Death by Directive

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On April 16, 1986 the California Court of Appeal for the Second District upheld Elizabeth Bouvia's petition to remove a feeding tube from her stomach. Approving her wishes, the court noted: "Is it not a medical decision for her physician to make. Neither is it a legal question whose soundness is to be resolved by lawyers and judges. It is not a conditional right subject to approval by ethic committees or courts of law. It is a moral and philosophical decision that, being a competent adult is hers to make alone."1

Bouvia v. Superior Court2 caps a decade of development of California law with respect to control of medical life support. It falls on a background of technical development that allows the marginal postponement of death often at great expense for an extended time. Increasingly, someone must make a choice to allow life to end rather than to rely on natural process. This new and unwanted obligation has forced patients, their families, the medical community and the courts to face issues previously avoided.

In the tradition of individual autonomy, the choice has ostensibly been left to each individual patient but has usually, in fact, been made by doctors applying "medical standards." Physicians have assumed the responsibility, leaving patients and their surrogates to go through courts to assert their right to decide. Commonly, unlike Elizabeth Bouvia, those affected were incompetent to choose by the critical time. Making decisions for them has proven perplexing both to surrogate decision-makers and to reviewing courts. California created a statutory directive through which one could make a prospective choice. Twelve years later, such a statute has been adopted by thirty-seven other states and the District of Columbia.3 It is seriously flawed and in need of revision.
I.

The ability, medically, to support life despite the failure of bodily functions grew significantly in the latter half of this century. Aggressive use of ventilators was a post World War II development.\(^4\) Dialysis machines did not become available until the sixties.\(^5\) Intensive Care Units (ICU’s), the locus of most critically ill patients, existed in about ten percent of hospitals in the sixties and are virtually universal today.\(^6\) Heart and kidney transplantation, not to mention open heart surgery and more minor replacement of arteries and valves, have joined the repertory of medical responses.\(^7\) Some artificial body components have been in use for some time, but artificial hearts,\(^8\) artificial blood\(^9\) and artificial skin\(^10\) are now available to add to the reservoir of donated supply. Diagnostic improvements such as computed tomographic (CT) and nuclear magnetic resonance (NMR) scanners have all added greatly to the efficacy of new drugs and procedures.\(^11\)

One can see the effect of new medications and processes in the changes in patterns of death. Contrasting the present with the turn of the century, one notes that communicable diseases have greatly declined as a cause of death while degenerative diseases have become more prominent. Heart disease, cancer and cerebrovascular disease

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5. Id. at 111.
6. U.S. Office of Technology Assessment, Intensive Care Units (ICUs): Clinical Outcomes, Costs, Decision Making (1984). “From 1981 AHA survey tapes it can be estimated that 78 percent of short-term general hospitals have at least one ICU or CCU, and that 93 percent of hospitals larger than 200 beds have a separate ICU.” Id. at 15.
7. See generally U.S. House of Representatives, Subcommittee on Investigations and Oversight of the Committee on Science and Technology, New Opportunities in Treating Kidney Disease (1982); President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 1 (1983) [hereinafter President’s Commission Report].
have replaced influenza, pneumonia and tuberculosis as major causes of death.\footnote{12} The dying population is older, more likely to be in a hospital and to have suffered from the cause of their death for an extended period than was previously true.\footnote{13} By 1949, half of all deaths occurred in hospitals. The percentage has increased about ten percent per decade. Modern medicine has gotten the population past life threatening diseases and to the point at which death more commonly comes from gradual bodily failure than from sudden infection. Its success has, in turn, increased life expectancy thereby increasing the elderly, more frail population.

Not surprisingly, these changes have created more disputes concerning treatment of the terminally ill, some of which have found their way to court. The litigation to date has typically concerned petitions to require patients to submit to life support or to require health care professionals to withdraw it.

The law has treated life support refusal as if it were a problem rarely to be confronted. In fact, the choice whether to continue to provide medical support is one that increasingly has to be made by someone. It has been estimated that it may be involved in at least six percent of the cases in hospital wards.\footnote{14} Statistics are difficult to gather since death is normally recorded as having resulted from an underlying disease rather than as a result of a decision to remove support.\footnote{15}

A recent empirical study of long term dialysis patients\footnote{16} provides some indication of the process. In a group of 1766 patients being treated for end-stage renal disease by dialysis, 155 died because dialysis was ended.\footnote{17} They represented nine percent of the patient group and twenty-two percent of those who died. Sixty-six of them were considered competent to make their own decision and did so, although in six cases, ending treatment was first suggested by a physician or by family. Discontinuance did not follow a set pattern although age and diabetes were the highest risk factors. Of the competent patients who discontinued treatment, about half did so at a

\begin{footnotes}
\item[15] \textit{Presidential Commission Report}, supra note 7: "[I]f an otherwise dying patient is not resuscitated in the event of cardiac arrest, or if pneumonia or kidney failure goes untreated, the underlying disease process is said to be the cause of death." \textit{Id.} at 68-69.
\item[17] \textit{Id.} at 15
\end{footnotes}
time during which they were not experiencing medical complications.\textsuperscript{18} Those who discontinued when a medical complication such as amputation or blindness occurred were not distinguishable by other characteristics from those who remained on dialysis under those circumstances.\textsuperscript{19}

II.

Studies of attitudes about death show great diversity of opinion.\textsuperscript{20} Some hold life very precious and want to remain alive as long as possible irrespective of pain and discomfort.\textsuperscript{21} Others want death to come quickly once they are diagnosed as incurably ill and death is probable from their disease.\textsuperscript{22} There are many points of view between these polar extremes.

That there is substantial interest in hastening rather than prolonging death is demonstrated by the apparent interest in directives to physicians to withhold life support. An estimated five million such directives have been executed.\textsuperscript{23} It is also popularly reported that in the Netherlands one in six deaths were actively caused by physicians at their patient’s request.\textsuperscript{24}

Limitation of medical life support may also become a product of cost containment efforts. During the last few years, there has been increased concern about the costs of health care. In fact, the United States is the best example of the fact that expenditures on medical care vary directly with the wealth of countries\textsuperscript{25} in the manner usually associated with luxuries and contrary to the pattern of necessities. It is easy to illustrate the high cost of medical treatment controlling for changes in population (i.e. by units of care). In 1950, a day’s stay in a hospital cost $14.00. It rose to $133.00 by 1975 and was at nearly $300.00 in 1982.\textsuperscript{26} The day rate at Stanford Hospital is now from $466 to $544 depending on room type. In real dollar terms, it has more than doubled just since 1965.\textsuperscript{27} Medical care has grown

\textsuperscript{18} Id. at 18.
\textsuperscript{19} Id.
\textsuperscript{20} See President’s Commission Report, supra note 7, at 21-22.
\textsuperscript{21} President’s Commission Report, supra note 7, at 21.
\textsuperscript{22} President’s Commission Report, supra note 7, at 21.
\textsuperscript{24} 60 Minutes: The Last Right? (C.B.S. television broadcast Jan. 5, 1986). See infra note 176.
\textsuperscript{25} Maxwell, Health and Wealth 41 (1981).
\textsuperscript{26} Menzel, Medical Costs, Moral Choices 1 (1983).
\textsuperscript{27} Id.
from 5.3% of the gross national product in 1960 to over 10% by 1984.28 Per capita annual expenditure has increased over ten times between 1950 and 1980.29 It is especially important to note that critical care administered in Intensive Care Units constitutes ten to fifteen percent of that amount, about 30 billion dollars.30

Terminally ill patients account for a disproportionately high percentage of medical costs. In 1974 Selam Mushkin31 estimated that over 20% of all non-psychiatric hospital and nursing home expenditures in non-governmental facilities were spent on the care of the terminally ill. Although only 5% of all Medicare enrollees died in 1967, 22% of all reimbursements were made on their behalf.32 The Health Care Financing Administration reported that the cost of such care ranged from nineteen to twenty-two percent of all reimbursed Medicare charges from 1974-1976.33 Detsky found that “the data indicate that the use of resources for dying patients exceeds resources use for other high cost patients.”34 The Massachusetts General Hospital patient classification system and the Therapeutic Intervention Scoring System provide improved data for prognosis.35 Quite consistently, there is an inverse relationship between favorable prognosis and expenditure.36

The high cost of critical care both in absolute terms and in relationship to the total cost of medical care has brought considerable current focus on it in the medical community. The fact that prognosis has become as reliable as it has results in some pressure for cost

29. Id.
30. The total cost of hospital care for 1984 was $157 billion. UNITED STATES ACCOUNTING OFFICE, CONSTRAINING NATIONAL HEALTH CARE EXPENDITURES: ACHIEVING QUALITY CARE AT AN AFFORDABLE COST Sept. 30, 1985, at 10. OFFICE OF TECHNOLOGY ASSESSMENT, INTENSIVE CARE UNITS (ICUs): CLINICAL OUTCOMES, COSTS, AND DECISION MAKING 22 (1984). The Office of Technology Assessment reported that the percentage of total hospital care costs attributable to ICUs is 15-20%. Combining the two figures, the total cost of ICU care for 1984 would be $23.7 to $31.5 billion. Id.
33. Id.
34. Schroeder, Showstack & Roberts, Frequency and Clinical Description of High-Cost Patients in 17 Acute-Care Hospitals, 300 NEW ENG. J. MED. 1306 (1979).
containment through limitations on expenditures for what is correctly perceived to be a high-risk, high-cost, low-yield group by reducing marginally effective therapies, those that add only slightly to the welfare of patients in general or those which add to welfare of only a small group of patients. 87

Technological advances continue. It is not possible to be certain about their future costs. It is always possible that low cost alternatives will be found for presently expensive treatment without a diminution of effectiveness and that new therapies will provide savings over those in place but cost savings have not been the rule to date. It consequently seems prudent to estimate that new technology will add to or at least maintain present costs.

