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ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY. By Norman L. Cantor. Indiana: Indiana University Press. (1993). 209 Pp. \$24.95.

*Reviewed by Barry S. Reed, M.D.**

“At one time, most people wanted to live as long as possible, and the medical profession sought to prevent death at all costs.”¹ However, modern advances of medical science can now prolong life and delay death more effectively than ever before. Increasingly, therefore, many persons are unwilling to pay the high cost of these technical accomplishments. This cost, measured in dollars, may run into the millions. However, the dollars are not always the most important cost. Cantor believes that the value of human life is diminished if such life is devoid of personal dignity. He also believes that human life is equally diminished if there is no dignity in dying. He feels that the circumstances of death are important aspects of human life and death. More persons are objecting to paying the price when the cost is measured in pain, suffering, embarrassment and the possibility of a final outcome of a dysfunctional body or mind. To make matters worse, the dysfunctional mind and/or body may not be connected. Such was the case of Nancy Cruzan. *Cruzan*² is one of the major points of discussion in Cantor’s recent book. Cantor writes, “One vehicle for controlling medical intervention is an advance directive. By advance directive, I mean a writing issued by a competent person intending to govern post-competence medical care.”³

Cantor’s book invites several levels of consideration. It is a reference of model statutory advance directives including the 1991 New Jersey advance directive statute as well as a review of statutes from other jurisdictions which govern advance directives. It is also a collection of forms and guidelines for assisting the draftsman of advance directives. The book is a

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1. NORMAN L. CANTOR, *ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY* vii (1993).

2. *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261 (1990).

3. CANTOR, *supra* note 2, at viii.

philosophical consideration of personal human values, such as the freedom to control the most personal human experience — dying. Of great assistance to the draftsman of advance directives is a value profile to assist in the subsequent decision making by the person who must interpret the intention and goals of the declarant after the declarant has become incompetent. The medical treatment choices facing an ill person may number into the thousands. Understanding what a declarant meant when he said, “this is all the medicine I want,” is particularly hard when the declarant does not know what the choices will be. At the time of the declaration, some of the choices will not even be in existence.

Cantor begins his book with a lengthy discussion of the several opinions in the U.S. Supreme Court decision in *Cruzan*. *Cruzan* suffered severe head injuries in a car accident which left her in a vegetative state. This condition is described by the noted neurologist, Dr. Fred Plum:

Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.⁴

One of the major holdings of the U.S. Supreme Court in *Cruzan* was the imposition of a requirement of a clear evidencing of Nancy *Cruzan*'s intent concerning her terminal care. The recollections of a former roommate from conversations were not clear and convincing evidence of the patient's desire to cease hydration and nutrition; further, due process did not require the state to accept the substituted judgment of close family members, absent substantial proof that their views reflected those of the patient.⁵

Advance directives provide a lasting expression of self-determination by a person who later becomes incapacitated. Advance directives share many of the features of a durable power of attorney, a living will, or the function of a conservator appointed to represent an incompetent or a minor. Cantor is a strong supporter of personal autonomy and explains that while courts have shown a tendency to respect and enforce advance directives, most persons do not write advance directives or even express or consider how they would want life saving medical care to be adminis-

4. *Matter of Jobes*, 529 A.2d 434, 438 (N.J. 1987).

5. *Cruzan*, 497 U.S. at 285-86.

tered, withdrawn, or rejected when they become ill. Approximately 50 percent of persons do not have a written will to dispose of their person-alty and realty, nor even a writing to direct the disposition of their person. Most people prefer not to deal with the fact that they will die, and, to avoid dealing with that reality, many do not have written wills nor do they care that advance directives exist.

