

Saint Louis University Law Journal

Volume 53
Number 4 *Still Crazy After All These Years: Is
Regulating Physician Practice an Exercise in
Futility? (Summer 2009)*

Article 8

2009

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Robert Schwartz
The University of New Mexico School of Law

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Recommended Citation

Robert Schwartz, *End-of-Life Care: Doctors' Complaints and Legal Restraints*, 53 St. Louis U. L.J. (2009).
Available at: <https://scholarship.law.slu.edu/lj/vol53/iss4/8>

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**END-OF-LIFE CARE:
DOCTORS' COMPLAINTS AND LEGAL RESTRAINTS**

ROBERT SCHWARTZ*

INTRODUCTION

In her thoughtful paper, Professor Johnson reviews how governments have attempted to use law to create a medical culture and patterns of medical practice that will serve the health of the public.¹ Professor Johnson describes just how those efforts have succeeded—and how they have failed—in areas as diverse as medical liability, informed consent, medical billing practices, the prescription of narcotic pain medication, and the care of nursing home patients.² She suggests that we often use the law to encourage providers (and especially doctors, who ultimately control all other providers) to do the right thing, and how doctors frequently respond to these legal incentives with complaints about how these incentives work in unexpected and perverse ways that undermine their original goals.³ Finally, Professor Johnson recommends that we ought to take those doctors' complaints seriously, even if we are appropriately skeptical that they are based on a misunderstanding of the law or self-interest of one form or another, because they can serve as sentinel events that will lead us to appropriate reconsideration of the underlying legal mechanisms.⁴

As Professor Johnson points out, physicians have a uniquely important perspective that makes their views particularly valuable to policymakers, even if their views are not always neutral or accurate.⁵ Doctors are uniquely able to describe how doctors react to laws that intend to regulate them, even if (maybe especially if) those doctors' reactions to the law are unpredictable or even irrational. When physicians, as a body, respond to new law by misreading or misunderstanding it, the rest of us ought to be sensitive to just why they are

* Weihofen Professor of Law and Professor of Pediatrics, University of New Mexico.

1. Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973 (2009).

2. *Id.*

3. *Id.* at 974–75.

4. *Id.* at 1031–32.

5. *See id.* at 976–79.

acting as they are. We may not ultimately accept the doctors' concerns at face value—those concerns may be the result of misunderstanding or self interest—but the very fact that doctors react as they do is relevant if we evaluate the law in terms of the incentives it provides to health care providers. Ultimately, we may not buy the provider's arguments on what a law means or how it should be applied, but the medical culture may still be more affected by the physician's perceptions of a legal requirement than it is by the actual requirement. The misunderstanding itself may provide us with data that are fundamental to understanding why the law is not working as the lawmakers expected it to work and what must be done to change the law to achieve its original goals.

Health lawyers and policymakers cannot always see the same shadows of the laws that are visible to health care providers, and sometimes those shadows have penumbras and emanations⁶ that are not visible to those outside of a narrow medical practice. Sometimes those shadows, whether real or imagined, cause doctors to act inconsistently with the intent of the law, and inconsistently with the requirements of good medical practice. Doctors may misread or misunderstand a law. Still, if the law as misread or misunderstood actually affects medical practice, we should not be blind to the fact of the misunderstanding. Listen to doctors' criticism of the law skeptically, Professor Johnson says, and we will know how to create better, more effective laws to serve the public's health.⁷

In fact, Professor Johnson's thesis, which she has demonstrated in a host of ways, is particularly well-demonstrated in the way the law has developed with regard to end-of-life care.⁸ What doctors perceive to be bad law may give rise to bad medical practice. This bad practice gives rise to doctors' complaints, which have given rise to new law designed to correct the perverse incentives in the earlier law. The legal response, though, has sometimes created incentives for other forms of bad practice, which then give rise to new complaints, and then a new generation of legal reform. The new generation of legal reform, whether "properly" understood or misunderstood, will give rise to yet another set of doctors' complaints, new law, and yet another generation of imperfect incentives for those providing end-of-life care. Doctors have not always properly understood the development of the law in this area, and they have not always adhered to the new generation of law. Still, their comments and

6. The "penumbras" and "emanations" of the Bill of Rights were famously described by Justice Douglas in *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965). Just as there are uncertainties about the meaning of constitutional law, there are uncertainties around the interpretation of statutes—especially those drafted to address public policy debates like that around end-of-life care.

7. Johnson, *supra* note 1, at 1031–32.

8. *See id.* at 981–84.

complaints about existing law have contributed to new and arguably more effective law.

The move from the recognition of “brain death”⁹ to the original living will and “Right to Die” statutes, to the more sophisticated advance directive statutes that recognized durable powers of attorney,¹⁰ to the Patient Self-Determination Act,¹¹ and the development of pain relief statutes,¹² physician-assisted death statutes,¹³ the Uniform Health Care Decisions Act,¹⁴ and the new California Right-to-Know End-of-Life Options Act of 2008,¹⁵ have all been powered, in great part, by doctors’ complaints about incentives created by the effects of then-current end-of-life law. Doctors have misunderstood much of this legislation, sometimes willfully, and they have ignored other parts of this law. Still, the law has created increasingly appropriate incentives by listening to the complaints of those doctors—even when those complaints are not really justified.

I. THE DEVELOPMENT OF THE LAW OF END-OF-LIFE CARE

At least from the turn of the twentieth century over a hundred years ago, American doctors have been enmeshed in a medical culture in which death is the enemy and the preservation of life, in any form, constitutes a victory over this enemy.¹⁶ American medicine was committed to using all of the resources available to save lives. The failure to do so was inconsistent with the expectations of medicine, and, implicitly, inconsistent with the legal requirement that governed the practice of medicine. Doctors would be acting inconsistently with both tort and criminal laws if they allowed patients who could be saved to die.

9. For a good history of the earliest discussion of “brain death,” see Alexander Morgan Capron & Leon R. Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87 (1972). See also *supra* notes 17–20 and accompanying text.

10. For a brief evaluation of the development of this law, see BARRY FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 287–301 (6th ed. 2008).

11. The Patient Self-Determination Act was passed as part of the Omnibus Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to -117, 1388-204 to -206 (codified as amended at 42 U.S.C. §§ 1395cc(f), 1396a (2006)) [hereinafter *The Patient Self-Determination Act*].