The aging of the population will contribute increasingly to the demand for expensive therapy. Critical care patients are, of course, disproportionately elderly. 88 Consequently, even providing continued support at present per capita levels will amount to a reduction of available resources for patients. For example, heart transplants cannot be provided to most of those whose lives they might extend. 89 It is possible to acknowledge that fact without admitting to health care rationing because it can be blamed on the scarcity of appropriate organs to transplant. The excuse is quite temporary. Artificial hearts have been developed and used. 90 They will, no doubt, be perfected in the near future. It is estimated that some 50,000 people per year would be suitable candidates for such hearts. The cost, when the device is perfected, is likely to be at least $50,000 per patient with additional first year costs of about $100,000. The total cost would be between 2.5 and 5 billion plus follow up costs. 91 Similar expenses attend liver and other transplants. 92 A transplant is, of course, only one of many treatments which might be beneficial. In the United States, an estimated two million patients die per year. 93 An increas-

37. Silverman, supra note 35, at 224-25. But see Scitovsky & Capron, Medical Care at the End of Life: The Interaction of Economics and Ethics, 7 ANN. REV. PUB. HEALTH 59, 70, 73 (1986) (asserting that the difficulty of separating dying patients from those critically ill prospectively is insuperable and that, in fact, expenditures on those who die are actually less than treatments for critically ill patients who survive).

38. PRESIDENT'S COMMISSION REPORT, supra note 7, at 17-18.

39. Efforts to improve the chances of locating a transplant organ for their children, have led several parents recently to make public appeals on television.

40. See Bernstein, supra note 8, at 71-72.


42. Id.

43. NATIONAL CENTER FOR HEALTH STATISTICS, VITAL STATISTICS OF THE UNITED STATES: MORTALITY Part B 7 (1973); U.S. GOVERNMENT PRINTING OFFICE, FACTS OF
ing number of patients utilize intensive care;\textsuperscript{44} the average cost for ICU treatment is $14,000 exclusive of physician fees and many other costs.\textsuperscript{45} If everyone died in an ICU, that cost alone would be 28 billion dollars.\textsuperscript{46}

The pressure of costs has led a number of commentators to predict that substantial reductions in resources will follow.\textsuperscript{47} A common focus of procedures which might lead to savings is reducing the range of persons admitted to intensive care and reducing such care for those for whom it is marginally useful. Since Great Britain has a system which delivers health care at substantially lower costs, British experience is one indication of the broader range of changes that might be anticipated.

As in the United States, there is no express rationing system for health care in Great Britain.\textsuperscript{48} Appropriate care standards accommodate the more limited resources. Some practices which would be common in the United States are rarely available but their unavailability is explained, within the system, by asserting that the treatments are medically inappropriate.\textsuperscript{49} The result is reflected in standards of care which have already incorporated the scarcity of supply. To a physician accustomed to practicing in the United States, the standards of care would, consequently, represent substantial diminution of optimal care.

Using the magnitude of utilization in the United States as a base, some forms of care are available in substantially reduced measure in Britain. Per capita expenditures run about one third as high as those in the United States.\textsuperscript{50} The British perform half as many X-rays and use half as much X-ray film for each examination as in the United States.\textsuperscript{51} The rate of treatment for chronic renal failure is less than half.\textsuperscript{52} Dialysis is carried out at less than one third the

\textsuperscript{45} Cullen, supra note 35.
\textsuperscript{46} Cullen, supra note 35, at 986.
\textsuperscript{47} See, e.g., PAINFUL PRESCRIPTION, supra note 41, at 122; Mechanic, Cost Containment and the Quality of Medical Care: Rationing Strategies in an Era of Constrained Resources, 63 MILBANK MEM. FUND Q. HEALTH & SOC. 453 (1985) [hereinafter Mechanic].
\textsuperscript{48} PAINFUL PRESCRIPTION, supra note 41, at 123-24.
\textsuperscript{49} PAINFUL PRESCRIPTION, supra note 41, at 25.
\textsuperscript{50} PAINFUL PRESCRIPTION, supra note 41, at 84.
\textsuperscript{51} PAINFUL PRESCRIPTION, supra note 41, at 28.
\textsuperscript{52} PAINFUL PRESCRIPTION, supra note 41, at 28.
Parenteral nutrition is used one quarter as often and CT-scanning equipment is only one-sixth of that available here. Coronary-artery surgery which has become an important life sustaining procedure in the United States is performed in Britain one tenth as often as in the United States. Intensive care beds are available in numbers one fifth to one tenth as many. Undoubtedly, British expenditures are quite lavish when compared to expenditures in underdeveloped countries.

There are other British treatments and procedures which are provided as readily as in the United States. These include treatment for hemophilia, radiotherapy for cancer, bone marrow transplantation, and chemotherapy for cancer of the sort highly responsive to such treatment (far less for less responsive sorts). The reasons underlying the difference are not officially articulated but one can speculate about some of them. There seems to be a preference for treating those who will benefit the most. Thus, treatment for hemophilia, which strikes young patients, is applied less frequently while dialysis—mostly required for the elderly is utilized far less. Chemotherapy in the most tractable cases is on par with the United States and in more hopeless cases far more rare. Relative expense probably explains the dirth of CT scan equipment.

A lack of formal rationing and medical justification of the standard of care being applied tends to obscure the relative scarcity of the extant system. Some clues help to illuminate the matter. The existence of queues, for example, indicates unmet demand. In Britain in 1979, of 566,000 patients awaiting surgery of all kinds, thirty-one percent had waited for more than one year. Seven percent of those on the waiting list were classified urgent and nearly three fourths of them had been waiting more than a month. In the United States, on the other hand, there appears to be a surplus of available hospital space and surgical talent despite some local shortages. With the exception of organ transplants, there appears

53. PAINFUL PRESCRIPTION, supra note 41, at 28.
54. PAINFUL PRESCRIPTION, supra note 41, at 28.
55. PAINFUL PRESCRIPTION, supra note 41, at 28.
56. PAINFUL PRESCRIPTION, supra note 41, at 28.
57. PAINFUL PRESCRIPTION, supra note 41, at 28.
58. PAINFUL PRESCRIPTION, supra note 41, at 29-31, 37-40.
59. PAINFUL PRESCRIPTION, supra note 41, at 28.
61. TASK FORCE REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, HEALTH CARE FINANCING ADMINISTRATION, PRESIDENT'S PRI-
to be no queue for medical procedures. Organ transplant procedures have escaped public wrath in part because the supply of organs is so short as to mask the rationing which takes place. When rationing criteria come to light they can evoke heated condemnation.62

Physicians say that they generally provide appropriate services on a first come first served basis if there are any temporary shortages. A study of practices during an extended nursing strike, supports this viewpoint.63 Most notably, the death rate appeared not to have been affected by the cutbacks suggesting that the attention to the admitted critically ill was maintained functionally static.64 Most of those who write about the need to ration available treatments speak of the problem as though it looms in the future but does not exist today.65

Aaron and Schwartz,66 who have compared the British and American systems, come to the conclusion that while the American system can absorb mild budget cuts without changing the provision of services significantly, severe cuts would lead to following the British archetype.67 In such a future, they conclude, terminal care would be much reduced. The reduction would follow redefinitions of standard medical care. According to Lo and Jonsen, some categorical removal of patients from life support by redefinition of appropriate care standards has already taken place in the United States. Patients with end-stage lung disease are generally not financed for extended use of ventilators. Patients with intractable gastrointestinal hemorrhage do not receive unlimited quantities of blood. Neither practice has been formally proposed or defended.68

Although he has not obtained much following for his position, former Colorado governor Lamm has strongly advocated reduction of

62. In June 1986, Loma Linda University Medical Center refused to consider an infant, Baby Jesse, for a desperately needed heart transplant because his young parents were unmarried. Loma Linda felt that they were unprepared to give Baby Jesse the extensive post-operative care which would be required. Loma Linda offered the baby’s parents a compromise: if they would give up custody of Jesse to his grandparents, it would consider him for a transplant. The parents agreed, and Jesse ultimately received a heart after a well-publicized battle. Wallis, Of Television and Transplants, TIME, June 23, 1986, at 68, 127.
64. Id. at 1159.
65. See, e.g., Aaron & Schwartz, supra note 60, at 52.
66. PAINFUL PRESCRIPTION, supra note 41.
67. See supra notes 55-65 and accompanying text.
68. Lo & Jonsen, Clinical Decisions to Limit Treatment, 93 ANN. INTERN. MED. 764 (1980).
expenditures on health care for the elderly. 69 He proposed redirecting the resources to meeting the needs of groups who have not already had as extensive use of public benefits as the elderly.

