

Legal Perceptions and Medical Decision Making

MARSHALL B. KAPP and BERNARD LO

*Wright State University,
University of California, San Francisco*

IN MARCH 1983, THE PRESIDENT'S COMMISSION FOR the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) (hereinafter referred to as the President's Commission) transmitted to the president and Congress a report titled *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions*. In his cover letter, Commission Chair Morris Abram stated:

Although our study has done nothing to decrease our estimation of the importance of this subject to physicians, patients, and their families, we have concluded that the cases that involve true ethical difficulties are many fewer than commonly believed and that the perception of difficulties occurs primarily because of misunderstandings about the dictates of law and ethics. Neither criminal nor civil law precludes health care practitioners or their patients and relatives from reaching ethically and medically appropriate decisions about when to engage in or to forego efforts to sustain the lives of dying patients.

Nonetheless, misperceptions of the law persist, influence medical decision making and action, and often have a negative impact on the care of dying patients, especially the elderly. Undue concern with

imagined legal requirements and consequences may cause physicians to neglect or devalue other, seriously significant factors that should figure prominently in the calculus of withholding or withdrawing life-sustaining treatment. Hence, this sort of approach is likely to yield neither an optimum decision-making process nor the "best" substantive decisions (Annas 1981; Burt 1981; Kapp 1986; Rothenberg 1982).

This article examines the influence of legal perceptions on medical decision making, focusing on care concerned with life-sustaining technologies and the elderly. The extent of this influence, the accuracy of the medical community's legal perceptions, and reasons for misperceptions are discussed.

The Law/Medicine Relationship

Traditionally, law and medicine have not had an antagonistic relationship. Rather, the relationship has been fundamentally a symbiotic, mutual, and cooperative one (Kapp 1985b). In fact, the medical profession has aggressively co-opted the legal system over the years and used the law's authority to serve its own ends. Illustrations of this interaction include the medical profession's traditional power to determine for itself the standards of care to be applied in a malpractice action, the standards of information disclosure that constitute informed consent, and licensure/discipline standards for determining who is allowed to be part of the medical profession. The role of government in influencing such standards has historically been negligible.

Today, however, both attorneys (Kapp 1985b) and physicians (Stone 1985) perceive that the traditional symbiotic law/medicine relationship is under challenge, for a variety of reasons. The law is both a product of, and a contributor to, myriad other social forces that help to bring about the present tension.

First, authority in our society is no longer automatically accepted by everyone. There is a new-found expectation of, and demand for, the public accountability of professionals, both collectively and individually. The medical profession is no exception.

A second factor exerting pressure to reexamine and redefine the law/medicine relationship is the civil rights movement. Beginning

with a narrow focus on racial justice, this movement succeeded in creating a mind-set that led to a more expansive generalization of rights. This notion of the value of personal rights spread eventually to health care, in terms of both broad "patients' rights" and particular, identifiable groups of health care consumers such as the handicapped or elderly. In the realm of health care, as elsewhere, people today have gone from marching in the streets to marching through the legislatures, administrative agencies, and courts.

Third, consumerism as a movement has progressed beyond Ralph Nader and specific cases to a more general rejection of unbridled professional dominance. The doctrine of caveat emptor has been substantially weakened, as witnessed by, for example, the proliferation of "second opinion" programs. The patient is now called a "client" or "consumer" and is no longer a passive part of a unilateral transaction. The physician/patient relationship today approaches more of an equal partnership.

Finally, government and public funds have become involved in the social financing of health care, especially in the last twenty years, through entitlement programs such as Medicare and Medicaid. This development has given the public an immediate financial stake, as well as an equally real but less tangible ethical interest, in the rights of patients within the health care system, in the access of persons to health care, and in societal control over the system's costs. This stake has compelled the legal system to become actively involved in surveillance of the quality of health care that is purchased with taxpayers' dollars.