12. See Johnson, *supra* note 1, at 1015–16 & 1016 n.223.

13. The first such statute to be adopted was the Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–995 (West 2003 & Supp. 2009).

14. UNIF. HEALTH-CARE DECISIONS ACT §§ 1–19, 9 U.L.A. 83–129 (2005 & Supp. 2008).

15. CAL. HEALTH & SAFETY CODE § 442 (West Supp. 2009).

16. See generally Robert A. Burt, *Doctors vs. Lawyers: The Perils of Perfectionism*, 53 ST. LOUIS U. L.J. 1177, 1180–82 (2009) (finding that “[f]ailure,” i.e., death, “is a defeated expectation on both sides” of the physician-patient relationship).

Against this legal background, medicine developed unprecedented ways to save lives—although frequently the result was just extending the dying process of a patient. The development of a new generation of ventilators, new treatments for victims of burns, newly effective kidney dialysis, and other medical advances, meant that those who would have died almost immediately could be saved—either to be returned to full health, kept in near-death limbo, or something in between. The dramatic improvement of transplant technology at this same time created an additional reason to keep some patients alive (or at least aerated) when a generation earlier those same patients would have died quickly. One result of the availability of life-extending technology and the ability to transplant organs was the development of the formal recognition of brain death, first in medical and scientific policy through Harvard's Ad Hoc Committee on Brain Death,¹⁷ then through individual state legislation,¹⁸ and finally through the Uniform Determination of Death Act.¹⁹ The initial committee convened at Harvard Medical School to address complaints of doctors over the use of the traditional heart-lung definition of death in an era of ventilators and transplants. Under the Committee's proposed definition of brain death at least those who had all of the neurological attributes of death could be declared dead, despite their continued assisted breathing and heartbeat.²⁰

Medical concern over the essential principle that the first goal of medicine was to save life manifested itself in other kinds of cases, too. While doctors agreed that it was appropriate to withhold treatment and let patients die under some circumstances, they complained that the law made them act otherwise. In some famous early lawsuits, for example—the *Quinlan*²¹ case in 1976 and the *Cruzan*²² case in 1990—family members, supported by physicians, sought recognition of the fact that the law did not require treatment under some defined circumstances. The limited success of those lawsuits fed into doctors' dissatisfaction with the incentives for end-of-life care created by the law.²³

17. The Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 85 (1968) [hereinafter Ad Hoc Committee] (defining determination of death); see Capron & Kass, *supra* note 9, at 87–89.

18. See Capron & Kass, *supra* note 9, at 108–11 (discussing the “Kansas Statute,” which was the first attempt by a state to formally define death).

19. UNIF. DETERMINATION OF DEATH ACT §§ 1–3, 12A U.L.A. 777–84 (2008).

20. This issue is not yet fully resolved in the law, of course, in part because of the different incentives and different interpretations of brain death that statutes provide physicians. See Jason L. Goldsmith, *Wanted! Dead and/or Alive: Choosing Among the Not-So-Uniform Statutory Definitions of Death*, 61 U. MIAMI L. REV. 871, 876 (2007).

21. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

22. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

23. See, e.g., Dorothy J. McNoble, *The Cruzan Decision—A Surgeon's Perspective*, 20 MEMPHIS ST. U. L. REV. 569, 569–71 (1990) (“Health care professionals had hoped that the *Cruzan* case would establish a constitutional guideline that would respect the personal nature of

The law of homicide, they argued, created uncertainties for those who took intentional acts (or withheld such acts) with the knowledge that doing so would likely result in the death of the patient.²⁴ Depending on the doctor's intent, the consequent death of a patient could constitute anything from involuntary homicide to first degree murder—a substantial disincentive when keeping the patient alive obviated any criminal and most civil risk for the doctor. To avoid criminal and civil liability, doctors would just keep their patients alive—or so some said.²⁵

At the same time, doctors complained that they were not providing patients with adequate pain relief because providing adequate relief could be seen as a violation of common law liability principles, or even a violation of the criminal laws against the distribution of narcotics.²⁶ We would like to live up to our ethical obligations and recognize that there are values separate from saving life, the doctors argued, but the incentives of the legal system make it impossible for us to do that. We would like to practice good medicine, but we cannot—the devil law makes us do it.

When doctors began to discuss the cases in which it would be appropriate to allow patients to die (and, maybe, to help them die), the legal policymakers were there to help support a developing consensus. If the law made it impossible for doctors to allow patients to die, then the law had the potential to help those doctors and patients too. State courts, legislatures, and, in some states, the people through the initiative process,²⁷ set out to find a way to correct the problem that had resulted in the doctors' complaints. As Professor Johnson points out, the law has established four different ways to do this:

- The first way is through education efforts.²⁸ Legislatures set out to educate doctors and families about the practical limitations of medicine, and the fact that the law did not absolutely prohibit the removal of all life-sustaining medical treatment. Indeed, in some

these decisions and oust the state altogether from an arena that has traditionally, and appropriately, been reserved for the patient, the family, and the doctor.”).

24. See generally Ann Alpers, *Criminal Act or Palliative Care?: Prosecutions Involving the Care of the Dying*, J.L. MED. & ETHICS 308, 310 (noting that doctors may be criminally liable for “any act that grossly deviates from the standard of care and results in a patient’s death” and providing examples of physicians who in fact have been held criminally liable for professional behaviors associated with their provision of palliative care); Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 49–54 (2007) (discussing how physicians who unilaterally terminate life saving medical treatment can be exposed to civil, criminal, and disciplinary sanctions).

25. See, e.g., McNoble, *supra* note 23, at 585–86.

26. Sandra H. Johnson, *Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act*, 24 J.L. MED. & ETHICS 319, 320 (1996).

27. See *infra* text accompanying note 85.

28. Johnson, *supra* note 1, at 1009–14.

states statutes were passed with the primary goal of simply articulating state policy and thus clearing up any misconception that the statutory or common law prohibited allowing a patient to die.

- The second way is through immunity legislation.²⁹ To more clearly respond to the notion that providers could be civilly and criminally liable for any unsaved patient, various right-to-die statutes were drafted to include provisions immunizing providers who acted in accord with the processes recognized in the statute for the removal of life sustaining treatment.³⁰ The benefits of these statutes were extended to both institutional providers, like hospitals and nursing homes, and to individuals.
- Third, the law also uses safe harbors.³¹ Safe harbors are another form of immunity, although the term “safe harbor” is more likely to be found in an administrative code, and the term “immunity” is more likely to apply in cases with potential exposure to tort liability.
- Fourth, the law attempts to correct the problem through the elimination of asymmetrical incentives.³² Using this device, the law could take two alternative approaches to dealing with the incentives that encourage doctors to over-treat patients at the end of life. Those incentives could be withdrawn, or other incentives could be added to counter them. At first glance the second alternative may not seem necessary, but the fact that many legal provisions may serve many different purposes may make it simpler to add a counter-incentive than to remove the original incentive.

