DECISIONS FOR THE DYING: AN EMPIRICAL STUDY OF PHYSICIANS' RESPONSES TO ADVANCE DIRECTIVES*

Joel M. Zinberg**

INTRODUCTION

Incompetent patients[1] pose serious decision-making problems for doctors and other health care providers. Every patient has the right to consent to, or refuse, medical treatment even if his decision seems unreasonable, ridiculous, or life threatening.[2] However,

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** Julius Silver Fellow, Columbia University School of Law; Rudin Fellow, The Center for the Study of Society and Medicine, Columbia University College of Physicians and Surgeons, B.A., Swarthmore College (1977); M.D., Columbia University College of Physicians and Surgeons (1981); J.D., Yale Law School (1988).

1. The term "incompetent" is used in a generic sense to describe persons who are incapable of making decisions for themselves. All patients are presumed to be competent "until satisfactory proof to the contrary is presented." Grannum v. Berard, 70 Wash. 2d 304, 307, 422 P.2d 812, 814 (1967). The criteria for determining competence to consent to medical care are generally the same as those used to determine competence to contract. Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1653 (1974).

A judicial decision is the only legally recognized process for determining capacity. In practice, cumbersome court proceedings are rarely used. Typically, physicians make ad hoc bedside determinations and are rarely questioned. Proposed New York State legislation authorizing adults to appoint a health care agent expressly provides for non-judicial determination of capacity. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT 152-53 (1987) [hereinafter N.Y. STATE TASK FORCE]. By formalizing the procedure, the proposal may complicate the situation. However, the issue of capacity is critical to the springing power of a health care agent.

2. Courts will not interfere with a competent person's decision except where it conflicts with overriding state interests such as: (a) protection of innocent third parties, (b) preservation of life, (c) prevention of suicide, and (d) maintenance of the medical profession's ethical integrity. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977).

These overriding state interests are poorly demarcated. Common examples of protecting innocent third parties are where refusal of treatment would create a danger to public health or would substantially impair the interest of others. *In re* Storar, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275, *cert. denied*, 454 U.S. 858 (1981). Illustrations are where a carrier of an infectious disease refuses treatment or a parent responsible for the care of young children declines life-saving treatment. *See* Jacobson v. Massachusetts, 197 U.S. 11 (1905) (state may require vaccination regardless of consent); Reynolds v. McNichols, 488 F.2d 1378 (10th Cir. 1973) (city may require prostitutes to accept treatment for venereal

when an individual is incompetent such decisions can only be

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disease); *In re* President and Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964) (transfusion ordered for Jehovah's Witness mother of seven month old baby); *In re* Winthrop Univ. Hosp., 128 Misc. 2d 804, 490 N.Y.S.2d 996 (N.Y. Sup. Ct. 1985) (blood transfusion ordered for mother of two young children); *In re* Jamaica Hosp., 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (blood transfusion ordered over mother's objection to save life of fetus). *But cf. In re* Osborne, 294 A.2d 372 (D.C. 1972) (no transfusion ordered over religious objections where children would be well cared for without father).

A state's interest in preserving life is demonstrated when a court orders treatment of a minor despite the mother's religious objections. *See* John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971). Similarly, a patient may not consent to intentional maiming or illegal treatment. State v. Bass, 255 N.C. 42, 120 S.E.2d 580 (1960) (doctor convicted of aiding and abetting mayhem because, at the victim's request, he anesthetized the victim's fingers so that the victim's brother could amputate them); Rutherford v. United States, 616 F.2d 455 (10th Cir.), *cert. denied*, 449 U.S. 937 (1980) (terminally ill patient cannot require interstate transport of laetrile without the drug first meeting FDA requirements). *See also* D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 5:15 (1981) (discussing consent to "unlawful" medical treatments and observing that courts are reluctant to consider treatments "unlawful").

A state's interest in preventing suicide is confined to self-induced death. Refusing treatment is not suicide because, theoretically, the cause of death is the underlying disease process which was not intentionally self-inflicted. Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980) (conscious patient may refuse respirator). *See also* Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 137, 482 A.2d 713, 720 (1984); *In re* Conroy, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985); *In re* Colyer, 99 Wash. 2d 114, 121, 660 P.2d 738, 743 (1983) (*overruled in part* by *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984)). Contrary to popular belief, suicide is not a crime. Aiding and abetting suicide is a crime in twenty-two states. *See In re* Caulk, 125 N.H. 226, 232, 480 A.2d 93, 97 (1984); D. MEYERS, *supra*, § 7:11 (general discussion of criminal implications of suicide); Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 350-51 (1986).

For the state's ill-defined and rarely enforced interest in the maintenance of the ethical integrity of the medical profession, see United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965) ("[d]octor's conscience and professional oath must also be respected").

The right to forego medical care is not restricted to life-sustaining treatment. It also includes treatable conditions. Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (N.Y. Sup. Ct. 1962) (upholding refusal of blood transfusion despite gastrointestinal bleeding); *In re* Yetter, 62 Pa. D. & C.2d 619, 623 (1973) (upholding schizophrenic patient's refusal, made when competent, to undergo surgery for suspected breast cancer).

The common law rights of self-determination (or patient autonomy) and bodily integrity are grounded in the law of trespass and battery. As Judge Cardozo stated in Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

Since Roe v. Wade, 410 U.S. 113, 140, 153 (1973), the constitutional right of privacy, i.e., the right to be free from government interference, is also cited as a ground for requiring patient consent. *E.g.*, Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *Satz*, 379 So. 2d 359; *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; *In re* Conservatorship of Torres, 357 N.W.2d 332 (Minn. 1984); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976), *rev'd on other grounds*, *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983). Professor Tribe noted that "by casting its holding [in

made vicariously.[3] The decision-making problems are primarily

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Quinlan] in federal constitutional terms the New Jersey court may have needlessly foreclosed more intelligent legislative solutions." L. TRIBE, AMERICAN CONSTITUTIONAL LAW 937 (1978). An individual can successfully assert his or her constitutional right of privacy only against governmental acts and not against acts of private defendants unless state action exists. *See* Polin v. Dun & Bradstreet, Inc., 768 F.2d 1204, 1207 (10th Cir. 1985). Some courts have found that the state's extensive authority over hospitals, health professionals, and incapacitated persons is sufficient to establish state action. *E.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); *Colyer*, 99 Wash. 2d at 120, 660 P.2d at 742. In Rivers v. Katz, 67 N.Y.2d 485, 493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78 (1986), the court did not rely on the constitutional right of privacy. It found that the patient's right to refuse antipsychotic medication was guaranteed by the due process clause of the state constitution.

The concept of consent has been expanded to mean *informed consent*. *See generally* T. BEAUCHAMP & R. FADEN, A HISTORY AND THEORY OF INFORMED CONSENT (1986). The physician now has an affirmative duty to inform the patient of the risks and benefits of consenting to or of refusing a proposed treatment or alternative treatments. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 780, 783 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (stating that it is "impossible to obtain a consent worthy of the name unless the physician" discloses the options and risks); Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (duty to warn patient that by refusing a Pap smear, she risks undetected cervical cancer). A failure to inform the patient properly is a species of negligence. "[T]he doctrine of informed consent has been affirmatively recognized in case law or statute in all but three American jurisdictions and only one [Georgia] explicitly purports to reject it." 3 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 193 (1982) [hereinafter HEALTH CARE DECISIONS]. For a comprehensive survey of informed consent at common law and by statute, see Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980). *See also* J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

There is, however, no conclusive empirical evidence on the effect of expanded disclosure on treatment. *See* Meisel & Roth, *What We Do and Do Not Know About Informed Consent*, 246 J. A.M.A. 2473 (1981). Its proponents argue that it improves rapport leading to fewer disappointments, fewer lawsuits, and better therapeutic results. 1 HEALTH CARE DECISIONS, *supra*, at 25. *See also* Gutheil, Bursztajn & Brodsky, *Malpractice Prevention Through the Sharing of Uncertainty: Informed Consent and the Therapeutic Alliance*, 311 NEW ENG. J. MED. 49, 51 (1984). Its critics suggest that it needlessly burdens physicians and frightens patients by burdening them with diagnostic and treatment uncertainties which they are unable and unwilling to understand, thereby exacerbating their anxieties and worsening therapeutic results. *See generally* Ingelfinger, *Informed (but Uneducated) Consent*, 287 NEW ENG. J. MED. 465-66 (1972) (editorial discussing lack of patient knowledge concerning procedure to which she consents); Loftus & Fries, *Informed Consent May Be Hazardous to Health*, SCIENCE, Apr. 6, 1979, at 11 (discussing informed consent in experimental procedures); Ravitch, *The Myth of Informed Consent*, SURGICAL ROUNDS, Feb. 1978, at 7 (editorial discussing common misconceptions about the role of informed consent); Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749 (1986) (discussing the law's failure to call for a commitment to patient autonomy).

Fiduciary law has also expanded to include the physician-patient relationship. The physician-fiduciary is obligated to make full disclosure to his patient-principal. *See generally* Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 796 (1983).

3. An incompetent person cannot be informed and cannot accept or reject treatment. However, the incompetent retains the same rights of self-determination and privacy as the competent adult. As a living person, an incompetent is entitled to equal treatment. *See, e.g.*, John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984); *Saikewicz*,

how such proxy decisions should be made and who should make them.[4]

Medical innovations, which make it possible to delay the death or prolong the life of terminally ill, incompetent, or permanently unconscious patients (hereinafter collectively referred to as "hopeless patients")[5] have focused public,[6] judicial,[7] and legisla-

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373 Mass. at 736, 745, 370 N.E.2d at 423, 427; *Conroy*, 98 N.J. at 359, 486 A.2d at 1229; *Quinlan*, 70 N.J. at 41, 355 A.2d at 664; *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 744. *See also* J. RAWLS, A THEORY OF JUSTICE 249 (1971).

4. The generally accepted model for medical proxy decision-making is the substituted judgment standard. The proxy attempts to decide what the incompetent adult would decide if he were competent. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 132 (1983) [hereinafter FOREGOING TREATMENT].

Substituted judgment is a potentially practicable standard for a once competent individual who has left clear and convincing evidence to indicate his or her preference. However, it does not yield coherent results in other cases as can be seen by the courts' struggle to rationalize their decisions in two seminal cases where there was no such evidence. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (involving a chronic incompetent patient, mentally retarded since birth) and *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976) (no probative evidence of patient's preference). The New York courts reject surrogate decision-making where there is no clear and convincing evidence of the patient's preferences while competent. *E.g.*, *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981) (consolidating two cases, the first of which involved the patient's clear indication of preferences, and the second of which involved the ability of a terminally ill patient, severely retarded since birth, to make a decision); *In re* O'Connor, N.Y.L. J., Oct. 18, 1988, at 21, col. 3 (Ct. App. Oct. 17, 1988) (testimony from incompetent patient's family insufficient to provide clear and convincing proof of patient's commitment to decline life-sustaining nutrition); People v. Eulo, 63 N.Y.2d 341, 357-58, 472 N.E.2d 286, 295-96 482 N.Y.S.2d 436, 446 (1984). *See also* Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983); *Foody*, 40 Conn. Supp. at 139-40, 482 A.2d at 721-22; *Conroy*, 98 N.J. at 361, 486 A.2d at 1231; Note, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689, 714 (1987).

The substituted judgment doctrine originated in nineteenth century English estate law as a means of authorizing gifts from an incompetent's estate to persons to whom the incompetent owes no duty of support. *Ex parte* Whitebread (in the Matter of Hinde), 2 Mer. Rep. 99 (1816). The doctrine was first recognized in the United States in *In re* Willoughby, 11 Paige Ch. 257 (N.Y. 1844). It was introduced into medical decision-making in an attempt to rationalize organ gifts for transplants from incompetents to relatives. *See generally* Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976). Other standards for vicarious decision-making are the "Best Interest Standard" and the "Reasonable Person Standard." They all fall short of true individual self-determination for incompetent patients. Self-determination for incompetent individuals may be unattainable. For a thoughtful discussion of inadequacy of these standards, see *In re* Jobes, 108 N.J. 394, 529 A.2d 434, 452-61 (1987) (Handler, J., concurring) (criticizing the substituted judgment standard). *See also* Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379-82 (1986); Gutheil & Appelbaum, *Substituted Judgment: Best Interest in Disguise*, THE HASTINGS CENTER REPORT, June 1983, at 8.

5. Permanently unconscious or vegetative includes all conditions of irremediable un-

tive[8] attention on these decision-making problems. The utility and morality of using costly or scarce medical technology to sustain the life or to delay the death of hopeless patients is questioned,[9] as is

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awareness (such as irreversible coma or persistent vegetative state) regardless of etiology, *e.g.*, brain injury, hypoxia, degenerative neurological condition. Individuals suffering from these conditions have no reasonable possibility of returning to normal cognitive function but may continue to live indefinitely, according to our current definition of death. They are capable of spontaneous respiration and some rudimentary circulatory and excretory functions mediated through the spinal reflexes and the lower brain stem. *See* FOREGOING TREATMENT, *supra* note 4, at 177-80.

Terminally ill is used to mean a patient who has an incurable and irreversible condition that, without the administration of life-sustaining treatment, will result in death within a specified or relatively short period of time. A condition which is incurable but can be treated, and to a greater or lesser degree arrested, is not terminal, *e.g.*, kidney failure, Parkinson's disease, and diabetes.

