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Time for a New Law on Health Care Advance Directives

by

GEORGE J. ALEXANDER*

During the last decade, states have enacted three different kinds of documents to deal with health care of incompetent patients. The legislation's main impetus and central focus have been to provide a procedure to approve life support termination in appropriate cases, although it also addresses other health care concerns. The earliest of the statutes was a natural death act, which authorizes a directive, popularly called a living will, to physicians. The second was a general durable power of attorney, sometimes in the form of a specially crafted health care durable power of attorney, which essentially empowers an appointed agent to make appropriate decisions for an incompetent patient. The agent is bound by directions contained in the appointing power. Finally, some states have enacted family consent laws empowering others, typically family, to decide health care matters absent a directive or power of attorney to guide them. At the end of 1990, Congress gave these laws new importance by mandating their observance.

The statutes differ;¹ provisions of one form conflict with provisions of another form.² Most contradictions raise problems, some nettlesome, others destructive of important interests. After more than a decade of experience with such forms, it is time to review the present state of the laws and to coordinate and debug them. In the author's view, a single statute incorporating the best of each of the three types of law is now in order. This Article suggests guidelines for that effort.

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The author thanks his research assistants, Kathleen Roberts and Stephen K. Meyer, for their tireless research in support of this Article.

1. See Beschle, *Autonomous Decisionmaking and Social Choice: Examining the "Right to Die,"* 77 Ky. L.J. 319, 335 (1989).

2. See generally Waters, *Florida Durable Power of Attorney Law: The Need for Reform,* 17 FLA. ST. U.L. REV. 519 (1990) (arguing that Florida's durable power of attorney law is not in harmony with the 1989 guardianship reforms).

The Article builds on the assumption that the state primarily is interested in assisting patients to control their own medical destinies. Regrettably, it is not clear that all present law is so premised, but there are powerful reasons it should be. Paternalism often has been repudiated domestically, but is now on the defensive throughout much of the world.

Human autonomy is expressing itself as a paramount concern even in places that would have seemed unlikely spawning grounds just a few years ago.³ Whatever else can be concluded about this development, it should be recognized that the desire for self-expression is a universal trait of overwhelming significance. National paternalism stands repudiated despite the substantial efforts of many governments to meet the needs of their constituents. The democracy wave has substituted its amalgam of wills for national planning.

Within the United States one hardly need compose a brief for self-governance. This country began as a noble experiment in universal suffrage over two hundred years ago. Despite an unswerving devotion to democratic principles, however, the country has had to awaken itself to the limits of popular participation. For almost a century, blacks were disenfranchised;⁴ for a longer period, the same was true of women.⁵ It is not always self-evident that pockets of powerlessness remain.

Among those presently disenfranchised are those said to be incompetent. Chief in that group are the frail elderly. Of course, because the elderly are our parents and friends we have not devised a system demonstrably uncaring. We simply have substituted the voices of the elderly with that of court appointed agents—normally called guardians, conservators, or a variety of less common names (“conservators”)—allowing the conservators to plan the welfare of their wards. Some conservators are deeply sensitive and compassionate. They usually are shocked when accused of working against the interests of their wards. Self-determination, however, is no less desired locally than it is nationally. Conservatorship has failed repeatedly. It is in a constant state of “reform,” but reform does not alter its fatal flaw:⁶ conservatorship deprives the elderly of their cherished freedom to decide.

3. See, e.g., Raufman, *Tunnel at End of the Light for Eastern Europe; Upheaval in Eastern Europe One Year Later*, Boston Globe, Oct. 21, 1990, National/Foreign, at 1; *Reunification of Germany*, L.A. Times, Oct. 17, 1990, at B6, col. 2.

4. See U.S. CONST. amend. XV (enacted in 1870, disallowing the denial of the right to vote based on racial grounds).

5. See U.S. CONST. amend. XIX (enacted in 1920, disallowing the denial of the right to vote based on gender).

6. Alexander, *Avoiding Guardianship*, ____J. ELDER ABUSE ____ (1990) (forthcoming).

Conservatorship has failed not only theoretically⁷ but practically as well. Indeed, the abuses of the sixties appear to be the abuses of the nineties.⁸ In the late seventies the author suggested adopting advance directives as an alternative to depriving people of their decisionmaking authority in the face of their declining capacities.⁹ An advance directive enables a competent person to govern what happens after incompetency.

The idea of the advance directive was to create a document that would adopt the free form of contracts and express the will of its maker in the maker's terms.¹⁰ What has emerged is far more complicated. Government again has asserted itself in the conditions that attach to the documents.

The rationale for advance directives is, of course, their enhancement of autonomy: they enable persons to protect their futures by foreclosing the plans of others to determine their destinies.¹¹ In that respect, they fundamentally differ from conservatorships. Both conservatorship and advance directives attempt to deal with problems arising in a future in which the person is unable to make competent decisions. Conservatorship imposes societal solutions and a court appointed enforcer.¹² Advance directives, however, provide either an agent to enforce a patient's stated desires or instruct physicians how their patient wants to be treated.

To some extent, forms of directives are a product of their history. The earliest type of law enacted to authorize directives, the natural death act, was popularly named a living will. The author has referred to durable powers of attorney for health care, the next set of directives, as second generation living wills. The new proposal embodied

7. As I have written about the abuses of conservatorships for a quarter of a century, I shall not repeat the discussion other than to refer the reader to a sampling of prior comments: G. ALEXANDER, *WRITING A LIVING WILL: USING A DURABLE POWER OF ATTORNEY* (1988) [hereinafter *WRITING A LIVING WILL*]; G. ALEXANDER & T. LEWIN, *THE AGED AND THE NEED FOR SURROGATE MANAGEMENT* (1972) [hereinafter *SURROGATE MANAGEMENT*]; Alexander, *Death by Directive*, 28 SANTA CLARA L. REV. 67 (1988) [hereinafter *Death by Directive*]; Alexander, *Premature Probate: A Different Perspective on Guardianship for the Elderly*, 31 STAN. L. REV. 1003 (1979) [hereinafter *Premature Probate*].

8. Compare *SURROGATE MANAGEMENT*, *supra* note 7, at 9 (hypothesizing that "surrogate management . . . is conducted in the specific interest of some person other than the incompetent" with Friedman & Savage, *Taking Care: The Law of Conservatorship in California*, 61 S. CAL. L. REV. 273, 285 (1988) (noting that conservatorships sometimes are sought to protect the interests of the conservator rather than the ward).

9. See *Premature Probate*, *supra* note 7, at 1031.

10. *Id.* at 1018.

11. See *id.* at 1006.

12. See, e.g., CAL. PROB. CODE § 1800.3 (West Supp. 1991) (authorizes court to appoint a conservator of the person or estate of an adult).

in this Article is for a third generation living will incorporating the first directive and its improvements.

Each of the three types of documents has an important function, and the three varieties can coexist fairly well despite their independent enactments and lack of extensive cross-referencing. Combining their provisions into a single law would clarify the alternative methods of health care decision making for incompetent persons.

Following the prominent plight of Karen Quinlan,¹³ California led the country in passing a law designed to allow patients in terminal stages of disease to give directives to physicians to inform them of the patients' desires concerning life support.¹⁴ Currently, natural death acts modelled on that law exist in forty-two other states.¹⁵ California

13. See *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976) (with concurrence of guardian and family, no criminal or civil liability may attach for discontinuation of life support of patient in persistent vegetative state upon medical determination of no reasonable possibility of recovery and after consultation with hospital ethics committee or similar body).

