# History of the advanced directive

## *A. The description of advanced directives*

Advanced directives are documents that express a patient's choices about medical care or name another person to make decisions regarding medical treatment in the event that the patient is unable to make these decisions themselves. The term 'advanced' is commonly is used to connote the idea that decisions made have been discussed before the urgent necessity of medical intervention arises. The term 'directive' intimates the intent of the document is to give guidance to the health care provider regarding the medical treatment desired by the patient.

Advanced directives in the United States are provided in two common forms:
1. Health Care Instructions known as a "living will"
2. An Appointment of a Health Care Representative known as a durable power of attorney

Health Care Instructions are documents which explain your preferences regarding cardio-pulmonary resuscitation, life-sustaining treatments, supportive care, symbolic care, and/or euthanasia to your health care provider(s). It is activated if you are determined to be unable to make competent medical treatment decisions.

An Appointment of a Health Care Representative is a legal document which permits the 'principle' (the patient) to appoint a representative to make health care decisions should the patient temporarily or permanently lose decision making capacity. The person selected does not have to be an attorney but serves as an 'attorney in fact.'

## *B. A short but important history of advanced directives*

The introduction of the term **living will** can be attributed to Luis Kutner in 1969. He "first proposed the concept of a testimony-type document with the intent to prevent or cease extra-ordinary means to prolong existence."[1] Kutner, a member of the Illinois and Indiana Bar Associations, suggested that the **living will** could address four perceived needs:

1. to resolve the disparity in the "judicial process which treated mercy killers no differently than murderers with malice."[2]
2. to allow the patient legally "the right to die if he so desires."[3]
3. to express a patient's desire to die, though s/he was "incapable of giving consent."[4]
4. to address the first three needs by providing the patient with the "necessary safeguards" to realize the solutions to their needs without being "cumbersome in application."[5]

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[1]Orbon, Margaret J.: "The 'Living Will' -An Individual's Exercise of His Rights of Privacy and Self-Determination," Loyola University of Chicago Law Journal. v. 7, no. 3, Summer 1976, p. 714.

[2]Kutner, Luis: "Due Process of Euthanasia: The Living Will, A Proposal, " Indiana Law Journal, v. 44, 1969, p. 549.

[3]Ibid., 543.

[4]Ibid., p. 550.

[5]Ibid., p. 551.

Kutner's solution was based on the legal precept that "a patient has a right to refuse to be treated, when he is *in extremis,* provided he is an adult and capable of giving consent."[6] Upon this precept he proposed that a document indicating that, if the condition should arise in which an "individual's bodily state becomes completely vegetative and it is certain that he cannot regain his mental and physical capacities, medical treatment shall cease."[7] He suggested six possible names that could be attached to such a declaration, one of which was the 'living will.'[8]

The Euthanasia Education Council applied Kutner's observation of the patient's right to refuse treatment and combined it with content common to the British Bill which predated Kutner's proposition, as well as to Millard's early propositions. The result of this synthesis was the "preparation and distribution of over a quarter of a million copies by the Council in 1973."[9] Eventually, the content of this document was adopted by at least thirty-eight states as of 1990, with California being the hallmark example.[10]

The California *"Natural Death Act"* of 1976 became the first legislative act providing for a legal directive which demands termination of medical treatment. The act incorporated the content of the living will common to that disseminated by the Euthanasia Education Council. The phrase "DIRECTIVE TO PHYSICIANS at the beginning of the text demonstrates this assertion. The Danforth Amendment or or Patient Self-determination Act brought the 'living will' to the federal level, compelling hospitals to seek completion of the form during the admission process. It is most important to note that the emphasis of the **living will** is withholding or withdrawal of care rather than the provision of care. This, in conjunction with the passing of the Oregon's assisted suicide law and the increase in managed care based upon economic risks and benefits, makes an understanding of the use of advanced directives of vital importance for the protection of patient health care choices.[11]

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[6]Ibid., p. 549.

[7]Ibid., p. 551.

[8]Ibid., p. 551.

[9]Russell, Olive Ruth: Freedom to Die: Moral and Legal Aspects of Euthanasia. (Human Sciences Press: New York, 1977). p. 181.

[10]Larson, Ed, and Beth Spring: *Euthanasia: Spiritual, Medical, and Legal Issues in Terminal Health Care*. Portland, Oregon, 1988, p. 159.

[11] For a more detailed discussion of the 'living will' from a Christian perspective confer Wernow, Jerome R.: "The Living Will," *Ethics and Medicine.* v. 10:2 (Summer, 1994) pp. 27-35.