6. *See, e.g.*, HEALTH CARE DECISIONS, *supra* note 2; FOREGOING TREATMENT, *supra* note 4; AMERICAN MEDICAL ASSOCIATION, STATEMENT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, WITHHOLDING OR WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT ("it is not unethical to discontinue all means of life-prolonging medical treatment" including nutrition and hydration for patients who are terminally ill or in an irreversible coma); NIH Workshop Summary, *Withholding and Withdrawing Mechanical Ventilation*, 134 AM. REV. RESPIRATORY DISEASE 1327 (1986) (outlining procedures for withdrawing and withholding respirators). Polls suggest that most (73%) Americans now favor "withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their family request it." Boston Globe, Nov. 28, 1986, at 7, col. 1. Another poll reported that 70% of Americans are willing to have their own life support disconnected although only 46% are willing to make that decision for a relative. Steuber, *Right to Die: Public Balks at Deciding for Others*, HOSPITALS, March 5, 1987, at 72. The two most prominent groups advocating patient self-determination are: the Society for the Right to Die, based in New York City, which promotes advance directives, and the National Hemlock Society, formerly based in Los Angeles and now operating in Eugene, Oregon, which promotes euthanasia and the right to die.

7. For examples of judicial treatment of vegetative patients see Rasmussen v. Fleming, 157 Ariz. 207, 741 P.2d 674 (1987) (en banc); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 428 U.S. 922 (1976). For judicial treatment of terminal patients see Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

8. See infra section I for a discussion of statutes.

9. It is argued that using limited or costly medical resources to sustain the life or delay the death of a hopeless patient is immoral. It compromises the welfare of others with no benefit whatsoever to the patient. It also deprives others of body parts for transplantation, which led in part to the development of the Harvard Criteria for whole brain death. *A Definition of Irreversible Coma*, 205 J. A.M.A. 337, 337-40 (1968). By prolonging the cellular and organ functioning of a patient who has irreversibly lost all cognitive qualities essential to humanness, we commit an immoral assault on human dignity. We denigrate what was formerly human by nurturing a living corpse. It also contradicts notions of distributive justice, i.e., an ethically appropriate way to spread limited resources throughout the moral community, or what Aristotle called fairness in distribution. *See* ARISTOTLE, THE NICOMACHEAN ETHICS 106-12 (D. Ross trans. 1980).

The utilitarians (which seem to include most health planners and economists) are less concerned with the individual's right of self-determination and the Hippocratic ethic, which is militantly individualistic, than with a cost-benefit approach which nets aggregate costs

whether the patients themselves would want to prolong such an inhuman form of existence.[10]

One suggested solution for competent individuals is the use of advance directives such as a "Living Will" (sometimes called an "instruction directive") or a "Durable Medical Power of Attorney" (sometimes called a "proxy directive").[11] These directives seek to promote patient self-determination by enabling an individual, while competent, to give instructions, or to appoint a proxy, to direct his medical care if he later becomes incompetent.[12] They also reflect a societal conclusion that withholding or withdrawing life-sustaining treatment for hopeless patients is morally acceptable.

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and benefits and seeks to maximize net benefits. *See* J. BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION (Harrison Ed. 1967); J. STUART MILL, UTILITARIANISM (Longmans, Green, and Co. 15th ed. 1907).

Some suggest that a strictly utilitarian argument can be a slippery slope. Attempts to accurately quantify benefits and harms are highly subjective. It is not obvious that people are interested in maximizing society's net benefit in preference to pursuing their own happiness or good (egoism). The economic and societal pressures may be moving us from a "right to die" to a "duty to die." Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES OF INTERNAL MED. 129, 131 (Jan. 1985). Governor Lamm of Colorado suggested old people had a duty to die and get out of the way. N.Y. Times, Mar. 29, 1984, at A16, col. 5. Netting aggregate harms and benefits does not tell who is harmed and who is benefitted. It could theoretically justify Nazi type human medical experimentation. If enough people are benefitted does that outweigh the harm to a small number of individuals? Thus, advance directives, and particularly living wills, may become a cost containment mechanism for curtailing treatment for the impaired elderly. "It makes one pause to hear policy planners make presentations about [diagnostic related groups] or prospective payment systems and also suggest that on admission all patients should be offered living wills." Cassel, *Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985*, 6 CARDOZO L. REV. 287, 293 (1984).

10. Prolonging a patient's cellular and organ functioning against the patient's wishes is an immoral assault on human dignity. "[I]n some cases treatment to perpetuate life in only its most primitive form has gone beyond any conceivable medical or moral purpose, its perpetuation offends fundamental sensibilities, and it should stop." *In re* Jobes, 108 N.J. 394, 529 A.2d 434, 460 (1987) (Handler, J., concurring).

11. These devices cannot address vicarious decision-making for the person who was never competent.

12. Advance directives may be as little used as traditional last wills and testaments, particularly by the less educated segments of the population. The economically disadvantaged may not have an estate worth devising. E. CLARK, L. LUSKY & A MURPHY, GRATUITOUS TRANSFERS 65 (2d ed. 1977) [hereinafter GRATUITOUS TRANSFERS]. However, their medical decision-making problems will not differ from those of wealthier patients. "The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this [living will] a tool which will all too often go unused by those who might desire it." Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983). The significant "right to die" cases involved patients who had never executed an advance directive. In the absence of legislative guidance, the courts sought an ad hoc decision-making procedure for for such patients.

A living will is an adaptation of the traditional last will and testament. Instead of directing the disposition of his estate, a competent individual directs his medical treatment if and when he develops an incurable and irreversible condition that will inevitably cause death within a relatively short period of time ("terminal condition")[13] and is no longer able to make decisions regarding his own medical care.

A durable medical power of attorney is an adaptation of the traditional power of attorney. Instead of investing a surrogate with authority to make decisions regarding his property, a competent individual instructs and empowers a surrogate to make decisions regarding his medical care if he becomes incompetent, regardless of whether he is or is not terminally ill.

The concept of the living will was first proposed in 1969 as a fiduciary compact between the patient and the health care provider.[14] However, there was uncertainty in the medical and legal professions as to the legality of such directives.[15]

In 1976, California attempted to alleviate the uncertainty by enacting the first living will statute.[16] Since then, thirty-seven other states and the District of Columbia have adopted living will statutes.[17] In 1983, California again led the way by enacting the first separate Durable Power of Attorney for Medical Care statute.[18] Four other states have since adopted separate durable medical power statutes,[19] and four states include some form of medical decision-making authority within their general durable power of attorney statutes.[20]

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13. *See supra* note 5. Most living will statutes restrict their use to terminally ill patients. However, they need not be so restricted and two states do allow their use for permanently unconscious patients (irreversibly comatose). *See infra* notes 29-74 and accompanying text (describing the living will statutes).

14. Dr. Luis Kutner proposed a living will "analogous to a revocable or conditional trust with the patient's body as the *res*, the patient as the beneficiary and grantor, and the doctor and the hospital as the trustees." Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 552 (1969).

15. CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1988).

16. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988). Living will legislation was introduced in fifteen states between 1971 and 1975. All the states except California defeated the bills. D. HUMPHRY & A. WICKETT, THE RIGHT TO DIE: UNDERSTANDING EUTHANASIA 99 (1986).

17. *See infra* note 30.

18. CAL. CIV. CODE §§ 2430-2444 (West Supp. 1988).

19. *See infra* note 33.

20. *See infra* note 35.

Legislative enthusiasm for directives has accelerated despite a lack of reliable information about how or whether directives have had a measurable effect on medical decision-making and in particular, the physicians' role in their operation and implementation. There has been no reliable study of physicians' understanding of and experience with living wills or medical powers of attorney or whether such directives have altered the treatment of hopeless patients.[21]

Physicians occupy a central and controlling role in the operation and implementation of directives. The attending physician's determination of incompetence is predicate to the operation of every directive. If the directive is a living will another predicate to its operation is the physician's determination that the patient's condition is incurable or irreversible and, without the administration of death-delaying (life-sustaining) treatment, the patient will die within a short time. Physicians' cooperation in the implementation of these directives is essential.[22]

This paper reports the results of an empirical study which examined the effectiveness of advance directives and physicians' experiences with and understanding of such directives. The author conducted a series of eighteen physician to physician interviews in Vermont, where living wills have been authorized since 1982.[23] The author also conducted a second series of thirty-nine physician to physician interviews in and around Los Angeles, California.

The results suggest that advance directives as presently conceived, have not significantly affected physicians' treatment of hopeless patients. Physicians are neither familiar with, nor particularly interested in, the statutes or the instruments. Few have encountered patients who have executed directives. Fewer still have altered their treatment decisions or recommendations because of them. The most important determinants of treatment decisions continue to be the traditional physician-patient-family consensus,[24]

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21. *See infra* notes 75-101 and accompanying text (discussing prior studies).

22. "Whatever the arrangement, however, there is no way for the physician to avoid assuming a major role." Relman, *Michigan's Sensible "Living Will"*, 300 NEW ENG. J. MED. 1270, 1271 (1979) (Editorial). Doctors have been known to manipulate findings of incompetency to justify medical interventions they favor. N. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 25 (1987).

23. Terminal Care Document Act, VT. STAT. ANN. tit. 18 §§ 5251-5262 (1987). A Durable Power of Attorney for Health Care was enacted in Vermont in 1987, after this study was completed. VT. STAT. ANN. tit. 14, §§ 3451-3467 (Supp. 1988).

24. Based on long standing social and medical traditions, health care professionals ac-

the physician's perception, real or imagined, of potential civil or criminal liability,[25] and the physician's moral, medical, or ethical treatment preferences.[26]

Genuine self-determination for incompetent patients is substantially unattainable.[27] However, competent persons can approximate a modicum of control over their medical care by executing advance directives if the directives are recent, are honored and appropriate due process safeguards ensure their validity. By executing such directives, competent persons can express preferences and provide guidance as to their care, if and when they become unable to participate in medical decision-making. Such directives may also promote physician-family consensus.

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cept consent from family members. However, family members do not have clear legal authority to act for an incompetent patient. N. CANTOR, *supra* note 22, at 107. *See also* Solnick, *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients*, 6 J. LEGAL MED. 1, 19-21 (1985). Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COL. L. REV. 985, 994 (1984); *See generally* M. MACDONALD, K. MEYER & B. ESSIG, HEALTH CARE LAW: A PRACTICAL GUIDE 18-53 (1985); Comment, *The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis*, 48 PITT. L. REV. 539 (1987). The New Jersey Supreme Court, which has been a leading court in this area, has approved of the usual practice: "In *Quinlan* we held that the patient's family members were the proper parties to make a substituted medical judgment on her [a patient in an irreversible vegetative state] behalf. We make the same determination today." *In re* Jobes, 108 N.J. 394, 415, 529 A.2d 434, 444-45 (1987) (citation omitted).

25. There is only one reported criminal prosecution of a physician for withdrawing care. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). Nevertheless, health care providers continue to view requests to withdraw life-sustaining treatment through the prism of concerns about civil and criminal liability. As the *Barber* court wryly observed, "[t]his case, arising as it does in the context of the criminal law, belies the belief expressed by many that such decisions would not likely be subjects of criminal prosecution." *Barber*, 147 Cal. App. 3d at 1014, 195 Cal. Rptr. at 488. This concern can be attributed, in part, to the perceived willingness of local prosecutors to aggressively pursue cases involving the withdrawal of life-sustaining treatment and to the rumblings of pro-life advocates. N.Y. STATE TASK FORCE, *supra* note 1, at 9-10. The fear may not be well founded, but it is real. It may soon be balanced by the fear of civil liability for refusing requests to forego treatment. *See* Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984); Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625 (1986). Comment, *Damage Actions for Nonconsensual Life-Sustaining Medical Treatment*, 30 ST. LOUIS U.L.J. 895 (1986).

26. Much of the litigation was precipitated by the refusal of physicians and hospitals to withdraw treatment on moral, ethical, or religious grounds. *See, e.g.*, Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986); Brophy v. New England Sinai Hosp. Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Jobes, 210 N.J. Super. 543, 510 A.2d 133 (1986), *aff'd as mod.* 108 N.J. 394, 529 A.2d 434 (1987). There has been opposition from right-to-life groups and physicians. Relman, *supra* note 22, at 1271.

27. The right of self-determination is the patient's right to make his own idiosyncratic informed choice. A proxy, regardless of how empathetic or well instructed, can only approximate that. *See supra* note 4.

Sections I and II briefly describe current advance directive statutes and prior empirical studies. Section III explains the methods and results of the author's study. The conclusion indicates why genuine self-determination is unattainable for hopeless patients and suggests the need for a due process procedure. A full exposition of those topics, however, is beyond the scope of this paper. Finally, the author argues that for the permanently unconscious patient who is not brain dead, according to the currently accepted Harvard criteria, the courts and the families have tacitly and correctly replaced self-determination with an expanded neocortically oriented concept of death.[28]

I. Existing Legislation

Existing statutes provide for two types of directives: the instruction directive (living will) and the proxy directive (durable power of attorney). Since California enacted its "Natural Death Act" in 1976[29] authorizing living wills, similar legislation has been

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28. "Now, however, we are on the threshold of new terrain—the penumbra where death begins but life, in some form, continues. We have been led to it by the medical miracles which now compel us to distinguish between 'death,' as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not." Severns v. Washington Medical Center, Inc., 421 A.2d 1334, 1344 (Del. 1980). The difficulty is the definition of death. A "court cannot attempt [overtly] to rewrite the statutory definition of death." *Barber*, 147 Cal. App. 3d at 1014, 195 Cal. Rptr. at 488. Expanding that definition to include neocortical brain death, as long as there are proper procedural safeguards, would avoid the cost, pain, delay, and judicial rationalizations regarding self-determination in the cases involving permanently unconscious persons. *See supra* note 4.

