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Withdrawal of Life Support: Conflict Among Patient Wishes, Family, Physicians, Courts and Statutes, and the Law

LYNDA M. TARANTINO*

INTRODUCTION

Advances in technology and medicine now enable physicians and machines to keep people alive who would have died just a few years ago.¹ Often machines artificially maintain the lives of those who will never regain consciousness, who will never be able to function again on their own, people who have no hope for a quality of life even close to what most of us would consider "living." In certain circumstances physicians automatically follow life-sustaining protocols, perhaps because the future health of their patients is sometimes uncertain. Unfortunately, once life support measures are taken they are often difficult to discontinue without the involvement of physicians, ethics committees, courts, families and even strangers. Although many patients benefit from current advances, it is also becoming more common for patients to become "prisoner[s] of technology" who must undergo a difficult, complicated, and drawn out process simply to be allowed to die with dignity, and on their own terms.²

* J.D., University at Buffalo School of Law, May 1994. Cited laws are current through March 28, 1994. As the laws in this area are changing rapidly, any reliance on citations in this article should be confirmed. The author wishes to thank fellow Buffalo Law Review Editors Paul Raimondi and Sharon Swift for their many contributions to this article.

1. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 270 (1990); Michele Yuen, *Letting Daddy Die: Adopting New Standards for Surrogate Decision Making*, 39 UCLA L. REV. 581, 583, 587 (1992).

When Americans died in 1950, the majority died at home with their families in attendance. Now, of the approximately 5500 Americans who die each day, 80% do so "wired and incubated in an institution where the expensive technology is arrayed and controlled by specialists who likely know little about the patient beyond the medical problem." *Id.* at n.33 (quoting Andrew H. Malcolm, *Reassessing Care of Dying: Policy Seen Evolving from A.M.A. Opinion*, N.Y. TIMES, Mar. 17, 1986, at col. 1); see also, Letters to the Editors, based on case presentation by Lisa L. Kirkland, *Brain Death and the Termination of Life Support: Case and Analysis*, J. OF CLINICAL ETHICS, SPRING 1992, at 78-82.

2. American Academy of Neurology in amicus brief for *Cruzan v. Harmon, et al*, 760 S.W.2d 408,423 (Mo. 1988), *aff'd*, 497 U.S. 261 (1990); BRUCE HILTON, FIRST DO NO HARM 17 (1991).

In *Cruzan v. Director, Missouri Department of Health*³, the Supreme Court recognized the right of competent individuals to refuse medical treatment. However, the Court left unclear the rights of an individual who is unable to make his or her own life support decisions, as well as the rights of family members to decide these issues. The Court invited states to clarify this new area of law.⁴ In the last few years every state has enacted some form of advance directive legislation, and most have changed definitions and added guidelines and restrictions in related areas. While recent legislation has given us all more freedom over our bodies, many statutes do not do enough. Countless inconsistencies between states, and even within a state's own legislation, confuse and provoke unnecessary court battles. Many statutes still offer no relief to incompetent patients in a permanent comatose state if they have given no clear indication of their treatment wishes. This Note examines how state laws have changed to reflect medicine's new abilities in the area of treatment decisions and how the statutes serve both to resolve and encourage conflict in health care decision-making. Part I attempts to define many new medical and legal terms in the context of the right to forego life-sustaining medical treatment. Part II examines the role of physicians and hospitals and how their policies, feelings and obligations may conflict with patient rights and influence court decisions. Part III explores the issues of conflict among patient directives, designated health care agents, state statutes and the courts in decisions to withdraw life support. Part IV examines the role of the family in life support decisions, and the conflict which may arise both among family members and between family and patient wishes. Finally, Part V suggests solutions for preventing disagreeable legal and ethical conflicts in the future.

I. BACKGROUND

A. *Life Support*

The terms "life support system" or "life-sustaining procedure" have been defined by virtually every state. At the very least, the terms encompass any medical procedure or intervention which, when applied to an individual, would serve only to postpone the moment of death.⁵ However, even this simple definition is subject to

3. 497 U.S. 261 (1990).

4. *Id.* at 289-92 (O'Connor, J., concurring).

5. See, e.g., FLA. STAT. ANN. § 765.101(11) (West Supp. 1993) (Florida now uses the term "life-prolonging procedure"); ILL. ANN. STAT. ch. 755, §40/10 (Smith-Hurd 1993); ME. REV. STAT. ANN. tit. 18-A, §5-701(b)(4) (West 1991 & Supp. 1992); N.C. GEN. STAT. §90-321(a)(2) (1992); 1993 OR. LAWS, ch. 767, sec. 1, §127.505(9); WASH. REV. CODE ANN. § 70.122.020(5) (West 1992 & Supp. 1993).

controversy, since some statutes still exempt or differentiate artificial nutrition and hydration⁶ from other life-sustaining procedures.⁷ This distinction is at odds with a great deal of medical research and writing, and much of our case law.⁸ Nearly every state's final court to consider the issue has concluded that artificial feeding is medical treatment which may be refused.⁹ However, many statutes either do not allow, or make it difficult for, an incompetent patient to refuse artificial nutrition and hydration. Additionally, some statutes state that life support may include any procedure that maintains an individual in a state of permanent unconsciousness.¹⁰ The effect of a definition encompassing *any* procedure maintaining permanent unconsciousness is to *allow* withdrawal of nutrition and hydration, thereby erasing the distinction made by many states.

Many people, as reflected in at least half of our state statutes, feel more of an emotional or moral distaste in discontinuing artificial nutrition and hydration than in discontinuing other forms of life support. This seems odd since most people now accept the disconnection of a ventilator and think carefully about even starting artificial respiration. Certainly the need for air is at least as basic and necessary as the need for food and water, yet not a single statute places limitations specifically on the disconnection of respirators. Currently, the distinctions statutes place on artificial nutrition and hydration only serve to put an additional, unnecessary limitation on physicians and families who have already decided that a patient has no hope and have already removed all other forms of life support. In fact, the nutrition and hydration problems encountered in many states serve to defeat the purpose of many statutes to allow a dignified death and prevent the hopeless prolonging of life.

B. *Persistent Vegetative State versus Terminally Ill*

"Persistent Vegetative State" [hereinafter PVS] is a relatively new medical term which has been adopted by the courts. PVS is

6. Any subsequent reference to nutrition and hydration is meant to refer to *artificial* nutrition and hydration which is mechanically administered.

7. IND. CODE ANN. § 16-36-4-1 (West Supp. 1994); MO. ANN. STAT. §404.820 (Supp. 1993); N.C. GEN. STAT. § 90-321 (1993). Maine, Oregon, North Dakota and Ohio have recently changed their statutes so that artificial nutrition and hydration are no longer exempt from their definitions of life support. See ME. REV. STAT. ANN. tit. 18-A, §5-701(b)(4) (West Supp. 1992); N.D. CENT. CODE § 23-06.4-02(4) (1991); OHIO REV. CODE ANN. § 1337.13 (Anderson 1989 & Supp. 1991); 1993 OR. LAWS ch. 767 sec. 1, § 127.505(9).

8. See *infra* notes 71-79 and accompanying text.

9. *In re* Guardianship of L.W. v. L.E. Phillips Career Development Center, 482 N.W.2d 60, 66 (Wis. 1992).

10. CONN. GEN. STAT. ANN. § 19a-570(1) (West Supp. 1993); ILL. ANN. STAT. ch. 755, §40/10 (Smith-Hurd 1993); LA. REV. STAT. ANN. § 40:1299.58.2(5) (West 1992).

used to describe those who are not terminally ill but are, for a reasonably long period of time,¹¹ in an unconscious or semi-unconscious state wherein the patient has no awareness, impaired brain functions, and practically no chance of recovery.¹²

"Terminally ill" must also be defined for a complete understanding of many statutes; although the term seems clear at first glance, it may mean different things to different people and different states. The state of Maine has defined terminal illness as "an incurable or irreversible condition from which, in the opinion of the attending physician, death will occur without the use of life-sustaining procedures."¹³ This definition, as are similar definitions in other states, is ambiguous since it depends on the definition of "life-sustaining procedures." Therefore, if nutrition and hydration are excluded from the definition of "life-sustaining procedures,"¹⁴ most patients in a PVS are not considered "terminally ill" and, therefore, are frequently denied the right to refuse life support. Other statutes define "terminal condition" as an "incurable condition caused by injury, disease or illness which, *regardless of the application of life-sustaining procedures*, would within reasonable medical judgment produce death . . .".¹⁵ Consequently, when statutes use the term "terminally ill" or require that death be "imminent" before life support is withdrawn, it is frequently done only to distinguish the with-

11. "According to the Guidelines, [for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment, National Center for State Courts 1991] an accurate diagnosis of persistent vegetative state is usually considered to be possible only after three months." *In re Guardianship of L.W. v. L.E. Phillips Career Development Center*, 482 N.W.2d 60, 64 (Wis. 1992).

12. According to Bernat:

[t]he persistent vegetative state (PVS) is a tragic neurological condition characterized by wakefulness without awareness. The typical patient has suffered profound damage to hemispheric cortical neurons, which is sufficient to abolish awareness of self and environment [including pain] but largely spares the brain stem ascending reticular activating neurons, thus not impairing wakefulness.

James L. Bernat, *The Boundaries of the Persistent Vegetative State*, J. OF CLINICAL ETHICS, 1992, at 176. PVS patients appear to have sleep/wake patterns and may have some primitive responses to stimuli, but are blind and unaware. They are usually respirator independent, do not feel pain, and may live in this state for years or even decades. *Id.* at 177; *In re Guardianship*, 482 N.W. 2d at 60, 64.

13. ILL. ANN. STAT. ch. 755, §35/2(d) (Smith-Hurd Supp. 1992); ME. REV. STAT. ANN. tit. 18-A §5-701(b)(9)(West Supp. 1993).

14. Stating that the administration of food and water is not a life-sustaining procedure seems a contradiction in terms. For further discussion on this conflict see *infra* notes 59-67 and accompanying text.