While his position has drawn strong criticism, it raises perspectives which cannot be ignored. As previously mentioned, the increasing elderly population is causing unprecedented medical expenses. 70 Likewise, the different costs of their care are creating other financial crises. The social security system is in danger. 71 Non-medical facilities to provide food and shelter are inadequate both in numbers and in quality. 72 The lower fertility of recent generations 73 has left a smaller number of workers to provide the resources with which to provide for their elders. In many respects the deficits of the present are legacies created by the expenditures of the elderly for which payment will be extracted from the young. A rebellion against a future in which such burdens increase seems quite plausible. Hints of sharper future generational divisions are already abundant. 74

The law respecting a right to choice has also seen a period of rapid acceleration. Before this decade of active litigation concerning life support removal, few cases had tested a patient’s control of refusal of medical procedures. Some cases announced the paramount right of patients to control the limits of their treatment even if death resulted, 75 but several well known cases concerning Jehovah’s Witness patients are contrary. 76 In those cases, courts ordered blood

70. Mechanic, supra note 47, at 465-66.
71. N.Y. TIMES, FEBRUARY 16, 1984, at A23, COL. 1. (Report by Committee for Economic Development warns that if U.S. economy does not perform as well as Congress expects, Social Security could reach another crisis in the 1980s. The 1983 amendments provide very little margin of safety); N.Y. TIMES, AUGUST 14, 1985, AT A1, COL. 8.
73. Scitovsky & Capron, Medical Care at the End of Life: The Interaction of Economics and Ethics, 7 ANN. REV. PUB. HEALTH 59, 60 (1986).
76. See, e.g., United States v. George, 239 F. Supp. 752 (D. Conn. 1965); Application
transfusions over the religious objections of members who would have died had they not received blood. In *Application of the President and Directors of Georgetown College,* a young mother of a seven month old child was admitted to Georgetown Hospital suffering from a bleeding ulcer. When she refused a blood transfusion, the hospital obtained a court order to administer it. The case has been explained as having upheld the mother’s duty of care for her infant child and as lacking more general application. However, subsequent cases involving Jehovah’s Witnesses allow a patient to refuse medical treatment even when minor children are present. Nonetheless, it has proven to be the high water mark for paternalistic intervention to require treatment.

Ten years ago, the matter of Karen Quinlan began a process of reexamination of the sparse precedents from which a consensus developed which allowed the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical Behavior Research (hereafter the President’s Commission) to conclude that “decisions about health care [including the choice to forego life sustaining treatment] ultimately rest with competent patients.”

In the period since *In re Quinlan,* twelve states and the District of Columbia have produced decisions dealing with the termination of life support. Although many allude to countervailing state
interests in supporting life, no appellate decision has found any of
them decisive. Four interests have been mentioned: the interests in
preserving life, preventing suicide, safeguarding the integrity of the
medical profession and protecting innocent third parties. Since the
cases have typically concerned patients who were either terminally ill
or in chronic vegetative state, there was little purpose in maintaining
life for the benefit of others. It has been possible to assert that
neither suicide nor threats to the sanctity of life were involved as
resulting death occurred, it was said, because of the underlying con-
dition. Most of the decisions also fit within the ambit of prevailing
medical practice which permits allowing patients a comfortable death
when further treatment is futile.

Quinlan expressly based its decision on the constitutional right
of privacy and many of the later courts have agreed. Massachu-
setts’ Supreme Judicial Court indicated that the right “is an expres-
sion of the sanctity of individual free choice and self-determination as
fundamental constituents of life” and that the value of life is not
lessened by a decision to refuse treatment but by the failure to allow

2d 921 (Fla. 1984); Sats, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), aff’d, 379 So. 2d 359
(Fla. 1980); In re Guardianship of Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); In re
Mass. 417, 497 N.E.2d 626 (1986); Spring, 380 Mass. 629, 405 N.E.2d 115 (1980);
Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Torres, 357 N.W.2d 332 (Minn.
1984); In re Conoy, 98 N.J. 321, 486 A.2d 1209 (1985); In re Quinlan, 70 N.J. 10, 355
A.2d 647, cert. denied sub nom., Garger, 429 U.S. 922 (1976); State of New Mexico ex rel.
Smith v. Fort, No. 14,768 (New Mexico 1983) (order granting alternative writ of prohibition);
In re Eichner, 102 Misc. 2d 184, 423 N.Y.S.2d 580 (1979), modified, 73 A.D.2d 431, 426
(1981); Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984); In re
Welfare of Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), modified sub nom., In re Guar-

83. See, e.g., President’s Commission Report, supra note 7, at 181-83; Bartling,
163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225 (1984); Sats, 362 So. 2d 160, 162 (Fla. Dist.
Ct. App. 1978), aff’d, 379 So. 2d 359 (Fla. 1980); Spring, 380 Mass. at 640, 405 N.E.2d at
123 (1980); Brophy, 398 Mass. 417, 497 N.E.2d 626 (1986); Commissioner of Correction v.
Myers, 379 Mass. 255, 261, 399 N.E.2d 452, 456 (1979); Saikewicz, 373 Mass. at 738, 370
N.E.2d at 424.

764, 764-68 (1980).
In addition to the right of privacy held to govern such cases, the Supreme Court of New Jersey in *In re Conroy* noted that there is also a common-law right to self-determination in these cases and that courts could rely on either. While it, as most other courts, emphasized that neither right was absolute and reviewed the variety of state interests that militated against such decisions, it concluded: "In cases that do not involve the protection of the actual or potential life of someone other than the decision-maker, the state’s indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient’s much stronger personal interest in directing the course of his own life."

Despite the fact that most of the reported cases concern patients unable to voice a choice, the courts have agreed that the rights of choice of the competent and incompetent are identical. However difficult to effectuate, there seems no principled reason to deny equal rights to incompetents. Thus, recent developments in rights of choice are probably of equal importance to both groups. Two recent California cases, all involving competent patients, have made recent additions to the law.

William Bartling was 70 years old when admitted to the Glendale Adventist Hospital. He had emphysema, arteriosclerosis and an abdominal aneurysm as well as a lung tumor. In taking a sample of tissue from his tumor for biopsy, the needle punctured and collapsed one of his lungs. His tumor proved malignant, the puncture did not heal and his lung did not re-inflate. At that point, a tracheotomy was performed and a ventilator installed. Despite his opposition to using the machine, his doctors insisted that it remain connected as he would die otherwise; ethical concerns barred their acceding to his contrary wishes. Bartling tried several times to remove the breathing machine and finally had his hands placed in restraints to prevent further efforts. He brought an action to require

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86. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426.
88. Id. at 350, 486 A.2d at 1223.
90. See infra note 97.
that the ventilator be removed. In a deposition he indicated that he
did not want to die, that he understood that removal of the ventilator
might well cause his death and that he nonetheless wanted it re-
moved. The trial court denied his request for an injunction on the
grounds that he was neither terminally ill nor permanently comatose
and that the law permitted removal of life support only under one of
those circumstances. He appealed but died prior to the appellate
hearing, still connected to a ventilator. The court of appeals heard
the case, notwithstanding his death, because of the importance of the
issues. It reversed the lower court, stating “if the right of a patient to
self-determination as to his own medical treatment is to have any
meaning at all, it must be paramount to the patient’s hospital and
doctors. The right of a competent adult to refuse medical treatment
is a constitutionally guaranteed right which must not be abridged.”

Bartling v. Superior Court left open four important issues
concerning competent patients wishing to refuse treatment. Had he
stated that he wanted to die rather than to live without a ventilator,
would the state interest in preventing suicide have overcome his in-
terest in control of his treatment? Would the court have granted his
injunction if his life expectancy in treatment had been longer? Testi-
mony in the trial court had given him up to a year to live if he could
be weaned from the ventilator. Would the same result apply if he
were less seriously ill? Could he have chosen to end artificial feeding
in place of removing his ventilator?

Bouvia answered three of them. Elizabeth Bouvia was a 28
year old woman whose cerebral palsy complicated by painful arthri-
tis has made her quadriplegic and unable even to sit upright. She
has been bedridden and in severe pain. Her ability to take nutrition
by mouth is so limited that her doctors felt it necessary to feed her
through a nasogastric tube to sustain her life. She objected and, un-
like Mr. Bartling, claimed that she wished to die rather than to un-
dergo further life in her helpless condition. When refused, she also
brought suit. To the trial court, her wish to die was an improper
motivation. Invoking the state interest in preventing suicide, it re-
fused her petition. Since that refusal, she has recanted her desire to
die but a second court did not believe her recantation. The court of
appeal, however, held that her decision to let nature take its course
was not the equivalent of a decision to commit suicide and that the
trial court erred when it made her motives determinative. Testimony

92.  Id. at 195, 209 Cal. Rptr. at 225.
put her life expectancy at fifteen to twenty more years to which the court commented, "It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live or, more accurately, endure, for 15 or 20 years." It also found the fact that she chose to remove a nutritional tube unexceptional.

Although these two cases advance decisional law to some extent, neither is very shocking. While Bartling, and Bouvia were alive when they resisted further life support, the perception of the quality of their remaining lives evokes outrage at the indignity of insisting on their submission to the insertion of unwanted tubes. Although the removal of nutritional support has been quite controversial, it has recently been accepted by the Judicial Council of the American Medical Association as an acceptable response to those permanently comatose. New Jersey has even more recently resolved other procedural questions in similar circumstances.