Under the traditional heart-lung definition and the whole brain definition of death, hopeless patients are alive. The Harvard Criteria for whole brain death requires cessation of function of the whole brain, including the brain stem, usually corroborated by two flat electroencephalograms measured 24 hours apart. *A Definition of Irreversible Coma*, *supra* note 9, at 337-40. However, it is probable that there are conditions where portions of the brain continue to function, yet for all practical and moral purposes the individual is dead. The patient's ability to respire and carry out rudimentary circulatory and excretory functions mediated through the brain stem or spinal arc reflexes may not be a sufficient indicator of human life when all cognitive function (neocortical function) is irreversibly lost. I believe most involved courts, physicians, and patients' families actually think of the permanently unconscious patient as dead and want to stop nurturing a living corpse. It may take the family some time to accept that realization but they sooner or later assert it. *See, e.g.*, *Brophy*, 398 Mass. at 422 n.5, 497 N.E.2d at 628 n.5 (two years); *Jobes*, 108 N.J. at 402, 529 A.2d at 438 (five years). *See* Smith, *Legal Recognition of Neocortical Death*, 71 Cornell L. Rev. 850 (1986) (arguing that law and medicine have given de facto recognition to the concept of neocortical death by permitting the withholding or withdrawal of life-support from patients who are not legally dead but are in an irreversibly noncognitive or persistent vegetative state). *See generally* President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Defining Death (1981).

29. Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1988).

adopted at an accelerating pace in thirty-seven other states and the District of Columbia.[30] Ten statutes were adopted between 1976 and 1980, thirteen between 1981 and 1984, and sixteen between 1985 and 1987. Although the statutes have much in common, no two statutes are identical. The National Commissioners for Uniform Laws perceived a need for consistency and transferability among the states and recommended a "Uniform Rights of the Terminally Ill Act" in 1985. This recommendation has not, as yet, had significant effect.[31]

Since California enacted its Durable Power of Attorney For Health Care statute in 1983,[32] four other states have adopted separate medical durable power of attorney statutes. These statutes authorize appointment of a proxy to act for the declarant if and when the declarant is incapable of participating in medical treatment decisions.[33] The living will laws in eleven other jurisdictions authorize

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30. ALA. CODE §§ 22-8A-1 to -10 (1984); ALASKA STAT. §§ 18.12.010-.100 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to -218 (Supp. 1987); COLO. REV. STAT. §§ 15-18-101 to -113 (1987); CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1988); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1988); FLA. STAT. ANN. §§ 765.01-.15 (West 1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1988); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1987); IDAHO CODE § 39-4501 to -4508 (1985 & Supp. 1988); ILL. ANN. STAT. ch. 110-½, paras. 701-710 (Smith-Hurd Supp. 1988); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns Supp. 1988); IOWA CODE ANN. §§ 144A.1-.11 (West Supp. 1988); KAN. STAT. ANN. §§ 65-28, 101 to -28, 109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1988); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1988); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1988); MONT. CODE ANN. §§ 50-9-101 to -104, - 111, -201 to -206 (1987); NEV. REV. STAT. ANN. §§ 449.540-.690 (Michie 1987); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (Supp. 1988); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -322 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1988); OR. REV. STAT. §§ 97.050-.090 (1984 & Supp. 1988); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1987); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1988); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1988); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987) and tit. 13, § 1801 (1974 & Supp. 1988); VA. CODE ANN. §§ 54-325.8:1 to :13 (Supp. 1987); WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1989); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1988); WYO. STAT. §§ 35-22-101 to -109 (1977 & Supp. 1988).

31. UNIFORM RIGHTS OF THE TERMINALLY ILL ACT, §§ 1-18, 9B U.L.A. 609 (1987 & Supp. 1988). *See also* MEDICAL TREATMENT DECISION ACT, *reprinted in* SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-1984, 35-38 (1984) (drafted in 1978 by the Yale Law School Legislative Services Project and sponsored by the Society for the Right to Die). This Model Act was amended in 1981 to permit the appointment of a proxy to make treatment decisions in accordance with the living will. *Id.*

32. CAL. CIV. CODE §§ 2430-2444 (West Supp. 1988).

33. ILL. ANN. STAT. ch. 110, para. 804-1 to -12 (Smith-Hurd Supp. 1988); NEV. REV. STAT. ANN. §§ 449.800-.860 (Michie Supp. 1988); R.I. GEN. LAWS §§ 23-4.10-1, 23-4.10-2 (Supp. 1988); VT. STAT. ANN. tit. 14, §§ 3451-3463 (Supp. 1988).

the declarant to designate a medical agent.[34] Four states allow delegation of authority to make medical care decisions in their general power of attorney statutes.[35] Maryland and Washington do not mention health care in their durable power of attorney statutes, but do implicitly endorse health care powers in other statutes.[36]

Twelve living will statutes include procedures for making decisions as to the medical care of incompetent terminally ill adults who never executed a living will while competent.[37] These proce-

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34. ARK. STAT. ANN. § 20-17-202 (Supp. 1987); DEL. CODE ANN. tit. 16, § 2502 (1983); FLA. STAT. ANN. § 765.07(b) (West 1988); IDAHO CODE § 39-4505 (Supp. 1988); IND. CODE ANN. § 16-8-11-14(g)(2) (Burns Supp. 1988); IOWA CODE ANN. § 144A.7 (West Supp. 1988); LA. REV. STAT. ANN. § 40:1299.58.3 C(1) (West Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590h § 3(e) (Vernon Supp. 1988); UTAH CODE ANN. § 75-2-1106 (Supp. 1988) (Utah actually provides a Special Power of Attorney form in its living will act); VA. CODE ANN. § 54-325.8:6(2) (Supp. 1987); WYO. STAT. § 35-22-102(a) (Supp. 1988).

35. In 1985, Maine became the first state expressly to include the power to consent to or refuse medical care in its general durable power of attorney statutes. ME. REV. STAT. ANN. tit. 18A § 5-501 (Supp. 1988). The statute contains the unusual provision that while a conservator or guardian has the same power as the principal to revoke or alter a durable power of attorney, only a court may suspend a medical agency. The three other state statutes are more general and seem less clearly aimed at granting authority to withdraw life-sustaining treatment. COLO. REV. STAT. § 15-14-501 (1987) (agent has powers "including by way of illustration but not limitation, the power to consent to or approve . . . any medical or other professional care"); N.C. GEN. STAT. §§ 32A-1(9), 32A-2(9) (1984) (first section grants agent authority to make decisions regarding "personal relationships and affairs" which the second section defines as "to provide medical, dental and surgical care, hospitalization and custodial care for the principal"); 20 PA. CONS. STAT. ANN. tit. 20 § 5602(a)(8)-(9), 5603(h)(1)-(2) (Purdon Supp. 1987) (the declarant may authorize admission to medical facility and consent to medical and surgical procedures).

36. MD. HEATH-GEN. CODE ANN. § 20-107(d) (1987) (lists individuals who "[i]n the absence of a durable power of attorney that relates to medical care . . . may give a substituted consent for furnishing medical or dental care and treatment to a disabled individual"); 1987 Wash. Laws ch. 162 § (1) (includes persons named in "a durable power of attorney that encompasses the authority to make health care decisions" on a list of individuals who can consent to health care for an incompetent patient).

37. *See, e.g.*, N.C. GEN. STAT. § 90-322(3)(b) (1985):

> [T]he extraordinary means to prolong life may be withheld or discontinued . . . with the concurrence (i) of the person's spouse, or (ii) of a guardian of the person, or (iii) of a majority of the relatives of the first degree, in that order. If none of the above is available then at the discretion of the attending physician the extraordinary means may be withheld or discontinued upon the direction and under the supervision of the attending physician.

See also ARK. STAT. ANN. § 20-17-202 (Supp. 1987); CONN. GEN. STAT. § 19a-571 (West Supp. 1988) (next of kin's wishes must be obtained whether or not directive present); FLA. STAT. ANN. § 765-07 (West 1986); IND. CODE ANN. § 16-8-11-14(g) (Burns Supp. 1988); IOWA CODE ANN. § 144A.7 (West Supp. 1988); LA. REV. STAT. ANN. § 40:1299.58.5(1) (West Supp. 1988); N.M. STAT. ANN. § 24-7-8.1 (1986); OR. REV. STAT. § 97.083(2) (1985); UTAH CODE ANN. § 75-2-1105(2)(b) (Supp. 1986); VA. CODE ANN. § 54-325.8:6 (Supp. 1987).

Eight of the above states include the power to name an agent in their living will statute. *See supra* note 34 and accompanying text.

dures, like the traditional intestacy statutes, designate by priority those closest to the patient to act as the patient's surrogate.

Ironically, Massachusetts, New Jersey, and New York, which provided the forums for many "right-to-die" cases, do not have advance directive statutes.[38] In 1987, the New York Task Force on Life and the Law proposed a durable medical power of attorney statute for consideration by the New York legislature in preference to a living will statute.[39]

A. Contents, Execution, and Revocation of Directives

Living wills are declarations governing medical care signed by a competent adult and witnessed by two disinterested individuals[40] in much the same manner as a traditional last will and testament. Twenty-one living will statutes also recognize a declaration signed by another at the declarant's direction before two witnesses (which is analogous to a nuncupative will)[41] and Missouri allows an unwit-

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38. For "right-to-die" cases in Massachusetts, see Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Hier, 18 Mass. App. 200, 464 N.E.2d 959, *appeal denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984); *In re* Dinnerstein, 6 Mass. App. 466, 380 N.E.2d 134 (1978).

For similar cases in New Jersey, see *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976), *rev'd on other grounds*, *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

For New York cases, see *In re* O'Connor, N.Y.L. J., Oct. 18, 1988, at 21, col. 3 (Ct. App. Oct. 17, 1988); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 745 (App. Div. 1987); Saunders v. State, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985).

39. N.Y. STATE TASK FORCE, *supra* note 1.

40. South Carolina is unique in requiring three witnesses. S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1987).

Most states require something to the effect that a witness not be "the person's spouse, heir, attending physician or person acting under the direction or control of the attending physician or any other person who has at the time of the witnessing thereof any claims against the estate of the person." VT. STAT. ANN. tit. 18, § 5254 (1987). The declaration forms of twenty jurisdictions include witness attestations or affidavits confirming that a witness is qualified. Nine states' forms require that the signatures be notarized. Eight statutes also specify special witnessing requirements for nursing home patients. Connecticut, Arkansas, and the Uniform Act do not specify qualifications for witnesses.

41. Nuncupative wills are witnessed, oral wills. They were originally intended to be the last minute, oral dispositions of a dying or sick person who was unable to make a written will (much as living wills are confined to terminally ill patients). Their use was restricted to the transfer of personalty. *See* GRATUITOUS TRANSFERS, *supra* note 12, at 281, 314-21 (2d ed.

nessed handwritten (holographic) declaration.[42]

Living wills are usually restricted to instructions to withhold or withdraw life-sustaining treatment if the declarant is terminally ill and incompetent. However, that need not be the case. Several states authorize instructions in their living wills either to provide or to withdraw care and two states allow directives to include vegetative patients.[43]

What constitutes life-sustaining medical treatment which may be removed or withheld is sharply disputed. Everyone agrees that comfort care and pain relief should not be withdrawn. However, there is disagreement about artificial nutrition. In recent decisions, courts equated artificial nutrition with other withdrawable medical treatment.[44] The legislative trend, however, is contrary. Twenty of

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1977).

42. Mo. Ann. Stat. § 459.015.1 (Vernon Supp. 1987). *See* Gratuitous Transfers, *supra* note 12, at 304-14 (discussing holographic wills).

43. For states that authorize instructions to provide or withdraw care see note 151 and accompanying text.

The states that allow directives to include vegetative patients are: Ark. Stat. Ann. § 20-17-201(7) (Supp. 1987) (permanently unconscious patients); N.M. Stat. Ann. § 24-7-2 (1986) (patients in irreversible coma).

Another restriction found in two-thirds of the jurisdictions specifies that a declaration will have no force or effect if the patient is pregnant. A similar pregnancy clause was deleted from the statutes in the District of Columbia and Virginia when women's groups questioned its constitutionality. Society for the Right to Die, Handbook of Living Will Laws 1981-1984, 16 (1984). In Maine, a pregnancy clause was only dropped after "serious debate." Society for the Right to Die, Handbook of 1985 Living Will Laws 7 (1986).

This pregnancy clause has been challenged on the grounds that it interferes with the right of privacy by limiting the right to have an abortion and by infringing on the right to refuse treatment. Dinino v. State *ex rel* Gorton, 102 Wash. 2d 327, 684 P.2d 1297 (1984). A woman who was neither terminally ill nor pregnant executed a directive which differed from the state's model directive by instructing that if she was pregnant and terminally ill, her pregnancy should be aborted and her directive should remain in force. The woman and her physician sought a declaratory judgment that the directive was valid, enforceable, and would protect physicians who followed it from liability. In the alternative, they sought a declaration that the statute was unconstitutional because it violated the right of privacy by inhibiting the right to have an abortion and by infringing on the right to forego medical treatment. The trial court held that the statute's pregnancy provision was unconstitutional but denied the motion for a declaration of the validity of the woman's directive. The Supreme Court of Washington, sitting en banc, ruled that the case did not present a justiciable controversy and refused to render a declaratory judgment on the constitutionality of the statute. *Id.* at 333, 684 P.2d at 1301.

44. Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986);*In re* Jobes, 108 N.J. 394, 529 A.2d. 434 (1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); Delio v. Westchester County Medical Center, 134 Misc. 2d 206, 510 N.Y.S.2d 415 (Sup. Ct. 1986), *rev'd*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987).

Discontinuing artificial feeding is more emotionally charged than discontinuing other

the thirty-nine living will statutes specifically provide that medically administered nutrition and hydration are not life-sustaining treatments which can be withdrawn pursuant to a directive.[45]

With two exceptions,[46] every statute suggests a form for the authorized directive. California and Oregon require use of the statutory living wills form.[47] Other states require that the statutory form be substantially followed.[48] Rhode Island requires use of the statutory durable power of attorney form.[49] Other suggested forms can be modified to a greater or lesser degree. California and Oklahoma provide that a binding living will can only be executed after the declarant learns of his terminal illness.[50] In the other jurisdictions, it can be executed at any time.

