Article 10 would preserve the integrity of an advance medical directive, power of attorney designation, or living will if the life of the adult was not in immediate danger.¹¹⁰ Moreover, once that danger passed, the legal directive would be enforced as the state of habitual residence asserted its jurisdiction over the adult.¹¹¹ The drafters of Article 10’s narrow definition of urgency, however, did not entirely squelch the opposition, for what Article 10 forbids, Article 11 proceeds to permit.¹¹²

Article 11 allows for the imposition of “temporary” measures by the state in which the incapacitated person is located.¹¹³ Article 11 states:

By way of exception, the authorities of a Contracting State in whose territory the adult is present have jurisdiction to take measures of a temporary character for the protection of the person of the adult which have a territorial effect limited to the State in question, in so far as such measures are compatible with those already taken by the authorities which have jurisdiction . . . and after advising the authorities having jurisdiction. . . .¹¹⁴

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.* The drafters provided the example of urgency jurisdiction arising over “an adult who . . . must undergo an urgent surgical operation.” *Id.* That jurisdiction would expire once the emergency had passed. *Id.*

111. *Id.*

112. Convention on International Protection of Adults, *supra* note 8, at art. 11.

113. *Id.* at art. 11(1).

114. *Id.*

The *travaux préparatoires* emphasized that this section was not intended to operate as an escape hatch to Article 10.¹¹⁵ Nevertheless, it permits a degree of intrusion upon the jurisdiction of the state of habitual residence. The local authority is forbidden from directly counteracting the measures taken by the state with jurisdiction, though it may still concern itself with the course of medical care given to the adult.¹¹⁶ For instance, Article 11 may not permit an abortion in the scenario described within the *travaux préparatoires* for Article 10, but it may permit a state to institute temporary measures pertaining to counseling, medication, and/or designation of hospital personnel to the incapacitated adult.¹¹⁷ None of those courses of action may directly affect the decision of the state of habitual residence to terminate the adult's pregnancy, but neither can they be said to fall completely outside its ambit.

The constraints within Article 11 are neither very meaningful nor effective. As long as such "temporary measures" are undertaken with advance notice to the state exercising jurisdiction, they will be perfectly in concert with the letter, if not the intent, of the Convention.¹¹⁸ Furthermore, in the context of an individual's medical care, it is difficult to envision an example of a policy which would have a significant extraterritorial impact. The state in which the adult is located may therefore undermine the jurisdiction of the state of habitual residence

115. EXPLANATORY REPORT, *supra* note 21, at 49.

116. *Id.*

117. *Id.* The *travaux préparatoires* includes an example of a permissible exercise of concurrent jurisdiction:

A situation may be imagined where the State on whose territory a young incapacitated adult is temporarily present decides, with a view to protection, to isolate him or her from certain persons in his or her immediate environment during his or her stay in that State or takes a measure of placement or temporary hospitalization, even in a non-urgent case.

Id. Nevertheless, this degree of discretion "does not confer jurisdiction on the State where the adult is present to authorise [sic] serious, definitive medical measures, such as an abortion, sterilisation [sic] or surgical operation entailing the removal of an organ or the amputation of a limb." *Id.* Despite this warning, "urgency" and the perception of danger or harm are subjective criteria, relying absolutely on the estimation of the state exercising jurisdiction. Convention on International Protection of Adults, *supra* note 8, at art. 10(1). A state may still intervene in medical treatment under the guise of protection, isolating the incapacitated adult from a close family member, a family physician, or even his or her legal counsel. *Id.*

118. EXPLANATORY REPORT, *supra* note 21, at 49.

at will, provided its actions are not directly incompatible and the appropriate notification is sent down the chain.¹¹⁹

D. Powers of Representation Under Article 15

Article 15 of the Convention preserves the right to have an existing designation of power of attorney from the adult's "habitual residence" honored by the state in which the adult is located.¹²⁰ It allows for the "existence, extent, modification and extinction of powers of representation," by prior agreement or by a "unilateral act, to be exercised when such adult is not in a position to protect his or her interests."¹²¹ Such arrangements will be "governed by the law of the State of the adult's habitual residence at the time of the agreement or act."¹²² Article 15 protects a modicum of the adult's own discretion. If he or she had the foresight to execute an advance medical directive or living will, then the Convention stands prepared to honor it.¹²³ Once again, however, the language permitting its enforcement may also sanction its disregard by the state in which the adult is located.