Until relatively recently, the main focus of medicine in the United States was on the control and cure of acute, episodic medical problems, such as infectious diseases. Most patients got sick, were treated, and either got better or died quickly. Today, concern for acute medical problems, such as heart attacks or traumatic injuries, is still an important component of medical care. Advances in medical technology and the aging of the population (a related trend) are, however, slowly shifting some of the emphasis in contemporary medicine from acute to chronic, long-term problems and their care. Many patients now have significant medical difficulties (such as hypertension or other heart disease, cancer, or pulmonary disease) that persist and require medical attention over a long period of time. The medical profession is still learning how to expand from an exclusively acute orientation to include a concern for chronic disabilities as well.

In addition, several age-related illnesses (e.g., Alzheimer's disease and other forms of dementia) diminish mental capacity. These deficits often make medical decision making more difficult and strain further the medicine/law relationship.

A related phenomenon is the advent of "halfway" technology. Technologies have been developed that can keep alive certain patients who previously would have succumbed, but that often are not capable of curing these individuals or restoring them to normal functional status. Ventilators, artificial means of feeding, and sophisticated antibiotics are well-known examples. The result is a sizable number of patients who exist in a state of mental and physical "limbo," neither dead, on the one hand, nor healthy and able to participate fully in life, on the other hand. Although this phenomenon is not age-related per se, many of the patients who occupy this middle status are elderly.

Nonetheless, as technological developments have occurred and become publicized, the demand for the use of such life-sustaining technologies has grown among physicians and the public alike. One explanation for the popularity of "high-tech" medicine is the "technological imperative," the (often unconscious) philosophy that simply because a particular technology exists, it must be used. Put differently, there is a reluctance to permit technology that has been developed at great cost and effort ever to sit idle. Another explanation is that it is impossible to predict accurately when sophisticated technological interventions will be successful not only in keeping the patient alive but in restoring the person to some degree of meaningful functioning capacity. There is a strong presumption toward applying fully any available technology that holds any potential for benefiting a patient.

The combination of an aging population and advances in medical technology has had an enormous impact on increasing total health care costs in the past twenty years. Providing more units of more sophisticated (as well as routine) care has resulted in an ever-larger public and private economic investment in the health care industry. A concerted effort is under way in this nation to attempt to curb excessive health care spending, through, for example, reimbursing hospitals prospectively for Medicare patients under a diagnosis-related group formula. But increasing quality for increasing numbers of older, sicker patients costs a great deal. The delicate cost-containment/quality balance carries the potential for further challenging the medicine/law relationship.

All the changes arising out of demographic and technological trends have affected modern relations between medicine and law. They have raised new substantive medicolegal questions, and fostered new legal approaches or processes to address them. There was no need to determine the appropriateness of withholding or withdrawing life-sustaining technologies such as ventilators, feeding tubes, and antibiotics when these technologies did not exist. There was no need to determine the legal status of a person with irreversible cessation of brain activities but artificially maintained breathing and heartbeat at a time when most patients either clearly died or clearly recovered. There was no need to agonize over forcing hemodialysis on a demented, unwilling patient before that technology became available (and before the aging of the population contributed to so many patients falling into that category).

We have new legal issues because we have options today that previously did not exist; our modern medicolegal dilemmas are largely the product of our successes. It is not that the law today intrudes into matters that were previously resolved privately; the law gets involved today in many matters that formerly did not come up at all and, therefore, did not need to be resolved, privately or publicly.

Thus, medicine and law are more closely intertwined than ever before, particularly regarding issues of life-sustaining technologies and the elderly. How this intertwining is perceived will largely determine whether it acts as a positive or negative force in making and acting on decisions.

Health Professionals' Perceptions of the Law

Differing Perceptions of the Law

Physicians and Nurses. Physicians fear liability for civil suits or criminal charges. Rising malpractice settlements and insurance premiums in the 1980s have increased physicians' concern about malpractice suits. Articles entitled "Diary of an Unfounded Malpractice Suit" (Riccardi 1985), "Who Can Sue You for Not Rendering Care" (Horsley 1984), and "How a Lawyer Decides Whether to Sue You for Malpractice"

(Rheingold 1985) convey this sense of fear and threat. Physicians worry that plaintiffs' attorneys can bring suits, even if there have been no medical or ethical mistakes.