15. OKLA. STAT. ANN. tit. 63 §3080.2 -.4 (West 1992 & Supp. 1993) (requiring, in some cases, a terminal illness to be in its final stage before nutrition and hydration may be withdrawn, and defining "final stage" as the last stage of a terminal illness or injury in which, *even with the use of medical treatment*, the person with the terminal illness or injury is in the dying process and will die within a reasonably short time).

drawing of nutrition and hydration from other forms of life support, especially since many patients receiving artificial nutrition and hydration will not die reasonably soon.¹⁶ In these instances, the terminal illness requirement serves to prohibit the withdrawal of nutrition and hydration where the patient will die solely from dehydration or starvation rather than from the existing terminal condition. These terms, when used to define what kind of patient may refuse life support, appear to be misleading and often breed confusion. For instance, Louisiana's and Florida's statutes require that a patient must be "terminal" before s/he may discontinue life support. Most people consider a "terminally ill" patient to be one who will die in the near future. However, the statute later defines "terminal" as a condition which may include patients in a PVS, who may live for years and who do not necessarily have a specific illness that will cause death.¹⁷

C. *Incompetency*

While *Cruzan* firmly established the right of a competent person to refuse life support, Nancy Cruzan's competency was not at issue. To most of us, it would seem that a patient who is conscious, with no brain injuries or evidence of senility, has the right to refuse medical treatment. However, even if a person falls into this category, a physician has the power to question the patient's competency and thereby take away an individual's right to refuse treatment. In fact, in certain circumstances courts and states have dictated that as many as two non-attending physicians must confirm that a patient is competent and fully informed before s/he can make a decision to forego life support.¹⁸ These requirements may possibly enable a second, non-attending physician to disagree with the attending physician's finding of competency and thereby generate further conflict. New York's statute, however, acts to protect the patient's decision by requiring a second physician's opinion only where the attending physician determines that the patient *lacks* capacity.¹⁹

16. ILL. ANN. STAT. ch. 755, § 35/2(d) (Smith-Hurd 1992); OHIO REV. CODE ANN. § 1337.13(E) (Anderson Supp. 1991).

17. FLA. STAT. ANN. § 765.101(11),(17) (West Supp. 1993); LA. REV. STAT. ANN. § 40:1299.58.2 (West 1992).

18. *In re Farrell*, 529 A.2d 404, 414 (N.J. 1987) (The court held that when dealing with an alleged competent patient living at home, in a hospital, or in a nursing home, two non-attending physicians must examine the patient to confirm that s/he is competent and fully informed about his or her prognosis, the medical alternatives available, risks involved, and likely outcome if medical treatment is disconnected).

19. N.Y. PUB. HEALTH LAW §2983 (McKinney 1990 & Supp. 1993) (for a decision to withdraw or withhold life-sustaining treatment, the attending physician who makes the determination that a principal lacks capacity to make health care decisions must consult

In *Ross v. Hilltop Rehabilitation Hospital*,²⁰ a physician questioned the competency of a conscious but paralyzed patient who requested that his gastrostomy tube be disconnected. When his request was not honored, the patient's estate brought an action against the hospital and treating physician, claiming violations of the patient's civil rights as well as the Rehabilitation Act. The District Court disposed of the claims by granting the defendants' motions for summary judgment due to the estate's failure to prove discrimination based on the patient's handicapped state and the estate's failure to establish the "state action" necessary to a state federal civil rights claim (the hospital and physician were private, therefore the federal Act did not protect the patient).²¹ The court also ruled that even if the Rehabilitation Act (protecting the handicapped from discrimination by the state) did apply, the fact that the physician questioned the patient's mental capacity to refuse care negated the claim.²²

This case illustrates how even a conscious patient can be denied the right to refuse treatment due to inadequacy of the law and a physician's ability to question competency, which may be biased. The patient, Mr. Rodas, was a thirty-four year old man who was paralyzed from the neck down and was unable to speak or swallow, but could communicate clearly through eye and head movement. Full sentences were communicated by the patient looking at letters of the alphabet.²³ The physician involved, Dr. Cobb, initially assumed Mr. Rodas was competent. This assumption changed for no other reason than that the patient, after several months in the facility, "consistently and continually requested that his feeding and hydration be discontinued."²⁴ The state court found that Mr. Rodas was competent based upon the testimony of psychologists and medical doctors that he "did not show signs of acute depression or depression that rose to the level of a mental disorder or mental illness."²⁵ However, the District Court refused to grant summary judgment on appeal because, among other issues of fact still unresolved, it felt that "Dr. Cobb had legitimate concerns about whether Mr. Rodas was mentally competent."²⁶ The court found the physician's concerns legitimate because Mr. Rodas had attempted suicide prior to his paralysis and was having marital and other stressful problems.²⁷

with another physician to confirm such determination).

20. 676 F. Supp. 1528, 1528 (D. Colo. 1987).

21. *Id.*

22. *Id.*

23. *Id.* at 1530.

24. *Id.* at 1532.

25. *Id.*

26. *Id.* at 1533.

27. *Id.*

The physician in *Ross* was also admittedly prompted to disregard the patient's wishes because he had seen "other severely disabled patients . . . [express] similar feelings as to the termination of treatment, but all had eventually changed their minds and had come to terms with their situations."²⁸ It is unclear whether the physician in *Ross* was justified in disregarding the patient's wishes. However, it is not difficult to imagine a situation where Dr. Cobb might disregard a request for termination of treatment by a patient who was unquestionably competent, based solely on his experiences with other patients who had changed their minds. This type of physician behavior is clearly inconsistent with case law and statutes giving competent patients the right to refuse treatment regardless of the physician's view of their reasons. Unfortunately, it appears that physicians are frequently in a position of possible conflict with patient wishes, family wishes, and law.

II. PHYSICIAN/HEALTH CARE WORKER CONFLICT

Two-thirds of the country's physicians say they have been involved in decisions like the Cruzans'. In thousands of cases, the parents' wishes were respected. But if a doctor (or hospital administration) disagrees, he or she has the power to make a court case of it. The motives for this are never simple and can vary widely, from the conviction that withdrawal [of life support] is wrong all the way to fear of lawsuits, fear of death, or an awe of technology.²⁹

Although a patient can express his or her wishes regarding life support in various ways, once a patient becomes incompetent it is the *physician* who must consider all relevant factors and physically disconnect life support. It is the physician's medical determinations and opinions which are relied on by courts, especially when the patient's wishes are not clear.³⁰

Physicians understandably are apt to hesitate before taking an action which will probably result in the death of a patient. Besides the fear of criminal or civil liability (which most statutes make unwarranted by exempting doctors from any liability for withdrawing life support pursuant to patient or family wishes),³¹ many physicians

28. *Id.*

29. HILTON, *supra* note 2, at 95.

30. Guardianship of Doe, 583 N.E.2d 1263, 1269 (Mass. 1992).

31. ARIZ. REV. STAT. ANN. § 36-3205 (1986 & Supp. 1993); LA. REV. STAT. ANN. § 40:1299.58.8 (West 1992); N.Y. PUB. HEALTH LAW § 2984 (McKinney 1990 & Supp. 1993). Illinois' new act immunizes health care professionals against liability incurred by carrying out a surrogate's directions. After the passage of the law, there were reports of a number of families and physicians acting under the new procedure. Jerry A. Menikoff et al., *Beyond Advance Directives - Health Care Surrogate Laws*, 327 NEW ENG. J. MED. 1165, 1168 (1992) (discussing Illinois Health Care Surrogate Act of 1991).

feel that withdrawal of life support poses a moral dilemma, and consequently overrule even clear wishes on the part of a patient and/or the patient's family.³² Even hospital staff members and non-attending physicians have the ability to prevent withdrawal of life support agreed upon by family treating physicians, and/or an ethics committee.³³

Physicians have always been taught that their job is to *heal* and *maintain* life, and disconnecting life support strikes many as not only being morally wrong, but evidence of their own professional failure.³⁴ In response to this professional dilemma, the American Medical Association, through its Council on Ethical and Judicial Affairs, issued the following statement dated March 15, 1986:

Withholding or Withdrawing Life Prolonging Medical Treatment

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death.³⁵

Although this statement still leaves much unclear and to the discretion of the physician,³⁶ at the very least it protects the ethical integrity of the medical profession in withdrawing life support.³⁷

32. For example, a two-year study of nursing home patients with living wills found physicians overrode them in about 25% of cases. Brian McCormick, *Flaws Surfacing in Use of Advance Directives*, 35 AM. MED. NEWS, Aug. 24, 1992, at 32.

33. *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633 (Mich. Ct. App. 1992). After consultation with treating physicians, the Neurorehabilitation Center staff, and family's priest and attorney, and authorization by the hospital's bio-ethics committee, a transfer to the hospital in order to withdraw life support was blocked by staff members of the Neurorehabilitation Center. The staff members simply contacted the Oakland County Prosecutor, who obtained an ex parte temporary restraining order, and later a preliminary injunction, prohibiting Joelle's transfer or her removal from life support. *Id.*

34. HILTON, *supra* note 2, at 98-104.

35. Robert L. Riskey, *Voluntary Active Euthanasia: The Next Frontier: Impact on the Indigent*, 3 ISSUES IN LAW & MEDICINE, Dec. 22, 1992 at 61.

36. This statement still leaves a question in the minds of physicians as to first what "imminent" means, and second, what the position of the AMA is regarding patients in a persistent vegetative state.

37. Physicians and hospitals have tried to argue that withdrawal of life support is contrary to the ethical integrity of the medical profession and therefore, should be weighed in the state's decision to allow patients to refuse treatment. *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987) (holding that even if conflict had existed between patient in chronic vegetative state and medical profession, "do not resuscitate" or "do not hospital-

Physicians and hospitals may still refuse to withdraw life support even after a court has ordered compliance with patient and/or family allowing physicians and hospitals that disagree on moral grounds with the ordered withdrawal of life support to inform the family and then transfer the patient either to another hospital or physician.³⁸ This issue was addressed in *Brophy v. New England Sinai Hospital, Inc.*³⁹ where the Massachusetts Supreme Court held that a hospital need not remove a feeding tube if it found it to be contrary to the ethical dictates of the medical profession, but that the "guardian [was authorized] to remove [the ward] from the hospital to the care of other physicians who [would] honor [patient's] wishes."⁴⁰

However, allowing a hospital or other health care facility to refuse to honor a patient's wish presents two important problems: 1) transfer of a patient in a PVS or other condition requiring life support is not only difficult but inconvenient and uncomfortable for the patient and family; 2) most of the statutes do not address what should be done if another facility is not willing to accept the patient. New York is the only state which statutorily responds to this dilemma. The New York statute states that transfer is allowed under reasonable circumstances (transfer must be prompt and the facility must be reasonably accessible), but ends by stating that "if such a transfer [cannot be] effected, the hospital shall seek judicial relief or honor the agent's decision."⁴¹ Thus, hospitals in New York can still,

ize" orders placed on patient's chart would not have brought into disrepute ethical integrity of medical profession, and thus, would not have implicated the state's interest in preserving ethical integrity of the profession as a factor to be balanced against patient's right to refuse medical treatment).