Powers of Attorney are written documents signed by a competent adult (principal) and usually acknowledged before a notary or

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treatments. Nutrition is not normally thought of as medical treatment. There are those who persist in believing that it is a violation of professional ethics and personal morality to withhold nutrition from any patient regardless of his state of health or previously expressed wishes. Withholding nutrition means starvation rather than death with dignity. *See* Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES INTERNAL MED. 129 (1985). On the other hand, withholding nutrition may be viewed as omitting to continue a treatment and allowing the medical condition, which includes the inability to eat, to take its natural course. AMERICAN MEDICAL ASSOCIATION, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, STATEMENT ON WITHHOLDING OR WITHDRAWING LIFE-PROLONGING TREATMENTS (Mar. 15, 1986).

45. ARIZ. REV. STAT. ANN. § 36-3201.4 (1986); COLO. REV. STAT. § 15-18-103(7) (1987); CONN. GEN. STAT. ANN. § 19a-570(1) (West Supp. 1988); FLA. STAT. ANN. § 765.03(3) (West 1986); GA. CODE ANN. § 31-32-2(5)(A) (1985); HAW. REV. STAT. § 327D-2 (Supp. 1987); IDAHO CODE § 39-4503(3) (1985 & Supp. 1988); ILL. ANN. STAT. ch. 110, para. 702(d) (Smith-Hurd Supp. 1988); IND. CODE ANN. § 16-8-11-4 (Burns Supp. 1988); IOWA CODE ANN. § 144A.2.5 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22 § 2921(4) (Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-605(1) (Supp. 1988); MO. ANN. STAT. § 459.010(3) (Vernon Supp. 1988); N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1988); OKLA. STAT. ANN. tit. 63, § 3102(4) (West Supp. 1988); S.C. CODE ANN. § 44-77-20b (Law. Co-op. Supp. 1987); UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1988); W. VA. CODE § 16-30-2(3) (1985); WIS. STAT. ANN. § 154.01(5)(b) (West Supp. 1988); WYO. STAT. § 35-22-101(a)(iii) (Supp. 1988).

Four other states indicate that feeding not necessary for comfort may be withdrawn. *See* ALASKA STAT. § 18.12.040(b) (1986); ARK. STAT. ANN. § 20-17-206(b) (Supp. 1987); MONT. CODE ANN. § 50-9-202(2) (1987); TENN. CODE ANN. § 32-11-102(a) (Supp. 1988).

46. DEL. CODE ANN. tit. 16, § 2501-2509 (1983); N.M. STAT. ANN. § 24-7-1 to -11 (1986).

47. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1988); OR. REV. STAT. § 97.055 (1984 and Supp. 1988).

48. *E.g.*, ARIZ. REV. STAT. ANN. § 36-3202(c); VT. STAT. ANN. tit. 18, § 5253. An alternate formulation is found in IDAHO CODE § 39-4504 (form must include "the elements set forth in this section").

49. R.I. GEN. LAWS § 23-4.10-1 (Supp. 1988).

50. CAL. HEALTH & SAFETY CODE § 7191(b) & (c) (West Supp. 1988); OKLA. STAT. ANN. tit. 63, § 3107(b) & (c) (West Supp. 1988).

subscribed by two qualified witnesses authorizing another person (agent) to act on the principal's behalf.[51] Under common law, the agent's authority terminated when the principal became incapacitated or died. A durable power, however, survives the principal's incapacity. All fifty states now allow a principal to create a durable power by directing in writing that the agent's authority survives the principal's disability or incompetence.[52] The fact that a durable power survives the declarant's loss of capacity makes it suitable for medical decision-making for incompetent patients.

Twenty-two states allow individuals to appoint an agent (eleven in a living will, nine in a Power of Attorney, and two implicitly, in other statutes) to make medical treatment decisions on their behalf.[53] However, the authority delegable pursuant to the eleven living will statutes is usually restricted to decisions regarding the withholding of life-sustaining treatment when the declarant is terminally ill and incompetent. Some commentators argue that the authority to make medical treatment decisions can be delegated under a state's general durable power of attorney statute.[54]

Proxy directives as a genre are more flexible than living wills. They are not confined to terminal care situations. Because they invoke the judgment of a rational living agent, they can be used for all health care decisions, not just withdrawal of life-sustaining treatment, anytime the declarant is temporarily or permanently unable to participate in treatment decisions. Some durable powers carry over to some post death activities, such as anatomical gifts and authorization of an autopsy.[55] The principal can tailor the power of attorney to his situation with very few restrictions. The most common limitations are that treating health care providers or their employees cannot be a proxy and an agent may not authorize

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51. Usually a witness may not be a doctor, an operator of a health care facility, an employee of a doctor or a health care facility, or the attorney-in-fact. At least one of the witnesses must be a person who is not a relative or entitled to inherit. *See, e.g.*, CAL. CIV. CODE § 2432(d), (e) (West Supp. 1988).

52. *See, e.g.*, N.Y. GEN. OBLIG. LAW § 5-1601 (McKinney 1978); UNIF. PROB. CODE § 5-501, 8 U.L.A. 513 (1983 & Supp. 1988). Some have gone as far as suggesting that the principal execute a durable power authorizing his attorney-in-fact to delay implementation of the principal's living will for tax benefits (*e.g.* delay death into the next tax year). Jorrie & Stanley, *The Tax Advantages of Lingering Death*, 48 TEX. B.J. 1070, 1072-73 (1985).

53. *See supra* notes 32-36.

54. *See* FOREGOING TREATMENT, *supra* note 4, at 146; Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985 (1984). *See also supra* note 35.

55. *See, e.g.*, CAL. CIV. CODE §§ 2433(a), 2434(b) (West Supp. 1988); ILL. ANN. STAT. ch. 110, paras. 804-3, -7(d) (Smith-Hurd Supp. 1988).

an illegal treatment. In some states, specific procedures such as sterilization, abortion, psychosurgery, or convulsive therapy, are not delegable.[56]

A directive is usually valid until the declarant dies or revokes it except in California and Rhode Island. In California, a living will is effective for five years. Rhode Island does not provide for living wills. In both California and Rhode Island a durable power is effective for seven years after execution unless the declarant specifies a shorter duration, revokes the directive, or dies. If a declarant lacks capacity to make health care decisions at the end of the durable power's term, the directive continues in effect until he recovers competence or dies.[57] Directives in all jurisdictions are readily revocable, orally or in writing, usually with a minimum of formality and at any time.[58]

B. When Directive Is Operative

Most directives are akin to springing powers. They become operative when the attending physician and any required consultants certify that the declarant lacks capacity to make treatment decisions.[59] If the directive is a living will, the physician must also certify that the declarant is terminally ill, that is, his condition is incurable and irreversible and, without life-sustaining treatment, he will die within a short time.[60]

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56. *See, e.g.*, CAL. CIV. CODE §§ 2435, 2443 (West Supp. 1988); NEV. REV. STAT. ANN. § 449.850 (Michie 1987).

57. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1988); CAL. CIV. CODE § 2436.5 (West Supp. 1988); R.I. GEN. LAWS § 23-4.10-2 (Supp. 1988).

58. In South Carolina, for example, revocation can be accomplished by defacing or destroying the directive, by written revocation, or by a verbal expression of revocation by the declarant to the attending physician. S.C. CODE ANN. § 44-77-80 (Law. Co-op. Supp. 1987). South Carolina also requires that a declaration set forth its own revocation procedure and requirements "in bold face print." S.C. CODE ANN. § 44-77-50 (Law Co-op. Supp. 1987). In addition to an oral revocation, Mississippi provides a revocation form which is to be "substantially" followed. MISS. CODE ANN. § 41-41-109 (Supp. 1988). Connecticut does not describe any revocation procedure. Almost all statutes provide that the will can be revoked regardless of the patient's mental or physical condition, except Alabama, Colorado, Kansas, Maryland, New Hampshire, New Mexico, Vermont, and Virginia which make no mention of the patient's mental state.

59. Many states do not have express provisions for springing powers in their durable power of attorney statutes and some states do not permit them. *See* Pierson, *Steps a Practitioner Can Take to Facilitate the Planning and Probate of a Client's Estate*, 14 ESTATE PLANNING 88, 89 (1987); Schlesinger, *Powers of Attorney, Preparing for Incapacity: A Comparison of Powers*, MANHATTAN LAW., Nov. 10-16, 1987, at 30.

60. How quickly death must occur to qualify as terminal varies from statute to statute:

All the statutes explicitly or implicitly require the physician to implement a valid directive. However, except for the North Carolina and Mississippi laws, the statutes provide no procedure for proving (probating) a living will or validating a durable medical power.[61] Presumably, it would suffice if the physician, absent knowledge to the contrary, assumes the directive to be valid and acts in good faith.[62]

Several states authorize anyone who believes that a living will is not a valid expression of the declarant's wishes to petition a court for appointment of a guardian.[63] But only Colorado requires the physician to notify a relative that a certificate of terminal condition has been signed making the living will operative.[64]

C. Penalties and Protections

The intent of the statutes is to encourage physicians to imple-

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Fourteen statutes do not specify any period of time, sixteen say death must be "imminent," and nine say death must occur within a "short time." What these phrases mean exactly is not clear. A Virginia court defined "imminent" to mean "within a few months." Hazelton v. Powhatan Nursing Home, Inc., Case Number 98287 (Va. Cir. Ct. Fairfax County Aug. 29, 1986) (order signed Sept. 2, 1986) (Fortkort, J.). The court rejected the definition "immediate, at once, within a day." *Id.*

The Uniform Act requires that death result in a "relatively short time." UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 1, 9B U.L.A. 611 (1987 & Supp. 1988). This formulation avoids "both the unduly constricting meaning of 'imminent' and the artificiality of another alternative—fixed time periods." *Id.* at 613. The reporters felt that this standard provides needed flexibility and allows the physician to exercise his medical judgment. *Id.*

61. North Carolina requires the will to be "proved before a clerk or assistant clerk of superior court, or a notary public." N.C. GEN. STAT. § 90-321(c)(4) (1985). In Mississippi, the will and any revocations must be filed with the bureau of vital statistics of the state board of health. MISS. CODE ANN. § 41-41-107(2) (Supp. 1988). Before withdrawing life-sustaining care, the physician must request and receive a certified copy of the declaration and a certificate indicating that no revocation has been filed. *Id.* § 41-41-115(1). However, Mississippi also allows a patient to revoke orally. *Id.* § 41-41-109(3). It is not completely clear how the two provisions are reconciled.

62. Five states require the physician to make a reasonable effort to check the will's validity. The statutes do not specify how exhaustive this check should be or suggest any procedures for carrying it out. CAL. HEALTH & SAFETY CODE § 7191(a) (West Supp. 1988); GA. CODE ANN. § 31-32-8(A)(3) (1985); MD. HEALTH-GEN. CODE ANN. § 5-604(D)(1) (Supp. 1986); TEX. REV. CIV. STAT. ANN. art. 4590h § 7(a) (Vernon Supp. 1989); WASH. REV. CODE ANN. § 70.122.060(1) (Supp. 1989). As noted previously, Mississippi requires the physician to request and receive a certified copy of the directive from the state board of health. *See supra* note 61.

63. Some states call this a "Safeguard Provision." *See, e.g.*, HAW. REV. STAT. § 327D-19 (Supp. 1987).

64. COLO. REV. STAT. § 15-18-107 (1987). Colorado also outlines a court procedure, somewhat like probate, to challenge and determine the validity of a declaration including a court appointed guardian ad litem and notice to family members. *Id.* § 15-18-108.

ment a declarant's instructions or the proxy's directions. To encourage this, all statutes explicitly immunize health care providers from civil or criminal liability if they act in good faith to honor a valid directive.[65] The statutes also provide that withdrawing life-sustaining treatment from a terminally ill patient pursuant to a valid directive is not homicide, euthanasia, or abetting a suicide.[66]

Most jurisdictions, with the exception of Connecticut, Delaware, and Idaho,[67] explicitly require the physician to (i) implement a living will or transfer the declarant to a physician who will,[68] or (ii) accept direction from the designated proxy.[69] However, only seventeen living will jurisdictions (not including Vermont) and no durable power of attorney for health care jurisdictions provide a penalty for failure to honor a directive or transfer the declarant. Ten jurisdictions, including California, subject the physician to professional discipline.[70] In two jurisdictions the physician may be civilly liable.[71] Failure to honor a directive is a misdemeanor in

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65. *E.g.*, CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1988) (living wills); VT. STAT. ANN. tit. 18, § 5259 (1987) (living wills). CAL. CIV. CODE § 2438 (West Supp. 1987) (durable powers); VT. STAT. ANN. tit. 14, § 3462(b) (Supp. 1988) (durable powers). Unlike the situation with living wills, the California Power of Attorney also immunizes the physician if he or she fails to comply with an agent's instruction to withdraw health care necessary to keep the principal alive. CAL. CIV. CODE § 2438(c).

66. *E.g.*, CAL. HEALTH & SAFETY CODE §§ 7190, 7192, 7195 (West Supp. 1987); VT. STAT. ANN. tit. 18, §§ 5259-60 (1987). *See also* CAL. CIV. CODE § 2443 (West Supp. 1988) (In stating that statute should not be read as condoning any life-ending acts other than the withholding or withdrawal of health care pursuant to a valid durable power of attorney for health care statute implicitly says that valid withdrawal by an agent is not homicide, euthanasia or suicide).

67. *See* CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1988); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); IDAHO CODE §§ 39-4502 to -4509 (Supp. 1988). These three statutes do not state that a directive is binding upon the physician.

68. *E.g.*, CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1988); VT. STAT. ANN. tit. 18, § 5256 (1987).

69. *E.g.*, ILL. ANN. STAT. ch. 110 ½, para. 804-8 (Smith-Hurd Supp. 1988). California's durable power for health care makes this requirement only implicitly. CAL. CIV. CODE § 2434(b) (West Supp. 1988).