Criminal liability for withholding life-sustaining treatment also concerns care givers. In 1982, two California physicians were charged with first degree murder after discontinuing mechanical ventilation and intravenous fluids on a patient who remained comatose after a cardiac arrest¹ (Lo 1984). The family had asked that this treatment be withdrawn. These unprecedented criminal charges were dismissed by a court of appeals. But many physicians feared that they could face similar criminal charges, even if they follow ethical and medical guidelines.

Concerns about criminal liability may persist even though such prosecutions are extremely rare and would be unlikely to succeed (Green 1984; Oakes 1982). Even a slight risk of criminal charges, with adverse publicity and stigma, may influence physician behavior. Physicians' worries increase when district attorneys make such statements as: "Take away food and water and I'll prosecute to the fullest" (Ginex 1982). Later, after attending a medicolegal conference, this prosecutor said that he had changed his mind. But such incidents may only reinforce physicians' fears that the law is inconsistent and that lawyers are uninformed about life-sustaining treatment. Resultant perceptions may compel the provision of medically futile, purposeless treatment to a dying patient, or might lead to maintaining someone on artificial life-support systems even after brain death has been clinically observed, until a court order for treatment cessation has been obtained.

Some physicians believe the law impedes good medical care for patients. Doctors who feel that they make complicated life-and-death decisions under great time pressures may resent having their decisions later second-guessed by judges and lawyers. Some physicians understandably doubt that judges and lawyers can make good decisions about patient care, because the legal system seems too slow for the exigencies of these situations. When decisions are appealed, maximal care is usually continued, and patients often die during the appeals

¹ *Barber and Nejdal v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983).

process. The most forceful expression of such physician hostility toward the law was an editorial in the prestigious *New England Journal of Medicine* concerning the *Saikewicz* case:

"To judges, in Massachusetts or elsewhere, who believe that the judiciary should routinely take responsibility for life-or-death decisions in the incompetent terminally ill patient, I respectfully suggest a guided visit to a large acute-care hospital, particularly to the pediatric and adult intensive-care units, where they can take sober cognizance of the numbers of urgent and complex medical problems that would have to be adjudicated in their courts" (Relman 1978).

An experienced and respected health care lawyer has also warned of the intrusion of law into medical practice: "Few trial court judges regard their role as necessarily positive, either for the patient or the legal process. . . . Our legal system, with all of its very positive virtues, cannot replace the more intimate struggle among those caring for the patient and those who care about the patient, to resolve many of these questions" (Rothenberg 1982).

Physicians are often antagonistic toward judges and lawyers as well. They blame judges for rulings that undercut physicians' ability to practice medicine. Similarly, they blame plaintiffs' lawyers for bringing unfounded civil suits. Such hostility by physicians toward another profession may be an attempt to assign blame for their own decreased autonomy and authority. Although the rhetoric is phrased in terms of benefiting the patient, an underlying issue may be loss of control and power by physicians, or even economic gain by the continuation of services.

The apparent inconsistency in the common law often confuses physicians. As discussed later in this article, case decisions in different states about life-sustaining treatment may be susceptible to different interpretations on such issues as to whether physicians and families of incompetent patients can decide to withhold such treatment without going to court. Furthermore, the common law is unavoidably uncertain in the medicolegal sphere, as in other areas. If the clinical circumstances of a case differ from the situations in previously decided cases, physicians cannot be sure that the previous rulings apply. In addition, in some states there are no test cases and, therefore, no precedents about life-sustaining treatment. Such uncertainty may frustrate physicians who seek guarantees that they will not face liability for withholding treatment.