94. Bouvia, 179 Cal. App. 3d at 1143-44, 225 Cal. Rptr. at 305.
95. "[S]ubstantial and respectable authority throughout the country recognize the right which petitioner seeks to exercise. Indeed, it is neither radical nor startlingly new. It is a basic and constitutionally protected right." Id. at 1139, 225 Cal. Rptr. at 302.
96. Wallis, To Feed or Not To Feed, TIME, Mar. 31, 1986, at 60.
97. Conroy involved an eighty-four year old woman living in a nursing-home. 98 N.J. 321, 485 A.2d 1209 (1985). She was legally incompetent, but had limited ability to interact cognitively with her environment. She had a variety of health problems which rendered her unable to swallow enough food and fluids to sustain her life. However, she was not unconscious, comatose, or in a persistent vegetative state.

Ms. Conroy's nephew and guardian petitioned the court to remove the nasogastric tube which supplied life-sustaining nutrients and fluids. The Supreme Court ultimately blocked removal of the tube, but it establishes three tests which may be employed to remove such life-sustaining treatment.

These tests, as the subsequent cases make clear, are limited to the factual situation at issue in Conroy. They apply only to incompetent, elderly, nursing home-bound patients, not in a permanent vegetative state, whose illness will result in the patient's death in a short period of time.

There are three tests described by the court. The "subjective test" allows removal of life-sustaining treatment whenever there is clear and convincing evidence that if the patient were competent, he or she would have declined the treatment. Id. at 360, 486 A.2d at 1229. The "limited-objective test" allows discontinuance of the treatment when there is some trustworthy evidence that the patient would have declined the treatment and the surrogate decision-maker is satisfied that the burdens of continued life outweigh the benefits. Id. at 368, 486 A.2d at 1232. The "purely objective test" permits removal of the treatment when the burdens of continued life clearly outweigh any benefits. Id.

In re Farrell involved a thirty-seven year old competent, terminally-ill patient suffering from Lou Gehrig's disease. 108 N.J. 335, 529 A.2d 404 (1987). Mrs. Farrell lived at home, but died during the pendency of the action in the supreme court. She petitioned the court to allow the removal of her respirator. The court found that she had the right to the removal of the respirator; in its decision the court announced the procedures which must be followed in the case of competent, adult patients who are living at home and request the removal of life-
As is often true in times of social transition, case law has created fictions to avoid affronting previously accepted norms. In life support termination, there is a fiction of medical determinism. Patients are seen as passive victims of their illness. They do not choose to die; death overtakes them. Their physicians do nothing to help them die. Death overwhelms them, too.

Bartling, presumably on advice of counsel, testified that he did not want to die. After an unsuccessful attempt to have her way despite a candid admission that she proposed to starve herself to death, Bouvia changed her story (perhaps honestly) to indicate that she would not seek to die. That allowed the courts in both cases to adopt the now common deterministic theme that death, when it comes, comes from the underlying illness not the termination of treatment.

The fiction requires that any action taken which will lead to death be described as, at worst, surrender to the futility of further treatment. Thus, the removal of Ms. Bouvia’s nasogastric tube has to be distinguished from discontinuing her feeding on the grounds that inserting the tube was a medical procedure when initiated and that its removal is the termination of a treatment. Of course, there are valid medical aspects of artificial feeding. It has medical consequences on other aspects of bodily functioning and the ability to fight sustaining treatment:

First, it must be determined that the patient is competent and properly informed about his or her prognosis, the alternative treatments available, and the risk involved in the withdrawal of the life-sustaining treatment. [citation omitted] Then it must be determined that the patient make his or her choice voluntarily and without coercion. After these assessments have been made, the patients’ right to choose to disconnect the life-sustaining apparatus must be balanced against the four potentially countervailing state interests. . . . To protect the patient who is at home, we require that two non-attending physicians examine the patient to confirm that he or she is competent and is fully informed about his or her prognosis, the medical alternatives available, the risk involved, and the likely outcome if medical treatment is disconnected.

Id. at 354, 529 A.2d at 413, 415.

The court also stated that judicial review is not required except in unusual situations where there is a conflict among family members or the physician involved. Id.


99. In Bouvia, the court stated: “[Bouvia’s] decision to allow nature to take its course is not equivalent to an election to commit suicide with real parties aiding and abetting.” 179 Cal. App. 3d at 1146, 225 Cal. Rptr. at 306. In Bartling, the court stated: “Several doctors also expressed the view that disconnecting Mr. Bartling's ventilator would have been tantamount to aiding suicide. This is not the case, however, where real parties would have brought about Mr. Bartling’s death by unnatural means by disconnecting the ventilator. Rather, they would merely have hastened his inevitable death by natural causes.” 163 Cal. App. 3d at 196, 209 Cal. Rptr. at 225.
disease. It sometimes involves serious risks. Artificial nutrients are readily distinguishable from normal food in appearance and formulation. Eating by mouth is not. When the American Medical Association's Judicial Council approved removing artificial feeding and hydration in some instances they could discuss the matter in the same manner as other aspects of treatment.  

Using medical explanations also has its utility for the courts. It removes the responsibility for decisions that seem harsh when explained in plainer language. To let a person starve herself to death is certainly less palatable than to permit the removal of a medical feeding tube. All the better if the patient will also agree that her purpose is not death but simply relief from the intrusion.

Rhetorical use of medical imagery to create the illusions that underlie legal fictions does not, of course, mean that the issues are truly medical. Blaming the underlying disease rather than the act of life-support removal is romantic but illogical. A person who removed a feeding tube from a recovering patient temporarily dependent on it would have a difficult time persuading anyone that the resulting death was caused by the underlying illness not by the removal of the tube. Although it is true that artificial feeding differs from normal eating, providing food and liquids is so psychologically bound to a level of expected non-medical care that physicians, not to mention lay people, have difficulty in equating its removal with the removal of respirators and other less commonly provided forms of help.  

To make a case depend on whether the person wishes to die as opposed to having necessary life support removed (a distinction the Bouvia appellate court would not abide) is too transparent to be useful and too insensitive to be ethical. If she were not aware of probable lethal consequences would she be competent to direct removal?

III.

As choice issues are masked as medical decisions, their answers

100. Barber, 147 Cal. App. 3d at 1016, 95 Cal. Rptr. at 490.
102. Bouvia, 179 Cal. App. 3d at 1145, 225 Cal. Rptr. at 306. The court stated: [T]he trial court seriously erred by basing its decision on the "motives" behind Elizabeth Bouvia's decision to exercise her rights. If a right exists, [which the court determines it does] it matters not what "motivates" its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's motives meet someone else's approval. (emphasis in original).

Id.
are increasingly relegated to medical decision makers such as the American Medical Association Judicial Council. At the moment, for example, would other doctors with patients like Bouvia be prevented from ethically removing artificial feeding on request because it has only been officially approved for permanently comatose patients?103

If one can believe removal of food and water can be relatively painless,104 it may have practical advantages. It provides a manner of allowing death for virtually any unconscious patient. Thus, it responds to one concern about an estimated 10,000 permanently comatose patients alive today. Also, unlike the removal of a ventilator which for many would cause death in minutes, death from deprivation of nutrition is likely to take place more slowly. In cases in which death is not imminent but the patient has suffered a great loss to the quality of life and wishes not to be rehabilitated to live under new circumstances, food and liquid withdrawal may provide a reflective period in which reconsideration is possible without thwarting an autonomous choice to die shortly if that persists. For the physician, the added time may provide reassurance that options have been carefully considered by the patient, the friends and family if the patient wishes to involve them and the hospital staff. Of course, the acceptance of death by deprivation of nutrition has brought renewed interest in more active lethal choices.105

The insistence of the courts that ethical concerns of physicians be a factor in counterbalancing the wishes of a patient for life support removal is itself a product of using medical metaphors in adjudicating the issue. As in the abortion cases in which a similar obfuscation took place, the proper role of physicians must be articulated differently. It must really be the woman, not her physician, who decides whether to carry the fetus after the physician has provided appropriate information. The fact that some doctors dislike abortions and that the Hypocratic oath prohibited them does not give physicians the right to make the decision which is constitutionally protected for pregnant women. In removal of life support, Bouvia, helps to focus a definition of an appropriate physician’s role which is more complicated than in the abortion cases.

Bouvia is clouded by the enormity of her distress as a quadriplegic with numerous additional medical problems. If weighed

105. See infra note 176.
by medical standards, however, the result might be more questiona-
ble. A number of others live in similar conditions. She will remain
sensate and her pain is presumably controllable with medication. It
is certainly appropriate for her physicians to feel that she can lead a
productive life, and they should be willing to contribute their skills
toward that end. That the court would not accept the physician's
conclusion in preference to hers seems to capture the appropriate
role for both. The physician's function initially is to diagnose and to
indicate the prognosis for the future. That role can be negatively
determinative but should not bar a patient's unwillingness to un-
dergo further suffering. If, for example, the physician concludes that
a patient would die shortly regardless of treatment and that treat-
ment would neither prolong life nor reduce suffering, they should
have no obligation to treat irrespective of the patient's wishes. Their
obligation then would merely be to provide for comfort to the extent
possible. The question of what is medically feasible should belong to
the experts in medicine. 106

Having determined that Ms. Bouvia's life support is feasible,
the balancing that remains weighs the quality of her life against the
pain and suffering that continued life promises her. Neither the doc-
tors nor the courts bring expertise to that narrow question. It has to
do with a variety of traits that are uniquely hers. 107 Experiences of
being dependent on others for almost all activities may seem to her
totally unacceptable while others may find such help acceptable in a
life they find productive. Her lack of personal privacy may seem in-
tolerable for reasons which may not be universal. No adequate objec-
tive measure of life quality can substitute for a personal decision.
Similarly, the fact that she refuses to consent to being nourished by
tube ought not to raise medical concerns. Whether or not tubal nu-
trition and hydration are considered treatment does not address the
question of whose decision controls whether she allows herself to be
kept alive. While the approval of the American Medical Associa-
tion's Judicial Council for removal of artificial feeding of perma-
nently comatose patients 108 should ease the concerns of doctors, it
should not govern the limits of such removal. The patient's consent is
a necessary prerequisite to such feeding not because it is a treatment
but because the law at least makes an unconsented touching

106. Lo & Jonsen, Clinical Decisions to Limit Treatment, 93 Ann. Intern. Med. 764,
766 (1980).
107. See generally President's Commission Report, supra note 7, at 21-23.
108. Wallis, To Feed or Not to Feed, Time, March 31, 1986, at 60.
tortious. Others may seem less sympathetic in their plight than Ms. Bouvia. Each will have to confront the quality of life that they can anticipate if they remain alive. So long as they have had the opportunity to weigh life quality as they perceive it, it is improper to reject their conclusion.