The description of the discussions on Article 15 bears the only explicit reference to advance medical directives in the entire record of the Convention.¹²⁴ Their mention is at once deferential and suspicious:

The powers thus conferred [in an agreement] may be very varied. They have to do with the management of the adult's property as well as his or her personal care. One often finds in them the instruction given to the person mandated to refuse any persistent course of treatment in the event of incurable illness. This type of mandate, which seems to be quite common in certain States, and particularly in North America, is unknown in a number of European States, including France, where the mandate necessarily comes to an end in the event of the onset of incapacity; hence the interest in having a conflict of laws rule on the subject.¹²⁵

While the drafters may have viewed the concept with varying degrees of distrust, Article 15 nevertheless seems to sanction the enforcement

119. *Id.*; Convention on International Protection of Adults, *supra* note 8, at art. 10(4).

120. Convention on International Protection of Adults, *supra* note 8, at art. 15(1).

121. *Id.*

122. *Id.*

123. EXPLANATORY REPORT, *supra* note 21, at 54.

124. *Id.*

125. *Id.*

of advance medical directives abroad. Such directives are placed on par with the more benign forms of guardianship and powers of attorney that Article 15 was intended to facilitate.¹²⁶

Advance medical directives, however, may implicate public policy concerns that could eviscerate the usefulness of the Convention for medical surrogates. Paragraph 3 of Article 15 holds that “[t]he manner of exercise of such powers of representation is governed by the law of the State in which they are exercised.”¹²⁷ This exception could void the substance of most advance medical directives. If the adult’s wishes run afoul of local laws, then the medical surrogate and treating physicians will not be able to carry out the adult’s wishes.¹²⁸ The Convention therefore shifts its deference from the advance medical directive back to the jurisdiction of the state in which the adult is located. Article 15 and all of the applicable law provisions of the Convention were never intended to “prevent the application of mandatory laws in the State where the adult is to be protected.”¹²⁹

“Mandatory laws,” moreover, are not limited to the national or regional laws of the state in which the adult is located.¹³⁰ The Article 15 exception “means, for example, that if there is a mandatory rule that permission for a given procedure must be given by a hospital committee, that rule prevails,” and the “conditions of implementation of a measure are governed by the law of the state where implemented.”¹³¹ Clearly, not just national public policies, but local law—or even a given hospital’s practice—may pose a significant barrier to the enforcement of a directive.¹³² Authorities on a provincial or municipal level may initiate an objection, even where the advance directive

126. DeHart, *supra* note 72 (referring to its protection of “powers of attorney,” commonly used in the U.S. but not recognized in some countries”).

127. Convention on International Protection of Adults, *supra* note 8, at art. 15(3).

128. EXPLANATORY REPORT, *supra* note 21, at 57. This public policy exception is even more restrictive than the one attached to Article 11 because “it is a matter of powers conferred by the adult himself or herself [rather] than when they derive from a measure of protection.” *Id.* It was noted that “[s]ome delegations expressed a fear that more or less scrupulous foreign mandatories might invoke their powers, against local law, to authorise [sic] blood transfusions or organ transplants for the adult.” *Id.*

129. DeHart, *supra* note 72.

130. *Id.*

131. *Id.*

132. *Id.*

would be executed without hesitation in another part of the country.¹³³ In the presence of any “mandatory law” to the contrary, the decision is taken out of the hands of the medical surrogate—and by correlation, the state of habitual residence—and dropped back into the lap of the state where the adult is located.¹³⁴