Physicians are bothered not only by case law, but also by administrative regulations and statutory law that carry out political decisions. They believe such legislation imposes some unrealistic demands and embodies unwise social policies. For example, Medicare regulations for federally funded hospice programs require physicians to certify that patients are terminally ill and will not survive more than 6 months (Brody and Lynn 1984; Fraser 1985). If patients survive longer than this, the hospice bears financial responsibility for their care. Such accurate prognostication, however, is beyond the scope of medical knowledge. In order to avoid admitting patients to hospice care who survive longer than 6 months, physicians would have to admit only those they expect to survive 2 or 3 months. As a result, many patients who will in fact live only 6 months are denied hospice care until the final stages of their illness. Furthermore, federal regulations impose costly programmatic requirements on hospices that receive Medicare payments, replace voluntarism with bureaucracy, and introduce financial incentives that conflict with hospice philosophy. For these reasons, most hospices have elected not to seek certification for Medicare reimbursement (Fraser 1985). Many physicians believe these federal regulations carry out unsound policy decisions that compromise the goal of the hospice to provide supportive care.

Given these legal fears and uncertainty, physicians may seek prior assurance in the courts that their proposed actions will not expose them to liability. Ironically, when physicians or hospitals seek declaratory relief from courts, they exacerbate the very situations they decry: slow judicial decisions that intrude on medical practice.

Nurses have different perceptions of the law than physicians do. They may face legal liability if they carry out physicians' orders that violate ethical or legal principles. They have become increasingly concerned about their own legal responsibility and liability. Nurses implement do not resuscitate (DNR) orders. They are usually the first people to respond to a cardiac arrest and initiate resuscitation. If an order not to resuscitate the patient is made against the wishes of the patient or the family (and contrary to ethical and legal principles), the nurse may bear legal responsibility for withholding resuscitation. Conversely, if a nurse knows that the patient does not want resuscitation but the physician declines to write a DNR order, the nurse could be in legal jeopardy for carrying out resuscitation. An even more difficult situation occurs when the physician gives an oral order not to resuscitate

the patient, but deliberately does not write a formal order in the chart. Nurses who follow such oral orders have no documentation that physicians told them not to resuscitate, and, hence, they risk legal liability. For these reasons, nurses may request that a hospital set up explicit DNR policies.

For nurses, ethical dilemmas usually involve disagreements with physicians (Grammelspacher, Howell, and Young 1986). Nurses increasingly seek a more active role in patient care (Prescott and Bowen 1985). They believe that since they spend more time with patients and families, they may know better than physicians what patients want or what is best for patients. One philosopher has suggested that an important change has occurred in the role of nurses (Winslow 1984). Previously, the metaphor of loyalty to a commander was used. But now, rather than playing a subordinate role to doctors, nurses are seeking the role of patient advocate.

This new role, however, may clash with the hierarchical power structure of hospitals. It may be difficult for nurses to question orders by physicians. Ironically, nurses may find that their concerns over their own legal liability provide an effective way to play a more active role. They have been able to change hospital policy, for example, in setting up formal policies for DNR orders. In turn, the existence of these policies may allow nurses to raise ethical concerns in particular cases and, thus, play a more active role in decisions.

A dramatic example of this is the *Barber and Nejd* case.² As mentioned earlier, two physicians were charged with first degree murder after discontinuing life-sustaining treatment on a patient who was comatose after a cardiac arrest. The case was brought to the attention of the district attorney by a nurse from the intensive care unit. She had insisted that the attending physicians, not the nurse, disconnect the ventilator. Later, when the patient continued to breathe by himself, she asked the physicians to order a misting device. The nurse and one of the physicians had a vehement public confrontation over whether a misting device was necessary. The physician believed that the nurse was insubordinate, while the nurse believed that the physician was belittling her suggestions to improve patient care. Her recourse to the legal system was a dramatic response to this disagreement. Although

² *Barber and Nejd v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983).

all legal issues were ultimately settled in favor of the physician defendants, this case illustrates how poor working relations with nurses may increase legal problems for physicians.