70. *See* CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1988); COLO. REV. STAT. § 15-18-113(5) (1987); D.C. CODE ANN. § 6-2425(c) (Supp. 1988); HAW. REV. STAT. § 327D-17(a) (Supp. 1987); KAN. STAT. ANN. § 65-28,107(a) (1985); MO. ANN. STAT. § 459.045 (Vernon Supp. 1988); OKLA. STAT. ANN. tit. 63, § 3107 (West Supp. 1988); S.C. CODE ANN. § 44-77-100 (Law. Co-op. Supp. 1987); UTAH CODE ANN. § 75-2-1112 (Supp. 1988); WIS. STAT. ANN. § 154.07 (West Supp. 1988).

California and Oklahoma only impose this "penalty" if the directive was executed or re-executed after the patient learned of their terminal diagnosis, otherwise the directive is only precatory. *Id.*

71. ALASKA STAT. § 18.12.070(a) (1986) (physician forfeits any fees for services provided to patient after withdrawal should have been effective, and may be liable to patient or his or her heirs for a civil penalty not to exceed $1,000.00 and any costs associated with the failure

three jurisdictions.[72] In one state, the physician is subject to professional discipline, possible loss of license and potential civil liability.[73]

There have been some unsuccessful lawsuits seeking damages for prolonging life-sustaining care against the patient's wishes.[74] To the author's knowledge no physician has been successfully sued, prosecuted or disciplined for complying with or not complying with a directive. However, this is an evolving area of potential tort liability.

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to comply, those amounts being the "exclusive remedy at law for damages"); MD. HEALTH-GEN. CODE ANN. § 5-607(a) (Supp. 1988). Maryland's statute makes no mention of how, or if, the physician is to ascertain that the directive is valid.

72. ARK. STAT. ANN. § 20-17-209(a) (Supp. 1987) (class A misdemeanor) A class A misdemeanor is punishable by imprisonment not exceeding one year and/or a fine not to exceed one thousand dollars. *Id.* §§ 5-4-201(b)(1), 5-4-401(b)(1) (1987); ME. REV. STAT. ANN. tit. 22, § 2928(1) (Supp. 1988) (class E crime). A class E crime is punishable by a prison sentence of up to six months or a fine of five hundred dollars or both. *Id.* tit. 17-A, §§ 1252(2)(E), 1301(1)(C) (1983); MONT. CODE ANN. § 50-9-206(1) (1987). A Montana physician who fails to comply or to transfer a patient to a physician who will comply "is guilty of a misdemeanor punishable by a fine not to exceed [five hundred dollars] or imprisonment in the county jail for a term not to exceed [one] year, or both." *Id.* The statute makes no mention of how or if the physician is to ascertain that the directive is valid.

These states impose the same penalties on physicians who fail to record the determination of a terminal condition in the patient's chart. ARK. STAT. ANN. § 20-17-209(b) (1987); ME. REV. STAT. ANN. tit. 22, § 2928(2) (Supp. 1988); MONT. CODE ANN. § 50-9-206(2) (1987).

73. TENN. CODE ANN. § 32-11-108(a) (Supp. 1988) (health care provider who does not make a good faith effort to comply with directive or transfer the patient "shall be civilly liable and subject to professional disciplinary action, including revocation or suspension of license").

74. Foster v. Tourtellotte, 704 F.2d 1109 (9th Cir. 1983) (affirming denial of attorney's fees after appeal on this issue from district court's denial of damages and attorney's fees for unwanted respirator care); Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986) (denial of survivors' suit alleging battery, violation of constitutional and federal civil rights, breach of fiduciary duty, and conspiracy arising from hospital's refusal to discontinue life-sustaining care); Spring v. Geriatric Authority, 394 Mass. 274, 475 N.E.2d 727 (1985) (widow sought to intercede alleging invasion of privacy). *Cf.* Bouvia v. County of Los Angeles, 195 Cal. App. 3d 1075, 241 Cal. Rptr. 239 (1987) (remanding to the trial court the issue of allowing attorneys' fees for work incurred in securing the removal of a nasogastric tube under state private attorney general statute); Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 97, 228 Cal. Rptr. 847 (1986) (remanding attorneys' fee request to trial court for determination of whether action vindicated important right affecting public interest under private attorney general statute); Leach v. Shapiro, 13 Ohio App. 3d 393, 496 N.E.2d 1047 (1984) (remanding after ruling that a cause of action exists for unwanted life-sustaining care).

The New Jersey Supreme Court recently approved awarding damages to the family of a brain dead patient when the hospital delayed removal of the respirator. However, the court based its opinion on the hospital's unreasonable violation of duty to the patient's family to turn over their son's body. Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988).

II. PRIOR SURVEYS

The Klutch Report[75] and the Stanford Survey[76] are two surveys of California physicians' attitudes toward living wills that were conducted within one and one-half years after California's Natural Death Act (Act) became law in 1976.[77] These studies warrant attention because they are the only previous studies of this nature and their conclusions are frequently cited.[78] Both relied on physician responses to mailed questionnaires. Neither produced substantial empirical data concerning the effect, if any, on actual treatment decisions.

The Klutch Report's questionnaire solicited comments and suggestions regarding the Act from 168 physicians who had ordered a minimum of 100 copies of California's statutory Directive to Physicians (the Act's living will "form") on the assumption that such physicians "would be more likely to provide us with more complete information about their experiences in the use of the form."[79] Sixty-six percent or 112 of the physicians representing "a virtual cross section of [California's] urban and rural communities"[80] responded. They were approximately evenly divided in their opinions whether the Act served any useful purpose.[81] The Klutch Report concluded that "the overwhelming majority of respondents — have not had occasion to utilize the Directive to Physicians in

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75. Klutch, *Survey Results After One Year's Experience with the Natural Death Act*, 128 W.J. MED. 329 (1978).

76. Note, *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 STAN. L. REV. 913 (1979) [hereinafter Stanford Survey).

77. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1987).

78. There have been other studies concerning living wills since then, but these did not examine physicians' experiences and did not elicit information on how and if patients who executed directives have been treated. *See* U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY 126 (July 1987) [hereinafter LIFE SUSTAINING TECHNOLOGIES] (citing Joint Commission on Accreditation of Hospitals survey where about 80% of hospitals and nursing homes said they recognize living wills); N.Y. STATE TASK FORCE, *supra* note 1, at 161-80 (discussing questionnaires to hospitals and nursing homes in New York State which asked about institutional acceptance of directives; unfortunately, "the responses were obtained from facility spokespersons, primarily administrators and therefore do not reflect the practices of individual physicians"); Anderson, *Living Wills: Do Nurses and Physicians Have Them?*, 86 AM. J. NURSING 271 (1986) (mailed questionnaire revealed that among the small number (17%) of physician respondents, only 7% had executed a living will for themselves; the study did not elicit information on the treatment of patients).

79. Klutch, *supra* note 75, at 329.

80. *Id.*

81. *Id.*

withholding or withdrawing life-sustaining treatment."[82] Only nineteen physicians "made use of the directive signed by an estimated 67 patients."[83] However, how or if the Directive influenced treatment is not specified. The report forthrightly acknowledged that "the survey results are not based upon the replies of a representative sampling of physicians, [and] the fact that the majority of respondents have not had occasion to utilize the Directive suggests that an insufficient period of time has elapsed to evaluate the effect of this legislation."[84] The Klutch Report was conducted in September, 1977, one year after the Act became law.[85]

For the Stanford Survey, a four page questionnaire was mailed in February, 1978 to 920 selected specialists who were members of the Santa Clara County Medical Society.[86] Thirty-one percent or 284 doctors responded.[87] The empirical data elicited as to the effect directives had on care was meager, incomplete, and buried in three footnotes.[88] Approximately three questions were directed toward evaluating the effect directives had on care.[89] The questionnaire asked, "[t]o your knowledge, how many of your patients have executed Natural Death Act directives?"[90] Fifty-six percent of the respondents said they knew one or more such patients, 36.7% said they knew none and 7.3% did not respond.[91] Twenty-two point nine percent of the respondents said one or more of their patients had executed directives and subsequently died.[92] Finally, 6.5% of the respondents said that since the Act took effect they had withdrawn or withheld treatment they previously would have administered.[93] Unfortunately, these responses were not pursued and it is

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82. *Id.* at 330.

83. *Id.*

84. *Id.*

85. *Id.* at 329.

86. Stanford Survey, *supra* note 76, at 924-25.

87. *Id.* at 925. Surveys using mailed questionnaires average 48% response rates, with a range between 20% and 80%. Higher response rates are associated with follow-up mailings, high salience of the topic to the respondent, and specific populations. N. CHANNELS, SOCIAL SCIENCE METHODS IN THE LEGAL PROCESS 158 (1985). The Stanford survey targeted a specific population, asked about a relatively well-publicized issue, and utilized a follow-up mailing. In this light, the 31% response rate attained seems quite low.

88. Stanford Survey, *supra* note 76, at 938 nn.109-11.

89. *Id.*

90. *Id.* at 938 n.109.

91. *Id.*

92. *Id.* at 938 n.110.

93. *Id.* at 938 n.111. The authors of the Stanford Survey had no consistent policy for reporting respondents who failed to answer questions. Doctors not responding to the question "[s]ince the Natural Death Act . . . have you ever withdrawn or withheld treatment

not clear what effect, if any, the directives had on the treatment these patients were given. One can not tell from these responses how many of the respondents withdrew or withheld treatment because of the directives; what kind of directives, if any, were involved; how many patients were affected; what conditions or circumstances, other than the directives, influenced the withdrawal, withholding or nature of treatment; whether the affected patients were incompetent or terminally ill; and what influence, if any, the family had on the respondents' actions.

The survey's authors were satisfied to conclude that "the Act has had only a small effect on actual cases so far"[94] and that "directives have not been widely used by doctors and patients."[95] However, based on sophisticated statistical analysis of the respondents' conjectures as to how they might respond to four hypothetical clinical situations in which patients had asked that treatment be withheld, the authors also concluded that "responses to the survey suggest that [the Act's] potential effect is great."[96]

However, the respondents' conjectures were not comparable. Most respondents only had "a vague understanding of its [the Act's] key technical provisions."[97] They appeared "confused about the scope of the Act and its specific provisions."[98] The responding physicians also had widely disparate understandings of such critical concepts as "terminal illness,"[99] "artificial life-sustaining procedures,"[100] and "imminent death."[101] The respondents' different

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when previously you would have administered it?" were credited with having answered in the negative. The text states that 6.5% said "yes." *Id.* at 938. The actual response to the question was: 6.5% "yes," 87.3% "no," and 6.2% of the doctors did not respond. *Id.* at 938 n.111.

At other times, non-responsive answers were treated as "yes" answers. When doctors were asked how many of their patients had executed directives, 36.7% said "none," 56% gave a number and 7.3% did not respond. *Id.* at 938 n.109. However, the authors reported in the text that "[n]early two-thirds of the doctors reported that some of their patients have executed directives." *Id.* at 938. In addition, of the doctors asked if any of their patients had died after executing a directive, 60% said "none," 22.9% gave a number, and 17.1% did not respond. *Id.* at 938 n.110. Yet, the authors stated, "40% report that at least one patient has died subsequent to filling out a directive." *Id.* at 938.

94. *Id.* at 939.
95. *Id.* at 945.
96. *Id.* at 939.
97. *Id.* at 931.
98. *Id.* at 940.
99. *Id.* at 932.
100. *Id.* at 932-33.
101. *Id.* at 933.

conceptions could not be mediated in responses to a mailed questionnaire. Responses based on the shifting sand of disparate premises, particularly to hypothetical situations, are not a sound foundation for what the respondents would or might do in the real world.

III. Study Methods and Results

Because physicians occupy a central and controlling role in the operation and implementation of advance directives, this study focuses on physicians' experiences with and understanding of such directives. The results are based on personal interviews with eighteen Vermont and thirty-nine California physicians in the spring of 1985.

A. Methods

1. Study Sites

Vermont and California were selected because both states have statutes authorizing advance directives[102] and because they provide contrasting populations and environments.

California has the longest experience with advance directives—it was the first state to enact a living will statute[103] and a durable power of attorney for health care statute.[104] It is a sprawling west coast state with a heterogeneous, multilingual population of approximately 25 million[105] and several heavily populated urban areas each with several well known, large, university affiliated medical centers. It is home to many patients' rights and right to die groups.[106] California courts have provided the forum for several oft cited "Right to Die" litigations.[107] It is also the only state whose

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102. *See infra* notes 103, 104, 112.

103. California enacted its Natural Death Act in 1976. Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1988).

104. Durable Power of Attorney for Health Care (1983). Cal. Civ. Code §§ 2430-2444 (West Supp. 1988).

105. Almanac of the 50 States, Basic Data Profiles with Comparative Tables 35-37 (E. Hornor ed. 1988).

106. Probably the best known is the National Hemlock Society which promotes euthanasia and distributes advance directives. At the time of this study the society was based in Los Angeles. It has since moved to Eugene, Oregon.

107. *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). None of these cases in-

experience with advanced directives has previously been surveyed.[108]

Vermont by contrast is a rural New England state with a homogeneous population of approximately 500,000.[109] Burlington, its largest city, has a population (including South Burlington) of approximately 45,000,[110] and is the home of its only university affiliated medical center.[111] Its living will statute was enacted in 1982.[112] At the time this study was conducted Vermont had no durable power of attorney for medical care.[113] Its courts have never addressed termination of medical care issues.

2. *Interviewee Selection*

Interviews were conducted in two Vermont cities: Burlington and Montpelier, the state's capital. Solicitations were mailed to the twenty-six Burlington physicians listed in the Directory of Medical Specialists as practicing specialties that are usually the most directly involved in caring for the terminally ill. The specialties were cardiovascular disease, hematology-oncology, pulmonary medicine, gastroenterology, geriatrics, and general surgery. Pediatric surgeons, thoracic surgeons, and surgeons over age sixty-five were not solicited. Because Montpelier's population is approximately 8,000, all of the city's general surgeons and internists or sub-specialists of internal medicine were solicited, for a total of six physicians.