While the *travaux préparatoires* explicitly affirmed the applicability of the Convention to advance directives,¹³⁵ the treaty itself does not hold out an exception to the public policy rule, nor does it indicate that the directives will be favored in the event of a clash with local public policy.¹³⁶ As the treaty is silent on the subject of the directives, reference to the accompanying record of the negotiations will not likely be persuasive. International law holds “[a]s a general proposition” that “the Vienna Convention on the Law of Treaties gives primary interpretive importance to the written text of a treaty.”¹³⁷ While the Vienna Convention at Article 32 provides that “[r]ecourse may be had to . . . the preparatory work of the treaty,” its use is limited to instances where the plain language “leaves the meaning ambiguous or obscure.”¹³⁸ The text of a treaty is thus “presumed to be the authentic expression of the intention of the parties” and “the starting point of interpretation in the elucidation of the meaning of the text. . . .”¹³⁹

The Vienna Convention at Article 31 further requires that “[a] treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context

133. *Id.*

134. Convention on International Protection of Adults, *supra* note 8, at art. 20.

135. EXPLANATORY REPORT, *supra* note 21, at 54.

136. *Id.*

137. Anthony D’Amato, *The ‘Sources’ of International Law*, in BURNS H. WESTON, RICHARD A. FALK & ANTHONY D’AMATO, INTERNATIONAL LAW AND WORLD ORDER: A PROBLEM-ORIENTED CASEBOOK 59 (2d ed. 1990). D’Amato refers to Article 31 of the Vienna Convention on the Law of Treaties, which provides a “general rule of interpretation.” *Id.*; see also Vienna Convention on the Law of Treaties, May 23, 1969, art. 31(1), 1155 U.N.T.S. 331 [hereinafter Vienna Convention].

138. Vienna Convention, *supra* note 137, at art. 32. Article 31 also allows for the consideration of documents directly related to the treaty, such as addenda and supplementary materials. *Id.* at art. 31(2). It states, “The context for the purpose of the interpretation of a treaty shall comprise, in addition to the text, including its preamble and annexes . . . [a]ny agreement relating to the treaty which was made between all . . . parties” and “[a]ny instrument which was made by one or more parties in connection with the conclusion of the treaty and accepted by the other parties as an instrument related to the treaty.” *Id.*

139. D’Amato, *supra* note 137, at 60.

and in light of its object and purpose.”¹⁴⁰ In resolving a conflict between an advance medical directive and a local policy, the interpretive principles of international law require an examination of the text of the treaty, with a heavy presumption in favor of honoring its plain meaning.¹⁴¹ The textual “starting point” within the Convention is Article 15, which explicitly curtails the medical surrogate’s “powers of representation” with the public policy exception.¹⁴² In this situation, where the terms are clear and their “ordinary meaning” and context point to the same conclusion, the treaty may signal the end of the analysis.¹⁴³ Local policy would trump the directive.

E. Articles 20 and 21: The Public Policy Exceptions

Advance medical directives are only one form of the “powers of representation” covered by the Convention.¹⁴⁴ They provide a compelling example, however, by which to imagine the ramifications of the public policy exception. Advance medical directives are essentially “written directives that give direction or guidance as to an individual’s future medical care in the event of mental incapacity.”¹⁴⁵ If an American citizen, traveling abroad, becomes incapacitated, the advance medical directive the individual executed while still of sound mind and body in the United States may or may not be of any use under the Convention. The public policies of the country where the individual becomes ill will determine whether the directive will be honored.¹⁴⁶ If the terms of the directive dictate a course of medical or palliative care at odds with the public policies of the resident country, then the American citizen may be placed under the protection of a local authority, who will disregard the directive and impose another form of treatment, essentially “annul[ing]” the adult’s intentions.¹⁴⁷ It is this very derogation of the patient’s wishes that an advance medical

140. Vienna Convention, *supra* note 137, at art. 31.

141. *Id.*

142. Convention on the International Protection of Adults, *supra* note 8, at arts. 15(1), (3).

143. D’Amato, *supra* note 137, at 59.

144. Convention on the International Protection of Adults, *supra* note 8, at art. 15(1).

145. LAWRENCE A. FROLIK & RICHARD KAPLAN, *ELDER LAW IN A NUTSHELL* 27 (2d ed. 1999).

146. Convention on International Protection of Adults, *supra* note 8, at art. 21.

147. EXPLANATORY REPORT, *supra* note 21, at 30.

directive is supposed to stave off. It is also what Article 15 of the Convention was ostensibly created to prevent.¹⁴⁸