38. ARIZ. REV. STAT. ANN. § 36-3205(c) (1986 & Supp. 1993); LA. REV. STAT. ANN. § 40:1299.53.7 (West 1992); N.H. REV. STAT. ANN. § 137-H:6 (1991); N.Y. PUB. HEALTH LAW § 2984 (McKinney 1990 & Supp.1993); S.D. CODIFIED LAWS ANN. §§ 34-12D-11, 34-12D-12 (1991 & Supp. 1992).

39. 497 N.E.2d 626 (Mass. 1986).

40. *Id.* at 629. The wife of the patient (the patient being in a PVS), brought suit when physicians and hospital refused to discontinue artificial nutrition and hydration. The Norfolk Division of the Probate and Family Court ordered continuation of nutrition and hydration and enjoined the removal of the tube providing nutrition and hydration. The Supreme Judicial Court of Massachusetts transferred the case from the Appeals Court on its own initiative. *Id.* at 628 n.5.

41. N.Y. PUB. HEALTH LAW § 2984 (McKinney 1990 & Supp.1993). A private hospital is not required to honor an agent's health care decision that the hospital would not honor if the decision had been made by the principal because the decision is contrary to a formally adopted policy of the hospital that is expressly based on religious beliefs or sincerely held moral convictions central to the facility's operating principles and has informed the patient or agent and the patient is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the agent's decision. If a transfer is not effected, the hospital shall seek judicial relief or honor the agent's decision. *Id.*

with court approval, refuse to comply with a patient's wishes even if the patient has no alternative.

In *Gray v. Romeo*⁴² the Court went a step further than the statutes permitting transfer in stating: "if Marcia Gray cannot be promptly transferred to a health care facility that will respect her wishes, the Rhode Island Medical Center must accede to her requests."⁴³ The *Gray* court partially relied on the New Jersey case of *In re Jobes*⁴⁴ which held that the nursing home involved *could not refuse* to participate in the withdrawal of the feeding tube by keeping it connected until the patient was transferred.⁴⁵ The *Jobes* court based its decision on the fact that the nursing home had not informed the family of its policy upon admission,⁴⁶ that it would be extremely difficult or impossible to find another facility to accept the patient and, to allow the nursing home to refuse cooperation "would essentially frustrate Mrs. Jobes' right of self-determination."⁴⁷ The *Gray* court based its decision on the Rhode Island statute guaranteeing a patient the right to refuse medical care.⁴⁸ The statutory guarantee, when combined with the Gray family's reliance on the hospital's "willingness to defer to their choice among courses of medical treatment,"⁴⁹ seems a sound basis for requiring personnel to withdraw the life support. After all, the health care workers are not being asked to affirmatively kill someone, but merely to disconnect tubes that they connected, consistent with Marcia Gray's right to refuse treatment. Unfortunately, the *Gray* decision is not likely to be repeated, since at the time there was no applicable countervailing statute allowing hospital personnel to refuse to take part in the withdrawal of life support,⁵⁰ as are now common.

42. 697 F. Supp. 580, 589-90 (D.R.I. 1988).

43. *Id.* at 591.

Recognition of Marcia Gray's right to terminate nutrition and hydration obviously places a great burden on health care professionals who rank giving food and water to the sick as one of their highest duties. . . Yet, even though Marcia Gray has decided to forego the use of the G-tube [Gastric feeding tube], she still needs medical attention. As unsettling as it must be to them, health care professionals must acknowledge Marcia Gray's right of self-determination.

Id.

44. 529 A.2d 434 (N.J. 1987).

45. *Id.* at 450.

46. Consequently, many nursing homes have made it their regular practice to spell out their policies to incoming patients. *See, e.g.*, policies of The Park Associates, Inc., on file with the Buffalo Law Review.

47. *Id.*

48. 697 F. Supp. at 589.

49. *Id.* at 590 (citing *In re Requena*, 517 A.2d 869 (N.J. App. Div. 1986)).

50. Actually, the hospital employees tried to invoke a statute stating that a health care worker may refuse on moral or religious grounds to participate in an *abortion or sterilization* procedure, but the court held that it was clearly limited to abortion and

As stated previously, courts, when concerned with resolving a conflict in the matter of withdrawal of life support, frequently rely on the opinions of physicians and hospital ethics committees in reaching their conclusions.⁵¹ While some physicians may disagree among themselves whether it is appropriate to withdraw life support,⁵² hospitals and physicians sometimes take *no* stand on the issue and are willing to be guided by the family, guardian, and/or courts.⁵³ The courts themselves have stated that life support issues are best left to patients, their families, and physicians, and that courts should become involved only in the event of conflict.⁵⁴

sterilization and did not apply to withdrawal of life support. 796 F. Supp. at 590.

51. *Guardianship of Doe*, 583 N.E.2d 1263, 1269 (Mass. 1992). "In reaching his decision, the judge relied on two neurological consultations, three reports of the Guardian ad litem, and a review of the case by a Wrentham Hospital ethics committee. None of these evaluations contested the recommendation that nasoduodenal feeding and hydration be discontinued." *Id.* See also, *In re Guardianship of L.W. v. LE Phillips Career Development Center*, 482 N.W.2d 60, 71-72 (Wis. 1992) stating:

a guardian may consent to the withholding or withdrawal of life-sustaining medical treatment on behalf of a once competent person whose conduct never was of a kind from which one could draw a reasonable inference upon which to make a substituted judgment, when: 1) the incompetent patient's attending physician, together with two independent neurologists or physicians, determine with reasonable medical certainty that the patient is in a persistent vegetative state and has no reasonable chance of recovery to a cognitive and sentient life; and 2) the guardian determines in good faith that the withholding of treatment is in the ward's best interests. . . .

Id. at 84-85.

52. See *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633 (Mich. Ct. App. 1992); *Gray*, 697 F. Supp. at 583; Affidavit of Defendant's In House Counsel at 2-3, *Dragonette v. Children's Hospital of Buffalo, Inc.*, (No. 8770/92) (out of court settlement) (physician not in attendance is against withdrawal of life support and will testify in court).

53. *Couture v. Couture*, 549 N.E.2d 571, 574 (Ohio Ct. App. 1989) (hospital is willing and desires to be guided by the wishes of Daniel's family and guardian) *superseded by Statute as stated in In re Guardianship of Crum*, 580 N.E.2d 876 (Ohio P. Ct. 1991); see e.g., Defendant's Affidavit, *Dragonette* (No. 8770/92) (there being no hospital policy governing what should be done in case of minor in PVS whose parents wish to remove artificial nutrition and hydration, in-house counsel informed hospital ethics committee that no action could be taken absent an order from the court).

54. *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d at 638 (concluding that the decision whether to end the dying process is a personal decision for family members or those who bear a legal responsibility for the patient); *Guardianship of Barry*, 445 So.2d 365 (Fla. Dist. Ct. App. 1984) (rejecting state's request that judicial review be required before life support may be withheld from a non-brain-dead minor where decision by parents is supported by at least two physicians); *In re Moorhouse*, 593 A.2d 1256, 1262 (N.J. Super. Ct. 1991) (holding that if any one of the involved parties, including the Public Advocate, disagrees with the decision to terminate life support, the decision cannot be implemented without a court order); *In re Farrell*, 529 A.2d 404, 415 (N.J. 1987) (noting that judicial review of a competent patient's refusal of life-sustaining medical treatment is generally inappropriate and is useful only in unusual circumstances, such as a conflict among the physicians, family members, or other health-care professionals).

"Although prior judicial approval is not required, the courts remain available in the event of disagreement between the parties, any case of suspected abuse, or other appropriate instances."⁵⁵ Unfortunately, it will become clear in the next sections that even if physicians agree and comply with the wishes of the patient and/or family, conflicts frequently arise among the latter.

III. PATIENT WISHES: CONFLICT AMONG ADVANCE DIRECTIVES, DESIGNATED AGENTS, AND STATUTES

There are currently several legally recognized written means of making one's wishes known regarding the withdrawal of life support. While many different names are used for these instruments, there are basically two categories: living wills and health care proxies. Both are accurately described as "Advance Directives" but the term is commonly used to refer only to the former.

A. *Living Wills*

[T]he knowledge that advance instructions will be honored may be a source of relief and reassurance. Limited studies tend to confirm both that loss of control over events prompts patients to suffer negative physical and emotional effects and that discussion of advance directives causes patients to worry less.⁵⁶

Living wills are health care instruments that are used to indicate one's specific wishes regarding health care in the event of incompetency. The primary purpose of a living will is to instruct physicians as to when they should discontinue life support and can specify certain circumstances for withdrawal of its different forms. At least partly in response to the controversial and highly visible litigation in the past ten years,⁵⁷ every state in our nation has enacted some form of advance directive legislation.⁵⁸ Many of the new

55. *Rosebush*, 491 N.W.2d at 638 (quoting *In re LHR*, 321 S.E.2d 716, 722-23 (Ga. 1984)).

56. Norman L. Cantor, *Prospective Autonomy: On the Limits of Shaping One's Post-competence Medical Fate*, 8 J. CONTEMP. HEALTH L. & POL'Y 13, 21 (1992).

57. See generally *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); see also, *Gray*, 697 F. Supp. at 583 (describing how the *Quinlan* case caused a discussion between Marcia Gray and her husband regarding her wishes on the topic of life support, which was later used as clear and convincing evidence that Marcia Gray would wish her nutrition and hydration to be withdrawn).