Other Professionals Whose Views Affect Perceptions. Others in the health care system may have different perceptions of the law. Hospital administrators wish to minimize legal problems, the cost of defending lawsuits, and bad publicity. Their primary responsibility is to the hospital corporation, not to its physicians, nurses, or patients. They may be unwilling to accept even minimal legal uncertainty over withholding life-sustaining treatment, and may recommend continuing such treatment or may insist on going to court for prior legal clarification, as happened in the *Bartling* case.³

Often administrators are more concerned about the legal risk of withholding life-sustaining treatment than of continuing possibly inappropriate treatment. Although the patients or their families have brought several suits against physicians and hospitals to have treatments discontinued or alleged battery for unconsented-to treatment, hospital administrators seem more willing to accept these legal risks. In general, neither adverse publicity nor large monetary settlements have been the outcome. In one recent case, an Ohio Common Pleas Court (trial level) allowed mechanical ventilation to be discontinued on a woman with amyotrophic lateral sclerosis who was in a persistent vegetative state after a cardiac arrest.⁴ The patient's husband subsequently also brought a civil suit alleging battery for treatment inflicted over family objections, which was dismissed.⁵ Hospitals and physicians can justify to themselves their actions in continuing life-sustaining treatment; in trying to benefit their patients, they believe it is appropriate to err on the side of continuing life in difficult cases. The public (and judges) seem willing, thus far, to accept this justification.

Administrators are concerned about the legal liability of the institution, as contrasted with physicians' concerns about their individual liability. Lack of formal institutional policies—for example, about DNR orders—may create liability for the institution. Thus, administrators may be

³ *Bartling v. Superior Court of California*, 209 Cal. Rptr. 220, 163; Cal. App. 3d 186 (1984).

⁴ *Leach v. Akron General Medical Center*, 426 N.E. 2d 809 (Ohio Ct. Common Pleas, 1980).

⁵ *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 469 N.E. 2d 1047 (Ohio Ct. Appeals, 1984).

more concerned than physicians about instituting hospital policies. Indeed, some physicians may be cynical about such guidelines, considering them impractical or even counterproductive. In such disagreements, the law may become a scapegoat.

Administrators also must deal with regulations and financial pressures that affect physicians only indirectly. For example, when a patient is decertified by Medicaid as not needing acute care hospitalization, the hospital will not be reimbursed for that patient's care. Physicians may feel trapped because their responsibility not to harm the patient conflicts with their responsibility to maintain the fiscal integrity of the hospital.

Similarly, under prospective payment by Medicare diagnosis-related groups, the hospital has financial incentives to discharge or transfer terminally or chronically ill patients out of the hospital as early as possible. The physician, however, who actually orders the transfer does not face the same direct financial pressures. Under current prospective reimbursement systems, the hospital bears the direct financial risk, not the physician. While the hospital is given a fixed sum regardless of the length of hospitalization, physicians can charge professional fees for each day of hospitalization. Care givers may believe such transfers harm terminally ill patients by disrupting continuity of care and causing psychological harm (Lind 1984). This difference in perspectives may lead to clashes between physicians and hospital administrators, with both parties blaming the legal or political systems.

Lawyers may perceive their role in different ways, depending on the identity of their client. Some lawyers may wish to help physicians and administrators minimize liability. They may point out all legal risks and recommend the course of action that poses the least legal risk. For these lawyers, patient and family welfare is of secondary, if any, importance. Others may view their role as helping to weigh the legal liability or uncertainty against other considerations, such as ethical and medical principles for decision making. Still others may see their task as preparing to defend the decisions made by physicians in good faith and in accordance with institutional and professional guidelines.

Hospital lawyers are more likely than physicians' lawyers to be consulted when the withholding of life-sustaining treatment is being considered. Few physicians retain lawyers whom they can consult about possible legal risks before they make such decisions. But it may be unwise for physicians to rely on hospital attorneys for legal advice.

Hospitals may have different legal liabilities and concerns. There may even be a conflict over whether the hospital or the physician is liable. Indeed, when faced with a malpractice suit, physicians frequently are advised to obtain legal counsel that is separate from the hospital counsel (Kaplan 1984). This potential conflict of interest may be especially common when physicians have their malpractice premiums paid by the institution, as in health maintenance organizations or university teaching hospitals.