The initial solicitations were by letters from Dr. Arthur H. Aufses, Jr., Chairman of Mount Sinai's Department of Surgery. These were followed by telephone calls. Of the 32 physicians solicited interviews were arranged with 16, one of whom subsequently canceled because of an emergency; two refused to participate; three had moved from the area; one had retired from practice; six were going to be out of town during the interview period; and four could

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volved living wills or durable powers of attorney.

108. *See supra* Section II.

109. ALMANAC OF THE 50 STATES, BASIC DATA PROFILES WITH COMPARATIVE TABLES, *supra* note 105, at 363-65.

110. *Id.*

111. The University of Vermont College of Medicine. University affiliated medical centers are generally the busiest and most up to date hospitals. Because the staff physicians have dual therapeutic and academic roles, they are often better informed than other physicians in the community.

112. Terminal Care Document Act, VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987).

113. A durable power of attorney for health care statute was enacted in 1987, to go into effect July 1, 1988. VT. STAT. ANN. tit. 14, §§ 3451-3467 (Supp. 1988).

not be reached. A medical resident, a pulmonary fellow, and an ICU (Intensive Care Unit) physician who had experience treating patients who had executed advance directives were subsequently added to the roster of interviewees at the suggestion of local physicians to make a total of 18 interviewees in Vermont.[114]

In California, the greater Los Angeles area was selected because of its large, heterogeneous population and the proximity of major medical centers. The large number of physicians in Los Angeles made it impractical to solicit all of them. Therefore, the intent was to locate and interview physicians who had encountered patients who had executed advance directives. Dr. Aufses wrote to colleagues who were the chairpersons of the Departments of Surgery at five major teaching hospitals and a large cancer treatment center in the Los Angeles metropolitan area.[115] They were asked to help locate physicians in any specialty who had encountered patients who had executed advance directives. The initial solicitation was followed by telephone calls to the respective chairpersons to obtain the names of potential interviewees. One reported that he was unable to locate anyone at his hospital. The remaining chairpersons did not locate many physicians who had treated terminally ill patients who had executed advance directives. However, they helped arrange interviews with physicians who either had or were likely to have treated such patients. They also helped arrange interviews with two hospital ethicists and a hospital risk management officer. The ethicists were able to suggest four additional physicians who had treated patients who had executed directives. The risk management officer did not know of any cases.

Three other persons were asked to help locate physicians who had treated patients who had executed directives: a Los Angeles attorney who had represented patients in several "right to die" cases, a trust and estates partner in a prominent Los Angeles law firm which prepared living wills as attachments to clients' wills, and the director of the National Hemlock Society.[116] This approach yielded one lead. Finally, each interviewee was asked to

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114. *See infra* Table I.

115. The six institutions were: Cedars-Sinai Medical Center (Los Angeles); City of Hope Medical Center (Duarte, California); University of California, Los Angeles, Medical Center (Los Angeles); University of California, Irvine, Medical Center (Irvine, California); University of Southern California Medical Center (Los Angeles); and the Wadsworth Veterans Administration Medical Center (Los Angeles).

116. *See supra* note 106 and accompanying text.

suggest other physicians who had or might have treated patients who had executed advance directives. Every lead was followed up by telephone and interviews were arranged. Only two physicians refused to participate.[117]

Thirty-nine Los Angeles area physicians were interviewed over a two and one-half week period in April, 1985.[118] These physicians had either treated patients who had executed advance directives or were involved with, or interested in, the treatment of terminally ill patients. Nine interviews were conducted by telephone when scheduling difficulties precluded an in-person meeting. The telephone interviews lasted approximately twenty-five to thirty minutes each. The in-person interviews averaged one hour.

3. Format

The interview format allowed the physician-interviewees to recount their experiences and observations at length. It also afforded an opportunity to resolve ambiguities and to capture detail and nuance that would have been lost in a mailing or questionnaire. The study was conducted as a joint project of New York City's Mount Sinai Medical Center's Department of Surgery and the Yale Law School. It was felt that medical sponsorship and a physician-interviewer would encourage physician-interviewees to be more forthcoming.

All subjects were interviewed by the author who is a physician. Each interviewee was asked an identical list of open ended questions.

B. Results

1. Physicians' Experience

Despite the special efforts described above, only forty-one physicians, two of whom refused interviews, were found in the densely populated Los Angeles metropolitan area who had, or were likely to have, treated patients who had executed advance directives. The few physicians who had experience with patients who had executed advance directives suggests that advance directives

117. It is unknown if or how many physicians declined at the earlier stages when asked to participate by the surgery department chairpersons.

118. *See infra* Table I.

are rarely used and perforce have little effect on medical decision-making.

Seventeen (44%) of the thirty-nine California interviewees and seven (39%) of the eighteen Vermont interviewees had actually treated terminally ill patients who had executed directives. Most had only treated one or two such patients.[119] The seventeen California interviewees collectively had treated seventy-two terminally ill patients who had executed advance directives. The seven Vermont interviewees collectively had treated twenty such patients. Fifteen (38%) of the thirty-nine California and five (28%) of the eighteen Vermont physicians interviewed never had a patient who, to their knowledge, had executed an advance directive.

2. *Physicians' Knowledge*[120]

All of the interviewees were acquainted with the concept of a living will. Many professed an interest in them. However, they were generally uninformed about the legal status of directives. In fact, three (8%) of the thirty-nine California and eight (44%) of the eighteen Vermont interviewees did not know that their respective states had living will statutes. Moreover, only six (15%) of the California and two (11%) of the Vermont interviewees knew the specifics of their respective state statutes.

While ten (26%) of the California interviewees knew that California authorized durable powers of attorney for health care, only five (13%) knew any specifics. At the time of the interviews, Vermont did not have a durable power for health care.[121] Vermont interviewees were unfamiliar with the concept of a medical agency.

Thus, most physicians who are charged with implementing valid directives did not know:

(1) that they are required to implement a valid directive or to

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119. *See infra* Table II. The conclusion that advance directives have been infrequently employed was confirmed by the hospital ethicists. One of them thought that the newer durable power of attorney would be more widely used and more likely to persuade physician compliance. He said he was therefore going to stop recommending living wills and instead suggest durable powers. The Los Angeles trust and estates attorney said that one-fourth of the new wills prepared by his firm were accompanied by living wills. He had not prepared any of the newer durable powers of attorney for health care, although his firm was exploring the subject. *See supra* text accompanying note 116.

120. *See infra* Table III.

121. *See supra* note 113.

transfer the patient, if possible, to a physician who would;

(2) the substantive and procedural requirements for making or revoking a valid directive;

(3) the number and qualifications of required witnesses;

(4) the duration of directives;

(5) the physician's role in the operation of a directive (*e.g.* certification of incompetence); or that

(6) the statute confers immunity from civil and criminal liability on physicians who, in good faith, implement a valid directive. This lack of knowledge was especially surprising in California which was the first state to enact a living will statute and a durable power of attorney for health care statute, and where living wills have been promoted by numerous organizations.

California is unique in requiring that a valid living will be a specified statutory form and executed or confirmed two weeks after the patient learns of his terminal illness.[122] Forty-one percent of the California interviewees had received informal living wills, that is, living wills that were not in the required statutory form. Approximately two-thirds of the seventy-two California patients with directives whom the physicians had treated had executed informal living wills. However, this fact did not affect the physicians' actions because, until the time of the interviews, they did not know that informal living wills were not binding.

The interviewees' lack of knowledge about directives, like their lack of experience with them, suggests that advance directives are infrequently used and perforce have little effect on medical decision-making. This confirms the opinion of many observers.[123]

3. Effect on Care of Patients

Only seven (39%) of the Vermont interviewees had treated terminally ill patients who had executed living wills. None had al-

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122. CAL. HEALTH & SAFETY CODE §§ 7188, 7191 (West Supp. 1988). Oklahoma also requires that the directive be re-executed subsequent to the terminal diagnosis in order to be binding. OKLA. STAT. ANN. tit. 63, § 63-3107(B) (West Supp. 1989). Oregon requires use of a statutorily specified form. OR. REV. STAT. § 97.055(1) (1984). Unlike California, neither of these states has both provisions.

123. *See* LIFE SUSTAINING TECHNOLOGIES, *supra* note 78, at 127. *See also* N.Y. STATE TASK FORCE, *supra* note 1, at 82.

tered the treatment because of the living will.

(i) Two said the living will did not affect care because they would have discontinued life sustaining treatment anyway, provided the patient's family did not object.

(ii) Two other interviewees had neither the opportunity nor the need to consider the directive because the patient died shortly after executing the living will.

(iii) A fifth physician transferred his competent patient to a neurologist for further treatment. As long as the patient was competent, the living will was inoperative.

(iv) The sixth Vermont interviewee had treated three terminally ill patients who had executed living wills. Two of the patients had been competent until the very end, and had altered the living wills almost daily. The physician was dubious about the directives' reliability. The third patient's family produced a living will late in the course of treatment. The interviewee doubted it applied. However, he had neither the need nor the opportunity to consider any of the directives. The first two patients died shortly after becoming incompetent and the third died shortly after the directive was produced. Nevertheless, the interviewee's exposition of doubts suggests that he would have resisted applying the directives to alter his treatment decisions.

(v) The seventh physician consulted on, but was not in control of, several patients' care. He said his colleagues' fear of liability persuaded most of them to delay implementing a directive until a physician-family consensus on a course of treatment was reached.

The treatment in California was not significantly different. Seventeen (44%) of the thirty-nine California interviewees had experience treating terminally ill patients who had executed formal or informal directives. The directives altered the care of only five of the seventy-two California patients these physicians treated.

In two cases, the directives persuaded the physicians to withhold treatment they would not otherwise have withheld.

Case 1: A comatose eighty-five year old woman was being sustained on a respirator following a cardiac arrest. Because she had a living will, the physician acquiesced in her son's request to discontinue treatment before he normally would have.

Case 2: This case involved withholding treatment. The patient

was in a hepatic coma as a result of a reaction to anesthesia and liver necrosis after surgery for removal of a large head and neck tumor. The patient's children produced a living will and requested a "do not resuscitate" or DNR order and non-aggressive care. The interviewee resisted the childrens' request. He believed the patient's condition was potentially reversible and he also doubted the living will accurately reflected the patient's wishes. He believed that the patient, whom he had known for years, was a fighter who would prefer aggressive treatment. The intensive care unit director disagreed with the interviewee's assessment of the patient's prognosis and wishes and urged him to seek the advice of the hospital's ethics committee. The committee persuaded him that by making the directive, the patient signalled a change of heart. The interviewee wrote a DNR order and agreed to forego aggressive treatment. Shortly thereafter the patient recovered, confirming the interviewee's medical judgment. However, the patient also confirmed that his living will accurately reflected his wishes regarding treatment. Nevertheless, the interviewee was still unsure that the patient would have wanted all life-sustaining therapy withdrawn.

In three other cases California physicians used the directives to defuse the constraint of family opposition to withholding or withdrawing treatment.

Case 3: This case involved a twenty-three year old female AIDS patient who had appointed her husband as her medical agent. The agent tempered the family's (parents and siblings) insistence on unlimited therapy. The agent's ability to persuade the family was decisive. The interviewee stated that he would not have relied on a living will to pursue a course contrary to the family's wishes.

Case 4: The patient was an elderly woman who, while competent, had emphatically confirmed to the physician her wishes to eschew aggressive therapy. She warned him of her daughter's probable opposition. The interviewee produced the living will which persuaded the daughter to agree to withholding aggressive treatment. Had the daughter objected, the physician would not have withheld therapy.

Case 5: The interviewee used the incompetent patient's living will to convince the family to accept his recommendation to discontinue aggressive care. This interviewee said he would have withdrawn care eventually even if he had been unable to persuade

the family.

In the remaining California cases in which interviewees encountered directives, the directives did not affect treatment. In all but two of these cases, the directives iterated the physician-family consensus not to pursue death delaying treatment. In the other two cases, the interviewees had no opportunity to consider the directives. One patient died within two days of appointing her son her medical agent. The other died at home, outside the physician's direct care. The interviewee was not sure she ever was incompetent.

The nonexistence of a directive did not influence any interviewee to administer more treatment than he otherwise would have. This contradicts an oft cited conclusion of the Stanford Survey which suggested that legalization of directives might create a presumption among some physicians that a patient who had not executed a directive wanted maximum care.[124]

4. *Physician Attitudes Toward Directives and Terminal Care*

The interviews suggest that the most important determinants of treatment decisions for incompetent patients are the physician-family consensus as to the proposed treatment and the physician's perception of potential civil or criminal liability. Other factors are the physician's medical judgment, her doubts regarding the reliability, accuracy, applicability, or necessity of the directives, and her moral and economic judgments.[125] These are not discrete con-

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124. "Ten percent of the doctors report that since the Act took effect they have administered treatment in situations in which they previously would have withheld care." Stanford Survey, *supra* note 76, at 939-40. What is not often quoted is the acknowledgement that "this result is very difficult to interpret" because some respondents' comments indicated that they had replied the way they had for reasons unrelated to the Act. *Id.* at 940 n.115. Most of the statutes specifically legislate against this presumption. In Vermont, for example, the law states "[t]his chapter shall not be construed to create a presumption that in the absence of a terminal care document, a person wants extraordinary measures to be taken." VT. STAT. ANN. tit. 18, § 5262 (1987). The California statute does not contain such a statement. Considering most physicians' ignorance of the statutes, it is hard to believe that it would make much difference.