58. Suzan Onel & Sigrid Fry-Revere, *Legal Trends in Bioethics*, 3 J. CLINICAL ETHICS 83-84, 151-152, 242 (1992); ALA. CODE §§ 22-8a-1 to -10 (1990); ALASKA STAT. §§ 18.12.010 to .100 (1991); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1993); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie 1987 & Supp. 1993); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1993); COLO. REV. STAT. §§ 15-18-101 to -113 (West 1989

statutes recognize living wills and give examples of acceptable formats.⁵⁹ These statutes do, however, differ in several respects:

In some states living wills may be executed by any person, at any time (and in some states they may be executed on behalf of minors), while in other states they require a waiting period, and may not be executed during a terminal illness. In most states they are of indefinite duration, although in some states they expire after a determined number of years. Some statutes address only the terminally ill, others include those in irreversible coma, and still others provide for different conditions to trigger the substantive provisions of the document. Some states require the for-

& Supp. 1992); CONN. GEN. STAT. §§ 19a-570 to -575 (Supp. 1993); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.101 to .401 (West Supp. 1993); GA. CODE ANN. §§ 31-32-1 to -12 (1993); HAW. REV. STAT. § 327D-1 to -27 (1993); IDAHO CODE §§ 39-4502 to -4509 (1993); ILL. ANN. STAT. ch. 755 act 40 § 35 (Smith-Hurd 1992); IND. CODE ANN. §§ 16-36-4-1 to -21 (West 1992 & Supp. 1994); IOWA CODE ANN. §§ 144A.1 to .11 (West 1992); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1992); KY. REV. STAT. ANN. §§ 311.622-644 (Michie/Bobbs-Merrill 1992); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1992 & Supp. 1993); ME. REV. STAT. ANN. tit. 18A, §§ 5-701 to -714 (West Supp. 1993); MD. CODE ANN. HEALTH-GEN. §§ 5-601 to -614 (Supp. 1993); MASS. GEN. L. 201D § 5 (Supp. 1993); MICH. COMP. LAWS ANN. §§ 700.496 (West Supp. 1993); MINN. STAT. ANN. §§ 145B.01 to .17 (West Supp. 1993); MISS. CODE ANN. §§ 41-41-101 to -121 (1993); MO. ANN. STAT. § 459.010 to .055 (Vernon 1993); MONT. CODE ANN. § 50-9-102 to -111, -201 to -206 (1993); NEB. REV. STAT. §§ 20-401 to -416, (1992); NEB. REV. STAT. §§30-3401 to 3432 (1992); NEV. REV. STAT. §§ 449.540 to .690 (1993); N.H. REV. STAT. ANN. § 137-H:1 to -H:16 (1993); N.J. STAT. ANN. §§ 26:24-53 to 24-78 (West Supp. 1993); N.M. STAT. ANN. § 24-7-1 to -10 (Michie 1983); N.Y. PUB. HEALTH LAW § 2984- 2994 (McKinney 1993); N.C. GEN. STAT. ANN. §§ 90-320 to -323 (1993); N.D. CENT. CODE §§ 23-06.4-01 to -14, 23-06.5-01 to -18 (1991 & Supp. 1993); OHIO REV. CODE ANN. § 1337.11-1337.17(Anderson Supp. 1992); OKLA. STAT. ANN. tit. 63, §§ 3101.1-3101.16 (West Supp. 1993); OR. REV. STAT. §§ 127.505 to .585, .605 to .650 (1991); R.I. GEN. LAWS §§ 23-4.10-1 to -4.10-12 (1989 & Supp. 1993); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op 1985 & Supp 1992); S.D. CODIFIED LAWS ANN. §§ 34-12D-2 (1986 & Supp. 1993); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1993); TEX. CIV. PRAC. & REM. CODE ANN. § 135.001 (West Supp 1994); UTAH CODE ANN. §§ 75-2-1101 to -1118 (1993 & Supp. 1993); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54.1-2981 to -2992 (Michie 1991 & Supp. 1993); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (West 1992 & Supp. 1993); W. VA. CODE §§ 16-30-1 to -3 (1991 & Supp. 1993); WIS. STAT. ANN. §§ 154.01 to .15 (West 1991); WYO. STAT. §§ 35-22-101 to -108 (1988 & Supp. 1993).

59. ALASKA STAT. § 18.12.040 (1991 & Supp. 1992); ARIZ. REV. STAT. ANN. § 36-3262 (1993); CAL. HEALTH & SAFETY CODE, § 7186.5 (West Supp.1993); CONN. GEN. STAT. ANN. §§ 19a-570(7), 19a-575 (West 1993); FLA. STAT. ANN §§ 765.302 (West Supp. 1993); HAW. REV. STAT. §§ 327D-1 to -5 (1993); IDAHO CODE § 39-4504 (1992); ILL. ANN. STAT. ch. 755, act. 40, § 45/4-1 (Smith-Hurd 1993); IOWA CODE ANN. § 144B (West Supp. 1993); LA. REV. STAT. ANN § 1299.58.3 (West 1992 & Supp. 1993); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701(b)(4), 5-702(a),(b) (West Supp. 1992); MD. CODE ANN., HEALTH-GEN. §§ 5-602, 5-603 (1990 & Supp. 1993); MINN. STAT. ANN. § 145B.03 and .04 (West 1989 & Supp. 1994); NEV. REV. STAT. § 449.610 (1991); OKLA. STAT. ANN. tit. 63 §§ 3080.4, 3101.2, 3101.4 (West 1994); OR. REV. STAT. §§ 127.510 - 127.585 (1991); S.C. CODE ANN. §§ 44-77-30, 44-77-40, 44-77-50 (Law. Co-op. 1991); S.D. CODIFIED LAWS ANN. § 34-12D-2 to -3 (1986 & Supp. 1993); WIS. STAT. ANN. § 154 to 155.20 (West 1993 and Supp. 1993).

malities of a will for the living will to be recognized by statute, while other states require different formalities.⁶⁰

Consequently, individuals are forced to carefully examine the sometimes complicated legal requirements in their respective states. The complexity of the advance directive statutes may be part of the reason why most Americans still have not taken advantage of their new ability to execute health care directives.⁶¹

Differences between state statutes may pose a problem in the event a resident of one state drafts a living will and subsequently moves to another state. Currently, some statutes do provide that living wills drafted elsewhere may be valid in the current state of residency,⁶² but others expressly void declarations which do not conform with specific requirements.⁶³

One problem with advance directives is that they cannot foresee the future. For example, future advances in medicine may be unintentionally precluded by an old advance directive.⁶⁴ Another conflict may arise if a declaration directs certain treatments or withdrawal of treatments if the now incompetent author is found to be pregnant. Several statutes deem some or all advance directives void in the event an incompetent patient is pregnant.⁶⁵ According to

60. BARRY R. FURROW ET AL., HEALTH LAW 1112-13 (2d ed. 1991).

61. McCormick, *supra* note 32, at 32; Yuen, *supra* note 1, at 592.

62. FLA. STAT. ANN. § 765.112 (West Supp. 1993); ILL. ANN. STAT. ch. 755, act. 40, § 45/4-1 (Smith-Hurd 1993); LA. REV. STAT. ANN. § 40:1299.58.10 (West 1992) (stating that a declaration properly executed in and under the laws of another state is deemed to be validly executed for purposes of this Part); MD CODE ANN., HEALTH-GEN. § 5-617 (1990 & Supp. 1993); N.H. STAT. ANN. § 137-H-14(a) (1992); W. VA. CODE § 16-30-11 (Supp. 1993) (stating that a living will executed in another state is valid in West Virginia as long as it is executed in compliance with either West Virginia law or the law of the state where the document is executed).

63. HAW. REV. STAT. §§ 327D-4.4.5 (1985 & Supp. 1992) (recognizing declarations, but only if it includes the checklist in §327D-4, specifying whether the declarant wishes the continuation of artificial feeding (if executed subsequent to July 1, 1991)); MINN. STAT. ANN. § 145B.03 (West 1989 & Supp. 1994); WYO. STAT. § 35-22-102(e) (1988 & Supp. 1993) (stating that all living will declarations must contain a warning to the declarant that living wills have significant medical, legal, and ethical implications).

64. According to McCormick:

the patient's expressed wishes at the time a directive is executed may not be the same months or years later when treatment is needed, Dr. Lo said. The patient's values or priorities may have changed, or new treatments may come into play that were unavailable when a living will was written.

McCormick, *supra* note 32, at 32.

65. "The declaration of a qualified patient known to the attending physician to be pregnant is given no effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures." ALASKA STAT. § 18.12.040(c) (1991); *see also*, FLA. STAT. ANN. § 765.113(2) (West 1986 & Supp. 1993); HAW. REV. STAT. § 327D-6 (1993); MICH. COMP. LAWS ANN. § 700.496(9)(d) (West Supp. 1993); OHIO REV. CODE ANN. § 1337.17 (Anderson 1993); S.D. CODIFIED LAWS ANN. § 34-

the Attorney General of Alaska, voiding the advance directives of a pregnant, incompetent woman is problematic under the U.S. Constitution.⁶⁶ Since it is settled that a woman has a constitutional right to make a determination regarding her pregnancy during the first two trimesters, i.e. abortion,⁶⁷ it follows that statutes denying the validity of her advance directive may be in direct conflict with this right.⁶⁸ Why do many statutes presume that a woman would wish to be kept alive artificially, with no hope of recovery, in order to bring a fetus to term? Even the Catholic Church recently expressed distaste for keeping a pregnant woman alive for the gestation period of a fetus only 13 weeks old.⁶⁹ Wisconsin's statute is the only one specifically stating that a health care agent *does* have the capacity to make decisions on behalf of a pregnant woman.⁷⁰

One more major conflict with statutes limiting the use of advance directives may occur when an individual directs that if s/he becomes terminally ill, or is in a PVS, artificial nutrition and hydration shall be discontinued. Several statutes limit the power of

12D-10 (Supp. 1993).