These techniques—especially the last one—have been applied regularly with regard to end-of-life care. If a doctor argues he cannot discontinue life sustaining medical treatment when that would otherwise be appropriate because it might constitute homicide, the law ought to create a new crime or tort that attaches to those who fail to properly discontinue life sustaining medical treatment. If legal fear discourages doctors from prescribing adequate pain relief, the law can create immunity, or a safe harbor, for prescribing in appropriate cases, and maybe it should recognize serious damages when a doctor fails to do so. As Professor Johnson points out, if law creates improper incentives, law can create compensatory (and thus proper) incentives, too.³³

29. *Id.* at 1014–18.

30. *See* discussion *infra* Part II.D.

31. Johnson, *supra* note 1, at 1018–22.

32. *Id.* at 1022–23.

33. *Id. passim.*

II. FINE TUNING THE LAW OF END-OF-LIFE CARE

Since the first discussion of the appropriate role of law in encouraging good end-of-life care in the middle of last century, the law has reflected consistent reevaluation of the incentives that govern doctors' behavior. Each new legal effort is followed by a new combination of helpful and perverse incentives—some with foreseen results, and some with unforeseen results. Each new legal effort is also followed by a new round of provider complaints about the unhappy incentives created by the early round of law.³⁴ Each time these new complaints are received, there is yet another iteration of law designed to maintain the helpful incentives and change those that lead to bad care to improve the legal environment in which end-of-life care is provided.³⁵

While each new iteration of law is the result of many inputs, the complaints of providers about how the law is working generally constitute an important source of information for policymakers. When lawmakers have listened carefully (but skeptically) to providers, the next round of legal changes has been most likely to lead to better end-of-life care. Essentially, the cycle goes like this: doctors complain that the law makes it difficult for them to provide end-of-life care; legislative or other legal authorities (like the judiciary) change the law; doctors apply the new legal policy and then discover that the new law creates impediments to the highest quality care; the law is changed again—and after each swing of the legal pendulum, the end-of-life care is marginally better than it was before, although still imperfect.

A. *First Try: Living Wills and Durable Powers of Attorney*

In the mid-1970s the first states reacted to doctors' complaints about the legal incentives to over-treat those who wished to discontinue treatment. The resulting living will statutes, passed first in California in 1976 and then in several other states by 1980, overcame the original problem created by the perverse legal incentive—to inappropriately treat in some cases—by allowing patients to declare what forms of treatment they would want later, when they become incompetent.³⁶ Providers noticed that the new statutes were not

34. See generally N.R. Kleinfield, *Patients Whose Final Wishes Go Unsaid Put Doctors in a Bind*, N.Y. TIMES, July 19, 2003, at B1 (providing anecdotal evidence of doctor complaints about end-of-life care laws in New York).

35. Cf. J. David Haddox & Gerald M. Aronoff, Commentary, *The Potential for Unintended Consequences from Public Policy Shifts in the Treatment of Pain*, 26 J.L. MED. & ETHICS 350 (discussing the steps taken to legitimize the prescribing of opioids for chronic pain relief and the reactions of physicians and public alike to the new public policy).

36. For a consistently reliable description of the development of these statutes, and full citations of the relevant statutes, see ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 7.01, at 7-9 & n.12 to 7-11 (3d ed. 2004 & Supp. 2008). For a brief account of this history, see FURROW ET AL., *supra* note 10, at 294-95.

adequate to deal with most cases, though, because it was virtually impossible for patients to predict the circumstances in which they would find themselves, and thus impossible to order this care far in advance.³⁷ A living will was valuable only if patients could predict with certainty what their condition would be and what treatment they would want.

What could be done about the necessary ambiguity and, thus, limited utility of living wills? Law to the rescue. In the 1980s, listening to doctors' complaints about the inability of patients to foresee their diagnoses and proposed treatments, many states enacted laws that recognized durable powers of attorney.³⁸ These documents could encompass decisionmaking in unforeseen circumstances, because they were based on the patient's appointment of a decisionmaker, not on the patient's making of a decision. If patients thought ahead and prepared durable powers to appoint agents to make decisions for them when they become incompetent to do so, it would allow for appropriate end-of-life care, even when the appropriate care was no care at all.³⁹

But the doctors quickly noticed that there were as few patients with durable powers as there were patients with living wills. The doctors could not overcome the legal incentive to treat unless the patients and their families took some kind of action before the emergency arose. What could be done to make these more effective? If only patients knew of the values of these living wills and durable powers (which were combined into "advance directives" by the late 1980s), and if only health care providers would ask for them, proper end-of-life care could be provided in accord with the wishes of patients. In a rare federal intervention in this area, Congress passed the Patient Self-Determination Act⁴⁰ in 1990. This statute—designed to address the problem reported by doctors who wanted to provide adequate end-of-life care—required health care institutions (including managed care organizations) to inquire about advance directives when admitting patients or conferring membership.⁴¹ It

37. See, e.g., sources cited *infra* note 43.

38. See FURROW ET AL., *supra* note 10, at 295–96. See generally MEISEL & CERMINARA, *supra* note 36, § 7-13 (providing a comprehensive list of state durable powers of attorney statutes).

39. The durable power movement was advanced by Justice O'Connor's concurring opinion in the *Cruzan* case, in which she pointed out that, "in [her] view," the availability of a process to appoint a surrogate decisionmaker "may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 289 (1990) (O'Connor, J., concurring).

40. The Patient Self-Determination Act, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to -117, 1388-204 to -206 (1990) (codified as amended at 42 U.S.C. §§ 1395cc(f), 1396a(w) (2006)).