The public policy exception demarcates quite clearly the limits of the Convention.¹⁴⁹ Of course, deference to local public policy is the current norm of international law,¹⁵⁰ with the Convention's articles on applicable law constituting the somewhat radical departure. The introductory note states the following: "These articles recognize the institution of 'powers of attorney' commonly used in the United States, but not recognized in some countries, and give effect to it and similar institutions whether or not the State where the power is granted or exercised has such an institution."¹⁵¹ Thus, some advance directives will have to be enforced where previously there was no such compunction in international law.¹⁵² It is, however, a decidedly qualified dictate.

Predicating the right of enforcement on compatibility with local public policies may fairly discount the choice of law provision in Arti-

148. See Norman Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182 (2001). Cantor explains, "[C]ompetent persons have a broad legal prerogative to decide how to respond to fatal afflictions—how much to struggle, how much to suffer, how much bodily invasion to tolerate, and how much helplessness and indignity to endure." *Id.* An advance medical directive makes it possible for them to dictate a course of medical treatment or to appoint a proxy or "health-care agent." *Id.* at 189. The directive holds both legal and emotional meaning for the patient:

People, while still competent, care mightily whether their cherished values, including dignity, will ultimately be respected in the dying process. In recognition of the importance of this self-determination, virtually all jurisdictions provide that a person's articulated wishes contained in an advance directive should be honored post-competence, just as a person's wishes about testamentary disposition of property are respected even though the dead person cannot sense violation of those wishes.

Id. In the United States, the laws governing advance medical directives vary somewhat from state to state. FROLIK & KAPLAN, *supra* note 145, at 27. The American Bar Association's Commission on Problems of the Elderly noted, "[S]tate advance directive laws are slowly moving toward acceptance of flexible, combined advance directives, but the states differ significantly in this regard." Charles Sabatino, *Ten Legal Myths About Advance Medical Directives* (Am. Bar Ass'n), at <http://www.abanet.org/elderly/myths.html> (last visited Aug. 22, 2002). The variations among state requirements, however, pale by comparison to the possible obstacles to establishing the validity of a directive in a foreign country. See DeHart, *supra* note 72.

149. See, e.g., Convention on the International Protection of Adults, *supra* note 8, at art. 21.

150. See Myers, *supra* note 18, at 5.

151. DeHart, *supra* note 72.

152. Myers, *supra* note 18, at 4.

cle 15 in a number of cases.¹⁵³ Indeed, there are no fewer than four reiterations of public policy exceptions throughout the treaty,¹⁵⁴ with Article 21 providing the most explicit example. It states that “the application of the law designated by the provisions of this Chapter can be refused only if this application would be manifestly contrary to public policy.”¹⁵⁵

In addition to Article 21, the Convention contains a further means of escape in the “mandatory law” provision.¹⁵⁶ Article 20 provides that the applicable articles of the Convention shall not affect those local laws that are considered obligatory by the state in which the adult is located.¹⁵⁷ It stipulates that the Convention “does not prevent the application of those provisions of the law of the state in which the adult is to be protected where the application of such provisions is mandatory whatever law would otherwise be applicable.”¹⁵⁸

This mutation of the public policy exception was included as an additional route for voiding the contents of an advance medical directive:

The exception for mandatory laws of the State in which the adult is to be protected was introduced with the medical field especially in mind. In particular, it was a counterweight to the possibility given to the adult of choosing the law applicable to the powers of representation . . . Article 20 will frequently be applied in medical matters and should make it possible to regulate the bulk of the problems encountered in this field during the negotiations.¹⁵⁹

Articles 20 and 21 thus beg the question: Are the applicable law provisions, and not the so-called public policy exceptions, the true deviations from the rule?