Chapter 1 reviews the current law which deals with the choices by competent patients to accept or refuse treatment. The rejection of treatments can be a fatal choice. Both state and federal courts have found in favor of patient autonomy in a long series of cases. But, Cantor points out, most of these decisions involve situations where the patient is confronted by a relatively short term life expectancy, usually involving a terminal illness. Some of these court decisions involved patients who were competent to make their own decision. Nancy Cruzan was, as noted above, not able to decide. Her parents wanted to stop parenteral (intravenous) nutrition, which was in accord with Nancy's verbalized wishes. The parenteral nutrition was probably the only treatment keeping Nancy Cruzan alive. The Missouri Supreme Court had rejected the parents' petition. The U.S. Supreme Court agreed with the Missouri court and rejected the parents' appeal of the Missouri court's decision. Chief Justice Rehnquist's decision found that, because Nancy Cruzan had not made a clear cut (written) expression about her post competence care, then the Court need not (but could) intercede on her behalf. Cantor then turns to discuss the dissenting and concurring opinions of the Court in an attempt to anticipate the Court's future decisions on the issue of advance directives. The result of these discussions was very confusing. After reading the *Cruzan* case, I realized that I had become lost in Cantor's academic tossing and turning of contingencies.

Chapter 2 discusses the problems of advance directives which are acted upon at a much later date than when written. Cantor believes that assuring that the declarant's wishes are respected is of very great importance. Cantor refers to this as prospective autonomy. A typical provision of advance directives, which Cantor supports, includes the appointment of an agent, who, Cantor describes as a Health Care Agent. The agent, who Cantor suggests should be a health care professional or a person who is knowledgeable of health care, could act as the patient would have acted and would be free to seek guidance and advice in forming judgments. Such an agent could be an ambulatory force that could respond to changes in technology or what Cantor describes as remote and abstract

developments.⁶ The agent is intended to become a medical fiduciary without fear of being overruled by such doctrines as *parens patriae* (in which the state asserts its right to dictate the care of an incapacitated person).

Advance directives are complicated by attempting to predict future events, circumstances, and human feelings that were not or could not be envisioned at the time of drafting of the directives. Add to this the development of incompetence of the declarant. Are there circumstances that might arise that might change the mind of the declarant, if he or she was not incompetent? Just as with wills, irrevocable trusts and contracts, the law has upheld such future interests long after a person's competency or life has ended. Cantor argues that preferences and intentions should be honored in the future even when the person becomes incompetent, unless there is a written change in their expressed intents. He also suggests that the person consider their own standards (religious, philosophical, or economic to list a few) that should provide the basis for an individual's advance directives. He also urges the person to consult an advisor, who is medically knowledgeable, as the draftsman of their advance directives. At the conclusion of this chapter Cantor restates his opinion of how *Cruzan* could have and should have been decided. Resigned to the Rehnquist majority opinion as it was written, Cantor concludes that *Cruzan* was a lost opportunity for the Court to agree with his notion of the constitutional basis for advance directives. Nevertheless, Cantor suggests that *Cruzan* should not be seen as an impediment to the adoption and utility of advance directives.

Chapter 3 discusses existing state statutes. In most instances these statutes are either living wills or laws that enable the appointment of a health care agent to exercise post-competent health care decisions. He cautions that the drafter must beware of the local variations that exist in the different jurisdictions.

In Chapter 6 Cantor describes a set of five medical scenarios. In these five patients, advance directives come into conflict with the declarant/patient's contemporaneous interests. This section of the book illustrates how moral decision making, personal autonomy, and the interpretation of the advance directives can collide.

One issue that Cantor only touched upon is the impact that finances will have on the use of the increasingly scarce resource of medical care. His illustration of the potential exhaustion of declarant's wealth is a mi-

6. CANTOR, *supra* note 2, at 24.

crossopic concern when compared to the societal health care financing question. What effect will society allow the financing of health care to have on life-and- death choices when medically it is probable that the patient cannot regain their mind or even a physical recovery? Cantor raises complicated issues that have no simple answers. As health resources become more limited, it will become increasingly important for individuals to clearly express how and under what conditions they wish to receive their share of health care.

Another topic not considered in any depth by Cantor is the role that has traditionally been served by the attending physician. Despite all of the technological changes over time, the age old doctor-patient relationship more than ever needs to be respected and the importance emphasized. Who would be more appropriate to act as a special counsel for the drafting of advance directives than the person who is likely to know best, after the patient, what the patient's interests and aspirations are? Our highly mobile society has limited the nature and number of life-long doctor-patient relationships. The physician has never been everything to everyone, but surely in those relationships that have been longstanding and close, there should be a prominent role in Cantor's scheme for the personal physician. The thought provoking ideas of this book need further consideration by physicians, attorneys and the public.