125. In a recent New York case, physicians refused to comply with an AIDS patient's living will and his medical agent's directions to discontinue further care, because they believed that with treatment he could recover from the acute infection (toxoplasmosis) which had rendered him unresponsive. Evans v. Bellevue Hospital, N.Y.L. J., July 28, 1987, at 11, col. 1 (holding that in view of the medical testimony the living will's phrase "no reasonable expectation of recovery" was too ambiguous to allow enforcement of either directive). Reliability as used here means the accuracy with which a directive reflects the declarant's

cerns. They overlap and intermingle. The perception of liability dictates, to a large extent, the need for a physician-family consensus. In addition to the physician's concern for and sense of obligation to the family, many interviewees were acutely aware that the patient's surviving family members are potential plaintiffs.

All of the interviewees knew advance directives existed. Eighty-four percent of the Vermont and 85% of the California interviewees said they approved of the concept.[126] Many said that advance directives were helpful in clarifying the patient's and the patient's family's wishes. Many even said they felt a moral obligation to implement advance directives.

However, their actions belied this enthusiasm. Prior to the interviews, only one of the eighteen Vermont and seven of the thirty-nine California physicians interviewed had informed any of their patients of the availability of advance directives. Parenthetically, one of the California interviewees was chagrined that after advising many patients to execute living wills, none did so. Physician inaction may be partially attributable to ignorance of the legal status of directives. However, after learning about their respective state statutes during the interviews, the majority still said they would not offer directives to their patients. The reasons for this hypothetical approval and actual rejection reflect the four factors which determine treatment decisions.

a. Physician-Family Consensus

The interviewees perceived a pressing need for a physician-family consensus on withdrawal of treatment. They had not implemented, and are unlikely to implement, any patient's directive if there is family disagreement. This, in part, reflects sensitivity to the surviving family's well-being, attempting to lessen potential guilt feelings that they did not do enough or the right thing. But a much stronger influence was the interviewees' perception of potential liability. The patient will be gone. The family will survive.[127]

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preferences.

126. *See infra* Table IV.

127. A similar phenomenon is seen in the world of organ transplantation. The Uniform Anatomical Gift Act (UAGA) provides that, given documentation of the donor's intent to donate, organs may be removed despite family objections. UNIFORM ANATOMICAL GIFT ACT § 2, 8A U.L.A. 15 (1983 & Supp. 1988). The UAGA has been adopted in some form by all 50 states and the District of Columbia. *Id.* Nevertheless, surgeons in 46 states and the District of Columbia, citing fear of liability, ethical considerations, and fear of bad publicity, will not

Most of the interviewees (61% (11) in Vermont and 74% (29) in California) would not rely on the statutory imprimatur, but would delay withdrawing treatment pending family agreement.[128] Of these, 55% in Vermont and 79% in California cited fear of liability as their primary concern.

Thus, as noted earlier, the two Vermont physicians who complied with their patients' directives would not have done so if the family objected.[129] The Vermont physician who consulted on several cases said that most of his colleagues delayed implementing a directive, even when they believed withdrawal of care was appropriate, until a family-physician consensus was reached.[130]

In three of the California cases the directive altered treatment because it convinced the family to abandon opposition to withdrawal of care.[131] In two of those cases, the interviewees would not have relied on the directives to pursue a course contrary to the families' wishes.[132] In the third case, the physician said he would have withdrawn care eventually regardless of family opposition.[133] But the fact is that he delayed withdrawing treatment until he obtained a family consensus. Similarly, the minority of interviewees who said they would implement a patient's directive to withdraw care despite family disapproval never had occasion to do so. Their answers were conjectures which await the test of experience.

The foregoing is not intended to reduce the concern for family consensus solely to the issue of potential liability. Physicians were genuinely concerned with family well-being. Of those interviewees who would delay action pending a family consensus, two of eleven (18%) in Vermont and six of twenty-nine (21%) in California, said they would not act contrary to family wishes because of their moral and ethical obligations to the family. These physicians did not discount liability. But they did not vouchsafe liability as their primary concern. Three other Vermont interviewees suggested they

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remove organs without family consent. Overcast, Evans, Bowen, Hoe & Livak, *Problems in the Identification of Potential Organ Donors*, 251 J. A.M.A. 1559, 1561-62 (1984). *See also* HHS, REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION 29 (1986) (Physicians almost always require the consent of the next of kin even when legally effective donor cards are present).

128. Eleven (61%) in Vermont and 29 (74%) in California. *See infra* Table V.

129. *See supra* p. 473.

130. *See supra* p. 474.

131. *See supra* p. 475, Cases 3, 4 & 5.

132. *Supra* p. 475, Cases 3 & 4.

133. *See supra* p. 475, Case 5.

sought family agreement primarily because the family knows the patient's wishes best.

The interviewees who would not act contrary to family wishes were almost unanimously confident that they could meliorate intra-family and physician-family disagreements within a few days. But whatever the reason, not one interviewee withdrew care without a physician-family consensus, regardless of the presence of directives. The majority said they would not implement a directive unless and until the family agreed to withdrawal of care.

The family's influence may also be demonstrated by the case of a California interviewee who treated a fellow physician with advanced cancer. A directive was not involved. The patient orally directed the physician to "do everything" no matter how futile it seems. When the patient went into septic shock and a coma, the physician abandoned his patient's instructions and acquiesced in the family's request to withdraw treatment. He too saw no value in continued treatment. He was wrong. The patient regained consciousness. A week later, after reprimanding the physician and telling him that the past week had been the most important in his life, the patient said goodbye to his family and died. This incident convinced the interviewee to "get his head out of his patient's decisions."

The interviews suggest that physicians will not terminate care if there is persistent family disagreement, even if the physicians are persuaded that continued treatment is futile and the directive accurately represents patient's wishes. However, directives may have a role to play in producing a physician-family consensus as they did in three of the California cases.[134]

b. Perception of Liability

Physicians' fear of potential lawsuits, prosecutions, and civil or criminal liability was the major impediment to withdrawing life sustaining treatment. Family members were generally feared as potential plaintiffs in civil actions. The notorious *Barber v. Superior Court* case[135] made criminal prosecution a genuine, palpable issue.

In *Barber*, two California physicians, with the family's con-

134. *See supra* p. 475, Cases 3, 4 & 5.

135. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

sent, removed intravenous hydration and antibiotics from a vegetative patient.[136] The patient died within days and the physicians were indicted for murder.[137] A magistrate dismissed the indictment, the Superior Court reinstated it, and finally a California Court of Appeals reversed and dismissed the indictment before trial.[138]

Though *Barber* did not involve an advance directive, every California interviewee volunteered it as a rationale for cautious reluctance to withdraw care, regardless of an advance directive. They found little solace in the case's ultimate dismissal, or in the fact that the California Natural Death Act explicitly provides immunity from civil or criminal liability for physicians and licensed health professionals who act in reliance on a directive executed in accordance with the statute.[139] Likewise, they found little comfort in the fact that the *Barber* prosecution was the handiwork of a "crazy," overzealous District Attorney who was subsequently voted out of office. They were not sanguine that that one prosecutor's being defrocked meant the end of aberrant criminal prosecutions.[140] The possibility of a civil lawsuit and particularly a criminal prosecution which would wreak havoc with their practice, reputation, and pocketbook, was sufficient to deter them from withdrawing care. As one interviewee said, "I don't want to be a test case."

The interviewees were also concerned about reaching a consensus with other involved health care providers, anyone of whom could "blow the whistle." Several notorious cases, including *Barber*, were instigated by complaint of a "pro-life" nurse.[141]

Prior to the interviews, very few interviewees knew that their

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136. *Id.* at 1010-11, 195 Cal. Rptr. at 486.

137. *Id.*

138. *Id.* at 1022, 195 Cal. Rptr. at 494.

139. CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1988).

140. Overly eager local prosecutors are not confined to California. *See* N.Y. STATE TASK FORCE, *supra* note 1, at 10.

141. This situation has arisen most often in the context of non-treatment of defective infants. *E.g.*, United States v. University Hosp., 729 F.2d 144 (2d Cir. 1984). The infamous Baby Doe case prompted the U.S. Department of Health and Human Services to issue so called "squeal rule" regulations, which required posting of signs in new born nurseries advertising a "hot line" to report instances of medical abuse or neglect of handicapped children. *In re* Infant Doe, No. 608204-004A (Monroe County (Ind.) Cir. Apr. 12, 1982). These regulations were eventually invalidated in American Academy of Pediatrics v. Heckler, 561 F. Supp. 395 (D.D.C. 1983).

respective state's statutes immunized them from civil and criminal liability for implementing a valid advance directive.[142] However, their ignorance only partially explains the statutes' failure to alleviate physicians' fears. Even after learning of the statutory immunity, most said they would not rely on the statute to protect them. Four California interviewees said that nothing short of a court order could convince them to withdraw care from a comatose patient.

c. Physician's Control

Most interviewees were uncomfortable with the changes directives would make in their traditional, albeit amorphous, modus operandi. Many doubted the necessity and usefulness of directives. Forty-six percent of the Vermont and 24% of the California physicians interviewed said that they knew their patients' wishes without a discussion or a directive. The Vermont physicians were particularly insistent that they knew what their patients wanted because they see their patients regularly over many years.

This was reflected in practice. Most of the interviewees were not inclined to discuss terminal care with their terminally ill patients. Only 23% of the Vermont and 41% of the California physicians interviewed said they initiate such discussions. Some will only discuss terminal care if the patient broaches the subject.[143] Some prefer to discuss terminal care with the patient's family.[144] One can also intuit that doctors are uncomfortable discussing death with patients. Three California interviewees volunteered that they and their colleagues view death as a defeat.[145]

Some interviewees also doubted that living wills accurately reflect the patient's wishes. Take, for example, the California physician who resisted the directive, and the urgings of the patient's family and a colleague, because he believed the patient was a fighter who would not want care withdrawn.[146] There was also the Vermont physician who had serious doubts as to the reliability or applicability of the living wills executed by three patients he had

142. *See supra* section III(B)(2). *See also infra* Table III.

143. Fifteen percent in Vermont and 11% in California.

144. Fifteen percent in Vermont and 19% in California.

145. *See* T. MIZRAHI, GETTING RID OF PATIENTS 103-04 (1986). While "getting rid of patients" by any means possible, for example by discharge or transfer, was viewed as a priority by most resident physicians, they typically viewed death as a failure, and felt compelled to keep patients alive at all costs. *See id.*

146. *See supra* p. 474, Case 2.

treated.[147]

The interviewees' experience with durable powers of attorney for health care,[148] was limited in California, where there was an enabling statute, and non-existent in Vermont, where at the time of the interviews, there was no statute authorizing them.[149] Nevertheless, four Vermont interviewees liked the idea of a medical agent, ten did not, and four had no opinion. Ten of the California interviewees preferred the living will to the medical agent, eleven preferred the agent, and eighteen had either no preference or opinion, or disliked all types of directives.

The Vermont and California interviewees who disliked medical agency objected primarily because it introduced a single third party decision-maker into the relationship. They were concerned that this might create intra-family conflict and conflict with the physician. One California interviewee expressly preferred the living will because it gave the physician more leeway.

The interviewees who preferred the medical agent did so for the diametrically opposite reason that an existing single decision-maker would provide the certainty a family consensus could not and the flexibility to address problems as they arise. Some also said that an agent would obviate the problems of defining terminal illness, extraordinary care, and related issues. However, a few conditioned their opinions on the proviso that the agent be a family member or that the appointment include explicit instructions.

The roots of the interviewees' ambivalence toward directives of any type are apparently: (1) fear of liability; (2) the perception that directives interpose an unnecessary additional control over, and interfere with, the physicians' professional actions; and (3) the perception that directives implicitly question the physicians' judgment of the patients' best interest. One interviewee volunteered that a substantial number of his colleagues dislike directives because they believe directives would curtail doctors' control of treatment. This observation is partially confirmed by the fact that many interviewees strongly opposed the interposition of formal ethics committees. Only three interviewees in each state agreed that other physicians or an ethics committee should be

147. *See supra* p. 474.
148. *See supra* note 104.
149. *See supra* note 113 and accompanying text.

consulted.[150]

The importance attached to control is illustrated by the interviewees' expressed reluctance to honor directives they do not agree with. Not one California interviewee knew that California's Durable Power of Attorney for Health Care statute allowed the patient to direct unlimited care regardless of their condition or chances for recovery.[151] Fifty-six percent (nine out of sixteen) of the Vermont and 61% (sixteen out of twenty-six) of the California interviewees who had an opinion said they would not honor a request for unlimited care. The idea of unlimited care apparently offended their moral and utilitarian judgments about using scarce or costly medical resources in situations where they would confer no benefit. Eight of the California interviewees objected primarily on the economic ground that unlimited care would be too expensive. Three of them, and two Vermont interviewees, overtly posited that the major reason for directives, which they had erroneously believed could only limit care, was to contain costs. In their view, unlimited care would waste money.

Only five California interviewees had treated patients who had

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150. Most statutes require the concurrence of at least two physicians that the patient is "qualified," in other words, terminally ill and incompetent, before implementing the directive.

151. The attorney-in-fact is required to act consistent with his principal's desires and is empowered to make health care decisions including "consent, refusal of consent, or withdrawal of consent to any care." The principal is assured that "health care necessary to keep you alive may not be stopped if you object." CAL. CIV. CODE § 2433 (West Supp. 1987).