One possible reason for such castrating exceptions is the multitude of reasons why governments enter treaties in the first place. Often they do not “deal with treaty problems solely in legalistic terms.”¹⁶⁰

153. Convention on International Protection of Adults, *supra* note 8, at art. 15.

154. *Id.* arts. 11(1), 15(3), 21, 22(2)(c).

155. *Id.*

156. *Id.* at art. 21.

157. *Id.* at art. 20.

158. *Id.*

159. EXPLANATORY REPORT, *supra* note 21, at 59–60.

160. Richard Bilder, *Managing the Risks of International Agreement*, in BURNS H. WESTON, RICHARD A. FALK & HILARY CHARLESWORTH, INTERNATIONAL LAW AND WORLD ORDER: A PROBLEM-ORIENTED COURSEBOOK 83, 85 (3d ed. 1997) [hereinafter WESTON, FALK & CHARLESWORTH].

Government officials probably look at questions of treaty obligation and breach more flexibly and in a broader context than traditional legal analysis assumes. For them, an agreement will often be not simply an instrument for creating legal rights and obligations but a multipurpose foreign policy tool, constituting one element in the more complex pattern of their nation's overall foreign policy. In this broader context, other foreign policy objectives will sometimes be more important than ensuring performance of the agreement.¹⁶¹

The Convention therefore may be perceived as a partial but politically convenient solution to a hopelessly divisive problem. Another possibility for the public policy exceptions is the deterrence of litigation and the encouragement of informal resolutions by the parties. The ambiguity within the Convention may discourage both sides of a dispute from bringing their case before a court of law.¹⁶² Without the treaty clearly in support of either side, private negotiations may be preferred to extended litigation, especially where a patient is dying.¹⁶³ This outcome is often preferred, even in countries recognizing the right to refuse treatment.¹⁶⁴

Another reason for the public policy exceptions may be found in the preamble of the Convention itself.¹⁶⁵ Among the purposes of the treaty was an affirmation of "the interest of the adult and respect for his or her dignity and autonomy" as "primary considerations" of the states.¹⁶⁶ It may well be that the Convention is simply built upon an impossible premise.

IV. Resolution

A. "Dignity" and Relativism in International Law

International legal theorists have defined "dignity"¹⁶⁷ by reference to "the particular cultural understanding of the inner moral

161. *Id.* at 84.

162. *Cf.* FROLIK & KAPLAN, *supra* note 145, at 45 (describing the effect of conflicts of law among American states).

163. *Id.*

164. *Id.*

165. Convention on International Protection of Adults, *supra* note 8, pmb., para. 4.

166. *Id.*

167. Rhoda E. Howard, *Dignity, Community, and Human Rights*, in HUMAN RIGHTS IN CROSS CULTURAL PERSPECTIVE 81, 81-91 (1992), reprinted in WESTON, FALK & CHARLESWORTH, *supra* note 160, at 727-30.

worth of the human person and his or her proper political relations with society.”¹⁶⁸ Under this theory, “dignity” is not a “claim that one is worthy of respect merely because one is a human being.”¹⁶⁹ Instead, it is a type of birthright that varies enormously among peoples:

[D]ignity is something that is granted at birth or on incorporation into the community as a concomitant of one’s particular ascribed status, or that accumulates and is earned during the life of an adult who adheres to his or her society’s . . . normative cultural constraints on his or her particular behavior . . . [It] is not private, individual or autonomous. It is public, collective, and prescribed by social norms.¹⁷⁰

Thus, the meaning of “dignity” turns entirely upon the society in which one finds oneself.¹⁷¹ In a field that cherishes those practices which are the longest and most widely held among nations, international law would not seem a proper vehicle for enforcing rights which turn upon such relative concepts.¹⁷²

In the context of international human rights, relativism holds that “local legal, political, religious, and other customs and traditions fundamentally determine the existence and scope of at least civil and political rights in a given society.”¹⁷³ According to relativists, “human rights standards . . . are locally defined and interpreted, differing from culture to culture, in keeping with the values of cultural pluralism, and thus are not to be judged against transboundary legal or moral standards without running afoul of the right of all peoples to self-determination.”¹⁷⁴ By incorporating a respect for dignity into the Con-

168. *Id.* at 727.