IV.

Many of the competent ill will not need help from courts or hospitals if they decide to forego further life support. It is usually possible to arrange a transfer to a doctor or institution that will view one’s plans more sympathetically or, that failing, to leave the institution and go home to die even if one’s doctors disapprove. Problems concerning competent patients are far less difficult than those of incompetent individuals. All courts that have decided the issue also have held that the right to refuse treatment was equally available to an incompetent patient but disagreed on methods of determining the choice. Quinlan held that Ms. Quinlan’s guardian and family

109. Subsequent to the appellate decision, Ms. Bouvia filed a lawsuit against her health care providers and the Glencur Medical Center for battery.


111. See, e.g., Saikewicz, where the court noted that the doctrine of substituted judgment should be used to determine the patient’s wants and needs. 373 Mass. 728, 370 N.E.2d 417 (1977). It stated: We take a dim view of any attempt to shift the ultimate decision-making responsibility away from courts of proper jurisdiction to any committee, panel, or group, ad hoc, or permanent. Thus we reject the New Jersey Supreme Court in the Quinlan case of entrusting the decision whether to continue artificial life-support to the patient’s guardian, family, attending doctors and hospital ‘ethics committee.’

Id. at 758, 370 N.E.2d at 434. Other courts have agreed with the New Jersey Supreme Court’s handling of the Quinlan case. In Severns, the court appointed the husband as guardian of the wife’s person and allowed him authority to make medical decisions for her. 421 A.2d at 1347. The court stated: “The Court of Chancery, in our opinion, may recognize the right of a guardian to vicariously assert the constitutional right of a comatose ward to accept medical care or refuse it.” Id. at 1347. However, the court required that the guardian submit to an evidentiary hearing before the court will grant him the authority to discontinue his wife’s life support systems.

Still other courts require a rigorous procedure be followed for terminating an incompetent patient’s life-support system. In Colyer, the court required that the following procedure be followed to terminate an incompetent’s life-support system. 99 Wash. 2d 114, 660 P.2d 738 (1983):

1. There must be a unanimous concurrence of the treating physician’s diagnosis by a prognosis board. The prognosis board is comprised of two disinterested physicians. They must find that the patient’s condition is incurable and there is no probability that the patient will return to a cognitive life. If no agreement can be reached, the court can make the findings by clear
should render their best judgment of what she would have chosen to

2. The court must appoint a guardian ad litem for the purposes representing the patient at the guardianship hearing.

3. The appointed guardian may exercise the patient's right to refuse medical treatment only if he deems it is in the best interest of the patient.

4. Alternatively, the court may appoint a guardian ad litem and judicially determine what is in the best interest of the incompetent person.

Peter involved a sixty-five year old nursing home patient who was in a persistent, vegetative state with no hope of recovery, although terminally ill, she may live for an extended period of time. 108 N.J. 365, 529 A.2d 419 (1987). Ms. Peter executed a durable power of attorney which appointed a surrogate decision maker for medical decisions, but it did not specifically authorize the removal of any life-sustaining treatment. The attorney-in-fact petitioned the court to remove the nasogastric tube which sustained her life.

The New Jersey Supreme Court first re-emphasized its prior holding that incompetency does not effect a patient's right to refuse or forego life sustaining treatment. "All patients, competent or incompetent, with some limited cognitive ability or in a persistent vegetative state, terminally ill or not terminally ill, are entitled to choose whether or not they want life-sustaining treatment." Id. at 372, 529 A.2d at 423. The New Jersey court then held that the tests articulated in Conroy are limited to their facts; it specifically held that the limited-objective and pure objective tests are inapplicable because "by definition such patients . . . do not experience any of the benefits or burdens" which the tests attempt to balance, and the court must instead be guided by Quinlan. Id. at 376-77, 529 A.2d at 424-25. The Quinlan test allows the guardian and family of a patient in a persistent, vegetative state to determine whether he or she would want the life-sustaining treatment continued. If the attending physician and the hospital prognosis committee verify the patient's condition, the family or guardian may terminate the procedures even without clear and convincing evidence that patient would have made the same decision. They need only render their best judgment as to what decision the patient would have wanted them to make. Id. at 377, 529 A.2d at 424.

However, in this case, Ms. Peter left clear and convincing evidence of her intention to remove life support apparatus, so the court applied the Conroy subjective test. "[T]he Conroy subjective test is applicable in every surrogate-refusal-of-treatment case, regardless of the patient's medical condition or life-expectancy." Id. Under this test, life-sustaining treatment may be removed when there is clear and convincing evidence of the patient's intentions. If the Conroy subjective test cannot be met because there is not clear and convincing evidence of the patient's intentions, the Quinlan test must be used. Once the subjective test is met the following procedures must be followed:

[T]he Ombudsman . . . must be given the opportunity to investigate and prevent any possible mistreatment of elderly nursing home patients who have been declared to be in a persistent vegetative state. Therefore, before life-sustaining treatment is withdrawn or withheld from such a patient, the surrogate decision-maker should inform the office of the Ombudsman for the Institutionalized Elderly that a decision to forego treatment has been made. The Ombudsman should secure two independent medical opinions to confirm the patient's medical condition, the medical alternatives available, the risks involved, the likely outcome if medical treatment is discontinued and that there is no reasonable possibility of the patient's recovery to a cognitive, sapient state.

Id. at 383-84, 529 A.2d at 429.

If the patient has designated a surrogate decision-maker, the Ombudsman should defer to that person to make any decision once his or her investigatory role has been fulfilled. If there is no surrogate specifically chosen, the Ombudsman, with the advice the attending physician, should ascertain whether there is a close family member who is willing to make the medical decisions. If there are no close family members, it will be necessary to have the court appoint a
do in the circumstances. Later courts have opted for more rigorous inquiry standards. \footnote{112} Substituted judgment, that is judgment made by a surrogate on the basis of what the patient would have wished, has been approved by courts and the President’s Commission\footnote{113} as appropriate, at least in cases in which there is clear evidence of the guardian. The court specifically states that a close friend is not a proper surrogate unless the patient has formally designated that person. \textit{Id.}

\textit{Jobes} involved a thirty-one year old nursing-home patient in a near persistent, vegetative state. 108 N.J. 394, 529 A.2d 434 (1987). Mrs. Jobes’ husband petitioned the court for the removal of the j-tube which was providing the food and hydration which sustained her life. The court found that this case was very similar to \textit{Quinlan}. The court applied \textit{Quinlan}’s substituted judgment analysis to this case and found that Mrs. Jobes’ j-tube should be removed. In this case, Mrs. Jobes did not make known her preferences should she find herself in a persistent, vegetative state so there is insufficient evidence to meet the \textit{Conroy} clear and convincing test. However, under the \textit{Quinlan} test, the proper persons to make the substituted judgment are the patient’s family which normally would include spouse, parents, adult children and siblings. If individuals from one of these groups is not available, the court must appoint a guardian; the court also gives a health care professional the right to ask for a guardian if he or she determines that the family is not looking out for the best interests of the patient. \textit{Id.} at 419, 529 A.2d at 448. The \textit{Quinlan} test requires the concurrence of a hospital prognosis committee which is not required in a nursing home. However, the court held that the decision making process should be substantially similar, but it recognized that there are safeguards present in a hospital which are not present in a nursing home. \textit{Id.}

For non-elderly non-hospitalized patients in a persistent vegetative state who, like Mrs. Jobes, have a caring family or close friend, or a court appointed guardian in attendance, we hold that the surrogate decision-maker who declines life-sustaining medical treatment must secure statements from at least two independent physicians knowledgeable in neurology that the patient is in a persistent vegetative state and that there is no reasonable possibility that the patient will ever recover to a cognitive, sapient state. If the patient has an attending physician, then that physician likewise must submit such a statement. These independent neurological confirmations will substitute for the concurrence of the prognosis committee for patients who are not in a hospital setting and thereby prevent inappropriate withdrawal of treatment. \textit{Id.}

Judicial review is not required for the decision to forego the life-sustaining treatment; it may be used only in special circumstances which may occur when there is a conflict among the family, the guardian, or the physician. Any interested person can petition the court in such a situation. \textit{Id.} at 423, 529 A.2d at 449.