41. 42 U.S.C. § 1395cc(f)(2).

also required those institutions to provide information about advance directives, and to follow the state law, whatever it might be.⁴²

B. Second Try: The Uniform Health-Care Decisions Act

That was not enough. Doctors continued to complain that few patients had advance directives, and that there was nothing they could do but provide legally required but medically inappropriate treatment for those who had not appointed an agent or declared how they would want to be treated under each imaginable circumstance.⁴³ In fact, doctors' complaints about being forced to provide inappropriate treatment got more intense, and the apparent need for legal reform to allow and encourage physicians to act properly led to an attempt to use a new proposed uniform act to tie up all of the loose legal ends that together still created incentives to provide inappropriate end-of-life care. The American Bar Association approved the National Conference of Commissioners on Uniform State Law's Uniform Health-Care Decisions Act⁴⁴ (Uniform Act) in 1994; this Uniform Act incorporated all four approaches that Professor Johnson discusses: education, immunity, the creation of safe harbors, and the elimination of asymmetrical incentives.⁴⁵

The Uniform Act's primary purpose is explicitly to overcome the concerns health care providers expressed with regard to earlier advance directive statutes. For example, it creates a default decisionmaker in every case by incorporating a family consent provision that allows those appointed by the patient, or family members of the patient, or, as a last resort, those who know the patient's values, to make health care decisions for the patient if no one higher in the decisionmaking hierarchy is available to do so.⁴⁶ In direct response to doctors' complaints that living wills and durable powers of attorney did not usually result in actual decisionmakers upon whom providers could rely without fear of liability (because so few patients had signed these

42. *Id.* § 1395cc(f)(1)(A).

43. *See generally* U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-95-135, PATIENT SELF-DETERMINATION ACT: PROVIDERS OFFER INFORMATION ON ADVANCE DIRECTIVES BUT EFFECTIVENESS UNCERTAIN 8–9, 14 (1995) (reporting that “[d]espite improved public awareness of patient self-determination issues” only about 10% to 25% of the adult population complete formal advance directives; that in 1993, an HHS-OIG study found that only 18% of hospital patients had advance directives; and that not only do advance directives lack clarity in the terms used but also that patients are often “not clear in their own minds what they want” because “[a]nticipating all the possible facts and variables is a daunting, if not impossible, task”); Pope, *supra* note 24, at 50–53, 51 n.284 (discussing legal uncertainty in the medical community regarding the physician's ability to unilaterally terminate life saving medical treatment which he or she considers inappropriate).

44. UNIF. HEALTH-CARE DECISIONS ACT §§ 1–19, 9 U.L.A. 83–129 (2005 & Supp. 2008).

45. *See id.* §§ 7–9, at 117–22; *see also supra* text accompanying notes 28–32.

46. UNIF. HEALTH-CARE DECISIONS ACT § 5, 9 U.L.A. 111–12.

documents), this statute created a list of default decisionmakers upon whom doctors may rely with legal certainty.⁴⁷

In this respect, the Uniform Act adopts an approach that several states had independently undertaken to address the problem doctors faced when there was no clearly identifiable health care decisionmaker upon whom they could rely—the creation of a statutorily defined default list of decisionmakers, most of whom are defined by their family relationship to the patient.⁴⁸ It also responded directly to medical concerns by providing that doctors could opt out of the obligations of the statute under some circumstances if their consciences required them to do so.⁴⁹ While it also recognizes a much more limited institutional right of conscience, the Act is especially powerful in allowing doctors to do what they determine to be ethically required.⁵⁰ Finally, the statute accommodates the many providers who were concerned that older legislation could be construed to require futile treatment.⁵¹ While what constitutes futile treatment may not be obvious, once it is identified, it is not required by this statute.⁵²

As Professor Johnson would have predicted, that statute provided for education, provider immunity, the creation of safe harbors, and the elimination of asymmetrical incentives to serve its goals. First, the Uniform Act made education of a public just becoming aware of advance directives easier by declaring that no particular form is required, and that any form is likely to be legally sufficient.⁵³ Thus, virtually all of the several kinds of forms available through health care providers, non-profits, religious organizations, and advocacy groups are legally acceptable, and different education sources—sometimes hospital ethics committees or advocates for patients with particular conditions, for example—can all participate in educating the public and providers as to the requirements of the law. The statutory form also uses the language of ordinary discourse and ought to be accessible to all; it does not require any legal or medical sophistication to draft an advance directive.⁵⁴ Further, it makes it easier to collect advance directives from members of the public by requiring no special signature form. There is no requirement of any witnesses, no notary need be present, and no formal action is required to validate the directive.⁵⁵ The statute also looks to educate providers about

47. *Id.* § 5(b), at 111.

48. *Id.*; see MEISEL & CERMINARA, *supra* note 36, § 7.04, at 7-51.

49. UNIF. HEALTH-CARE DECISIONS ACT § 7(e), 9 U.L.A. 118.

50. *Id.*

51. *Id.* § 7(f), at 118.

52. *Id.* § 7(f) cmt., at 119 (“‘Medically ineffective health care’, as used in this section, means treatment which would not offer the patient any significant benefit.”).

53. *Id.* § 4, at 99.

54. UNIF. HEALTH-CARE DECISIONS ACT § 4, 9 U.L.A. 99.

55. *See id.* §§ 2, 4 & cmt., at 106.

individuals' end of life choices; it requires that all advance directives—including oral ones acceptable under the statute—be noted in the patient's record.⁵⁶

Second, the statute includes both immunity provisions and safe harbors, although it is not always so easy to distinguish one from the other. Both doctors and family members who make decisions under the statute are formally immune from civil and criminal liability as long as they act in good faith, meeting one of the greatest concerns of doctors.⁵⁷ Essentially, the statute provides that if the Act conflicts with any liability provision elsewhere in the law, the immunity provision prevails.⁵⁸ The law creates safe harbors, too, in several ways. For example, it tells health care institutions exactly what those institutions must do in order to assert a conscience exemption.⁵⁹

Finally, in several ways the statute attempts to overcome the asymmetry of current incentives that doctors claim encourage them to continue treatment under all circumstances, even when it is inappropriate. Most significantly, doctors claim that their fear of civil and criminal liability encourages over-treatment. In reaction to this complaint, the Uniform Act provides a context in which a provider would be as likely to be liable for over-treatment as under-treatment,⁶⁰ and the doctor would be fully protected from liability only if he could justify the treatment choice as the decision of the patient or the patient's designated decisionmaker.⁶¹

Furthermore, and perhaps more directly, the Uniform Act attempts to restore symmetry to the incentives shown to providers by providing for liquidated damages on behalf of a patient when a provider does not follow the statute's directives.⁶² More significantly, as a practical matter, the statute provides for the award of attorneys fees for one seeking to enforce the statute.⁶³ This creates symmetry in incentives to litigate, and it ought to cause doctors to avoid continuing treatment just because doing so restricts their risk of liability. Following the adoption of the act, physicians run a risk of liability

56. *Id.* § 7(b), at 117.