169. *Id.* at 728.

170. *Id.*; cf. Robert D. Sloane, *Outrelativizing Relativism: A Liberal Defense of the Universality of Human Rights*, 34 VAND. J. TRANSNAT’L L. 527, 527–95 (2001). Sloane argued, “Norms that promote human dignity exist in nearly all societies. Properly interpreted, recast, and reoriented, these norms arguably can be redeployed in the service of human rights; they provide the ‘raw material’ from which to forge genuine ‘cross-cultural’ universality.” Sloane, *supra*, at 578.

171. Sloane, *supra* note 170, at 560. According to Sloane, relativists believe that, “because every culture has its own distinctive *topos*, or cultural vocabulary, human rights may be an inappropriate or myopic functional concept to promote human dignity in certain cultural communities.” *Id.*

172. See *Statute of the International Court of Justice*, 1978 U.N.Y.B. 1052, art. 38 (providing that the International Court of Justice shall render its decisions pursuant to treaties in force between the parties and “international custom, as evidence of a general practice accepted as law”).

173. WESTON, FALK & CHARLESWORTH, *supra* note 160, at 718.

174. *Id.* at 718–19. The authors recount the historical clash between “relativists” and “universalists” in the field of human rights. *Id.* at 718. They explain that relativists perceive the sweeping guarantees contained in human rights instru-

vention, relativists would argue that the drafters have entered a morass, particularly in the context of medical care decisions, from which there is no legally or morally certain exit.¹⁷⁵

In the United States, legal efforts to preserve the dignity of the elderly are often focused upon the creation and enforcement of advance medical directives and living wills.¹⁷⁶ The U.S. Supreme Court has recognized a “liberty interest” which grants American citizens the right to refuse unwanted medical treatment.¹⁷⁷ Justice Stevens explained:

[T]his right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces, not merely a person’s right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death.¹⁷⁸

The Supreme Court found this interest “includes protection for matters ‘central to personal dignity and autonomy,’” encompassing “the individual’s right to make certain unusually important decisions that will affect his own, or his family’s, destiny.”¹⁷⁹ It is predicated on the “abiding interest in individual liberty that makes certain state intrusions on the citizen’s right to decide how he will live his own life intolerable.”¹⁸⁰

This “liberty interest,” however, is not recognized by all countries, several of which criminally punish medical practitioners who do not act under all circumstances to save a patient’s life.¹⁸¹ By contrast,

ments as lacking “respect for national sovereignty and territorial integrity as well as noninterference in the internal affairs of States, and the non-use of human rights as an instrument of political pressure.” *Id.* By contrast, the universalists adhere to the ideal of “fundamental freedoms” which extend across regional, ethnic, racial, and cultural differences. *Id.*

175. *Id.* at 718–19.

176. FROLIK & KAPLAN, *supra* note 145 (discussing the legal instruments which pertain to health care decision making).

177. *Washington v. Glucksberg*, 521 U.S. 702, 722 (1997).

178. *Id.* at 743 (Stevens, J., concurring).

179. *Id.* at 744.

180. *Id.* at 745.

181. *See id.* at 710–14 (discussing the common-law countries’ history of punishing assisted suicide). The Court found “[i]n almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide.” *Id.* at 710. The common-law tradition “has punished or otherwise disapproved of both suicide and assisting suicide” for almost 700 years. *Id.* at 711; *see also* *Rodriguez v. British Columbia*, 107 D.L.R. 342, 401–04 (Can. 1993) (examining euthanasia laws in Austria, Spain, Italy, England, the Netherlands, Denmark, Switzerland, and France).

other countries are much more lenient than the United States, some with laws expressly allowing their doctors to assist in the suicides of terminally ill patients.¹⁸² Denmark, the Netherlands, and Singapore all permit physician-assisted suicide.¹⁸³ In the United States, currently only Oregon has legalized euthanasia.¹⁸⁴ The Oregon Death with Dignity Act of 1994 “would permit qualified patients who suffer from a terminal disease to voluntarily request a prescription for medication to end their lives in a humane and dignified manner.”¹⁸⁵ The U.S. Supreme Court, however, has held that there is no constitutional right to euthanasia, upholding statutes from both New York and Washington which expressly criminalized physician-assisted suicide.¹⁸⁶ Where stark disagreement exists within a nation regarding the scope of a supposed “liberty interest,” the differences across cultures may prove to be insurmountable.