The New Jersey Supreme Court also held that the nursing home could not refuse to participate in the withdrawal of the j-tube from Mrs. Jobes. The trial court had found that the nursing home objected to the removal on moral grounds and that, therefore, it need not participate in the withdrawal. The supreme court found that if the nursing home were permitted to refuse to allow the withdrawal while Mrs. Jobes was a patient there, it is likely that her wishes may never be carried out due to the difficulty in finding a facility which would take her and participate in the removal. Since this nursing home did not put the Jobes on notice that it would not participate, it may not now assert their moral right. The court does not decide whether notification would insulate a nursing home from participation in removal of the j-tube. \textit{Id.} at 425, 529 A.2d at 450.

\footnote{112} See supra notes 97 & 111.

\footnote{113} See President’s Commission Report, supra note 7, at 132-133.
patient's desires. Morally and legally, this means of determining individual wishes comes closest to allowing the autonomy of competent patients to make choices based on different perceptions of life quality. In those cases in which there is insufficient data to allow substituted judgment, some courts have adopted a best interest test by which surrogates would decide whether to remove life support.114 However, some courts have held that when a patient is in a persistent vegetative state, a best interest test may not be used because there are no benefits to weigh against burdens.115 Typically, a best interest inquiry balances the benefits and burdens of continuing treatment. Others have refused to do so116 or have accomplished the same end by ruling that life continuation is always in the best interests of a patient who has not indicated contrary wishes.117

114. See, e.g., Foody, 40 Conn. Supp. 127, 482 A.2d 713 (Conn. Sup. Ct. 1984). In Foody the court stated:

If the exercise of the right is to be maintained where no expression has been made by an incompetent patient as to treatment, it must take place within the context of an analysis which seeks to implement what is in the person's best interests by reference to objective socially shared criteria.

Id. at 129, 482 A.2d at 721. See also Colyer:

A guardian of the person has the power to 'care for and maintain the incompetent or disabled person, assert his or her rights and best interests, and provide timely, informed consent to necessary medical procedures.' (quoting WASH. REV. CODE § 11.92.040(3))(emphasis in original) As refusal of life sustaining treatment is an individual's personal right, we conclude that under this provision the guardian has the power to assert such a right.

99 Wash. 2d at 129, 660 P.2d at 746-47. See also Conroy where the court stated:

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or withdrawn . . . if a pure-objective test is satisfied . . . [T]he net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life.

98 N.J. at 366, 486 A.2d at 1232.


117. See, e.g., Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). The court stated:

"Should the probate judge then be satisfied that the incompetent individual would . . . have chosen to forego potentially life-prolonging treatment, the judge shall issue the appropriate order. If the judge is not so persuaded, or finds that the interest of the state require it, then treatment shall be ordered." Id. at 757, 370 N.E.2d at 434. See also Conroy:

When the evidence is insufficient to satisfy either the limited-objective test [life-sustaining treatment may be withheld when there is some trustworthy evidence that the patient would have refused treatment and the decision maker is satisfied that the burdens of continued living outweigh the benefits] or purely objective standard [the net burdens of the patient's life with the treatment clearly outweigh the benefits the patient derives from life], however, we cannot justify the termination of life-sustaining treatment as clearly furthering the best interests of
Beyond determining an appropriate standard, courts have taken quite different approaches to questions concerning oversight of the procedure. New Jersey’s high court indicated that it expected family concurrence and review by a hospital ethics committee.\textsuperscript{118} In the case of patients from nursing homes, it also wanted review by an Ombudsman already charged with oversight of the elderly in such institutions.\textsuperscript{119} Its Massachusetts counterpart denied the right of any group to make such a decision without reference to courts.\textsuperscript{120} The New Mexico Supreme Court believed itself powerless without legislative direction\textsuperscript{121} but the Legislature quickly provided a procedure by which a substitute judgment made by all of the family in good faith would suffice.\textsuperscript{122}

A major problem in ascertaining the wishes of a patient has almost always arisen from the absence of an indication of what he or she would want done. There is general agreement that if the patient’s wishes were known, they would be respected.

So long as a person continues to be conscious and is treated as competent, individualized treatment corresponding to individual views is possible. Making a surrogate choice for incompetents is far more difficult.

Irrespective of how it is attempted, making decisions that duplicate what another would have decided is virtually impossible. Considering the wide range in decisions which the same people make on different occasions, the changes of mind and the alterations of attitudes, it would be impossible to foretell what decision the patient would have made at any given point. All of the prior decisions which serve as models necessarily reflect different circumstances. They were made when the person was healthier and able to communicate. How would the presence of the disabilities presently plaguing him affect the type of decision that was formerly made? Even the patient may not have known the answer before he experienced the differing circumstances under which he now lives. If one adds the personal attitudes, the biases and, perhaps, the personal motives of a surro-

\textsuperscript{98} N.J. at 368, 486 A.2d at 1233.
\textsuperscript{118} Conroy, 98 N.J. at 375, 486 A.2d at 1242; \textit{See supra} note 111.
\textsuperscript{119} Conroy, 98 N.J. at 375, 486 A.2d at 1242.
\textsuperscript{121} State of New Mexico \textit{ex rel.} Smith v. Forte, No. 14,768 (order granting alternative writ of prohibition).
\textsuperscript{122} In 1984, the Legislature passed the Right to Die Statute, N.M. \textit{Stat. Ann.} §§ 24-7-1 to 24-7-11 (1984).
gate, the result will certainly be a distortion of the decision which the patient would have made himself. Realizing the impossibility of a perfect result, courts or the Legislature must provide for some method of surrogate decision making and will have to settle for the best available even if that is quite imperfect.

The surrogates of choice have invariably been members of the family. However they are to make or suggest a choice respecting treatment, they appear to courts to be those most likely to know about the patient's habits and wishes and most likely to effectuate them. The President's Commission recommends that when there are several equally acceptable options, the one chosen should be selected by the family. The involvement of the family is so well-known that those who wish otherwise are on notice to make specific provisions. Unfortunately, while the interests of family members may be consistent with a patient's wishes and while they are the only available surrogates in many cases, one must consider potential conflicting interests involved as well. In some cases, the family and patient will have differing religious or ethical views about death. More antagonistic relationships may attend the fact that some may have conflicting current endeavors, may be heirs on the patient's death or may bear the financial and emotional burden of the illness.

Conservatorship disputes have certainly demonstrated the potential for adversarial approaches among family members.


124. See, e.g., Spring:
The judge properly relied in part on the opinion of the ward's wife of fifty-five years. That opinion was corroborated by that of the son, and there was every indication that there was a close relationship within the family group, that the wife and son had only the best interest of the ward at heart, and that they were best informed as to his likely attitude. 380 Mass. at 640, 405 N.E.2d at 122; see also Bludworth: "[T]he means developed by the courts to afford this right [to refuse medical treatment] to incompetent persons is the doctrine of 'substituted judgment.' Under this doctrine close family members substitute their judgment for what they believe the terminally ill incompetent person, if competent, would have done under these circumstances." 452 So. 2d at 926.


126. It is less likely that such differences will exist within a family than between the patient and another surrogate chosen from a different background, however, and the family ought not to be disqualified on that ground alone.

127. Alexander, Premature Probate: A Different Perspective on Guardianship for the
acting as surrogates for health care, one would expect no better results than those achieved in property management. Most states which legislatively authorize directives to physicians respecting removal of life support, disqualify family members as witnesses because of such concerns. Whatever supervisory scheme is superimposed on the charge to family surrogates, it is quite likely that they will control the process in most cases because they will be accepted as both better informed and as benevolent.

V.

To counterbalance reliance on such surrogates in health care matters, the author recommended the use of health care durable powers of attorney in a Stanford Law Review article, suggesting that they take the name of the far more limited natural death act directives known popularly as "living wills." The name has not been adopted but the device has. Its main feature is the appointment of

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130. Alexander, supra note 127.

a surrogate of choice to direct health care and financial concerns for those declared to be incompetent and to avoid a court imposed guardianship or conservatorship. It seeks to retain control for the person even though he or she is declared legally incompetent.

Some states now have specific durable powers for health care as statutory provisions. In other states, general durable power legislation is thought to authorize the creation of health care surrogates. Part of the popularity of durable powers in life support refusal cases comes from their being unencumbered by the many limitations that have attended natural death act directives. As an expression of an incompetent patient’s current wishes, the prior competent statement appears to many courts and to the President’s Commission the most preferable choice. Given the changes of the last decade, there is a need to alter legislation dealing with both natural death act directives to physicians and the appointment of health care surrogates.

Natural death acts have been passed in thirty seven states.
They typically provide that if the maker is unable to give instructions, is terminally ill and death is imminent the process of dying should not be extended through extraordinary means. Some states have further limited the ability to use a directive by requiring a period of deliberation after the diagnosis of terminal illness, making them ineffective during the pregnancy of the patient, making them effective for only a limited number of years and prohibiting their

137. California Health & Safety Code section 7188 provides for a directive which states: If at any time I should have an incurable injury, disease, or illness certified to be terminal . . . and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and . . . my death is imminent . . . I direct that such procedures be withheld or withdrawn.


138. Id. §§ 7188, 7191.


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application to withholding food and fluids. As mentioned, they also expressed distrust of persons with conflicting interests such as members of the family, heirs, physicians and others by prohibiting them from providing the necessary witnessing of the documents.