66. "Subsection (c) is constitutionally problematic . . . [it], in essence, would take this constitutionally recognized right from a woman who has expressed her wishes, and perhaps even alter the form declaration to state her specific wishes, regarding life-sustaining measures during her first two trimesters of pregnancy." ALASKA STAT. § 18.12.040(c) annot. (1991) (opinion of attorney general).

67. See *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S. Ct. 2791 (1992).

68. See ALASKA STAT. § 18.12.040(c) annot. (1991) (opinion of attorney general). For a comprehensive discussion arguing that pregnancy provisions in statutes recognizing living wills are unconstitutional, see Hope E. Matchan & Kathryn E. Sheffield, *Adding Constitutional Depravation to Untimely Death: South Dakota's Living Will Pregnancy Provision*, 37 S.D. L. REV. 388 (1992).

69. "In any right-to-life - or - death - debate, the Roman Catholic church is vociferous, particularly in Bavaria. Traditionally a fervent protector of the unborn child, the Church in Germany has come out against preserving this particular life." Liz Hunt, *Marion The Human Incubator Splits the Conscience of a Nation*, THE INDEPENDENT, Nov. 1, 1992, at 3, available in LEXIS, Nexis Library, INDPNT File.

Women's rights groups say that the decision to sustain the pregnancy has reduced women to mere "baby machines," and that Marion's right to a dignified and peaceful death has been denied. Opinion polls show that more than 80 per cent of Germans think that Marion should be taken off life support. *Id.* Marion's parents wished to maintain the life support and will take care of the baby. However, the final decision to start life support was the physician's. This decision has been criticized as "experimental" and opponents wonder what effects this strange pregnancy will have on the fetus. *Id.*

70. WIS. STAT. ANN. § 155.20 (West 1991 & Supp. 1993).

In the absence of a specific directive by the principal or if the principal's desires are unknown, the health care agent shall, in good faith, act in the best interests of the principal in exercising his or her authority. *If the principal is known to be pregnant, the health care agent may make a health care decision on behalf of the principal that the power of attorney for health care instrument authorizes.*

Id. § 155.20(5),(6) (emphasis added).

advance directives by prohibiting the removal of any form of life support unless the patient is terminally ill.⁷¹ Fortunately, some states which had previously denied individuals the ability to direct in advance withdrawal of nutrition and hydration either when terminally ill or in a PVS, have recently amended their statutes to allow one or both.⁷² However, many states still place restrictions and limitations on the withdrawal of nutrition and hydration that they do not place on other forms of life support.⁷³

Many states place this added emphasis on nutrition and hydration in spite of the fact that there is a great deal of authority stating that it should not be distinguished from other forms of life support.⁷⁴ In *Guardianship of L.W.*,⁷⁵ the Supreme Court of Wisconsin

71. FLA. STAT. ANN. § 765.101(11) (West Supp. 1993); ILL. ANN. STAT. ch. 755, act 40, § 35/2(d) (Smith-Hurd 1992); OHIO REV. CODE ANN. § 1337.13(B) (Anderson 1993); OKLA. STAT. ANN. tit. 63, § 3080.4 (West Supp. 1994); WIS. STAT. ANN. § 154.01 (1991).

72. See, e.g., ARIZ. REV. STAT. ANN. §§ 36-3201 to -3204 (1993); CONN. GEN. STAT. ANN. § 19a-570(1) (West 1990 & Supp. 1992) (changing definition of life support in 1991 to include nutrition and hydration); FLA. STAT. ANN. § 765.101 (West Supp. 1993) (changed in 1990, then again in 1992: nutrition and hydration are no longer distinguished from other "life-prolonging procedures"); IOWA CODE ANN. §§ 144A.2, 144B.6 (West Supp. 1993); LA. REV. STAT. ANN. § 40:1299.58.2 (West 1992) (changing definition of "terminal and irreversible condition" to include those in a continual profound comatose state with no reasonable chance of recovery); MASS. GEN. L. 201D § 5 (Supp. 1993); N.Y. PUB. HEALTH LAW § 2984 (McKinney 1993) (newly recognizing health care agents and allowing agent to request the withdrawal of artificial nutrition and hydration, but only where patient's wishes are specifically known); N.C. GEN. STAT. § 90-322(a) (1990 & Supp. 1992); OR. REV. STAT. § 127.505(9) (1989 & Supp. 1991) (removing the "terminally ill" requirement for withdrawal of life-sustaining procedures).

73. IDAHO CODE § 39-4504 (1992); ILL. ANN. STAT. ch. 110 1/2, para. 702(d) (Smith-Hurd 1991-1992); KY. REV. STAT. ANN. § 311.622-.644 (Michie/Bobbs-Merrill Supp. 1992); MINN. STAT. ANN. § 145B.03 (West Supp. 1993); MO. ANN. STAT. § 404.820 (Vernon Supp. 1993); MONT. CODE ANN. § 50-9-202 (1993); NEV. REV. STAT. § 449.624 (1991); N.H. REV. STAT. ANN. § 137-H:6 III (Supp. 1993); N.C. GEN. STAT. § 90-321(b) (1990 & Supp. 1991); N.Y. PUB. HEALTH LAW § 2982(2) (McKinney 1993); N.D. CENT. CODE § 23-06.4-02(4) (1991); OHIO REV. CODE ANN. § 1337.13(c) (Anderson 1993); OKLA. STAT. ANN. tit. 63 § 3080.4 (West 1992 & Supp. 1993); OR. REV. STAT. § 127.505(4) (1991); R.I. GEN. LAWS § 23-4.11-3 (1992); S.C. CODE ANN. § 44-77-40 (Law. Co-op. 1991); S.D. CODIFIED LAWS ANN. § 34-12D-2 (Supp. 1993); WIS. STAT. ANN. § 154.01 (West 1991).

74. See AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics, Op. 2.18 (1986). "Courts generally consider artificial hydration and nutrition . . . medical treatment." *Guardianship of Doe*, 583 N.E.2d 1263, 1267 n.11 (Mass. 1992) (citing *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986)); see *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990) (although the Supreme Court Justices wrote a number of opinions, eight of nine Justices agree that withdrawal of feeding and hydration is medical treatment); *Gray v. Romeo*, 697 F. Supp. 580, 587 (D.R.I. 1988); *In re Estate of Longeway*, 549 N.E.2d 292, 296 (Ill. 1989); *Matter of Sue Anne Lawrance*, 579 N.E.2d 32 (Ind. 1991); *In Matter of Conroy*, 486 A.2d 1209, 1236 (N.J. 1985); *In re Grant*, 747 P.2d 445 (Wash. 1987).

75. 482 N.W.2d 60 (Wis. 1992). "Nearly every state's final court to consider the issue has concluded that artificial feeding is medical treatment which may be refused. We

sin relied on the New Jersey Supreme Court's statement on artificial feeding:

Once one enters the realm of complex, high-technology medical care, it is hard to shed the "emotional symbolism" of food. However, artificial feedings such as nasogastric tubes . . . are significantly different from bottle-feeding or spoon feeding—they are medical procedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning. Analytically, artificial feeding . . . can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.⁷⁶

The most frequently cited authority on this issue is Justice O'Connor's concurring opinion in *Cruzan* where she states that artificial nutrition and hydration are forms of life support and should not be distinguished therefrom.⁷⁷ Consequently, it is possible that a state statute prohibiting withdrawal of nutrition and hydration as opposed to other life support might be challenged as unconstitutional under the Due Process Clause.⁷⁸ Although the nutrition and

reach the same conclusion." *Id.* at 63.

76. *Id.* at 66 (quoting *In re Conroy*, 486 A.2d at 1236 (citations omitted)).

77. 497 U.S. at 287-92 (O'Connor, J., concurring). Justice O'Connor noted that artificial feeding should not be distinguished from other forms of medical treatment because regardless of whether the court deems the method used to pass food and water into the body medical treatment, it involves some degree of intrusion and restraint.

Feeding a patient by means of a nasogastric tube requires a physician to pass a long flexible tube through the patient's nose, throat, and esophagus and into the stomach. Because of the discomfort such a tube causes, "[m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube." . . . A gastrostomy tube (as was used to provide food and water to Nancy Cruzan), or jejunostomy tube must be surgically implanted into the stomach or small intestine.

Id. at 288-289 (O'Connor, J., concurring) (citing AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics, Op. 2.20 (1989) on the issue of withholding or withdrawing life-prolonging medical treatment); see also THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 59 (1987) (providing that consensus of medical community does not support maintaining distinction).

78. Justice O'Connor stated:

Requiring a competent adult to endure such procedures [insertion of nutrition and hydration mechanisms] against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

497 U.S. at 289 (O'Connor, J., concurring); The Supreme Court in *Cruzan* indicated in dicta that the constitutional right to refuse medical treatment encompasses the right to refuse artificial nutrition and hydration. Jill Hollander, *Health Care Proxies: New York's Attempt to Resolve the Right to Die Dilemma*, 57 BROOK. L. REV. 145, 168 (1991) (citing *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 288 (1990) (O'Connor, J., concurring)).

hydration issue was not before the Supreme Court in *Cruzan*, the Supreme Court's remarks may at least deter the passage of further legislation maintaining such a distinction.⁷⁹

Several other possible conflicts may occur in the use of living wills, one being a conflict with one's self: "[i]t is easy to envision instances of extreme dissonance between the perceptible interests of a now incompetent patient and the advance directive purporting to govern medical intervention for that patient."⁸⁰ For example, a person who is a "vitalist," (one who believes in preserving life at any cost) and specifies that s/he does not wish life support to be withdrawn for any reason, might later experience a great deal of unforeseen pain, which, if s/he was able, might cause the patient to retract an advance directive.⁸¹ Additionally, some individuals might word their advance directives in such a way that precludes a treatment or withdrawal of treatment not envisioned at that time.⁸² Therefore, statutes should require individuals to address the possibility of the development of new treatments. Lastly, a living will may conflict with a health care proxy, also executed by the individual, either by both documents specifically stating conflicting directions, or by giving the health care proxy the ability to make a decision when the living will has already dictated a clear action or non-action. Consequently, statutes dealing with life support issues should require or at least suggest clauses in any advance directive specifying which document will take precedent, or, as many statutes now do, state that the health care proxy must act consistently with the living will.⁸³

B. *Health Care Proxies*

Besides the term "proxy," two other terms have been used to designate a surrogate decision maker for the event of incompetence: "durable power of attorney," and health care "agent." All of these documents are prepared in the anticipation of incompetency and the wish to designate someone whom the individual trusts to make health care decisions on his or her behalf. As the states began to recognize living wills, many statutes have also recognized health care proxies and provided examples of desirable forms for this purpose.⁸⁴ Two problems may occur with the use of proxies: 1) the sur-

79. John Nicholas Suhr, Jr., *Cruzan v. Director, Missouri Department of Health: A Clear and Convincing Call for Comprehensive Legislation to Protect Incompetent Patients' Rights*, 40 AM. U. L. REV. 1477, 1512-13 and n.195 (1991).