14. See CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1990).

15. See Alabama Natural Death Act, ALA. CODE §§ 22-8A-1 to 10 (1981); Alaska Rights of the Terminally Ill, ALASKA STAT. §§ 18.12.010-.100 (1990); Arizona Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. §§ 36-3201 to 10 (1986 & Supp. 1989); Arkansas Rights of the Terminally Ill or Permanently Unconscious, ARK. STAT. ANN. §§ 20-17-201 to -202 (1987 & Supp. 1989); Colorado Medical Treatment Decision Act, COLO. REV. STAT. §§ 15 18 101 to 113 (1989 & Supp. 1990); Connecticut Removal of Life Support Systems, CONN. GEN. STAT. ANN. §§ 19a 570 to -575 (West Supp. 1990); Delaware Patient's Right to Terminate Treatment, DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); District of Columbia Natural Death Act of 1981, D.C. CODE ANN. §§ 6-2421 to 2430 (1989); Florida Right to Decline Life-Prolonging Procedures, FLA. STAT. ANN. §§ 765.01-.15 (West 1986); Georgia Living Wills Act, GA. CODE ANN. §§ 88 4101 to -4112 (Harrison 1986 & Supp. 1989); Hawaii Medical Treatment Decisions Act, HAW. REV. STAT. §§ 327D 1 to -27 (Supp. 1989); Idaho Natural Death Act, IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1990); Illinois Living Will Act, ILL. REV. STAT. ch. 110 1/2, paras. 701 710 (1988); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. §§ 16 8 11 1 to -22 (Burns 1990); Iowa Life-Sustaining Procedures Act, IOWA CODE ANN. §§ 144A.1-.11 (West 1989); Kansas Natural Death Act, KAN. STAT. ANN. §§ 65-28,101 ,109 (1985); Louisiana Declaration Concerning Life-Sustaining Procedures, LA. REV. STAT. ANN. §§ 40:1299:58.1-.10 (West Supp. 1990); Maine Living Wills, ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1989); Maryland Life Sustaining Procedures, MD. HEALTH GEN. CODE ANN. §§ 5-601 to -614 (1990); Minnesota Adult Health Care Decisions, MINN. STAT. ANN. §§ 145B.01 .17 (West Supp. 1990); Mississippi Withdrawal of Life-Saving Mechanisms, MISS. CODE ANN. §§ 41-41 101 to -121 (Supp. 1990); Missouri Declarations, Life Support, MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1990); Montana Living Will Act, MONT. CODE ANN. §§ 50 9 101 to -206 (1989); Nevada Withholding or Withdrawal of Life-Sustaining Procedures, NEV. REV. STAT. ANN. §§ 449.540-690 (Michie 1986 & Supp. 1989); New Hampshire Terminal Care Document, N.H. REV. STAT. ANN. §§ 137-H:1 to :16 (Supp. 1989); New Mexico Right to Die Act, N.M. STAT. ANN. §§ 24 7 1 to -11 (1986); North Carolina Right to Natural Death; Brain Death, N.C. GEN. STAT. §§ 90 320 to -323 (1989); North Dakota Uniform Rights of Terminally Ill Act, N.D. CENT. CODE §§ 23-06.4 01 to -14 (Supp. 1989); Oklahoma Natural Death Act, OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West

also was the leader in enacting second generation living wills, durable powers of attorney for health care.¹⁶ Thirty-two states have adopted second generation living wills¹⁷ and further adoptions are almost certain. In addition, general durable power of attorney laws were pressed into similar service in several states by amendments expressly providing that the laws govern health care decisions as well.¹⁸ Finally, a third round of laws¹⁹ recently has been passed appointing members of the

Supp. 1990); Oregon Directive to Physician, OR. REV. STAT. §§ 127.605-650 (Supp. 1990); South Carolina Death with Dignity Act, S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1989); South Dakota Health Care Consent Procedures, S.D. CODIFIED LAWS ANN. §§ 34-12C-1 to -8 (Supp. 1990); Tennessee Right to a Natural Death Act (Living Wills), TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1990); Texas Natural Death Act, TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (Vernon Supp. 1990); Utah Personal Choice and Living Will Act, UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1989); Vermont Terminal Care Document, VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); Natural Death Act of Virginia, VA. CODE ANN. §§ 54.1-2981 to -2992 (1988 & Supp. 1990); Washington Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1990); West Virginia Natural Death Act, W. VA. CODE §§ 16-30-1 to -10 (1985); Wisconsin Natural Death Act, WIS. STAT. ANN. §§ 154.01-15 (West 1989); Wyoming Living Will Act, WYO. STAT. §§ 35-22-101 to -109 (1988).

16. See CAL. CIV. CODE § 2400 (West Supp. 1989).

17. See ARK. STAT. ANN. § 20-17-202 (1989); CAL. CIV. CODE § 2431 (West Supp. 1990); DEL. CODE ANN. tit. 16, § 2502 (1983); D.C. CODE ANN. § 21-2201 (1989); 1990 Fla. Laws 223; GA. CODE ANN. § 31-36-1 (Harrison 1990); IDAHO CODE § 39-4505 (1990); ILL. ANN. STAT. ch. 110 1/2, para. 802-1 (Smith-Hurd Supp. 1990); IND. CODE ANN. § 16.8-12-5 (Burns 1990); IOWA CODE ANN. § 144A.7(1)(a) (West 1989); 1989 Kan. Sess. Laws 181; 1990 Ky. Acts 123; LA. REV. STAT. ANN. § 40:1299.58.1 (West Supp. 1990); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (Supp. 1990); MD. EST. & TRUSTS CODE ANN. § 13-601 (1981); MINN. STAT. ANN. § 145(B).01 (West Supp. 1990); MISS. CODE ANN. § 41-41-151 (Supp. 1990); NEV. REV. STAT. ANN. § 449.810 (Michie Supp. 1989); 1990 N.Y. Laws 752; OHIO REV. CODE ANN. § 1337.12 (Baldwin Supp. 1989); OR. REV. STAT. § 127.510 (Supp. 1990); R.I. GEN. LAWS § 23-4.10-1 (1989); S.D. CODIFIED LAWS ANN. § 59-7-2.5 (Supp. 1990); TENN. CODE ANN. § 34-6-202 (Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 4590h-1 (Vernon Supp. 1990); UTAH CODE ANN. §§ 75-2-1105 to -1106 (Supp. 1989); VT. STAT. ANN. tit. 14, § 3453 (1989); VA. CODE ANN. § 54.1-2986(2) (1988); WASH. REV. CODE ANN. § 11.94.046 (Supp. 1990); W. VA. CODE § 16-30A-3 (Supp. 1990); 1989 Wis. Laws 200; WYO. STAT. § 35-22-102 (1988).

These laws differ from state to state in several significant respects, some of which are addressed below.

18. See LA. REV. STAT. ANN. § 40:1299.58.1 (West Supp. 1990); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (Supp. 1990); WASH. REV. CODE ANN. § 11.94.046 (Supp. 1990).

19. See CONN. GEN. STAT. ANN. § 19a-571 (West Supp. 1990); D.C. CODE ANN. § 21-2210 (1989); FLA. STAT. ANN. § 744.304 (West 1986 & Supp. 1990); IDAHO CODE § 39-4303 (1985); IND. CODE ANN. § 16-8-3-3 (Burns 1990); IOWA CODE ANN. § 255.11 (West 1985); MD. HEALTH-GEN. CODE ANN. § 20-107 (1990); N.M. STAT. ANN. § 24-7-8.1 (1986); N.Y. PUB. HEALTH LAW § 2972 (McKinney 1989); N.C. GEN. STAT. § 90-322 (1985); S.C. CODE ANN. § 44-77-10 to -80 (Law. Co-op. 1990); S.D. CODIFIED LAWS ANN. § 34-12C-3 (Supp. 1990); TEX. HEALTH & SAFETY CODE ANN. § 672.009 (Vernon Supp. 1990); UTAH CODE ANN. § 75-2-1107 (Supp. 1990); VA. CODE ANN. § 54.1-2986 (1988); WASH. REV. CODE ANN. § 7.70.065 (Supp. 1990); W. VA. CODE § 16-5c-5a (Supp. 1990).