57. *Id.* § 9, at 121.

58. *Id.*

59. UNIF. HEALTH-CARE DECISIONS ACT § 7, 9 U.L.A. 118.

60. *See id.* § 13(d), at 125 (“This [Act] does not authorize or require a health-care provider or institution to provide health care contrary to generally accepted [and applicable] health-care standards . . .” (first alteration in original)).

61. *See id.* § 5(j) & cmt., at 112 (permitting a provider to require written authorization from an individual claiming authority to act as a surrogate for the patient, stating “facts and circumstances reasonably sufficient to establish the claimed relationship,” and which the provider might subsequently point to in order to establish good faith action for purposes of the statutes provider immunity).

62. *Id.* § 10, at 122–23.

63. *Id.*

whether treatment is withheld or continued, and they also benefit from immunity to this increased reservoir of liability when they scrupulously navigate only within the safe harbors defined in the statute. What is more, private litigants now have the opportunity to use the law to encourage doctors to follow its provisions.

C. *Third Try: POLSTs*

From the perspective of someone who understands the logic perfectly, but who does not understand medical culture, the Uniform Act appears like the patch to fix almost all of the doctors' complaints about the process of end-of-life decisionmaking. Although a wide range of providers were consulted in the development of that statute, the law has not been nearly as effective as its drafters had hoped—in large part because it assumed that the medical culture was more malleable than it has proven to be. The Uniform Act creates a health care environment where end-of-life decisions are made by patients and families—where everyone agrees the decisionmaking locus should be—and not by doctors or health care institutions.

The actual environments where these decisions are usually made—emergency rooms, intensive care units, nursing homes—have been less amenable to a statutory change that put those outside the hospital staff in charge. Hospitals are hierarchical institutions that demand immediately identifiable and reliable decisionmakers who understand their institutions. Essentially, hospitals (and nursing homes) were not ready to remove decisionmaking authority from doctors, who ultimately possessed it. When those hospitable to patient decisionmaking began to understand why the Uniform Act could not fully succeed in their institutions, they began to look for a way in which the Uniform Act's principles could be applied so that the decision would ultimately be in the hands of the doctors themselves. Only through this application would these decisions actually be given effect in the institutions.

Doctors' complaints about losing their authority in the end-of-life decisionmaking process were addressed through the development of the physician's order regarding end-of-life care, most commonly called the Physician Orders for Life-Sustaining Treatment⁶⁴ (POLST) or, in New York,

64. See Susan E. Hickman et al., *Hope for the Future: Achieving the Original Intent of Advance Directives*, HASTINGS CENTER REP., Nov.–Dec. 2005, at S26, S27–S28. For an update on the adoption of physician's orders with regard to end-of-life care and a complete list of resources relating to POLSTs, see POLST, Resources, <http://www.ohsu.edu/polst/resources/index.htm> (last visited June 4, 2009).

the Medical Orders for Life Sustaining Treatment (MOLST).⁶⁵ Also called Physician Orders for Scope of Treatment (POST),⁶⁶ and, most recently, the Physician's Orders to Permit Natural Dying (PO-PND),⁶⁷ these orders address most of the issues that arise in the context of the advance directive contemplated by the Uniform Act, but they are ultimately identified as orders of the doctor, not directives of the patient.⁶⁸ As a consequence of this change in form, arguably they are more likely to be carried out, even without the force of a statute behind them. Furthermore, they clean up the uncertainties that might arise in the application of the Uniform Act by focusing on one episode (they are short term documents, but renewable) and dealing with do not resuscitate orders, medication issues, assisted eating and drinking, and sometimes other questions. Most physician's orders programs provide that the forms will be on some specially colored paper (usually bright pink or green) so they will be easily identifiable in the file—and so they will be formally recognized documents.

The preparation of such a document requires serious and extensive consultation between the patient (who also must sign the document in some versions of this process), the patient's family (who must sign if the patient does not have capacity to do so), and the physician (who must agree to be available to confirm all of the signatures). These documents are not designed to replace the Uniform Act; rather, they are designed to make the decisions made under the Uniform Act actually effective by translating them from patients' requests (as they were seen) into doctors' orders (which will actually be followed).

In some states, this has been a legal movement, and the validity of these physicians' orders is recognized in statute law.⁶⁹ In some states the documents

65. See New York Dep't of Health, Medical Orders for Life Sustaining Treatment, http://www.health.state.ny.us/professionals/patients/patient_rights/molst/ (last visited June 4, 2009).

66. See, e.g., West Virginia Health Care Decisions Act, W. VA. CODE §§ 16-30-3(u), -25 (LexisNexis 2006).

67. See, e.g., Stanley A. Terman, Advance Directive/Physician's Orders to Permit Natural Dying, <http://www.caringadvocates.org/AD-PND.PO-PND.php> (last visited June 4, 2009) (providing information about PO-PNDs and sample PO-PND forms).

68. For a comprehensive discussion of these physician orders programs, including how they improve issues associated with advance directives as contemplated by the Uniform Act, and the process typically involved with executing a physician order document, see Hickman et al., *supra* note 64.

69. See, e.g., CAL. PROB. CODE §§ 4780-4786 (West Supp. 2009) (authorizing POLSTs); IDAHO CODE ANN. §§ 39-4512A to -4512C (2008) (authorizing the use of POSTs); MD. CODE ANN., HEALTH-GEN. §5-608.1 (LexisNexis 2005 & Supp. 2008) (authorizing the use of "Instructions on Current Life-Sustaining Treatment Options" (previously "Patient's Plan of Care")); N.C. GEN. STAT. § 90-21.17 (LexisNexis 2007) (recognizing MOSTs); W. VA. CODE §§ 16-30-3(u), -25 (recognizing the use of POSTs); see also Kathy L. Cerminara & Seth M. Bogin, *A Paper About a Piece of Paper: Regulatory Action as the Most Effective Way to Promote*

are recognized through hospital policy, or even through custom.⁷⁰ In either case, POLST, or POLST-like documents, demonstrate Professor Johnson's theme once again: that doctors, at the cutting edge of end-of-life care, understand, as a practical matter, why current processes are not achieving their ends. While we should view doctors' complaints skeptically, we are able to improve the quality of medical care by acknowledging their perspective and reviewing their recommendations.⁷¹ Some advocates of the Uniform Act viewed doctors' complaints about moving the power of decisionmaking from doctors to patients as nothing more than the doctors' attempt to maintain power in an increasingly patient-oriented health care system. Others recognized that the doctors really did understand what was required to carry out patients' desires in real world settings.