80. Cantor, *supra* note 56, at 13.

81. *Id.* at 14.

82. *Id.* at 13-22; see also McCormick, *supra* note 32, at 32.

83. See *supra* notes 85-88 and accompanying text.

84. CONN. GEN. STAT. ANN. § 1-54a (West Supp. 1993); FLA. STAT. ANN. §765.203 (West Supp. 1993); ILL. REV. STAT. ch. 755, para. 40/5 *et seq.* (1993); IND. CODE ANN. §16-

rogate may allow his or her own feelings determine what to do rather than what the patient would have wanted (the surrogate may even act contrary to a living will); and 2) the surrogate may be subject to contrary restrictions by statutes.

Along with the growing enthusiasm for proxy decision making, ethical and empirical doubts have arisen about "whether proxies can select interventions that the patient would have selected."⁸⁵ Proxies are obviously prone to their own "biases, prejudices, and psychological agendas."⁸⁶ Some statutes even enable a surrogate decision-maker to override a patient's directives.⁸⁷ Connecticut and Hawaii, however, specifically forbid agents from voiding a declaration of a patient's wishes, and Arizona's, Oregon's, Florida's and Wisconsin's statutes require that the agent act in good faith consistent with any valid declaration executed by the patient.⁸⁸

While a health care proxy instrument leaves much to the discretion of someone other than the patient, it can be argued that proxy decision making may be more accurate than a sometimes-limiting living will.⁸⁹

Formal advance care documents completed months or even years before often utilize "general and imprecise" terms as well as vague hypothetical situations that may be only marginally related to the actual clinical circumstances. Proxies, on the other hand, make "real time" decisions. They have knowledge of the patient's specific situation and prognosis; they also have the opportunity for detailed discussions of the various treatment options with the physician and other health care staff.⁹⁰

As stated above, even if the proxy is able to make a decision which the patient would have made if competent, some statutes limit a proxy in what s/he can or cannot decide.⁹¹ For instance, in *In*

36-4-1 (West 1992 & Supp. 1994); IOWA CODE ANN. § 144B (West Supp. 1993); MICH. COMP. LAWS ANN. §700.496 (West Supp. 1993); MO. ANN. STAT. §404.820 (Vernon Supp. 1993); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:6 (1993); N.Y. PUB. HEALTH LAW § 2984 (McKinney 1993); N.C. GEN. STAT. §90-321(a)(2) (1993); OHIO REV. CODE ANN. § 1337.13 (Anderson 1993); OR. REV. STAT. § 127.530-.580 (1991); VA. CODE ANN. § 54.1 to 2986 (Michie 1991 & Supp. 1993); WIS. STAT. ANN. § 155.20 (West 1991).

85. Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy decision making for incompetent patients: an ethical and empirical analysis*, 267 JAMA 2067 (1992).

86. *Id.* at 2068.

87. See, e.g., Health Care Surrogate Act, ILL. ANN. STAT. Ch. 755 para. 40, *et. seq.* (Smith-Hurd 1993)

88. ARIZ. REV. STAT. ANN. § 36-3206 (1993); FLA. STAT. ANN. §§ 765.105, 765.205 (West Supp. 1993); HAW. REV. STAT. § 327D-4 (1993); OR. REV. STAT. § 127.535(4) (1991); WIS. STAT. ANN. § 155.20(5) (West 1991).

89. Emanuel, *supra* note 85, at 2068.

90. *Id.*

91. Erica F. Wood, *Guardianship: Legislative Developments*, 209 PRACTICING L. INST. 275, 303 (1992) (citing FLA. STAT. ANN § 744.3725 (current version at § 765.05)

re *Guardianship of Browning*,⁹² in spite of the fact that Mrs. Browning had a living will directing that she not be kept alive by artificial means, and had appointed a health care proxy who requested that her feeding tube be removed, the trial, district, and Florida Supreme Court refused to enforce the request based upon Florida living will law.⁹³ The Florida living will statute pertained only to those whose death was imminent, and at the time specifically excluded artificial sustenance from its definition of "life-prolonging procedures;"⁹⁴ because Mrs. Browning was not terminally ill, the court was forced to base its authorization of the removal from life support on her constitutional right to privacy.

In response to the *Browning* case, the Florida legislature passed a bill allowing individuals, through a living will, to refuse nutrition and hydration if they were not helping the patient get better, but the Act was vetoed by the governor.⁹⁵ In 1990, the legislature was able to amend its living will laws to allow terminally ill patients to have artificial nutrition withdrawn, but a health care agent still could not request their withdrawal if not specifically authorized by the advance directive.⁹⁶ However, 1992 amendments loosened these requirements further with the addition of surrogacy laws for those without formal proxies or advance directives.⁹⁷ Additionally, even if a patient has specifically requested that artificial nutrition be withdrawn under certain circumstances, the Florida statute still gives the patient's next of kin the right to negate the withdrawal for a reasonable length of time even though all of the living will requirements have been met.⁹⁸ Statutes such as Florida's which contain language regarding the rights of family members hold potential for additional conflicts.

(West 1986 & Supp. 1992); N.D. CENT. CODE §30.1-28-12(4) (1990); OKLA. STAT. ANN. tit. 63, § 3080.4 (current version at tit. 30, § 3-119(3))(West 1992 & Supp. 1993)).

92. 568 So.2d 4 (Fla. 1990).

93. *Id.*; see also HILTON, *supra* note 2, at 69.

94. Sarah J. Elliott, *Life and Death After Cruzan: Recent Developments in Right to Die Cases*, 7 HEALTHSPAN 12, 13 (1992).

95. HILTON, *supra* note 2, at 68-70.

96. FLA. STAT. ANN. § 765.075 (West 1986 & Supp. 1992) (repealed 1992).

97. FLA. STAT. ANN. § 765.401 (however, Florida's new terminology is inconsistent with that of other states: "surrogate" refers to a formal written appointment of a decisionmaker by the patient, while "proxy" refers to a person making the decisions where there is no document designating such).

98. FLA. STAT. ANN. § 765.105 (West 1993).

IV. FAMILY CONFLICT

While statutes giving family members the ability to override a patient's directives are rare, some statutes do give families decision-making power in the event that there is no advance directive.⁹⁹ Family members have traditionally been expected to make decisions for incompetent patients by physicians and the courts.¹⁰⁰ There is, however, some doubt as to whether families can make the best decisions for a relative when confronted with their personal feelings and interests. Incompetent family members may be both emotional and financial burdens and, therefore, "family, more than anyone else, may have a serious conflict of interest."¹⁰¹ However, many feel families generally "are motivated by affection and concern for their loved one, not a conflict of interest."¹⁰²

Making life or death decisions for someone is psychologically stressful. Surveys show that people are more hesitant to terminate care for a relative than for themselves. Thus, even if a patient's preferences are known, proxy decision makers may be hesitant to implement them, trying to avoid the moral and psychological responsibility for terminating life-sustaining treatments for a loved one.¹⁰³

Lastly, even family members may not know what the patient would have wanted.¹⁰⁴ However, if the law is tailored to allow family members to make health care decisions without conclusive knowledge of a patient's wishes, fewer court battles would arise while the patient's best interests may still be manifested:

Family members have a unique knowledge of the patient. [They] will know [his or her] lifestyle, values, medical attitudes, and general world view. . . . Even if no prior statements were made, in the context of the individual's entire prior mental life, including his or her philosophical, religious, and moral views, life goals, values about the purpose of life, . . . and attitudes toward sickness, medical procedures, suffering and death that the individual's likely treatment/non-treatment preferences can be discovered.¹⁰⁵

99. CONN. GEN. STAT. ANN. § 19a-571 (West Supp. 1993); ILL. ANN. STAT. ch. 755, §40/25 (Smith-Hurd 1992) (Health Care Surrogate Act); IND. CODE ANN. §16-36-1-5 (West 1992 & Supp. 1994); IOWA CODE ANN. § 144A.7 (West 1991 & Supp. 1992); LA. REV. STAT. ANN § 40:1299.58.5 (West 1992); MD. CODE ANN. HEALTH-GEN. § 5-605 (1993).

100. Emanuel, *supra* note 85, at 2067; *see, e.g., In re Quinlan*, 355 A.2d 647 (N.J. 1976); *In re Jobes*, 529 A.2d 434 (N.J. 1987).

101. Emanuel, *supra* note 85, at 2068 (quoting ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS* (1989)).

102. Joseph Fins, *When others must choose: Deciding for patients without capacity*, 93 N.Y. ST. J. MED. 204, 205 (1992).

103. *Id.*

104. *Id.*

105. *Id.*

Conflict can also occur *between* family members. Parents, spouses, adult children, and siblings can all have very different attitudes and interests toward the withdrawal of life support of a family member. Some statutes have attempted to deal with intra-family conflicts by listing family members (sometimes with friends and others) in order of their decision-making authority.¹⁰⁶ Illinois' statute attempts to deal with this problem by further specifying that if there is more than one person in a given category on the list, for example, three siblings, these people are asked to reach a consensus. If they fail to do so, they can make decisions by a majority vote.¹⁰⁷ At first glance, it may seem strange to statutorily rank those having decision-making authority and require them to "vote" on the life of a relative. However, I have seen evidence even in my own family of how certain family members may feel better able or more entitled to make decisions than others. This type of exclusion or disagreement can cause a great deal of division, resentment, and bitterness at a time when families should be drawing together. If statutes such as Illinois' dictates exactly who must make a decision, some intra-familial pressure may be relieved. The voting strategy may at least force families to discuss the issues from more than one angle.