These family consent laws allow the appointment of specified family members as health care surrogates without court intervention.

family as health surrogates in the absence of a prior writing by an incompetent patient.²⁰

Of course, advance directives are not necessary for everyone. To the extent that one trusts the conservatorship process, there is little cause to make a directive, aside from avoiding the expense of obtaining the conservatorship appointment. Thus, a directive requiring acts that would not be expected from a conservator should be treated as a probable rejection of the conservatorship remedy. For example, directions to buy speculative stocks, to sell personal jewelry absent financial pressure to do so, to administer experimental drugs or perform experimental surgery, and certainly to remove life support would seem to indicate a knowing choice of outcomes that could not be expected from state administration.

A patient may create an advance directive merely to inform physicians of the patient's wishes, but that effort is hardly worthwhile if the desired treatment is ordinary care. To the extent a patient makes a choice among acceptable alternatives, the patient appears also to make a decision not to allow others to make that choice. Even if a patient makes a directive out of concern that the state would not deal with her medical needs by appointing a conservator, such a directive probably would be limited to facilitating the appointment of either a conservator or an agent. She thereby could not account for other provisions. Thus, having made a directive, especially a detailed one, a person should be assumed to have chosen self-direction over paternalistic care. As a corollary, the state should not impose a conservator in the alleged best interests of the ward since the ward has indicated that she considers the directive to be a superior method of guiding care.²¹

Probate is an apt analogy here.²² Probate law provides for two forms of distribution upon death. If a person cares to have control over how the estate is distributed, she writes a will. There are numerous limits on what can be directed,²³ but in the main, property passes as the testator wished. If there is no valid will, the state provides

20. The list of cases is growing in which courts attempt to achieve a result appropriate for a particular patient without the benefit of an advance directive. For a discussion of these cases, see *Death by Directive*, *supra* note 7, at 86-92.

21. This analysis depends on whether the maker understands the consequences of her acts and knows about available alternatives. If this is an incorrect assumption about a substantial number of present directives, it certainly would become a more correct assumption under the author's proposed new law.

22. See *Premature Probate*, *supra* note 7, at 1018.

23. For example, a testator may not intentionally omit a surviving spouse from her will or bequeath the family house to the detriment of her surviving spouse and children. J. RITCHIE, N. ALFORD & R. EFFLAND, *DECEDENTS' ESTATES AND TRUSTS* 146, 152, 182 (7th ed. 1989).

for distribution by intestacy.²⁴ The state's purpose is to get property into the right hands and to settle the estate by using *the state's* conception of what most people would (or should) want. If one likes the state's distribution scheme there is little reason to expend the time and money to make a will.

Most states appear to have modelled advance directives in this manner. Several expressly have indicated that the purpose of the directive is to avoid conservatorship or have provided ways to avoid the interference of a conservator if one is appointed.²⁵ Others have adopted the contrary position and have subordinated an agent appointed by a directive to a conservator.²⁶ Subordination, of course, invalidates the choice not to accept statutory solutions because the conservator likely will be bound to the state's general principles governing conservatorship rather than to the terms of the advance directive. At a minimum, the maker is deprived of the choice of administrator and, consequently, the guarantee of her chosen outcomes.

Subordination should run in the opposite direction. If a person appoints an agent under an advance directive, a court should appoint a conservator, if at all, only for matters not governed by the directive. Since conservatorship is established for those who cannot properly arrange for their needs, making an advance directive that appoints a person to satisfy needs arguably obviates the need for an additional appointment.²⁷

Of course, conservatorship can be viewed and actually can function as a means of checking abuses by durable power agents or physicians. As a solution to the problem of abuse, however, conservatorship is grossly overbroad. Other ways exist to chasten errant delegates. Statutes generally provide for court review of the handling of an advance directive on a petition supported by evidence of abuse.²⁸ Financial agents routinely are required to give accountings as conservators presently are required to do.²⁹ The directive itself might require the agent to be accountable to a named person or group on penalty of losing the agency in favor of an alternate agent. If a maker is particularly concerned about interference with her wishes, however, there

24. *Id.* at 85.

25. *See, e.g.*, GA. CODE ANN. § 31-36-6(c) (Harrison 1990).

26. *See, e.g.*, COLO. REV. STAT. § 15-18-112 (1989); MINN. STAT. ANN. § 145B.03 subd. 3 (West Supp. 1990).

27. *Cf. In re Estate of Brooks*, 32 Ill. 2d 361, 374, 205 N.E.2d 435, 443 (1965) (holding that it is unconstitutional to appoint a conservator without notifying a patient to obtain consent to a blood transfusion if such transfusions are against the patient's religion).

28. *See, e.g.*, CAL. CIV. CODE §§ 2431-2444 (West Supp. 1991).

29. *See, e.g.*, CAL. PROB. CODE § 2620 (West Supp. 1991).

should be a method (though not an easy one) for making an advance directive unchallengeable. For example, one might borrow from the California Durable Power of Attorney law³⁰ the provision rendering difficult a challenge to the directive if an attorney has attested that she has fully informed the maker of the meaning of its provisions.³¹ Also, the state should allow the potential ward to nominate a conservator if one is to be appointed.³² One can anticipate and block some overreaching by disqualifying people such as health care providers and nursing home operators from accepting agency in an advance directive.³³ Naturally, any such disqualification deprives the maker of some degree of free choice, but the disqualification can be justified by the anticipated conflict of interest that otherwise might result.

Although most of the present legislative restrictions to autonomous choice are contained in natural death acts, there are similar complications in the durable powers of attorney statutes as well.³⁴ The principal focus of many of these restrictions has been on what is popularly called the right to die.³⁵ As impediments to autonomous choice, these restrictions must be reexamined.

To be sure, each state has an interest in the life and welfare of its citizens. The state's interest in a patient's life, according to the United States Supreme Court, is compelling.³⁶ Since many issues concerning the health care of incompetent patients, especially life support termination, are complex and difficult, it is understandable that various states arrive at different compromises among competing interests.³⁷ The clashing viewpoints on life support termination make it unlikely that there will be universal agreement.³⁸ The fact that most

30. CAL. CIV. CODE §§ 2400 2423 (West Supp. 1991).

31. *See id.* § 2421.

32. *See, e.g.*, MINN. STAT. ANN. § 145B.03 subdiv. 3 (West 1989).

33. *See, e.g.*, GA. CODE ANN. § 31 36 5(b) (Harrison 1990).

34. *See, e.g.*, CAL. CIV. CODE § 2435 (West Supp. 1991) (A durable power of attorney may not authorize the attorney in fact to consent to commitment of the principal to a mental health facility, or to consent to shock therapy, psychosurgery, sterilization, or abortion on behalf of the principal.)

35. For example, some states restrict the removal of hydration and nutrition or require that patients be terminally ill before a directive's provisions apply. *See generally* Mayo, *Constitutionalizing the "Right to Die,"* 49 MD. L. REV. 103 (1990) (arguing that the constitutional right of privacy does not extend to decisions made on behalf of permanently unconscious patients to have life-sustaining treatment discontinued and that continued state supervision is appropriate).

36. *See generally* Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990) (upholding a state's right to require clear and convincing evidence of a patient's wish in proceedings in which a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state).

37. *See Death by Directive, supra* note 7, at 77 79.