None of the living will statutes prohibit persons who wish to be kept alive when they become terminally ill from executing a directive to that effect. Both Maryland and Indiana expressly provide for the rights of such persons. MD. HEALTH-GEN. CODE ANN. § 5-611 (1987) ("An individual . . . may execute a declaration directing the initiation or continuation of life-sustaining procedures."). The Indiana statute creates two forms: a "Living Will Declaration" for those desiring the withholding or withdrawing of life-sustaining care and a "Life-Prolonging Procedures Declaration" for those desiring the use of life-prolonging procedures. IND. CODE ANN. § 16-8-11-12 (Burns Supp. 1988). Several states recognize the right to make a declaration "to provide, withhold or withdraw life-prolonging procedures." FLA. STAT. ANN. § 765.02 (West 1986); N.H. REV. STAT. ANN. § 137-H:1 (Supp. 1988); UTAH CODE ANN. § 75-2-1102(2) (Supp. 1988). Similar declarations are made in the legislative findings preceding the Arizona act and in the Policy Statement preceding the Iowa act. Tennessee affirms the "inherent right . . . to accept, refuse, withdraw from" medical care and defines a Living Will to be "a written declaration stating declarant's desires for medical care or noncare." TENN. CODE ANN. §§ 32-11-102, 32-11-103(4) (Supp. 1988). Arkansas formerly provided that "every person shall have the right to request that such extraordinary means be utilized to prolong life to the extent possible." ARK. STAT. ANN. § 82-3801. This provision was deleted in 1987.

See also Kapp, *Response to the Living Will Furor: Directives for Maximum Care*, 72 AM. J. MED. 855 (1982).

orally requested unlimited care. Only one was put to the test and he succumbed to the family's request to discontinue care.[152] Two cardiologists said they opposed unlimited care and such requests by their patients made little practical difference. Resuscitative efforts following cardiac arrest for patients with advanced heart disease are rarely successful.[153] Two interviewees jointly treated a patient with end-stage AIDS who had orally requested unlimited care. Each said he would have been willing, but his colleague was unwilling, to honor the request. The patient suffered a cardiopulmonary arrest and died despite resuscitative efforts. No DNR had been written.

d. Due Process Considerations

Though fear of liability was important, the interviewees had made no effort to ascertain whether the directives offered were valid. Only one California interviewee once consulted the hospital ethicist to ascertain whether directives were legitimate. When queried whether they believed some summary procedure to validate (prove) the authenticity of directives would be helpful, the interviewees were divided. Six of the thirteen Vermont and sixteen of the thirty-two California interviewees who ventured an opinion said that such a procedure would be useful. The others thought it would be an unnecessary intrusion into the doctor-patient relationship and expressed a generalized distrust of lawyers, courts, and formal procedures.

CONCLUSION

The obvious conclusion of this study is that directives still have "had only a small effect on actual cases so far."[154] The effect of directives has not increased in the seven or eight years since the Klutch Report and the Stanford Survey.[155] However, it is no longer true that the majority of physicians "have not had occasion to utilize the Directive."[156]

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152. *See supra* p. 478-79.

153. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281, 1282-83 (1987).

154. Stanford Survey, *supra* note 76, at 939.

155. *See supra* section II. This study yielded no evidence to support the oft-cited claim of Concern for Dying that millions of living wills have been requested and distributed from their offices. If so, they apparently have not been used.

156. *See* Klutch, *supra* note 75, at 330.

It is unlikely that directives have great potential for resolving the medical decision-making problems of hopeless patients. This is true even if factors which have contributed to their ineffectiveness so far, such as fear of liability, and physician and patient lack of knowledge, are eliminated. Directives, like traditional last wills and testaments in their sphere, only offer a small informed minority of the population an opportunity to obtain an imperfect degree of control over their medical care while incompetent. Absent some compulsion, most competent people are unlikely to document their medical treatment preferences, and the chronic incompetent cannot. As the *Barber* court observed, "the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused."[157]

It may be suggested that directives be institutionalized, that is, every patient be offered, or required to execute, a directive on admission to a hospital. That course presents its own slippery slope. For the anxious patient unaware of the full significance of the directive, and often under implicit or explicit coercion to sign, the directive would become an additional meaningless piece of paperwork passing between strangers,[158] and do nothing to enhance patient autonomy.

Directives under optimal conditions, can only approximate patient autonomy. The gap between autonomy and the directive's contents widen as the time span between execution and operation grows and as unanticipated conditions arise. Except for valid living wills executed in California or Oklahoma,[159] patients perforce execute directives with little or no information about their eventual incapacitating illness and the risks and benefits of accepting or re-

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157. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983). As Freud observed:

> Our own death is indeed unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators. Hence . . . at bottom no one believes in his own death, or to put the same thing in another way, in the unconscious everyone of us is convinced of his own immortality.

S. Freud, *Thoughts for the Times on War and Death*, in 54 GREAT BOOKS OF THE WESTERN WORLD 761 (1952).

158. Cassel, *Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985*, 6 CARDOZO L. REV. 286, 293 (1987).

159. These two states require the patient to re-execute the directive after learning their terminal diagnosis in order to make the directive binding. *See supra* note 50 and accompanying text.

jecting alternative treatments that will then be available. Thus, their treatment instructions are uninformed.[160] There also is anecdotal evidence that some patients do not discuss treatment preferences with the surrogate they designate in a durable power or notify the surrogate of the designation.[161] But these infirmities are the subject of another discussion.

Directives focus on approximating the hopeless patient's right of self-determination. Perhaps, the question should be whether a hopeless patient has rights and what those rights are. As Professor Tribe noted in commenting on the seminal *Quinlan*[162] case, in which a hopeless patient's father sought authorization to remove her respirator, "the task of giving content to the notion that she had rights, in the face of the recognition that she could make no decisions about how to exercise any such rights, remains a difficult one."[163] The real issue in *Quinlan* and other cases of that genre[164] was not vindication of the hopeless patient's rights. Rather, as Professor Tribe said,

> attributing 'rights' to Karen at all was problematic; more realistically at stake were the desire of her anguished parents to be rid of their torment and the interests of society in freeing medical decision makers from blind adherence to a practice of keeping vegetating persons 'alive' simply out of fear of prosecution.[165]

It may be more realistic to accept the concept that under restricted circumstances, it is socially and morally acceptable to permit a surrogate to choose a hopeless patient's death rather than struggle to rationalize the choice as an exercise of the incompetent's right of self-determination. Courts which have applied the "best interest" standard, have accepted this concept. Their deci-

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160. *See* Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENG. L. REV. 113 (1987) (arguing that living wills abandon the link between information and decision and therefore actually discourage physician-patient discussion).

161. *See* LIFE SUSTAINING TECHNOLOGIES, supra note 78, at 116.

162. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976), *rev'd on other grounds*, *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

163. L. TRIBE, *supra* note 2, at 936 n.11. *See also* Kamisar, *Speaking Out: Karen Ann Quinlan and the "Right-to-Die"*, 29 LAW QUADRANGLE NOTES 2 (Univ. Mich. L. School 1985) ("[W]as it really a 'right-to-die' case? I think not. I believe it more accurate—albeit much more troublesome—to view it as what might be called a 'power-to-let-some-other-die' case.").

164. *See, e.g.*, Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

165. L. TRIBE, *supra* note 2, at 936 (footnote omitted).

sions would be better served by making the idea explicit.[166] It also may be perfectly moral to accept the concept that permanently unconscious individuals who have lost all social and experiential capacity are living corpses whom we can ethically stop nurturing.[167] Using limited or costly medical resources to nurture a corpse is immoral. It is not simply that resources could be better used elsewhere. Rather, it is morally and ethically wrong to squander resources on permanently unconscious patients who derive no benefit

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166. In *Barber*, the California court ratified discontinuance of life sustaining nutrition because it was in the best interest of patients in a persistent vegetive state who could feel no pain and who had no "reasonable possibility of return to cognitive and sapient life." Barber v. Superior Court, 147 Cal. App. 3d 1006, 1019, 195 Cal. Rptr. 484, 492 (1983) (quoting *Quinlan*, 70 N.J. 10, 355 A.2d 647, 669 (1976). *See also In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988) (holding that a conservator may decide to forego life sustaining treatment if there is no reasonable possibility of return to cognitive and sapient life and that therefore the conservatee would be better off dead).

The New Jersey courts, which with the Massachusetts courts, have been pioneers in this area of the law, proposed a three step inquiry. First is the purely subjective or "substituted judgment" test, which asks what did the patient want. Failing clear, reliable, or credible evidence of the patient's wishes, there are two "best interest" tests: the limited-objective test, which melds information of the patient's wishes with the surrogate's view of the patient's best interest; and failing any evidence of the patient's wishes, resort is had to the pure-objective test, which is the surrogate's good faith determination that in the particular circumstances the patient is or is not better off dead. *See* Matter of Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). The New York courts have bucked the trend insisting on clear and convincing evidence of the patient's express wish to forego life sustaining treatment. *See, e.g., In re* O'Conner, N.Y.L. J., Oct. 18, 1988, at 21, col. 3 (Ct. App. Oct. 17, 1988).

Many courts denominate withdrawing treatment as substituted judgment even when there is little or no evidence of the patient's wishes. Thus, the Massachusetts's Supreme court ratified withdrawing treatment as substituted judgment, even though the patient never formulated any intent since he had never been competent. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). By contrast in an analogous case, the New York Court of Appeals refused to approve withholding treatment because, in its opinion, the chronically incompetent patient never could have formulated and certainly could not have expressed, an intent. *In re* Storar, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, *cert denied*, 454 U.S. 858 (1981). *See also* Kamisar, *The Real Quinlan Issue*, N.Y. Times, June 17, 1985, at A19, col. 1.

> We cannot enter the minds of comatose people to learn if they wish to struggle on. But we can end the fiction of presuming to speak in their behalf. Instead, let courts be honest and say life-support systems should be turned off not because of patient's wishes but, alas, because they think the patient is "better off dead."

Id.

167. *See generally* Veatch, *The Whole-Brain-Oriented Concept of Death: An Outmoded Philosophical Formulation*, 3 J. THANATOLOGY 13 (1975) (arguing that earlier "crude formulations of the so-called 'brain definition of death' " should be replaced by a neocortical brain death standard); *See also* Younger & Bartlett, *Human Death and High Technology: The Failure of the Whole Brain Formulations*, 99 ANNALS INTERNAL MED. 252 (1983); Green & Wikler, *Brain Death and Personal Identity*, 9 PHIL. & PUB. AFF. 389 (1980).

from the procedures.[168] It also is an immoral assault on human dignity to treat a corpse as living.

Directives, provided they are knowledgeably made, implemented and enforced, may serve a function for those competent individuals who are sufficiently motivated to execute them, especially by promoting physician-family consensus. However, directives cannot answer the question of how to make treatment decisions for the permanently unconscious patient[169] and the irreversibly infirm senile patient[170] who were not prescient enough to document their preferences or for the never competent terminally ill patient who never had preferences to document.[171] For those individuals, a process for selecting suitable surrogate decision-makers[172] and explicit criteria to guide their decisions may be a better staff to lean on. A summary due process procedure structured with cognizance of the finality and significance of the life-death determination involved is essential to assure the validity of directives and surrogate decisions, and to obviate physician, patient, and family doubts.

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168. Veatch, *supra* note 167, at 17; *See also* N. CANTOR, *supra* note 22, at 86-87.

169. *See, e.g.*, Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976), *overruled in part*, *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

170. *See, e.g.*, *In re* Hier, 18 Mass. App. Ct. 200, 464 N.E.2d 959, *appeal denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

171. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Storar;, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

172. Such a process may be analogous to intestacy statutes.

DECISIONS FOR THE DYING

TABLE I

SPECIALTIES INTERVIEWED:

SPECIALTY	VERMONT	CALIFORNIA
ONCOLOGY	3	9 (1)
SURGERY	6	9 (1)
GERIATRICS	3	4 (2)
PULMONARY MEDICINE	3	4 (2)
CARDIOLOGY	1	3
INTENSIVE CARE (ICU)	1	3 (1)
INTERNAL MEDICINE	1	7 (2)
TOTALS:	18	39 (9)

NOTE: Numbers in parenthesis indicate telephone interviews.

TABLE II

PATIENTS TREATED WITH DIRECTIVES	VERMONT DOCTORS	CALIFORNIA DOCTORS
0	11 (61%)	22 (56%)
1	3	8
2	2	2
3	1	1
4	0	0
5	0	0
6-9	0	2
10 or more	1	4
TOTALS	18	39

TABLE III

KNOWLEDGE OF STATUTES:

	NEVER HEARD OF LAW	HEARD OF, KNEW NO DETAILS	READ LAW OR KNEW DETAILS
VERMONT	8 (44%)	8 (45%)	2 (11%)
CALIFORNIA:			
Natural Death Act	3 (8%)	30 (77%)	6 (15%)
Durable Power	10 (26%)	24 (61%)	5 (13%)
Both Laws	2 (5%)	34 (87%)	3 (8%)

TABLE IV

GENERAL VIEWS ON DIRECTIVES

	VERMONT	CALIFORNIA
LIKED DIRECTIVES:		
Clarify Patient's Wishes	5	15
Doctor Can Use To Convince Family	6	5
Vehicle to Discuss Terminal Care	3	2
Legal Protection for the Doctor	-	4
Alleviates Family Guilt	2	-
Identifies Single Decisionmaker	-	2
Assure Patients Their Wishes Will be Followed	-	1
No Reason Given	-	4
	16	33
DISLIKED DIRECTIVES		
Unnecessary	1	1
Patient May Change Mind	1	1
Not Reassured on Liability	-	2
Written Documents Too Awkward	-	1
Patients Ignorant of Medicine	-	1
	2	6

Note: When more than one reason was given only the primary one is reported in this table.

TABLE V

WILLINGNESS TO FOLLOW DIRECTIVE AGAINST FAMILY WISHES AND REASONS

VERMONT		
NO:		
	Fear of Liability	6
	Obligation to Family/Family Guilt Feelings	2
	Family Knows Patient's Wishes Best	3
		11 (61%)
YES:		
	Should Follow Patient's Wishes	4
	Must Do What Is Best For Patient	3
		7 (39%)
CALIFORNIA		
NO:		
	Fear of Liability	23
	Obligation to Family/Family Guilt Feelings	6
		29 (74%)
YES:		
	Should Follow Patient's Wishes	7
	Would Follow Durable Power But Not Other Directives - More Flexibility	2
	Because Law Requires	1
		10 (26%)