Risk managers (many of whom have not been to law school or had other training in legal matters) are hired by hospitals to minimize financial and legal liability for the hospital. Their work includes implementing quality assurance programs, identifying potential problem areas, investigating accidents or incidents, and determining when to negotiate out-of-court settlements. When a lawsuit is brought, the risk manager prepares or coordinates litigation. Fearing large settlements by sympathetic juries, risk managers may wish to settle some suits out of court for low payments even if claims may not be meritorious. This approach may seem more cost effective than spending money for legal fees and risking a larger settlement in court (Danzon 1985).

Risk managers also give a great deal of prospective advice to medical and nursing staff on how to avoid legal difficulties. For many physicians and nurses, risk managers are the chief source of "legal" guidance. Such guidance is usually biased toward continuation of life-sustaining treatment for the dying patient.

Insurance companies wish to minimize their expenditures for defending against and compensating patients who bring suit. Hence, they too may seek to settle some cases out of court even when the plaintiff does not have a strong case, rather than bear the expense of litigation and risk larger verdicts by a jury. Although this strategy is pragmatic and reasonable from the viewpoint of the insurance company, some physicians named in questionable suits may wish to pursue a different strategy. Physicians do not pay the costs of the settlement or verdict directly and some may be concerned about vindicating their reputations. If they are outraged by what they consider unfounded suits, they may seek exoneration in court. Physicians may perceive out-of-court settlements of unfounded suits as yet another example of how the "legal" system puts them in jeopardy even when they may not be at fault.

Influence of Delivery Setting. Perceptions of the law differ in various sites of practice. In teaching hospitals, responsibility for decisions

may be diffused among many care givers. Attending physicians on the faculty may not be as involved in decisions as are residents, interns, and medical students. In one study, attending physicians, who have legal responsibility for patient care, were involved in decisions to withhold cardiopulmonary resuscitation (CPR) in only 39 percent of cases (Uhlmann, McDonald, and Inui, 1984). In the other cases, residents and interns made these important decisions.

Yet, inexperienced physicians and students in teaching hospitals may not appreciate legal and ethical guidelines about life-sustaining treatment. The New York State grand jury in 1983 investigated a case in which a decision to withhold cardiopulmonary resuscitation from an elderly woman was made inappropriately by a medical student without regard to her preferences and without discussing the decision with more senior physicians (Supreme Court of the State of New York 1983). The grand jury found that the lack of a formal hospital DNR policy contributed to this violation of ethical and legal standards.

Physicians in training may feel insulated from legal concerns for several reasons. They may not understand the relevant ethical and legal issues about life-sustaining treatment. Their malpractice premiums are usually paid by the hospital. The likelihood of their involvement in a future lawsuit seems remote, and attending physicians have ultimate legal responsibility for decisions.

One component of the delivery setting that can influence physicians' perceptions of the law is the reimbursement system. Fee-for-service and prepaid health care systems have different financial incentives, including incentives regarding life-sustaining treatments (McPhee, Lo, and Charles 1984). In turn, these economic incentives may influence physicians' willingness to assume legal risks. In fee-for-service medicine, life-sustaining treatment generates income for both the hospital and the physician. Hence, physicians may be more likely to continue life-sustaining treatment than to go to court or accept even a small risk of legal liability for discontinuation. In contrast, in prepaid care under prospective or capitation payments, the physician and the hospital may suffer financially if expensive forms of life-sustaining treatment are continued for a long time. This economic incentive may encourage the physicians to withhold life-sustaining treatment even when there is some legal risk. Prepaid systems, however, are sensitive to charges that they would discontinue treatment to save money for the providers. Such charges were alleged, for example, in the *Barber and Nejdil* case.

In reaction, prepaid systems may be very conservative about discontinuing treatment.

Physicians who are salaried and whose malpractice premiums are paid by employers, as in health maintenance organizations or in academic medical centers, may be willing to accept some legal uncertainty in decisions about life-sustaining treatment. In contrast, those in fee-for-service practice, who pay malpractice premiums from their gross income, may be more concerned about increases in premiums for bad ratings. They may also be more concerned about how adverse publicity may affect their practice. In turn, they may be unwilling to accept even minimal legal uncertainty.