The doctors were in a unique position to see how the law really worked, which, of course, was not entirely the way it was designed to work. In some ways, the advance directive movement had succeeded, but in some ways it would continue to fail because American health care institutions were not willing to listen to anyone other than doctors. By listening to those doctors, we were able to craft a system that gave authority to patients in practice, through the device of formally returning authority to doctors. Because the physician's order movement was not one based entirely in law, it did not use the devices Professor Johnson described—education, immunity, the creation of safe harbors, and newly symmetrical incentives—as statutory movements had. The consequence, however, is in fact the same—the creation of a form that will educate doctors as well as patients, effectively give doctors who follow it immunity as long as they stay within the safe harbors, and end the asymmetry of hospital incentives that now require following the last doctor's orders even if they conflict with the patient's legally expressed wishes.

D. Fourth Try: The Right to Know End-of-Life Options Act

Sometimes doctors can identify legal gaps that adversely affect care, but the law cannot act to fill those gaps. The most recent statutory acknowledgement that our medical culture requires physicians to issue orders to provide for end-of-life care is found in California's Right to Know End-of-Life Options Act⁷² (RTKEOLO), which was signed into law in that state at the very end of 2008. Because it has just become effective, it is difficult to know just what the consequences of the Act will be—but it was designed to

Use of Physician Orders for Life-Sustaining Treatment, 29 J. LEGAL MED. 479, 491–93 (2008) (discussing and comparing state statutes that recognize physician orders).

70. See Cerminara & Bogin, *supra* note 69, at 486–88 (discussing states' grassroots implementation of POLST or POLST-like programs).

71. See Johnson, *supra* note 1, at 1031–32.

72. CAL. HEALTH & SAFETY CODE § 442 (West Supp. 2009).

overcome problems in the culture of end-of-life care that were recognized by doctors who regularly engaged in that care.⁷³ Unfortunately, there was an insufficient legislative majority in support of any particular resolution of that problem, and its resolution thus may have to await an appropriate judicial review.

Ostensibly, the statute simply articulates the obligation of physicians to inform terminally ill patients about the end-of-life care options that are available to them when those patients request that information.⁷⁴ We might assume that this was also implicit in the law of informed consent in California. Although the RTKEOLO bill was substantially amended in its journey through the California legislature, the original text was designed to protect medical practice in just the ways that Professor Johnson suggested such legislation often works: it explicitly incorporated as appropriate end-of-life options the very alternatives that had been the subject of legal ambiguity. It was designed to educate health care providers, patients, and families of those options, and even in its final diluted form, it implicitly provides legal immunity to those practitioners who act within the limits—really, the safe harbors—identified in the statute.

By its terms, the statute requires that providers inform terminally ill patients about their right to refuse or withdraw life-sustaining treatment, about hospice care (at home and in a health care setting), about their prognosis with and without curative treatment, and about the full range of palliative care that is available.⁷⁵ Most doctors—and legislators—agreed on that part of the solution to the legal gap that health care providers had identified. As originally drafted, though, the bill would have required physicians to inform patients about two forms of end-of-life care that some physicians thought were illegal—“voluntary stopping of eating and drinking” (VSED), which includes the decision of the patient to refuse nutrition and hydration by mouth and by medical means,⁷⁶ and palliative sedation, which is the “administration of sedative medication to the point of unconsciousness.”⁷⁷ In addition, before those sections were completely eliminated from the bill, the bill was amended to include the description of palliative sedation as an “intervention of last resort to reduce severe, refractory pain or other distressing clinical

73. *See id.* § 442 (historical and statutory notes).

74. *See* § 442.5.

75. *Id.* § 442.5(a)(1)–(6).

76. Assemb. B. 2747, 2008 Leg., Reg. Sess., Sec. 2, § 442(g) (Cal. 2008) (as amended in Assembly, May 15, 2008).

77. *Id.* Sec. 2, § 442(e).

symptoms,”⁷⁸ and it noted that “[p]alliative sedation is not intended to cause death or shorten life.”⁷⁹

The RTKEOLO legislation grew out of complaints by physicians about (1) the information that was available to patients making end-of-life decisions, and (2) in particular, the failure of many patients to be told about VSED and palliative sedation, options available to those patients. Initially the bill was opposed by physicians who oppose VSED and palliative sedation, and who claim to foresee the next iteration of problems that would arise out of the application of the formal legal approval of these processes.⁸⁰ The statute was successful in addressing one problem recognized by physicians under current law—the failure of the medical system to educate patients about end of life options generally. On the other hand, the original draft of the bill, with its references to VSED and palliative sedation, included the clear message that both VSED and palliative sedation were permitted, and that patients must be informed about those options.⁸¹ Because these provisions were removed from the bill, these alternatives remain in legal limbo in California, and some physicians may remain reluctant to provide this care which others assume to be among reasonable and legally permitted medical alternatives.

By defining and limiting the use of VSED and palliative sedation, the intermediate draft of the bill would have created safe harbors for providers who acted within those definitions. For example, the statute would have been explicit in allowing doctors to order palliative sedation only when the purpose of that treatment is to relieve severe, refractory pain, and to neither cause death nor shorten life (assuming those can be distinguished).⁸² Any physician would have known how to navigate VSED and palliative sedation while staying within the safe harbor implicitly created by the statute, and thus physicians would have benefited from de facto immunity by acting within those statutory limits. Similarly, the original bill would have removed the asymmetrical incentives that zealous prosecutors can impose on doctors who believe that their patients may wish to consider VSED or palliative sedation. Physicians no longer would have been at risk of criminal liability if they recommended or carried out these options, and that risk, as small as it may be, is probably sufficient to discourage some doctors from even providing relevant

78. *Id.*

79. *Id.*

80. See generally Kevin B. O’Reilly, *California Law Mandates Discussing End-of-Life Options*, AMER. MED. NEWS, Nov. 10, 2008, <http://www.ama-assn.org/amednews/2008/11/10/prsc1110.htm> (noting physicians’ fears that the bill, as originally drafted, would lead to the legalization of assisted suicide).