38. *See Note, I Have a Conscience, Too: The Plight of Medical Personnel Confronting*

(perhaps all) states agree that a terminal patient who desires treatment stopped and has clearly and competently so indicated has a right to refuse further medical aid³⁹ provides support for at least a provision of this type in a new law. Claims of a state interest in life or preventing suicide seem fairly feeble in this context.⁴⁰

There are, of course, other concerns about authorizing patient autonomy respecting the right to die. Aside from the strong moral and religious opposition,⁴¹ such permission might lead to disguised murder. More commonly, it surely would create psychological pressure on the patient to stop the expense, both financial and emotional, that critical care usually represents. Still, with medical science increasingly capable of keeping patients alive artificially, the incidence of the need to make life termination decisions increases.⁴² Presently, seventy percent of the deaths occurring at a hospital result from the termination of treatment.⁴³

The disabled may warrant special concern. Representatives of the disabled have led the opposition to any easing of the life support removal bans (let alone promoting euthanasia) on the ground that devaluing life will result in their charges' harm.⁴⁴ At the least, treatment will be less heroic; perhaps there will be stronger pressure to accept the desirability of ending the lives of the disabled. The specter of the Nazis' elimination of those they called unworthy of life springs to mind.⁴⁵ It may be true of the elderly, in general, that to ease an end to life is to jeopardize life. No easy answer exists to such problems except alertness to their possibility. Ultimately, the danger of their eventuation must be weighed against the pain of keeping those alive who have decided rationally, without outside pressure, that death with dignity is preferred. To the author, the latter seems the more difficult choice to make.

the Right to Die, 65 NOTRE DAME L. REV. 699, 710 (1990) (authored by Irene Prior Loftus) (discussing *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988), wherein the individual patient's self-determination interest was held to outweigh the state's interest in preserving life, preventing suicide, protecting innocent third parties, and maintaining the integrity of medical ethics); see also Beschle, *supra* note 1, at 333 (noting that theoretically diverse approaches of Massachusetts and New York courts on treatment termination both essentially require the court to determine the choice an incompetent would make were she competent).

39. See *Death by Directive*, *supra* note 7, at 86; *Cruzan*, 110 S. Ct. at 2851.

40. See *Death by Directive*, *supra* note 7, at 79, 97.

41. See *Cruzan*, 110 S. Ct. at 2853.

42. See *Death by Directive*, *supra* note 7, at 69, 97.

43. *Dying: Fear of Being Suspended in a Vegetative State Has Triggered an Unprecedented Demand for Living Wills Since High Court Ruling*, L.A. Times, July 17, 1990, at E1, col. 4.

44. See Peters, *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891, 938-45 (1989).

45. K. BINDING & A. HOEHE, *DIE FREIGABE DER-VERNICHTUNG LEBENSUNWERTEN LEBENS* (Leipzig' 1920).

An additional countervailing interest is sometimes urged on behalf of dependent children.⁴⁶ The loss of support gets little consideration in most life support termination cases because the former supporter generally cannot assist the dependent child either financially or psychologically because of imminent death. A notable exception is that a majority of states bar the termination of the life supporting care of a pregnant woman.⁴⁷ A few limit such negation of the woman's choice to pregnancies involving viable fetuses or fetuses that could develop to viability.⁴⁸ The latter seem in line with the present constitutional resolution of the abortion question.⁴⁹ The majority of states, which negate an advance directive that would lead to the maker's death, seem dubious. So long as women remain free to choose to have an abortion in the first trimester for any reason or none at all, imposing a higher standard of review on terminal patients appears to violate constitutional privacy doctrine as it now stands.

Can it be true that a state has a sufficient interest in a pregnancy (even one likely doomed by the ill health of the mother) to force a prospective mother to carry a child whom she probably will not have

46. See *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (sustaining a hospital's administration of emergency blood transfusion to a patient whose religious convictions prohibited such measures and whose husband refused to authorize transfusion on similar grounds, when the hospital was exposed to potential civil and criminal liability for failing to take appropriate action, when the patient was the mother of a seven month old child whose "abandonment" it was in the state's interest to prevent, and when the patient's voluntary presence in the hospital gave rise to the inference that she wanted her life preserved though she could not "consent" to the means of doing it).

47. See ARIZ. REV. STAT. ANN. § 36 3205 (1986); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990); CONN. GEN. STAT. ANN. § 19a 574 (West Supp. 1990); DEL. CODE ANN. tit. 16, § 2503 (1983); FLA. STAT. ANN. § 765.08 (West 1986); GA. CODE ANN. § 88-44103 (Harrison Supp. 1989); HAW. REV. STAT. § 327D-6 (Supp. 1989); IDAHO CODE § 39-4504 (Supp. 1990); IND. CODE ANN. § 16-8 11 11 (Burns 1990); KAN. STAT. ANN. § 65-28,103 (1985); MD. HEALTH-GEN. CODE ANN. § 5 605 (1990); MISS. CODE ANN. § 41-41 107 (Supp. 1990); MO. ANN. STAT. § 459.025 (Vernon Supp. 1990); NEV. REV. STAT. ANN. § 449.610 (Michie 1986); N.H. REV. STAT. ANN. § 137 H:14 (Supp. 1989); N.D. CENT. CODE § 23 06.4 03 (Supp. 1989); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1990); S.C. CODE ANN. § 44 77 70 (Law. Co op. Supp. 1989); TEX. HEALTH & SAFETY CODE ANN. § 672.019 (Vernon 1990); UTAH CODE ANN. § 75 2-1109 (1990); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1990); WIS. STAT. ANN. § 1514.03 (West 1989).

48. See ALASKA STAT. § 18.12.040 (1986); ARK. STAT. ANN. § 20 17 206 (Supp. 1989); COLO. REV. STAT. § 15 18 104 (1989); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith Hurd Supp. 1990); IOWA CODE ANN. § 144A.6 (West 1989); MONT. CODE ANN. § 50-9 202 (1989); UNIF. RIGHTS OF TERMINALLY ILL ACT § 6, 9B U.L.A. 75 (Supp. 1990).

49. See *Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040 (1989) (upholding state statute requiring physicians to perform fetal viability tests on women believed to be at least twenty weeks pregnant); *Roe v. Wade*, 410 U.S. 113 (1973) (subsequent to viability, state may regulate and even proscribe abortion except when necessary to preserve the life or health of the mother).

a chance to nourish? Can the state constitutionally choose between the two lives and cause the woman's death by procedures designed to save the child?

Under *Roe v. Wade*, the state must consider not only the mother's physical burden of the period of gestation but also the mother's interest in the life she may bring into the world.⁵⁰ Until a state can establish a right to interfere in a healthy person's decision not to give birth, the state should not be allowed to require a woman to give birth to a child doomed to be motherless. At the moment, the law seems to bar a state from merely inquiring about the reason for a woman's decision if she is a competent adult.

Many courts, however, have long recognized an additional interest in the medical profession that impinges on the rights of patients.⁵¹ If physicians, in general, or the specific treating physician object to a call to cease treatment, that objection often is entitled to some weight. A majority of states have addressed the possible conflict between the treating physician and the patient by providing in their physician directive laws for the transfer of a patient by a doctor offended by the patient's wishes.⁵² In many states, however, this conflict remains unresolved by statute. Although physicians ordinarily are involved in treatment and, thus, in treatment cessation, their most pressing interests should be satisfied if they are not required to participate in treatment cessation to which they are opposed. A fair balance between

50. See *Roe*, 410 U.S. at 153.

51. See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 589-91 (D.R.I. 1988) (The integrity of medical ethics is subordinate to the wishes of the patient. If prompt transfer of the patient to a facility that would respect the patient's wishes is impractical, the objecting hospital must terminate nutrition and hydration.); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (Hospital should not be compelled to withhold food and water contrary to generally established and accepted medical principles to comply with guardian's wishes. Hospital must assist guardian in transferring ward to suitable facility where guardian's wishes may be effected.).