Many decisions about life-sustaining treatment for elderly incompetent patients are made in nursing homes rather than acute care hospitals, and there may be a great discrepancy between actual practice in nursing homes and ethical and legal ideals. More than in acute care hospitals, decisions in nursing homes may be made informally without standard procedures or even open discussion among those involved. Anecdotal evidence (Hilfiker 1983) suggests that decisions about transfer to acute care hospitals or about treatment of infections with antibiotics are often made unilaterally by physicians. Few nursing homes have policies about cardiopulmonary resuscitation or about withholding care (Miles and Crimmins 1985). Even if such policies exist, they are often vague and poorly disseminated, and compliance may be poor. Physicians spend little time in these facilities. They may visit patients only the once a month that is required by Medicare or Medicaid, unless they are employed directly by the nursing home as medical director. Because they are not actively involved in the nursing home, physicians may regard guidelines about DNR orders and withholding treatment as bureaucratic impositions that do not improve patient care.

Nurses, too, may play a different role in these settings. Because physicians are not as available, nurses may have more responsibility and discretion. To decrease their own legal liability, they may want more explicit procedures for making decisions about life-sustaining treatment and formal, written orders rather than oral ones. Once again, the threat of legal difficulties may lead people to place blame on the legal system, rather than recognizing the underlying ethical problems or institutional shortcomings.

Nursing home administrators have particular concerns with elder abuse laws and licensing requirements. Decisions about life-sustaining

treatment undoubtedly will be increasingly scrutinized because of concern about the quality of care in nursing homes and the vulnerability of frail elderly nursing home patients. The New Jersey Supreme Court, in the *Conroy* decision, noted that nursing home patients may have no family, do not have a close relationship with their physicians, and may be victims of abuse.⁶ The *Conroy* ruling declared that every time the withholding of treatment from incompetent nursing home patients is considered in New Jersey the situation has to be investigated by the state ombudsman as a possible case of elder abuse. The court intended these procedures to protect frail nursing home residents. Nursing home administrators may wish to avoid such investigations, which may be long and expensive and generate adverse publicity.

In response to these dilemmas, nursing home administrators may adopt a legally conservative policy. If there is any perceived risk of legal liability for withholding life-sustaining treatment, they may urge that treatment be given. Alternatively, they may encourage the transfer of patients to acute care hospitals when a medical crisis like pneumonia develops, rather than deciding the question of withholding treatment in the nursing home. Such decisions may not be consistent, however, with the patient's wishes or interests.

Sources of Perceptions

These perceptions about the law are shaped by several sources. Medical education and medical journals provide little information about legal issues, and available information is often ultraconservative or inaccurate. An example is the American Heart Association course on cardiopulmonary resuscitation (CPR), required of most physicians each year to renew hospital privileges or medical licenses. This course advises that CPR be administered to almost all cardiac arrest victims brought to the emergency room without prehospital CPR, unless an order not to resuscitate has been appropriately made. CPR is recommended even for patients typically designated "dead on arrival," because a plaintiff's attorney may successfully contest the claim that circulatory arrest had been present for such a long time that recovery of brain function would be impossible (McIntyre 1983). Such conservative advice suggests

⁶ *In the Matter of Claire C. Conroy*, 486 A. 2d 1209 (N.J., 1985).

that the risk of malpractice is so great that physicians would be prudent to provide treatments even though they are extremely unlikely to benefit the patient.

Articles in medical journals may provide incorrect legal information. One legal expert attacked articles about the *Saikewicz* ruling as “casual, offhand, misleading, or just plain wrong” (Annas 1982). Similarly, an article on advance directives did not realize that the California statute on the durable power of attorney for health care requires surrogate decision makers to follow the previously expressed preferences of patients (Scheiderman and Arras 1985). The article, therefore, incorrectly criticized the durable power of attorney for health care for not respecting patient preferences.