The strictness and vagueness of provisions has proved troublesome. Commentators noticed that about half of the California patients who were diagnosed as having a “terminal condition” did not remain conscious for the two additional weeks before they became legally entitled to make a binding directive. A terminal condition is defined in the California law as one in which death is imminent regardless of the life sustaining procedures used. As the President’s Commission noted, survival to complete a directive “would require a miraculous cure, a mis-diagnosis, or a very loose definition of the word ‘imminent.’” In fact, those who could properly execute a directive had little incentive to do so because the act merely allowed the termination of treatment that could not prevent their imminent death. Although the statute was drafted with Karen Quinlan’s case in mind, Ms. Quinlan would not have benefited from the Act since her death was not imminent.

Although the acts typically reserve common law rights irrespective of the utilization of a statutory directive, the common law has been sparse. Had case law been better developed, there would have been no original need for natural death acts or their very recent adoption by many states.

The Acts cannot be viewed as an effective response to the problems of life support termination. Data on their effect on medical practice is contradictory, but demonstrates at least that they have not become a central manner of resolving life support termination decisions. There is some indication that the presence of the statute has led many doctors to regard the absence of a directive as rejecting termination of life support despite the fact that their patient may

145. President’s Commission Report, supra note 7, at 142.
146. California Health and Safety Code section 7193 states: “Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner.” CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1987).
147. Redleaf, supra note 143, at 945.
have had contrary expectations.\textsuperscript{148}

Despite its inadequacies, most states have now adopted a natural death act. Many of the Acts avoid some of the problems of the California prototype but, in the main, they copy it. Since the formalities of execution differ from state to state, there remains the additional problem that a directive executed in one state which has a natural death act will not qualify in another which has a differing one.

In 1985, the Commissioners on Uniform State Laws adopted an act entitled the Uniform Rights of the Terminally Ill Act.\textsuperscript{149} While its adoption would eliminate inconsistencies and assure the effectiveness of directives in other states, it carries forward most of the problems of its progenitor. Only "qualified patients" are entitled to the benefits of the Act.\textsuperscript{150} A condition to being "qualified" is a prior diagnosis of terminal illness.\textsuperscript{151} Fortunately, the Act does not also carry forward the California limitation on making directives.\textsuperscript{152} Any person who is at least 18 and of sound mind may do so at any time.\textsuperscript{153} Since revocation remains possible indefinitely, and can be exercised irrespective of "competency,"\textsuperscript{154} that change brings the benefits of rumination and deliberation without limiting the effects of later perspectives.\textsuperscript{155}

When the patient is "no longer able to make decisions regarding administration of life-sustaining treatment"\textsuperscript{156} attending physicians shall either act in accordance with the declaration or transfer the patient.\textsuperscript{157} The directive may request the termination of treatment which, "when administered to a patient, will only serve to prolong the dying process."\textsuperscript{158} It is difficult to imagine a treatment that could

\textsuperscript{148} President's Commission Report, supra note 7, at 144.
\textsuperscript{150} Id. § 2.
\textsuperscript{151} Id. § 1.
\textsuperscript{152} Id. § 2(a).
\textsuperscript{153} Id.
\textsuperscript{154} Id. § 4(a). The individual may revoke the directive at any time and in any manner regardless of the individual's mental or physical condition as long as the revocation is communicated to the physician. The intention of the Commission on Uniform State Laws is to allow an individual freedom to revoke the directive at any time without the encumbrance of complicated procedural requirements.
\textsuperscript{155} The intended result might be better achieved by a provision making the directive ineffective while the maker objects to its effectuation. Revocation normally denies the maker future use of the directive since the maker will likely be found incompetent to execute it anew.
\textsuperscript{156} Id. § 3(ii).
\textsuperscript{157} Id. But see Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (transfer not permitted even on moral grounds).
\textsuperscript{158} Unif. Rights of the Terminally Ill Act, 9B U.L.A. 609 § 2(b) (1985).
ethically be administered only to prolong dying even without a directive. Karen Quinlan would certainly again not qualify. Further, the Uniform Act nullifies a declaration to end life support for a pregnant woman whose fetus could "develop to the point of live birth with the continued application of life-sustaining treatment" unless the directive otherwise provides\(^{150}\) (the model declaration in the statute makes no mention of the issue).\(^{160}\) It also expressly rejects mercy-killing or euthanasia negatively using three different verbs (it does not condone, authorize or approve) for emphasis.\(^{161}\)

The presumption against life support termination for a pregnant woman in her first trimester, at least, seems clearly unconstitutional on privacy grounds.\(^{162}\) The state's interest in the woman's life which provides balance for her interest in limiting her consent to unwanted medical treatment (especially that which merely prolongs the dying process) is quite weak. The state's interest in preventing what is essentially an abortion of the fetus if she dies before it can be saved must be even more subordinated to the woman's choice.\(^{163}\) It cannot be required that she must remain alive though dying when in the normal case she is not required to consent to the use of her healthy body at least in the early months of pregnancy.\(^{164}\) The denunciation of euthanasia is equally unfortunate in its lumping of active and passive euthanasia. While these terms are also quite imprecise, they connote the distinction between actively causing death as by administering a lethal agent for the sole purpose of killing and more passive acts such as decisions to forego resuscitation or removal of life support. The former is still generally anathema in the medical community\(^{165}\) and is only recently becoming accepted by the general public.\(^{166}\) The latter has growing support from both groups.\(^{167}\)

159. Id. § 6(c).
160. Id. § 2(b). The declaration, which requires two witnesses states:
   
   If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Id.

161. Id. § 10(g).
164. Id.
166. Id. See also infra note 176.
While the attitude of the medical community ought not to be determinative of such issues it is of political importance.

In a subtler fashion, the Uniform Act shifts control further in the direction of the medical community. Several acts are criminalized by the proposed statute. Failure to record a declaration provided by the patient, altering, concealing or coercing the making of a declaration or its revocation are typical. Also criminalized is the failure of a doctor who does not wish to comply with the directive to “as promptly as practicable take all reasonable steps” to see to the patient’s transfer. The refusal to comply is expressly not proscribed and, indeed, physicians are expressly immunized from civil and criminal responsibility as well as professional discipline for actions under the Act which “are in accord with reasonable medical standards.” The qualified transfer provision begs the most difficult question: what if after reasonable steps the doctor is unable to transfer the patient? Does the patient’s wish or the doctor’s govern? That, after all, is the central subject of the legislation.

One provision of the Uniform Act is particularly worthy of future adoption, however. It provides that the declaration may be revoked by the patient at any time and in any manner without regard to mental or physical condition. While such a provision leaves open a great potential for manipulation it wisely recognizes the ultimate preference for life when in doubt as to the patient’s wishes. There should be a counterpart provision that a reinstatement of a declaration is acceptable on similar terms so that the underlying document is not lost because of a recanted expression of changed intentions. This purpose might be accomplished, for example, by providing that life support not be removed from patients whose last expressed wish was to have it maintained but that the validity of the directive would not be affected unless it was validly formally revoked.

VI.

While both the model act and the extant statutes fix earlier and more naive notions, case law has made many advances in dealing with specific cases. New legislation is required to consolidate the
benefits of both the individual directive and the appointment of a medical surrogate for that purpose. For some persons, appointing trusted friends who understand one’s point of view will be a good solution given the complexity of circumstances in which the need for a surrogate decision may be required. In other cases, there may be no one sufficiently trusted or available. A directive with necessarily more general provisions may be best in such instances. Combining both would be even more prudent. A document encompassing both would better deserve the name “living will.”

There are several changes which should be captured by such a new law. It should state the competent patient’s right to refuse any type of treatment as well as any other form of care which is objectionable without qualifying the circumstances for such a decision. A patient should have the opportunity to prepare a directive to that effect but it should be suspended during a period in which he repudiates its direction whether competent or not. No one’s life should be ended over his protest even if competency determinations were uncontroversial. A surrogate, named in the directive, should be authorized to interpret the patient’s wishes in specific circumstances. Physicians should be obligated to follow the directions provided or to transfer the patient. In cases in which transfer is medically inappropriate, doctors should comply with the directive. Failure to do so should be grounds for professional punishment and legal liability.

Public opinion is increasingly accepting the right to choose death as an alternative to treatment. Case law is slowly promoting it and medical opinion has come to accept both more patient control and a greater range of choice in life support removal. One

173. ALEXANDER, supra note 131.
175. See cases cited supra note 82.
176. See, e.g., SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-1984. 3-6 (1984). “Recent opinion polls in the Netherlands show that the majority of the Dutch population (56%) do not object to interventions taken to shorten the lives of terminally ill patients. Only about 23% of the population take a definite stand against euthanasia. The number of opponents to euthanasia decreased from about 48% in 1972 to about 43% in 1976 and to 23% in 1979.” HIJHORST, RELIGION AND EUTHANASIA IN THE NETHERLANDS: ON THE CLARIFICATION OF TWO OPPOSITE FACTORS 9 (1982). “According to the most recent poll in 1985, 67 per cent have no objection against active euthanasia and 84% are not against passive euthanasia.” Admiraal, ACTIVE VOLUNTARY EUTHANASIA, VOLUNTARY EUTHANASIA 186 (1986).