52. See ALA. CODE § 22-8A-8 (1990); ALASKA STAT. § 18.12.050 (1986); ARIZ. REV. STAT. ANN. § 36-3204 (1986); ARK. STAT. ANN. § 20-17-207 (Supp. 1989); CAL. HEALTH & SAFETY CODE § 7191 (West Supp. 1990); COLO. REV. STAT. § 15-18-113 (1989); D.C. CODE ANN. § 6-2427 (1989); FLA. STAT. ANN. § 765.09 (West 1986); GA. CODE ANN. § 88-4108 (Harrison 1986); HAW. REV. STAT. § 327D-11 (1985); IDAHO CODE § 39-4508 (Supp. 1990); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IOWA CODE ANN. § 144A.8 (West 1989); KAN. STAT. ANN. § 65-28,107 (1985); ME. REV. STAT. ANN. tit. 22, § 2926 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-604 (1990); MINN. STAT. ANN. § 145B.06 (West Supp. 1990); MISS. CODE ANN. § 41-41-115 (Supp. 1990); MO. ANN. STAT. § 459.030 (Vernon Supp. 1990); MONT. CODE ANN. § 50-9-203 (1989); N.H. REV. STAT. ANN. § 137-H:6 (Supp. 1989); N.D. CENT. CODE § 23-06.4-08 (Supp. 1989); TENN. CODE ANN. § 32-11-108 (Supp. 1990); UTAH CODE ANN. § 75-2-1112 (1990); VA. CODE ANN. § 54.1-2987 (1988); WASH. REV. CODE ANN. § 70.122.060 (Supp. 1990); WIS. STAT. ANN. § 154.07 (West 1989); WYO. STAT. § 35-22-104 (1988).

the pain of a dying patient and a physician's moral code would seem to justify depriving an offended physician of a more decisive role. A new act should explicitly adopt the transfer requirements already in use in a number of states.

Present natural death acts were not written to be all-inclusive. They typically recite that they do not affect other rights.⁵³ The natural death acts were born of a problem newly realized and are riddled with restrictions presumably attributable to excessive caution and lack of experience.⁵⁴ As a result, express provisions were made for the possibility of less restrictive treatment at common law. In contrast to the natural death acts, durable powers actually were borrowed from estate practice, a field in which they were not a novelty. In asset management, durable powers generally carry few restrictions;⁵⁵ thus, although only the basic durable power law has been adopted, few legislative restrictions attach to health care provisions. In the laws specifically passed to deal with health care, some of the excessive caution of natural death acts was carried forward.⁵⁶ As a general matter, however, these laws are still much less restrictive than natural death acts.⁵⁷

It is a current curiosity that the strictures of natural death acts can be avoided by not making a directive at all⁵⁸ or by creating a durable power. Since the passage of the early natural death acts, there has been extensive examination of treatment termination issues. Appellate courts have written thoughtful opinions on the subject to guide lower courts.⁵⁹ Currently, there are enough carefully reasoned opinions that each state should be capable of writing a clearer, more comprehensive statute.

Natural death acts focus on instructions to physicians. A new law should have provisions with the same focus. These provisions specifically might contain whatever restrictions the state wishes to impose on self-determination of death, permitting options and dropping the present statement that these options are not in derogation of other rights. Presumably, by drawing on a number of court decisions resolving such issues, these restrictions could be significantly less onerous than those in present natural death acts. At least the statutes

53. See, e.g., TENN. CODE ANN. § 32-11-110 (Supp. 1990); W. VA. CODE § 16-30-9 (1985).

54. See, e.g., FLA. STAT. ANN. § 765.08 (West 1986) (prohibiting the discontinuation of medical treatment if the patient is pregnant).

55. WRITING A LIVING WILL, *supra* note 7, at 50.

56. See, e.g., CAL. CIV. CODE § 2436.5 (West Supp. 1991) (requiring renewal of durable power for health care every seven years).

57. See *supra* note 17.

58. *In re Estate of Greenspan*, 137 Ill. 2d 1, 25-28, 558 N.E.2d 1194, 1202-03 (1990).

59. Many of the cases are reviewed in *Death by Directive*, *supra* note 7, at 78-92.

should be sufficiently flexible to encourage rather than deter the creation of directives.

With respect to a wish to have life support terminated, present natural death act statutes (and even durable power for health care laws) tend to be quite limited. For example, although statutes generally allow the removal of respirators and ventilators and the request for do-not-resuscitate orders by advance directive, most stop short of authorizing means of effecting what is popularly known as death with dignity.⁶⁰ No statute authorizes lethal injection, for example, even under circumstances in which a patient may die by withholding medical aid. Many physician directive statutes forbid the termination of hydration and nutrition even when food and liquids are administered by intubation.⁶¹ These statutes intentionally discriminate between persons who have a mortal dependency on medical treatment and those who will survive if normal needs for food and shelter are provided. Although courts generally have placed tubal nutrition and hydration in the medical treatment category,⁶² physician directive statutes often appear to prohibit any form of terminating the supply of food and liquids.⁶³

It is curious that physician directive statutes that were spawned by the plight of Karen Quinlan would not have helped resolve her case. She, as many after her, was in a coma and might have survived for an indefinite period so long as food and fluids were continued.⁶⁴ As it turned out, she did not, but many patients in persistent vegetative states may live for decades in that condition, given shelter, food, and

60. See, e.g., CAL. CIV. CODE § 2443 (West Supp. 1991) (prohibiting provisions for mercy killing or suicide).

61. ALA. CODE § 22-8A-3 (1990); ALASKA STAT. § 18.12.040 (1990); ARIZ. REV. STAT. ANN. § 36-3201 (1986); ARK. STAT. ANN. § 20-17-206 (Supp. 1989); CONN. GEN. STAT. ANN. § 19a-570 (West Supp. 1990); D.C. CODE ANN. § 6-2421 (1989); FLA. STAT. ANN. § 765.03 (West 1986); GA. CODE ANN. § 84-4102 (Harrison 1986); HAW. REV. STAT. § 327D-4 (Supp. 1989); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IND. CODE ANN. § 16-8-11-4 (Burns 1990); IOWA CODE ANN. § 144A.2 (West 1989); KAN. STAT. ANN. § 65-28,102 (1985); ME. REV. STAT. ANN. tit. 22, § 2922 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-602 (1990); MO. ANN. STAT. § 459.010 (Vernon Supp. 1990); MONT. CODE ANN. § 50-9-202 (1989); N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1989); N.D. CENT. CODE § 23-06.4-02 (Supp. 1989); OKLA. STAT. ANN. tit. 63, § 3102 (West Supp. 1990); OR. REV. STAT. § 127.605 (Supp. 1990); S.C. CODE ANN. § 44-77-20 (Law. Co-op. Supp. 1989); TENN. CODE ANN. § 32-11-103 (Supp. 1990); UTAH CODE ANN. § 75-2-1103 (1990); WIS. STAT. ANN. § 154.01 (West 1989); WYO. STAT. § 35-22-101 (1988).

62. See *Death by Directive*, *supra* note 7, at 82.

63. See, e.g., N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1989) (life sustaining procedures that may be terminated "shall not include the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to provide comfort or eliminate pain").

64. Friedrich, *A Limited Right to Die*, *TIME*, Jul. 9, 1990, at 59.

liquids.⁶⁵ A few states expressly permit the inclusion of a provision to terminate food and liquids along with other directives but do not prohibit such acts without this provision.⁶⁶ Some of these states limit removal authority to documents that expressly so direct.⁶⁷

The result, in any event, is curious. Depending upon the form of statute and the type of patient need, some may have their suffering ended by using a directive while others may not. If nothing short of ending feeding and the supply of liquids will result in death, even patients in states permitting directives to include hydration and nutrition removal will probably at best die slowly by dehydration. Physicians are directed to make the patients as comfortable as possible during that time.⁶⁸ Nonetheless, the procedure appears cruel, which suggests it eventually may be replaced with a more palatable alternative. Active euthanasia is, of course, still extremely controversial.⁶⁹

Even one of the least controversial forms of treatment for terminal patients, do-not-resuscitate orders, may raise difficult problems. For a variety of reasons, a number of terminally ill people prefer to die outside of hospitals. They may wish to refuse treatment should they have heart failure or otherwise be stricken while at home or in a public place.⁷⁰ In such circumstances, do-not-resuscitate orders may be demanded in advance directives. These orders should not be difficult to implement in a hospital. In public, on the other hand, they become very hard to enforce. Emergency medical personnel understandably are trained indiscriminately to resuscitate and transport the victim to a medical facility. Even if other problems concerning the appropriateness of refusal of life support are solved, it may be unreasonable for a person who lives in our society to expect not to be treated if stricken ill in a public place. The core of the problem is not

65. *Id.*

66. See IDAHO CODE § 39 4504 (Supp. 1990); MINN. STAT. ANN. § 145B.03 (West Supp. 1990).

67. See, e.g., COLO. REV. STAT. § 15-18 104 (1989 & Supp. 1990).

68. See, e.g., ALA. CODE § 22-8A-4 (1990); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith Hurd Supp. 1990); ME. REV. STAT. ANN. tit. 22, § 2925 (Supp. 1989).