The preservation of dignity may provide the starting point for efforts to protect the elderly, but if dignity is a normatively relative concept, i.e., one highly dependent on societal mores and values, it does not lend itself easily or readily to cross-cultural understandings.¹⁸⁷ And yet, such understandings must be codified within treaties before they can be enforced across borders. It is perhaps not accidental that the term “dignity” is nowhere clearly defined within the Convention.¹⁸⁸ Its meaning is made implicit in the interpretation of every

182. See Danish Circular No. 157 of 15 September 1998, on the duties of physicians in connection with living wills, *reprinted in* World Health Organization’s International Digest of Health Legislation, at <http://www-nt.who.int/idhl/en/ConsultIDHL.cfm> (permitting “[t]he administration to a patient whose death is inevitable of analgesics, tranquilizers, or the like that are necessary in order to alleviate his condition, shall be authorized even if this hastens the moment of death”).

183. *Id.*; The Netherlands Law of 12 April 2001 (Stb. 194) on the review of the termination of life on request and assisted suicide, and amending the Criminal Code and the Law on the disposal of the dead (the Law on the termination of life on request and assisted suicide), *reprinted in* World Health Organization’s International Digest of Health Legislation, at <http://www-nt.who.int/idhl/en/ConsultIDHL.cfm>; Dr. John Keown, *To Treat or Not to Treat: Autonomy, Beneficence and the Sanctity of Life?*, 16 SING. L. REV. 360 (1995).

184. FROLIK & KAPLAN, *supra* note 145, at 55.

185. *Id.* at 54.

186. *Id.* at 55.

187. See Sloane, *supra* note 170.

188. The only explicit use of the term is in the Preamble. Convention on International Protection of Adults, *supra* note 8, pmbl., para. 4.

article and every section which follows,¹⁸⁹ and this gaping omission allows the Convention to achieve the more limited objectives of the applicable law provisions. Private international law disputes that center on property issues may find a quick and certain resolution provided within the Convention's articles.¹⁹⁰ Disputes of a medical nature will not be so easily settled.

The elderly who find themselves incapacitated in foreign lands may appear to be sheltered from the local laws and customs by virtue of the Convention, but the public policy exceptions within the treaty impose narrow parameters upon its shelter, deferring to those same local laws and customs precisely where a real clash of interests is most likely.¹⁹¹ The parties to the Convention may agree to take measures to preserve the dignity of an incapacitated adult, but what constitutes "dignity" under the laws of any given state will necessarily inform the type and extent of those measures.

B. The Future of the Convention

As of this writing, only two nations—France and the Netherlands—have signed and become parties to the Convention.¹⁹² The United States, as one of the principal drafters, has yet to do so. However, the indications are strong that it will, as the "delegates indicated their general satisfaction with the completed text and their inclination to sign and eventually to accede to the Convention."¹⁹³

In the United States, treaties stand on par with Acts of Congress and the Constitution.¹⁹⁴ Once signed, the Convention on the Interna-

189. For instance, the Preamble "affirm[s]" that among the primary goals of the Convention is the preservation of "respect for [the adult's] dignity and autonomy," for which the drafters "have agreed on the following provisions." Convention on International Protection of Adults, *supra* note 8, at pmb., paras. 4, 5.

190. See, e.g., Convention on International Protection of Adults, *supra* note 8, at art. 9 (governing the exercise of authority for measures of protection for the adult's property).

191. *Id.* at pmb., para. 4, art. 21.