The Ohio case, *Couture v. Couture*,¹⁰⁸ illustrates one type of intra-family conflict which may arise. The case involved the divorced parents of an incompetent adult child. Daniel Couture's mother was appointed guardian by the probate court after a hearing. At the guardianship hearing, she testified that it would be in Daniel's best interest to withdraw artificial nutrition and hydration. Her position was formulated with the advice of Daniel's physician and the support of other family members.¹⁰⁹ Consequently, Daniel's father objected and instituted legal proceedings in several forms to oppose and prevent the proposed withdrawal, including a petition to remove Ms. Couture as guardian.¹¹⁰ In spite of his father's protests, evidence was introduced of Daniel's prior statements and wishes.¹¹¹ However, for reasons unexplained, Ms. Couture voluntarily withdrew as guardian while the case was pending appeal and her ex-husband

106. CONN. GEN. STAT. ANN. § 19a-570(1) (West 1990 & Supp. 1992) (spouse, adult son or daughter, either parent, adult sibling, grandparent); FLA. STAT. ANN. § 765.401 (West Supp. 1993); IND. CODE ANN. §16-8-12-5 (Burns 1993) (for a minor: judicially appointed guardian, parent, adult sibling); ILL. ANN. STAT. ch. 755, act 40 § 25 (Smith-Hurd 1992); MD. CODE ANN., HEALTH-GEN. § 5-605(a) (Michie 1993).

107. Menikoff et al., *supra* note 31, at 1167 (discussing formerly ILL. ANN. STAT. ch. 110 1/2, para. 804-1 et seq. (Smith-Hurd 1991 & Supp. 1992)).

108. 549 N.E.2d 571 (Ohio Ct. App. 1989).

109. *Id.* at 572.

110. *Id.*

111. *Id.*

was appointed.¹¹² However, on appeal, the Ohio Ct. of Appeals held that the power-of-attorney-statute precluded the guardian from requesting the withdrawal of nutrition and hydration.¹¹³ This case demonstrates some of the familial and legal entanglements which can occur under present laws, even when all parties involved feel that they have the patient's best interests at heart.

Lastly, in the event that the patient has provided no advance directives, there is no guarantee that an elderly patient *has* a family to make a decision for him or her. Many elderly patients either have no known living relatives, or have no relative who wishes to make health care decisions on the patient's behalf. To be truly effective and comprehensive, our society should not promulgate laws which are based on ideal family situations. Even if laws are enacted granting families the authority to make health care decisions for an incompetent, where does that leave the right to refuse treatment for someone with no family? Who should make health care decisions for these patients? Most statutes leave this question unanswered.

V. SOLUTIONS AND CONCLUSIONS

The new federal Patient Self-Determination Act,¹¹⁴ which went into effect December 1991, is a step, though small, toward resolving some of the uncertainty in withdrawing life support. The Act requires Medicare and Medicaid accepting hospitals, health maintenance organizations, nursing homes, and home health agencies to provide a patient, upon admission, with written information concerning their right to execute advance directives under state law and to record any advance directives the patient might have.¹¹⁵ The theory behind the Patient Self-Determination Act appears to be that if the public is educated as to its rights regarding the termination of life support, more people will execute advance directives, and fewer conflicts will result.¹¹⁶ However, confronting people with life support issues and advance directives upon admission to a hospital may not be an optimal solution. Being admitted to a hospital for a health problem usually produces great stress, and may prevent many patients from easily or rationally making decisions regarding their possibly impending incompetency.¹¹⁷ Additionally, under the Patient

112. *Id.* at 572-73.

113. *Id.*

114. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388-115 (codified at 42 U.S.C.A. § 1395 cc. (West Supp. 1993)).

115. Charles P. Sabatino, *Health Decisions Power of Attorney*, CONSUMERS' RES. MAG., Feb. 1992, at 32.

116. Yuen, *supra* note 1, at 591-92.

117. Menikoff et al., *supra* note 31, at 1165.

Self-Determination Act, physicians, who are probably best prepared to enter into extended discussions leading to informed patient choices, are given no specific role.¹¹⁸ Consequently, admissions personnel or anyone else a hospital appoints, may be responsible for informing patients of their advance directive rights, and may not be able to answer questions at all, let alone engage in a discussion tailored to an individual's needs. It might be better to encourage physician involvement in this process, preferably in an office setting and before a major health problem arises.

The 1989 Uniform Rights of The Terminally Ill Act¹¹⁹ encourages states to draft legislation regarding treatment refusal rights. Unfortunately, this Act was not designed to apply to patients who are not terminally ill or have not executed advance directives¹²⁰ and, at least partly for this reason, no state has yet adopted it in its pristine form.¹²¹ Consequently, there is still a great need for more uniformity among the states on these important issues.¹²² Because of the vast group of people and many situations on which the Act provides no guidance, the time has come for a similar act by the federal government addressing these issues.

The most problematic difference among state statutes is the issue of withdrawal of artificial nutrition and hydration. As discussed previously, statutes should not distinguish this treatment from other forms of life support.¹²³ Further, the definition of "life support"

118. *Id.*

119. UNIF. RIGHTS OF TERMINALLY ILL ACT § 1, 9B U.L.A. 127 (Supp. 1994).

120. Suhr, *supra* note 79, at 1497. The author states:

The URTIA [Uniform Rights of the Terminally Ill Act], however, is limited in scope and provides no guidance for situations involving significant categories of patients. The URTIA does not encompass minors, persons who have not executed a declaration before becoming ill, adults who have never been capable of executing medical directives, and non-terminal patients who will never regain consciousness.

Id.

121. FURROW ET AL., *supra* note 60, at 1113. However, the Act does treat artificial nutrition and hydration the same as other methods of life support, *id.* at 1122, therefore, it is unfortunate that all the states did not adopt at least this part of the Act.

122. The decision of the United States Supreme Court to opt out of providing much constitutional guidance to the states may create a crazy quilt of state laws such that a patient who would have a "right to die" that could be exercised by his family in California or New Jersey would not have that right (or would not have a right that could be exercised by his family) in Missouri or New York. *Id.* at 1081.

123. "One of the most significant barriers to enforcement of an incompetent's wishes through the proxy mechanism is the [common] requirement that the principal's preferences regarding artificial nutrition and hydration must be specified before his or her agent is deemed to have the authority to decide these questions." Hollander, *supra* note 78, at 167. Unfortunately, this limitation on artificial nutrition and hydration has been encouraged by many state statutes, including the original legislation proposed by the New York State Task Force on Life and the Law, which did not address the issue at all

should be simplified and used consistently across the country. Perhaps the best definition of life support is *any* medical procedure or intervention which, when administered to a patient, serves to prolong the process of dying.¹²⁴ The federal government should again step in and provide some unified standards and definitions, since large differences in these statutes may encourage "forum shopping"¹²⁵ and restrict the right to free travel among the states.¹²⁶ Uniformity would also eliminate the problems inherent in executing an advance directive in one state and then later moving to another state with different requirements.

Besides uniformity, there are several specific, important changes that need to occur in both law and education. Obviously, physicians and other health care workers should be informed of new laws and their corresponding responsibility to recognize advance directives and proxies. It is especially important to convey the message that if physicians and health care workers follow advance directives they will be protected from liability. Additionally, health care facilities which disagree with a patient's or family's wishes to terminate life support should, in the very least, be required by legislation to allow another physician to come into that facility to discontinue the treatment when a transfer would be difficult.

Most importantly, state legislation needs to recognize and deal with the fact that many individuals will never execute any form of advance directive.¹²⁷ "[M]any people may not see a need to complete

(thereby leaving intact the current statute which makes the distinction). *Id.* at 161, 167. See also, AMA Council on Ethical and Judicial Affairs, *supra* note 74, at Op. 2.18 and *supra* note 63 and accompanying text.

124. This definition is adopted primarily from the Uniform Rights of the Terminally Ill Act. Suhr, *supra* note 79, at 1517 & n.212; see also, ME. REV. STAT. ANN. tit. 18-A, § 5-701 comment (West 1993) (discussing why Maine's legislators chose to simplify its definition and why other state statutes are confusing and problematic).

125. Early in 1991, the father and guardian of Christine Busalacchi sought to move his vegetative daughter to a clinic outside of Missouri (for consultation with a nationally known neurologist who happened to practice in a clinic which was not legally or ethically opposed to withdrawal of life support). The state of Missouri sought an order forbidding the move. The Missouri Court of Appeals determined that there was a need for a new hearing on the *reason* for the move. The court feared that Mr. Busalacchi was just trying to get his daughter into a state and clinic that would more easily permit the withdrawal of life support: "we will not permit [the] guardian to forum shop in an effort to control whether Christine lives or dies." FURROW ET AL., *supra* note 60, at 1082.

126. *Id.* at 1080-82. Also, see Shapiro v. Thompson, 394 U.S. 618 (1969) (discussing the requirement that "all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement"). *Id.* at 629.

127. Even among the large percentage of the public who express an interest in controlling their own care at the end of life, only a small proportion currently execute advance directives. Menikoff et al., *supra* note 31, at 1165 (footnote omitted).

an advance directive; they may be relying on their family members to make decisions for them when they are incompetent, and they may believe (perhaps incorrectly) that this will take place even if they fail to act."¹²⁸ In addition, even living wills do not help in decisions for minors, infants, or patients who have never been mentally competent.¹²⁹

Currently, many states presume that patients want treatment, "at any cost, monetary or personal - a conclusion that study after study demonstrates is contrary to the wishes of the great majority of the public."¹³⁰ This presumption results in thousands of incompetent, unconscious patients being sustained, perhaps against their will, causing needless family anxiety, clogging of the courts, uncomfortable and expensive legal delays, and the wasting of finite health care dollars.¹³¹ If an incompetent patient has not legally designated a health care proxy, courts and the law should automatically recognize a close family member (or friend if necessary) as surrogate decision maker.¹³² At least 28 states have laws of this sort, but others,

128. *Id.*

129. Edmund D. Pellegrino, *Ethics: Analysis of Patient Self-determination Act*, 268 JAMA 355 (1992).

130. Menikoff et al., *supra* note 31, at 1165.

131. Saving public resources is an important utilitarian benefit of advance directives. Their widespread use and implementation might well result in a reduction of expensive life-preserving medical machinery. Cantor, *supra* note 56, at 21.