69. *But see* Bouvia v. Superior Ct., 179 Cal. App. 3d 1127, 1147, 225 Cal. Rptr. 297, 307 (1986) (Compton, J., concurring). Compton stated,

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

Id.

70. See, e.g., New York's Do-Not Resuscitate Law, N.Y. PUB. HEALTH LAW §§ 2960, 2978 (McKinney Supp. 1990).

legal but practical. Emergency forces have enough to do without becoming concerned with the state of advance directives when they arrive at the scene. Yet important reasons may justify allowing terminal patients who can do so to leave hospitals if they wish. For example, discharging these patients may free needed space, be less expensive, and allow more contact with loved ones. It seems more civilized to allow terminal patients a final surrounding of choice rather than the forced interior of an institution.

One might devise a way to wear identification indicating the wish not to be resuscitated, but that probably would be ineffective. Emergency personnel might well wonder whether the decision was made legally and correctly and even who attached the identification. Emergency personnel might want medical input. A registration system with a central emergency center might handle the problem. Once an appropriate do-not-resuscitate order is issued, the patient would receive an identification with an index number to be carried on the person of the patient. The identification could be discovered (ideally by the person calling for emergency aid) and a radio check on its validity and the identifying characteristics of the person who made the advance directive could be obtained from the registry. The check potentially could be completed before arrival at the scene. At worst, it could be initiated immediately on contact by emergency personnel. A registration system should be legislatively authorized.⁷¹

Even under the circumstances most favorable to following an advance directive, it does not seem likely that a state legislature would enact a statute that allows lethal injection. Assisting suicide generally is a criminal act despite the direction of the person who dies.⁷² In most of the civilized world, assisted dying is prohibited.⁷³

The Netherlands is a notable exception:⁷⁴ euthanasia is well established, but at least at the moment, there appears to be no provision for assisting foreigners wishing to die. Perhaps that will change. Perhaps other countries will adopt the position of the Netherlands. Possibly some states will enact an assisted suicide law. Recently, such an initiative was proposed in California, but did not make the ballot.⁷⁵

71. Santa Cruz County, California, has a system for processing advance directives. The 911 emergency operator checks a file for registered physician directives before dispatching emergency aid.

72. See Peters, *supra* note 44, at 963.

73. See generally *Death by Directive*, *supra* note 7.

74. *60 Minutes: The Last Right?* (CBS television broadcast, Jan. 5, 1986); *Washington State Confronts Euthanasia*, Wash. Post, Feb. 6, 1991, at A7, col. 2.

75. Proposed "Humane and Dignified Death Act," November 1988.

Public opinion polls seem to favor a similar type of provision for the terminally ill.⁷⁶

If a terminally ill person could travel to a place in which active assistance in dying was provided, would advance directives be allowed to authorize transportation of the maker for that purpose? This problem might be anticipated in drafting current documents.

Of course, treatment cessation is not the only issue of concern. While directives to physicians are limited to life support instructions, durable powers of attorney also can direct the many medical (and financial) issues that can be anticipated to arise on incapacity. An improved advance directive law should allow the maker this option as well. After all, incompetents may well require a variety of treatments, and there is no reason to require the appointment of either an agent or conservator to insure that physicians serve the patient as the patient wishes. To ensure that the broader potential does not delay addressing issues relating to dying, the law should allow codicils to expand the original directive like will codicils.⁷⁷

At the same time, teeth should be put into directives to physicians. So long as the medical community ignored advance directives, the directives could be seen as either useless or only marginally effective.⁷⁸ Such a perception was likely to become self-fulfilling. Life support is almost invariably supplied in hospitals. Increasingly, the primary site of death is hospitals.⁷⁹ Physicians appear generally to believe that treatment decisions are theirs to make; some even believe that they have interests which must be balanced *against* the wishes of their patients. Some courts agree.⁸⁰

Undoubtedly, the recent congressional passage of provisions concerning advance directives will address these problems. The Omnibus Budget Reconciliation Act of 1990⁸¹ requires Medicare providers to take an active role in informing patients about their right to participate in and direct health care decisions and requires providers to encourage and honor advance health care directives. It further mandates that each provider maintain written policies⁸² ensuring that patients are given written notice of their rights to control medical treatment under state

76. *Right to Die: The Publics View*, N.Y. Times, June 26, 1990, at A18, col. 2 (81% of persons polled would allow a feeding tube to be removed from a comatose individual with no brain activity upon the request of family).

77. See J. RITCHIE, N. ALFORD & R. EFFLAND, *supra* note 23, at 7.

78. See Mayo, *supra* note 35, at 146.

79. *Death by Directive*, *supra* note 7, at 69.

80. Note, *supra* note 38, at 707 n.53.

81. Pub. L. No. 101 508, 104 Stat. 1388 (1990).

82. *Id.* § 4206(f)(1).

law, including the right to make an advance directive,⁸³ and that patients' medical records are marked to indicate whether advance directives exist.⁸⁴ To ensure that decisions are made freely, the act prohibits conditioning medical care (or otherwise discriminating) on whether such a directive has been executed.⁸⁵ Finally, the Act provides that the provider must ensure compliance with both common law and statutory state law respecting advance directives⁸⁶ and educate the staff *and the community* about advance directives.⁸⁷ When the law becomes effective in 1992, its impact on issues discussed in this Article should be substantial.

States may want further to support patient control. To that end the proposed law might criminalize the refusal to follow a proper directive and make refusal actionable by private injunctive proceedings. Awarding attorney fees to the winning party may be justifiable and would dissuade harassing law suits against physicians while enabling agents without ample resources to pursue actions. Whether these additional enforcement measures are required might be best assessed after the federal law has had a chance to alter present practices. The routine inquiry about directives by hospitals and others should reduce the apprehension that patients presently exhibit.

One of the most promising aspects of the congressional provision is its requirement that medical staffs be educated about advance directives. If physicians become better informed, they may become effective promoters of such documents. At the moment, physicians are not well informed. One study found that eighty-five percent of California physicians surveyed either knew nothing or little about advance directives.⁸⁸ It is appropriate to urge a patient to consider making an advance directive incident to a routine hospital admissions.⁸⁹ The routine exercise of the request will lessen its threatening nature.

Of course, the necessity for a directive stems from the incapacity of the principal. Some states prohibit anyone from exercising health care powers while the maker is competent.⁹⁰ All states allow a com-

83. *Id.* § 4206(f)(1)(a)(i).

84. *Id.* § 4206(f)(1)(B).

85. *Id.* § 4206(f)(1)(C).

86. *Id.* § 4206(f)(1)(D).

87. *Id.* § 4206(f)(1)(E).

88. Zimberg, *Decisions for the Dying: An Empirical Study of Physician's Responses to Advance Directives*, 13 VT. L. REV. 445, 472 (1989).

89. Lowry, *Led by Court, Hospitals Take New Interest in Living Wills*, N.Y. Times, July 23, 1990, at A1, col. 1.

90. *See, e.g.*, CAL. CIV. CODE § 2434 (West Supp. 1990); IDAHO CODE § 39-4505 (Supp. 1990); W. VA. CODE § 13-30A-3 (Supp. 1990).

petent maker to revoke the instrument. A greater problem exists with respect to a maker who, though now legally incompetent, wishes to change a directive.

Some statutes at least allow the revocation of authority to remove life support if the patient can communicate, irrespective of whether he or she is then thought to be competent.⁹¹ At a minimum, a new statute should have such a provision. Decisions about competency are controversial. They should not be allowed to interfere with an announced decision not to die. After all, had the patient not given authority for a contrary position, life would have been maintained as a routine application of state law.