192. Hague Conference on Private Int'l Law, *Full Status Report for Convention #35*, (July 17, 2001), at <http://www.hcch.net/e/status/stat35e.html> (last visited Aug. 22, 2002). The Netherlands signed the Convention on January 13, 2000, while France became the next signatory on July 13, 2001. *Id.*

193. DeHart, *supra* note 72, at 4.

194. U.S. CONST. art. VI (stating "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the land").

tional Protection of Adults will indefinitely bind the United States government and citizens of the United States,¹⁹⁵ and therefore there will not be an opportunity for an easy or specious escape from its application in the difficult cases. Louis Henkin noted that “nations will observe international obligations, unless violation promises an important balance of advantage over cost.”¹⁹⁶ With a treaty’s acceptance “comes observance, then the habit and inertia of continued observance.”¹⁹⁷ The concern that “every nation’s foreign policy depends substantially on its ‘credit’—on maintaining the expectation that it will live up to international mores and obligations” will mitigate in favor of honoring the terms of treaties, even where they may yield an unjust or even immoral result in an individual case.¹⁹⁸

In its current form, the Convention employs terms too dependent on the interpretation of each of the contracting parties. There is too much allowance made for public policy in the context of medical care decisions. The uncertainty within the Convention might be minimized, however, by clarifying its application in those instances.

One possible option for the drafters is to merely avoid the extra-territorial enforcement of advance medical directives and living wills altogether. Instead, such controversies might be left to the local authorities of the state in which the adult is located. While this option may sacrifice some of the noblest goals of the Convention, the treaty will at least be clearly written to affect the intentions of all the parties. To aim for more might actually yield less in the long run, as a consensus built upon misunderstanding will eventually collapse. It would be better to avoid the situation of an adult traveling with the expectation that his or her advance medical directive will be honored.

A less drastic proposal might allow the Convention to permit a contracting state the option of enforcing such decrees by local officials, and, in the event of their refusal, for representatives of the state of habitual residence to arrange for enforcement by a diplomatic agent. For example, a type of diplomatic immunity could be granted to the adult’s medical surrogate or to a physician in the employ of the State Department who would execute the provisions of the adult’s direc-

195. *Id.*; see also Vienna Convention, *supra* note 137, at art. 42 (concerning the validity and continuance in force of treaties).

196. LOUIS L. HENKIN, *HOW NATIONS BEHAVE* 46 (2d ed. 1968).

197. *Id.* at 57.

198. *Id.* at 48–63.

tive. This solution could create some bureaucratic difficulties, but it would provide some middle ground between respecting the integrity of a highly cherished local public policy and honoring the substance of an advance medical directive.

Finally, the Convention would be clarified without significant alteration if the mandatory law exceptions were required to be decreed by the signatories prior to the Convention's ratification and entry into force.¹⁹⁹ By specifying the mandatory laws in advance, the temptation to invoke this sweeping privilege will be minimized, particularly in situations where the merits of invoking the exception are questionable.

V. Conclusion

Before the Convention on the International Protection of Adults can be interpreted according to the principle of *pacta sunt servanda* of the Vienna Convention,²⁰⁰ its ambiguities on the enforcement of medical care directives must be removed or resolved. Until then, the meaning of "good faith" will be as infused with relativistic confusion as the term "dignity." By clarifying the scope of the public policy and mandatory law exceptions, the Convention may still provide the possibility of enforcing advance directives abroad, according to uniform, reliable guidelines. Failing that clarification, it would be wise to avoid the issue altogether, rather than create a false sense of agreement amongst the parties to the Convention and a false sense of security amongst adults who might otherwise have decided to stay home.

199. See EXPLANATORY REPORT, *supra* note 21, at 60. This suggestion was considered and set aside during the negotiations. *Id.* Some of the drafters would have preferred each Contracting State to draw up a list of its provisions which it considers to be mandatory to enable the other Contracting States to respect them as far as possible when taking the measures of protection falling within their jurisdiction and intended for implementation in another State.

Id. The proposal was rejected for fear "of implementation problems." *Id.*

200. Vienna Convention, *supra* note 137, at art. 26.