At one county-run facility providing long-term care, there were more than 50 patients in a persistent vegetative state when the Illinois law [automatically designating health care surrogates for incompetents] took effect, virtually none of whom had executed advance directives. Under earlier Illinois law, even a court-appointed guardian would have had to go to court to request the termination of artificial hydration or nutrition for one of these patients.

Menikoff et al., *supra* note 31, at 1168. In the case of *In re Wanglie*, No. PX-91-283 (Minn. Dist. Ct., Probate Div., (1991)), the medical cost of maintaining Mrs. Wanglie (who was in a PVS and on a respirator) was \$45,000 per month; terminally ill patients account for a disproportionately high percentage of medical costs. California, for example, fails to provide public health services, except for the very poor, and those who have insurance are often restricted by limits. It is not uncommon for families to be forced to sell their homes to pay for the medical treatment of a relative. Yuen, *supra* note 1, at 583 (footnote omitted).

132. Suhr, *supra* note 79, at 1516. Florida and Illinois have recently enacted statutes allowing family and friends to act as surrogate decision-makers in the absence of a written proxy. FLA. STAT. ANN. § 765.401 (Supp. 1993), ILL ANN. STAT. ch. 755, § 40/25 (Smith-Hurd 1992). One solution that has been advocated is to reconceive the justification for proxy decision making. The President's Commission and others maintain that even if proxy decision makers cannot accurately predict the patient's preferences, social policy should honor a family's "good faith" decisions based on the patient's "best interests." This position is justified because "the family deserves recognition as an important social unit that ought to be treated, within limits, as a responsible decision maker in matters that ultimately affect its members"; because of the special "interpersonal union" among members; and because families "grieve for the patient's suffering and death." Emanuel, *supra*

like New York, assume a patient wants life support unless the family can prove otherwise at the highest standard of proof.¹³³ Unfortunately, it may be necessary for more individuals with the power to change state law to personally experience many of the problems discussed here before laws will change. New York's Governor Cuomo has recently proposed new laws dealing with life support issues in the wake of his personal struggle with his mother's incapacitation due to a stroke over two years ago.¹³⁴

The four dissenting Justices in *Cruzan* would recognize the decisions of a surrogate under appropriate circumstances; in her concurrence Justice O'Connor suggests that the duty to give effect to those decisions may well be constitutionally required.¹³⁵ Certainly, studies have shown that surrogate decisions are not always perfect. "Nonetheless, most of us would probably be more comfortable knowing that our family and friends are taking care of us than having such decisions made by bureaucrats,"¹³⁶ or relying on a court to find "clear and convincing" evidence of treatment wishes before life support may be withdrawn.¹³⁷ An analogy can be made to regular wills. Only 25% of Americans execute testamentary wills, yet most have some assets.¹³⁸ Many people do not bother to execute wills be-

note 85, at 2070.

133. *Better Law Needed to Help When Life Has Flown Away*, BUFF. NEWS, Feb. 7, 1993, at G8. Hearings began in Albany, New York, in February 1993, debating a health care surrogate bill prepared and pushed by the Task Force on Life and the Law. *Id.*

134. New York and Missouri are the only two states where the law explicitly denies family members authority to make life support withdrawal decisions. Cuomo's proposed law would enable family members to become surrogate decision makers. Nicholas Goldberg, *A Time to Die - Cuomo Proposes Law to Allow Kin to Pull Life Support*, NEWSDAY, Mar. 12, 1993, at 3.

135. "[T]he Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment." 497 U.S. at 289 (O'Connor, J., concurring). Otherwise States may frequently fail to honor a patient's intent. *Id.* at 301 (Brennan, Marshall, Blackmun, and Stevens, J., dissenting).

136. Menikoff et al., *supra* note 31, at 1166.

137. In a scholarly and cogent review of the case law, the [New York State] Task Force [on Life and the Law] illustrates how the doctrine of clear and convincing evidence came to dominate surrogate decision making in New York. More importantly, the report notes how this stringent criterion has failed to meet the needs of the incapacitated. Fins, *supra* note 102, at 204-05.

Under the Task Force's proposal, surrogates would be authorized to make treatment decisions for incapacitated patients without clear and convincing evidence of a patient's wishes, and without a living will or health care proxy instrument. Bioethics review committees would make sure that the surrogate's decision reflected the patient's best interests, as well as making health care decisions for those without any family. However, the provision for bioethics review committees seems to "undermine the deference which should be accorded to family members who serve as surrogates." *Id.*

138. Menikoff et al., *supra* note 31, at 1165.

cause the law provides a satisfactory fallback: assets go to the family anyway.¹³⁹ The same should be true for living wills; if a patient has given no previous indication of her/his wishes, the family should have the authority to decide life support issues. Legislation should list family members in the order of authority and provide guidelines for cases of intra-familial conflict, as in Illinois's statute discussed previously in section IV.¹⁴⁰ If the family member blatantly demonstrates that s/he does not have a patient's best interests in mind, *then* the courts can intervene.¹⁴¹

Beyond the problems created by differences between state laws and the individual shortcomings of state laws, there is the problem that advance directives are useless unless the family, physicians, and health care agents know of them ahead of time and are willing to recognize them. If a health care agent is designated, an individual should give the proxy as much information as possible regarding what the individual's wishes are should s/he become incapacitated.¹⁴² Also,

[t]he best way to avoid [the problem of 'third-party reluctance'] is to talk to health care providers to make sure they understand the document and have no objections to following it. If objections arise, [patients] need to work them out, or . . . choose to change physicians. Once [an individual] signs a[n advance directive], [s/he must] give a copy of it to [his or her] attending physician.¹⁴³

Additionally, any type of advance directive should be indicated in every patient's chart.

139. *Id.*

140. ILL. ANN. STAT. ch. 755, act. 40, § 45/4-1 (Smith-Hurd 1993).

141. Blatant disregard for a patient's best interests might be demonstrated by a family member who does not visit the patient, who expresses obvious dislike for the patient, or who states that s/he is motivated by a possible death benefit. Clearly, not all relatives who disregard a patient's best interests will be obvious about it. However, if a health care worker senses an uncaring attitude on the part of the relative, s/he can always try to obtain a court order stopping the withdrawal of life support. The idea is to take the burden of proof off the much more common caring relative who *is* concerned with the patient's best interests. This will make it much easier for concerned families to decide that a patient's interests would best be served by a dignified death.

The suspicion that families and physicians would fail to serve the needs of patients and loved ones, however, seems counterintuitive. Mandated approval of decisions to withdraw or withhold burdensome life-sustaining therapy from patients who are neither terminally ill nor permanently unconscious seems to improperly question the standing and judgment of family and medical professionals. This skepticism seems particularly unfounded when surrogate and physician are in agreement about a course of action.

Fins, *supra* note 102 at 205.

142. McCormick, *supra* note 32, at 33.

143. Sabatino, *supra* note 115, at 34.

Individuals need either to be educated or to educate themselves regarding newly legislated rights to refuse treatment, dictate what types of treatment they might wish in the event of incompetency, and designate health care proxies. Physicians can do their part by informing patients of new laws routinely, and lawyers can make individuals aware of these issues when clients request estate assistance. Advance directives and proxy forms should be executed along with testamentary wills. Despite the difficulties involved, the "multiplicity of prospective medical situations" should not prevent individuals from executing advance directives:

[a]lthough it might not be possible to formulate a comprehensive directive which anticipates all possible situations because of the limits of one's imagination, every competent person is capable of addressing a few precepts or guidelines regarding his future medical care. A person can articulate certain principles—whether grounded on religious scruples, personal philosophy, or personal notions of dignity—which will be relevant across a wide spectrum of medical conditions.¹⁴⁴

Individuals should be encouraged to execute both a living will and a health care proxy, and to combine them in one document if possible.¹⁴⁵ This way, one document cannot supersede the other, but will necessitate dual consideration. A consolidated document, as well as discussing issues with a proxy in advance, will insure that a surrogate decision maker adheres to specific guidelines, thereby making it easier to represent the patient's wishes.¹⁴⁶ Even if one or both types of advance directives are uncertain or unrecognized in a particular state, a consolidated document will still carry substantial "moral weight" if there is ever a question of an incompetent's best interests.¹⁴⁷

144. Cantor, *supra* note 56, at 17.

145. Sabatino, *supra* note 115. "A designation may include a statement of the patient's desires on care, custody, and medical treatment." MICH. COMP. LAWS ANN. §700.496 (West Supp. 1993).

146. Emanuel, *supra* note 85, at 2071. Alone, advance directives and substituted judgments (either by proxies or another appointed surrogate decision maker) may both be problematic. At times, there are good reasons to overrule advance directives, such as when a new treatment could help a patient who did not anticipate the advancement in an overly-specific living will. Also, surrogates may misconstrue or misrepresent the patient's wishes because of serious financial or emotional conflicts of interest. "These difficulties would seem to favor executing both instructional and proxy directives." Pellegrino, *supra* note 129, at 355.

147. See Cantor, *supra* note 56, at 33.

Encouraging patients to execute advance directives is a worthy goal. Although such documents are certainly not perfect and may in many instances be difficult to interpret, it is usually much easier to determine and respect a patient's wishes when there is an advance directive than when the patient has left no indication of his or her wishes.

Menikoff et al., *supra* note 31, at 1165 (footnote omitted).

In summary, there are two categories of problems that need to be addressed in the realm of life support. First, individuals, hospitals, and all health care workers need to be educated on their rights and protections. Second, current state and federal laws fall short of addressing all of the issues involved in the withdrawal of life support, breeding confusion, conflict, and too great a difference in the rights of patients in different states to die with dignity. Education, clarification of terms and concepts, and uniformity on the part of state statutes, as well as laws ensuring that *all* patients will have the right to withdraw life support, must be encouraged both by state and federal action.