In 1985, “[o]ne-sixth of all the people who died in Holland, some 20,000 people, were killed by doctors on purpose, and not one of those doctors went to jail, even though it is illegal to practice euthanasia.” 60 Minutes: The Last Right? (CBS television broadcast Jan. 5, 1986). The Euthanasia Society in the Netherlands has been working to make active euthanasia legal.
must still question the extent to which patient autonomy ideals are

However, active euthanasia is “classed in the criminal code as a form of murder punishable by up to 12 years in prison. But so long as doctors meet medical and ethical criteria developed in a series of judicial decision since 1973 they are seldom prosecuted.” Wall St. J., Aug. 21, 1987, at 11, col. 4. These standards have also been incorporated into guidelines promulgated by the Dutch Medical Association. The doctor may not actively euthanize a patient unless the request comes from the patient, himself/herself; the patient must be competent and fully conscious; and the patient must ask repeatedly for the procedure. In addition, the patient must have physical or mental suffering which is deemed to be unbearable, and there must be no chance for improvement. Id.

“Efforts to get clarifying legislation on euthanasia through the Dutch Parliament have thus far failed; the issue splits the two parties in the governing coalition. The Christian Democrats prefer keeping euthanasia a crime, with very limited exceptions; the small Liberal Party would like to move toward legalization. The government still hopes to have a proposal ready for debate this fall but is having a hard time working one out.” Id. at 11, col. 4.

Doctors are usually not prosecuted for engaging in active euthanasia if the judicially created guidelines are followed. However, because the prosecution decision is left in the hands of the 2090 local prosecutors, doctors are uncertain as to whether they will be prosecuted. Id. For example, a doctor in Amsterdam was charged with administering active euthanasia in the case of a thirty-two year old multiple sclerosis victim. He was tried at The Hague, and he admitted that he had given the patient a fatal injection. Because the patient was in a great deal of pain and facing a terminal illness, the judge found that the doctor was faced with a conflict: his duty to the patient and his duty to obey the law. The judge found him not guilty. 60 Minutes: The Last Right? (CBS television broadcast Jan. 5, 1986). On the other hand, in the sixty-five cases of active euthanasia reported to the Ministry of Justice, nine resulted in prosecution. Wall St. J., Aug. 21, 1987, at 11, col. 4.

Therefore, it seems that the reality in the Netherlands is that people are allowed to plan their deaths due to the availability of euthanasia. However, the government has not sanctioned the practice. Courts are forced to indulge in a legal fiction that adherence to guidelines means that no crime has been committed although it is clear the letter of the law is broken.

In California there is an initiative proposed for the November 1988 ballot which would allow physician assisted euthanasia. It has not qualified for the ballot as of this writing. The proposed amendment to the California Civil Code is the Humane and Dignified Death Act, which specifically provides that a patient who is terminally ill may sign a written directive instructing his/her physician to administer aid-in-dying. For a patient to be considered terminal, a medical decision must be made that the patient’s condition is incurable in the opinion of two physicians. The Act defines “aid-in-dying” as any medical procedure that will end the life of the patient swiftly, painlessly, and humanely. The directive is revocable by destroying the instrument, by a separate written instrument or by a verbal expression of revocation. See supra note 155. Procedurally, the Act is very similar to the provisions of the durable power of attorney for health care set forth in California Civil Code sections 2430-2444. See supra note 155 The same formalities are required for execution, it remains in effect for seven years unless the patient is then comatose in which case it continues in effect until the person regains the ability to communicate. In addition, it offers immunity from criminal and civil liability to the physician and health care facility if they comply with the terms of the act.

The directive is considered to be a conclusive presumption that its terms reflect the patient’s wishes. However, there are built-in safeguards. The decision to administer aid-in-dying must be reviewed by a hospital committee of three persons to assure all of the following: (1) the directive was properly executed; (2) the directive has not been revoked; (3) two physicians have determined that the patient’s condition is terminal; and (4) the time of death is properly decided by the surrogate decision maker. The act also contains a statutory form which will effectuate its terms.
DEATH BY DIRECTIVE

actually incorporated into medical practice.

Even expressed agreements which seems to prevail cannot be trusted to have changed procedures well entrenched in a prior time when the patient's participation in decision making was less valued. One must still inquire to what extent competent patients are consulted about their wishes, especially life and death decisions? A study completed by the President's Commission found that 41% of physicians would either provide the patient with a straight forward, statistically based prognosis for the disease or tell the patient that it is likely that he will die within a year. However, only 41% of physicians surveyed said they would provide the patient with a hard estimate. The survey undertaken by the Stanford Law Review

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177. A perspective may be obtained by looking at the procedures of Stanford University Hospital with respect to do not resuscitate orders. Office Memorandum from Stanford Univ. Medical Center Committee on Medical Ethics to Stanford Univ. Medical Center, Medical Nursing and Patient Support Staff (Jan. 1985) (Draft Ethics Committee Mailing #2). It begins with a recognition of the importance of patient participation:

We would like to feel confident that DNR orders at the Stanford University Hospital are consistently executed with knowledge by and the informed consent from patients or their legal guardians. We are aware of many instances of competent patients who have clearly and consistently requested not to be resuscitated and who still end up undergoing CPR. At the other end of the spectrum, the potential for problems in communication at a major teaching hospital regarding this issue . . . [is shown by a study which concluded that] of 157 physicians responsible for care of patients who underwent CPR at Beth Israel (Boston) Hospital in 1981, 151 professed to believe that patients of families should be involved in DNR decisions. However, of the 154 patients who were resuscitated, only 19% actually discussed this with their doctors, and only 33% of the families were consulted. Further interviews with 24 mentally competent patients who survived resuscitation revealed only weak correlation between patient and physician perception of any communication that did take place.

Id.

To insure that patients be afforded better opportunities for participation, Stanford distributes a Patients' Rights and Responsibilities statement which includes an invitation to discuss "issues of withdrawing or withholding of life support in the setting of terminal illness" with their physician and to obtain further information at the Patient Relations Office. The policy statement itself, however, is less encompassing. A "No Code" order should be considered when the patient has an irreversible, incurable medical condition and death is expected to occur as a result of the patient's underlying medical problems. Once these criteria are satisfied, then the attending physician must exercise his or her best judgment to determine whether a no code order is appropriate. (emphasis added).

The hospital distributes copies of both directive to physicians and durable power for health care forms for those who chose to contact the Patient Relations Office and presumably acts consistently with their requirements when they are made known. the exclusion of both the patient and the family from those who must exercise judgment about no codes probably is simply inartful.

shortly after the passage of the California Natural Death Act\textsuperscript{180} found a gap between physician views that patients had a right to make informed decisions about life support after they are diagnosed to be terminally ill and assuring that they were informed. Some assumed that other doctors had informed them. Others were euphemistic in their descriptions (for example suggesting that the patient put his affairs in order). Some informed the family but not the patient. A small percentage (7\%) indicated that they sometimes did not tell patients even if neither they nor their family knew independently.\textsuperscript{181} All answers were self assessments. It seems likely that the answers overstated the information that was actually passed.

The active public discussion of death issues will probably increase the amount of information that patients have. Many more persons will have heard of the issues concerning life support and will know to ask about them. Members of the family and friends will likewise probe more. Each experience of a close friend dying in a hospital will also increase the sophistication of those who participate in making late life choices or hear about their being made. Doctors will likely improve in their communication and consultation as their audience learns to expect participation. Thus, it may now be possible to use a device as new as a living will on a larger scale.

If living wills are to be effective for more than a small group of the well-informed, there will have to be a commitment to providing publicity about the options available. The general public will have to be urged to consider life-end issues earlier in their lives and model living wills will have to be made easily available. The fact that as many as five million have already chosen to draft directives under the present unfavorable circumstances\textsuperscript{182} indicates that there is potential for involving a far larger number.

There is insufficient data to determine the costs of providing only as much life support as patients want. It seems quite probable that the costs are less than the amount spent at the moment. Prior systems of health reimbursement which compensated health providers for service provided with little control of the extent of treatment, medical predilections for life over death (a normally excellent perspective) and a growing concern for potential legal liability have no doubt kept many patients in treatment when they would have preferred an earlier death. Reimbursement reform combined with relief

\begin{footnotes}
\item[179.] Redleaf, \textit{supra} note 143.
\item[180.] \textit{CAL. HEALTH \\& SAFETY CODE} §§ 7185-7195 (West Supp. 1987).
\item[181.] Redleaf, \textit{supra} note 143, at 929.
\item[182.] \textit{See} Nelson, \textit{supra} note 23.
\end{footnotes}
from concern about exposure to law suits should make a noticeable difference. Given the reluctance to cut health care resources that has existed to date, the government and private employers may be willing to support the amount of medical life support that is desired. In any event, the adjustments should diminish the reductions that are made if further cost cutting measures are instituted. There is reason to believe that many patients with incurable and ultimately terminal diseases seek to be spared the full course of possible treatment to keep them alive.\(^\text{183}\)

If no changes in present practices are made, on the other hand, the threat of reductions by changes in medical standards of care seems quite likely. In an egalitarian manner, all would be denied some of the less promising forms of life support. Given the higher percentage of older patients who chose to end dialysis support,\(^\text{184}\) one could conclude that dialysis might properly be age restricted in the British manner. Certainly, dialysis was less effective for older and diabetic patients than for the general population. On the other hand, it should be noted that a majority of patients continued treatment at least during the minimum year they were studied. For them, unavailability would have meant death.

Generally, egalitarian reductions would result in denying persons who feel strongly about continuing to “fight” death irrespective of odds the resources to do so as well as likely keeping many alive after they pass their own point of decision to die. Denying the former group its preference would be even more acceptable at a time of resource depletion in which funds for such people could only be obtained by increasing the risks to the remainder of those requiring health care.

\(\text{183.} \) President's Commission Report, supra note 7, at 95-100.
\(\text{184.} \) See supra note 16.