The result of revoking the authority to remove life support, however, is permanent. If an incompetent patient revokes, the presumption of competence cannot be used to revive the document or make a new one. There is, in other words, relatively easy revocation but not easy reinstatement. Although that rule is symmetrical, it is not sensible. The states presume competency revocation, defying the customary treatment of incompetency for strong policy reasons. The reasons for allowing patient self-determination are also strong. There are alternatives to voiding the document because of a change of mind. For example, the document might be considered suspended by the change of mind and the suspension dropped if the patient again sought its ends. The absence of continued resistance might end the suspension. Family or courts might be empowered to reinstate the document, even absent competent consent, subject to the patient's refusal assuming that the patient is in a condition to communicate refusal. Thus, the deliberate, competently chosen outcome would prevail over the effects of hesitation.

A related problem is whether states will require that advance directives be reexecuted periodically or whether they will allow older documents to govern conduct at a significantly later time. Most states allow directives, once valid, to remain in force indefinitely.⁹² California, however, requires their reexecution periodically.⁹³ Periodic

91. See, e.g., ALASKA STAT. § 18.12.020 (1986); D.C. CODE ANN. § 6-2424 (1989); HAW. REV. STAT. § 327D 12 (Supp. 1989); OKLA. STAT. tit. 63, § 3104 (Supp. 1990).

92. See, e.g., WIS. STAT. ANN. § 154.05 (West 1989) (providing that a directive is valid unless revoked or superceded by the express wish of a competent patient).

93. California requires physician directives to be reexecuted every five years. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990) (California requires the reexecution of durable powers for health care only every seven years. CAL. CIV. CODE § 2436.5 (West Supp. 1990)). Wisconsin and Idaho had similar requirements for physician directives but dropped them. IDAHO CODE § 39-4506 (1985) (current version at § 39.4507 (Supp. 1990)); WIS. STAT. ANN. § 1154.03 (West 1989).

reexecution is necessary only if a person remains competent or regains competency.

Most physician directive statutes also avoid the problem of outdated documents by requiring that the maker be in a terminal condition at the time of execution.⁹⁴ The original directive statute, enacted in California, takes an extreme view by requiring diagnosis of the terminal condition two weeks before the document becomes binding.⁹⁵ Colorado requires one week.⁹⁶ Studies indicate that these waiting provisions effectively bar most people from executing the document.⁹⁷

Desires expressed earlier in life or while in better health may exaggerate the limitations that age and infirmity actually impose. Commonly, many persons happily accept living with physical limitations they once would have thought unbearable.⁹⁸ Whether that supports dismissing an earlier writing is another matter. As the advance directive represents a position once formally adopted, it likely represents a deliberate position worthy of implementation. After all, it could have been revoked by the maker. Alternatively, an intermediate position could be adopted that would give the advance directive diminished effect with the passage of time.⁹⁹ Longevity of the document alone does not justify completely disregarding the expressed views of the maker.

The third generation advance directive should deal sensitively with this complex issue. Perhaps the best direction lies in requiring the maker to specify in the document any desired form of assistance in dying beyond suspension of medical machinery such as removal of tubal feeding or suspension of chemotherapy. It might be better to provide a substitute for starvation and dehydration as the only acceptable means of allowing a person not dependent on medical machinery to die. Once we confront the fact that removal of food and water kills all patients,¹⁰⁰ a form of more direct and less gruesome help can be accepted as an alternative. Careful screening would be required to ensure against the previously mentioned improprieties.

94. Only Arkansas and Texas allow patients who are not in a terminal condition to execute advance directives. ARK. STAT. ANN. § 20-17-202 (1987); TEX. REV. CIV. STAT. ANN. art. 4590h-1 (Vernon Supp. 1991).

95. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990).

96. COLO. REV. STAT. § 15-18-104 (Supp. 1990).

97. Redleaf, *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 STAN. L. REV. 913, 928 (1979).

98. Peters, *supra* note 44, at 914.

99. Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 768 n.125.

100. See *Death by Directive*, *supra* note 7, at 84.

A further word on the implementation of directives to allow dying is in order. Some consideration must be given to ensuring that a decision to be allowed to die remains acceptable to the patient. Life support termination decisions may cause almost immediate death, as in the case of turning off a ventilator for a dependent patient. On the other hand, they may cause death more slowly, as in the case of the removal of a feeding tube.¹⁰¹ In the latter case, there appears to be no good reason for postponing action once it is determined that the decision was appropriately made and has not been repudiated. In the former, it may be wise to provide for a short term postponement to assure a cooling off period. During the cooling off period anyone who has the right to object to the procedure, including, of course, the patient if she can communicate, can effect a change in the cessation of treatment. Because many people who have made and confirmed a decision to be allowed to die change their mind, the law should allow a short time, after all other hurdles are crossed, for sober last minute contemplation.

Whatever choices are made concerning the issues discussed, durable powers of attorney for health care should provide the model for providing instructions on health care. Comparable provisions should deal with asset management. No directive can be as effective as an agent charged with carrying out instructions. The concept is good and needs little adjustment, but it does require the maker both to craft a document and to find a trusted agent to make it work. Actually, regression might be in order because durable power laws were less complicated when they merely addressed asset management before the new class of health care durable power laws were passed.

An additional problem of conflict of laws has not yet spawned reported cases. In an increasingly mobile society, it is unrealistic to expect that the drafter of advance directives necessarily will be in the state in which the document was drawn or, for that matter, in her then home state. A few statutes accommodate that problem by enforcing a document that is valid in the state in which it was made.¹⁰² Minnesota accepts a directive that substantially complies with its own law.¹⁰³ At the opposite extreme lie California and Oregon, which prescribe a form to be used or at least prescribe a number of necessary provisions that

101. *See id.* at 84.

102. ALASKA STAT. § 18-12.090 (1986); ARK. STAT. ANN. § 20-17-212 (Supp. 1989); ME. REV. STAT. ANN. tit. 22, § 2930 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-612 (1990); MONT. CODE ANN. § 50-9-111 (1989); OKLA. STAT. tit. 63, § 3103.1 (Supp. 1991); UNIF. RIGHTS OF TERMINALLY ILL ACT § 13, 9B U.L.A. 80 (Supp. 1990).

103. MINN. STAT. ANN. § 145B.15 (West Supp. 1990).

might well be omitted in a draft prepared elsewhere.¹⁰⁴ Worse yet, the requirements of those states differ from each other. The requirement that specific provisions or forms be used does not foreclose a court from accepting a conflicting document made by persons not under the state's jurisdiction at the time.¹⁰⁵

The great majority of states do not prescribe the precise form or mandate the inclusion of specific provisions. They allow different forms and they do not resolve the conflicts of law question. Although their laws probably raise fewer problems than the restrictive states' statutes, they are not ideal either. The conflicts question is yet to be resolved, and it still remains open to the courts to refuse to enforce an out of state form.

No state appears to require its courts to allow the appointment of an agent who, because she is located outside the state, may not be easily amenable to the state's laws. Although a court seemingly could condition enforcement of a directive on the agent's voluntary compliance with state requirements, the uncertainties involved do not provide peace of mind for elders. The new law should contain a provision validating a directive that complies with the requirements of the maker's state of domicile when the directive was made. The state also could impose other requirements from its own laws if the maker becomes a domiciliary. Even then, the document should at least be accepted in any legal proceeding as an indication of the maker's wishes.

Natural death laws do not require the appointment of agents. That feature removes a nagging problem of durable powers of attorney. Many elders may have significant trouble finding a willing and able agent who is likely to remain healthy and competent. Many elders have no one. On the other hand, the presence of someone with legal authority to enforce the patient's wishes increases the likelihood of those wishes being effectuated. Although physicians must follow physician directives, patients by definition are incompetent to make—let alone enforce—their directives when the time comes. Because patients enforce their own mandates, many physicians likely control the medical fate of their patients.¹⁰⁶ At least, elders may fear that their documents are ineffectual.

104. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990); OR. REV. STAT. § 127.610 (Supp. 1990).

105. Some statutes now so provide. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4590h-1, sec. 13 (Vernon Supp. 1991).

106. See *Fear of Being Suspended in a Vegetative State Has Triggered an Unprecedented Demand for Living Wills Since High Court Ruling*, L.A. Times, July 17, 1990, at E1, col. 4.

The third generation living will could resolve the problem by enlarging the group of persons who are available for selection as attorney-in-fact. Since the primary reason for appointing an agent outside of available family probably is the avoidance of family interference with an elder's wishes, the agent need not be a close relative of the elder. It suffices that the person is willing to follow the provisions of the durable power and that she is competent to act. A corps of volunteers willing to serve such a purpose might be relatively easy to develop since there are already many models of community elder support. It would seem a worthy project for one of the many community-minded service organizations to adopt; perhaps funding for the organization of such groups might be appropriate. The sponsoring group could undertake training and supervision of volunteers. Laws should be amended to allow such organizations to be named as either the principal agent or as an alternate agent in an advance directive.¹⁰⁷

At present, advance directives end at death. It might be wise to allow an agent-based directive to exist long enough for the agent to have an autopsy conducted as a means of enforcing predeath medical directives.¹⁰⁸

One commentator has suggested that the doctrine of *cy pres* might be adapted to give effect to a maker's perspectives given changed circumstances.¹⁰⁹ Thus, the intent of the maker might be effectuated by substituting a feasible means of execution for one that has become impossible.

The fact that only those with an advanced education are likely to use physician directives and powers of attorney supports finding an appropriate alternative. Physician directive and powers of attorney put a high premium on expression skills and on experience with legal documents.¹¹⁰ Many people made wards under conservatorship laws

107. Health care durable power of attorney laws generally require that the health agent be a named person. See, e.g., Oregon Durable Power of Attorney for Health Care, OR. REV. STAT. §§ 127.505 .585 (1989).

108. See, e.g., GA. CODE ANN. § 31 36-7 (Harrison 1990) (agent may be empowered to make an anatomical gift, authorize an autopsy, or direct the disposition of a principal's remains); ILL. ANN. STAT. ch. 110 1/2, para. 802-5 (Smith-Hurd Supp. 1990) (unless agency states an earlier termination date, the agency continues until the death of the principal); KAN. STAT. ANN. § 58-625 to -632 (Supp. 1989) (agent may make decisions about organ donation, autopsy, and disposition of the body); MINN. STAT. ANN. § 145B.03 (West Supp. 1990) (since "health care" needs to cease at death, presumption must be that agency also ceases); TENN. CODE ANN. § 34-6-201 (Supp. 1990) (health care is limited to treatment decisions, thus creating the presumption that the agency ends at death).

109. Gelfand, *supra* note 99, at 794 n.254.

110. *Doing Justice to Life; For the Cruzans, Pain for Principle, a Triumph*, N.Y. Times, June 27, 1990, at A22, col. 1.

likely do not possess either skill.¹¹¹ If the law is to apply to all classes, the new law should provide alternative directions in the event that the dying person has never provided written directions. Of course, every effort should be made to facilitate the use of durable powers and directives, but not providing an adequate alternative is probably insensitive to the differences among people.

A significant problem lies in the small number of directives that presently are prepared. Death is an unpleasant subject that most people avoid discussing or even considering. Although in a recent poll the majority of those questioned approved of living wills, only fifteen percent had made one.¹¹² On the other hand, fifty-six percent had informed family members of their wishes.¹¹³ The recently passed of federal law can be expected to increase the number of directives drawn.

To some extent, it is inappropriate to require that people use these documents rather than other alternatives when the intent is to promote self-determination. More effort must be made, however, to lessen the burden of making directives. State-approved forms, already available in most states,¹¹⁴ are useful especially if they do not limit the ability of the maker to direct conduct in other terms. These forms provide an inexpensive and uncomplicated means of preserving a person's wishes.

Whether a thoughtful, literate person would adopt a form might depend on the extent to which that person had specific concerns that

111. In the New York study of guardianship, a large number of wards were state charges who, presumably, often would be undereducated. *SURROGATE MANAGEMENT*, *supra* note 7.

112. *L.A. Times*, July 17, 1990, at E1, col. 4.

113. *Developments in the Law Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1647 n.35 (1990).

114. See ALA. CODE § 22-8A-4 (1990); ALASKA STAT. § 18.12.010 (1986); ARIZ. REV. STAT. ANN. § 36-3202 (1986); ARK. STAT. ANN. § 20-17-202 (Supp. 1989); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990); COLO. REV. STAT. ANN. § 15-18-104 (1989); CONN. GEN. STAT. § 19a-575 (West Supp. 1990); D.C. CODE ANN. § 6-2422 (1989); FLA. STAT. ANN. § 765.05 (West 1986); GA. CODE ANN. § 31-32-3 (1986); HAW. REV. STAT. § 327D-4 (Supp. 1989); IDAHO CODE § 39-4504 (Supp. 1990); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IND. CODE ANN. § 16-8-11-12 (Burns 1990); IOWA CODE ANN. § 144A.3 (West 1989); KAN. STAT. ANN. § 65-28,103 (1985); LA. REV. STAT. ANN. § 40:1299:58.3 (West Supp. 1990); ME. REV. STAT. ANN. tit. 22, § 2922 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-602 (1990); MINN. STAT. ANN. § 145B.04 (West Supp. 1990); MISS. CODE ANN. § 41-41-107 (Supp. 1989); MO. REV. STAT. § 459.015 (Supp. 1990); MONT. CODE ANN. § 50-9-103 (1989); NEV. REV. STAT. ANN. § 449.610 (Michie 1986); N.H. REV. STAT. ANN. § 137H:3 (Supp. 1989); N.C. GEN. STAT. § 90-321 (1985); N.D. CENT. CODE § 23-06.4-03 (Supp. 1989); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1990); OR. REV. STAT. § 127.610 (Supp. 1990); S.C. CODE ANN. § 44-77-50 (Law. Co op. Supp. 1989); TENN. CODE ANN. § 32-11-105 (Supp. 1990); TEX. HEALTH & SAFETY CODE ANN. § 672.004 (Vernon Supp. 1990); UTAH CODE ANN. § 75-2-1104 (1990); VT. STAT. ANN. tit. 18, § 5253 (1987); VA. CODE ANN. § 54.1-2984 (1988); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1990); WYO. STAT. § 35-22-102 (1977); UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9B U.L.A. 70 (Supp. 1990).

would not be protected by the form. In that regard, it would be especially useful to have an authoritative interpretation of the form provisions enacted along with them. While the interpretations would not be as binding as the language of the form, they would provide a first step in dealing with ambiguities. The issue is of sufficient importance to make form drafting the subject of educational campaigns.

Finally, in the event that a person does not create a physician directive or durable power appointment, a statute could take care of problems without the necessity of court intervention. The new statute might continue to name the persons who would be empowered to act on behalf of the patient absent a directive and further be broadened to express the totality of health care the state would allow them to direct. Depending on the satisfaction with these provisions, a patient would choose whether to make an alternative document and, if so, what its provisions should be. Disagreement with the medical care provisions provided in the new statute would trigger at least a physician directive. If a patient does not trust one of those persons empowered to act on her behalf, she could appoint an agent.

Improvements in medical technology have made advance directives far more important than they would have been at an earlier time.¹¹⁵ The authorizing laws have been passed quickly, but have not been coordinated with other state laws. Substantial overlap exists, and yet significant gaps exist as well. Cases relating to terminal care also have flourished in the past decade. It is a good time to differentiate and reorganize the laws that exist. A single package, especially one that spells out the results of failing to make a directive, would make directives more useful and, consequently, more likely to be used.

115. *Death by Directive*, *supra* note 7, at 69.