81. See Bill Analysis, Assemb. B. 2747, 2008 Leg., Reg. Sess. (Cal. 2008) (as amended in Assembly April 24, 2008), available at http://info.sen.ca.gov/pub/07-08/bill/asm/ab_2701-2750/ab_2747_cfa_20080502_154817_asm_floor.html.

82. See *supra* text accompanying notes 78–79.

information to patients.⁸³ Unfortunately, as a result of the amendments of the bill, physicians still face uncertainty over the legal propriety of VSED and palliative sedation.

With regard to the RTKEOLO Act, providers told the legislature about the ambiguity they faced under previous law. It simply was not clear whether or not VSED or palliative sedation were permitted. The law was asked to resolve this uncertainty. The state legislature recognized the importance of telling patients of the options available to them at the end of life, and it recognized that physicians had not been doing so before. It filled in that legal gap. While the legislature also recognized the problem of the uncertainty surrounding VSED and palliative sedation and set out to resolve it, the legislature turned out to be as ambivalent about the solution as providers—and the rest of society—had been.

E. A Note on Physician-Assisted Death

While a discussion of physician-assisted death is beyond the scope of this brief essay, it is worth considering the application of Professor Johnson's thoughts on doctors' complaints about "bad law" to this area of law. In fact, there has not been much fine tuning of common law or legislation providing for physician-assisted death, and doctors—who have been prominent among those who have supported and opposed physician-assisted death—have not provided consistent analysis of the few laws that exist. The first statute formally permitting physician-assisted death, the Oregon Death with Dignity Act,⁸⁴ became effective a decade ago, and it has since been the subject of a great deal of data collection and analysis. Like the Oregon statute, the newer Washington statute was approved through the initiative process rather than the

83. The ambiguity faced by physicians in this area is demonstrated by the fact that the American Medical Women's Association (AMWA) felt obliged to include a statement in its recent "Statement on Aid in Dying" within which the organization attempted to define the way out of the quandary:

AMWA also supports the following practices in the care of terminally ill patients and maintains that these practices are not forms of physician assisted dying.

- The provision of palliative care measures to alleviate pain even if the patient's death is a possible side effect of the treatment.
- The withdrawal or withholding of life-sustaining measures as requested by a patient or surrogate thereby allowing the patient to die as a direct result of his/her illness.
- Providing only supportive care to patients who voluntarily stop eating and drinking.

American Medical Women's Association, *Aid in Dying*, <http://www.amwa-doc.org/index.cfm?objectId=242FFEF5-D567-0B25-585DC5662AB71DF9> (last visited July 13, 2009) (footnotes omitted). Of course, the first bullet point refers to palliative sedation and the last to VSED. If the status of these forms of treatment were well-established, such a statement would not have been necessary.

84. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–.897 (West 2003 & Supp. 2009).

normal legislative process.⁸⁵ More recently, a Montana state court has found a state constitutional right to obtain physician assistance in death, and that decision is now pending in the Montana Supreme Court.⁸⁶

Because none of the state law in this area developed through the legislative process, doctors' complaints about this area of law have taken different forms than the more usual doctors' complaints about law that has bad consequences on the practice of good medicine. However, we can review doctors' comments on new and proposed physician-assisted death statutes to glean the insights that doctors have on how such laws actually affect the practice of medicine.⁸⁷ In fact, physicians' arguments with regard to physician-assisted death, on either side of the issue, have been directed to what those physicians see as the real consequences of the existence of laws permitting physicians to assist in the death of their patients.⁸⁸ Doctors are not so likely to believe that there will be very many cases of physician-assisted death, at least if it is regulated in ways similar to the way it is regulated in Oregon. On the other hand, many providers have warned policymakers that the environment in which we provide-end-of life care will change in radical ways (positively or negatively, depending on the observer) if there is legal authorization of physician-assisted death.⁸⁹ We may not have to choose between the complaints made by doctors who support physician-assisted death and those who oppose it; however, as Professor Johnson instructs us, we should listen carefully to the arguments raised by each side, and to the complaints about the current and prospective law that come from each side. Doctors are not as concerned about the actual

85. See Washington Death with Dignity Act, WASH. REV. CODE § 70.245.010–904 (2008).

86. *Baxter v. State*, No. ADV-2007-787 (Mont. Dist. Ct., Dec. 5, 2008) (on file with *Saint Louis University Law Journal*), appeal filed DA-09-0051 (Mont.) (May 15, 2009).

87. These arguments can be found in a number of different and inconsistent sources. Most are summarized in MEISEL & CERMINARA, *supra* note 36, and some are expanded upon in an excellent account of what the future of the debate on physician-assisted death holds, MARGARET PABST BATTIN, *ENDING LIFE: ETHICS AND THE WAY WE DIE* (2005).

88. See generally Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Towards Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 *NEW ENG. J. MED.* 303, 303 (1996) (noting that physicians who support the legalization of physician-assisted death emphasize “the relief of suffering, individual autonomy, and patient’s right to be free from paternalistic state intrusion,” while physicians who oppose legalization argue that doing so would “represent a profound change in social values, have serious unintended consequences, and that any gains from accepting the practice are not worth the risks”); BATTIN, *supra* note 87, at 25 (providing an anecdotal example of a physician who believes that legalizing physician-assisted death might compromise physician judgment in the “conditions of medical practice in urban hospitals”).

89. See, e.g., BATTIN, *supra* note 87, at 25 (2005) (discussing the concern that physician-assisted death laws would lead to widespread abuse of the practice).

operation of a physician-assisted death statute as they are about the real consequences it will have for end-of-life care.⁹⁰

Doctors who support physician-assisted death, for example, do not argue that the primary benefit of the statute will be the few people who take advantage of its terms. After all, only a few dozen people take a lethal prescription written under the Oregon Death with Dignity Act each year,⁹¹ but the statute has changed the practice of medicine in other ways, too. Doctors who support such legislation argue that it will lead physicians to focus more on end-of-life care and provide better care generally.⁹² They point out that the very existence of the legal option of physician-assisted death will assure terminally ill patients that they are in control, and that they do not need to choose death now to avoid untreatable pain later.⁹³ In fact, some argue, the existence of a physician-assisted death option may actually go a long way to create an environment in which terminally ill patients opt to stay alive longer

90. See Johnson, *supra* note 1, at 992–1005.

91. OR. PUB. HEALTH DIV., DEP'T HUMAN SERV., 2008 SUMMARY OF OREGON'S DEATH WITH DIGNITY ACT (2009) (reporting that since the Act became effective in 1997, 401 patients have died using prescriptions written under the terms of the Act; and that in 2008, 54 out of 88 prescriptions for "lethal medications" were used).

92. See, e.g., Timothy E. Quill, *Legal Regulation of Physician-Assisted Death—The Latest Report Cards*, 356 NEW ENG. J. MED. 1911, 1912 (2007) (noting that legalization of physician-assisted death in Oregon resulted in "more open conversation and careful evaluation of end-of-life options" between both patients and their physicians and patients and their families). See also OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., SIXTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 15–16 (2004), noting that:

The availability of [Physician Assisted Suicide (PAS)] may have led to efforts to improve end-of-life care through other modalities. While it may be common for patients with a terminal illness to consider PAS, a request for PAS can be an opportunity for a medical provider to explore with patients their fears and wishes around end-of-life care, and to make patients aware of other options. Often once the provider has addressed patients' concerns, he or she may choose not to pursue PAS. The availability of PAS as an option in Oregon also may have spurred Oregon doctors to address other end-of-life care options more effectively. In one study Oregon physicians reported that, since the passage of the Death with Dignity Act in 1994, they had made efforts to improve their knowledge of the use of pain medications in the terminally ill, to improve their recognition of psychiatric disorders such as depression, and to refer patients more frequently to hospice.

93. See, e.g., Timothy E. Quill, *The Million Dollar Question*, 352 NEW ENG. J. MED. 1632, 1632 (2005) (suggesting that simply knowing that they have the ability to end their own life, allows terminally ill patients to feel less "trapped" and thus "freer to keep going"); see also PHYSICIAN ASSISTED DYING: THE CASE FOR PALLIATIVE CARE & PATIENT CHOICE (Timothy E. Quill & Margaræt P. Battin, eds. 2004) [hereinafter PHYSICIAN ASSISTED DYING]; Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557 (2000).

because they will be in charge of their own medical destiny.⁹⁴ Some doctors tell us that permitting physician-assisted death may actually decrease its incidence.⁹⁵

Similarly, those doctors who oppose the legalization of physician-assisted death are not so worried about the actual implementation of those statutes, because those physicians know that the numbers of covert and arguably illegal physician-assisted deaths dwarfs the number that will be done, with much greater oversight, under a statutory scheme. Instead, they oppose physician-assisted death because they believe that it will create an environment in which those given the choice are denigrated by the very existence of the choice, that the right to physician-assisted death will become an obligation (for the disabled, for example),⁹⁶ and that it will destroy the doctor-patient relationship by causing patients to see doctors as agents of death as well as agents of life and health.⁹⁷ Physicians understand that the debate over the legal status of physician-assisted death is not really about those few deaths that will occur under those statutes, but about the effect of the statutes on other aspects of end-of-life decisionmaking. Perhaps we will benefit from their insights and complaints by evaluating how to institute a physician-assisted death statute that really does recognize the social value of sometimes devalued people, like the disabled, that does not denigrate those groups, and will still allow individual patients to control their own medical destiny, maintain control of their dying process, and have access to adequate pain relief. Perhaps, in fact, that is what California's Right to Know End-of-Life Options Act does.⁹⁸ Perhaps we have been educated by listening—skeptically, of course, because doctors are also acting to protect their own values and resources—to doctors' complaints about the law and doctors' suggestions about how the law should work.

94. See, e.g., OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 15–16 (2006); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363 (2001).

95. See, e.g., PHYSICIAN ASSISTED DYING, *supra* note 93; Cavin P. Leeman, Letter to the Editor, *Physician-Assisted Death*, 347 NEW. ENG. J. MED. 1041, 1041 (2002) (noting that only a third of patients requesting physician-assisted death actually used it).

96. See, e.g., R.J. George et al., *Legalised Euthanasia Will Violate the Rights of Vulnerable Patients*, 331 BRIT. MED. J. 684, 684 (2005) (arguing that legalized physician-assisted death would not only create a "duty of therapeutic killing" for physicians but it also would "infer a duty to die" on individuals with disabilities). See generally BATTIN, *supra* note 87, at 26 (noting the concern among physicians about the potential for abuse of legal physician-assisted death in situations dealing with certain "vulnerable groups," including women, people with disabilities, and the elderly).

97. See generally MEISEL & CERMINARA, *supra* note 36, § 12.04(F) (discussing fears that legalizing physician assisted death would "undermine public trust in medicine's dedication to preserving the life and health of patients").

98. See discussion *supra* Part II.D.

CONCLUSION

The law attempts to create a medical culture that will allow—or even require—good health care. In creating this law, lawmakers should be sensitive to suggestions made by those who actually provide the care. Although doctors and other providers may mistake or misinterpret the law, they understand the real world consequences of the law in ways that lawyers cannot. The very fact that a doctor mistakes or misunderstands a law relating to end-of-life care is highly relevant to those who are charged with figuring out how the law should be changed. Laws govern through their terms, and also through their shadows. As Professor Johnson explains, in crafting law to lead to good quality health care, policymakers should remember that health law is often most effective when it educates, creates immunities for providers, creates safe harbors, or eliminates asymmetrical incentives.⁹⁹ Doctors are particularly helpful in guiding lawmakers to an understanding of what kinds of tools will be most useful under particular circumstances.

From the original living will legislation to the advance directive movement, to the Uniform Health Care Decisions Act to recent statutes like the California Right to Know Act, Professor Johnson's thesis is demonstrated particularly clearly by considering the development of law relating to end-of-life care. It has taken several legal iterations, each improving on the last, to create the current law of end-of-life care. The improvement in each iteration is the result of our careful but skeptical attempt to listen to doctors' descriptions of their experiences with the last round of legal developments.

Lawyers are used to analyzing what laws do, but it is harder for lawyers to see the shadows those laws cast and to identify the effect of those shadows on the health of the community. We will be better off if we depend on those who practice medicine amid those shadows to help us determine why the shadows are cast as they are, and how we could create ones that provide just the shade that we want. We should listen to doctors seriously, albeit skeptically, when we refine the law with regard to end-of-life care.

99. See Johnson, *supra* note 1.