Advice by hospital lawyers and risk managers may lead to confusion or conservative approaches to risk management. One expert in health care law lamented that “many lawyers advising Massachusetts hospitals on the law of the *Saikewicz* case lack experience and training in health law and have little familiarity with either medical practice or hospital procedures” (Annas 1982).

The lay press often portrays litigated cases as complicated, time consuming, and acrimonious. Reports suggest that a strong legal case can be made for either side, regardless of the medical facts. Thus, physicians become cynical about the ability of the courts to resolve ethical dilemmas in medicine, but also feel that they have no alternative. The media do not suggest a less dramatic alternative: that improved communication between care givers, patients, and families can lead to mutually acceptable decisions (Lo 1984, 1986).

The apparent inconsistency in the common law often confuses physicians. Decisions in different states about life-sustaining treatment may not be consistent on such issues as to whether physicians and families of incompetent patients can decide to withhold such treatment without going to court or whether artificial feeding may be withheld in some circumstances. Furthermore, the common law is unavoidably uncertain in the medicolegal sphere, as in other areas. If the clinical circumstances of a case differ from the situations in previously decided cases, physicians cannot be sure that the previous rulings apply. In addition, in some states there are no test cases and, therefore, no precedents about life-sustaining treatment. Such uncertainty may frustrate physicians who seek guarantees that they will not face liability for withholding treatment.

Even in the absence of explicit judicial or legislative authorization in a particular state, however, a medical professional's legal risk for a good-faith decision made in conjunction with an incompetent patient's family is virtually nil. Nevertheless, such decisions are, in legal jurisdictions that have not yet ruled on this subject, made and implemented under a cloud of some uncertainty that raises the anxiety level of medical professionals.

Myths about the Law

There are several possible explanations for the growth of erroneous and negative perceptions concerning the law's impact on decisions about life-sustaining technologies (Kapp 1986). First, as noted earlier, many medical professionals labor under an honest but unfortunate misunderstanding of what the law is and what it requires. Legal pronouncements often are attributed to courts and legislatures that have no basis in fact.

Second, as indicated, many attorneys and risk managers who advise medical professionals and institutions in life-sustaining situations err greatly on the side of legal conservatism, to the point where their caution in seeking absolute legal immunity before any action is taken wastes time, energy, and emotion in a way that is a disservice to both the client and affected patients and families (Annas 1984; Kapp 1985a, 1987).

A conservative, formality-based bias toward risk management in situations of decision making concerning life-sustaining technologies is simple to comprehend, but it is also deeply unfortunate. In a number of ways, such an approach neglects or devalues other, seriously significant factors that should figure prominently in the calculus of withholding or withdrawing life-sustaining treatment. Hence, this sort of approach is likely to yield neither an optimal decision-making process nor the "best" substantive decisions (Annas 1981; Burt 1981; Rothenberg 1982). Perhaps the worst effect of such an approach is that medical professionals may become imbued with the false belief that the formal, legalistic manner of dealing with difficult medical decisions is the best, or even the only, course of action.

Third, and perhaps most important, the tendency to blame the law for intractable decision-making problems partially represents a conscious (though more often an unconscious) attempt to circumvent the difficult

and fundamental ethical, social, psychological, and economic issues that are implicated in decisions about life-sustaining technologies, instead of directly confronting those issues (Cassel 1985; Kerschner 1985). The law may be a more attractive opponent to face than the patient's incurable condition, as well as a source of social validation ("hand holding") for decisions for which the physician does not wish to bear responsibility alone (Cassel 1985). Physicians are professionally conditioned to feel a sense of personal failure when a patient dies. The law is often cited, and lawsuits threatened, to promote the personal emotional needs and agendas of the participants, as a way to flex muscles and let out frustrations (Hofmann and Smoot 1985). It is instructive that in Canada, where a different legal system makes the fear of malpractice actions much less of a factor, issues and practices in decision making about life-sustaining technologies seem just as troubled and unclear as in the United States (Clayton 1985; Law Reform Commission of Canada 1979). This phenomenon underscores the argument that the central issues and practices are fundamentally ethical rather than legal.

Whatever the cause, it is easy for the law to become a scapegoat and the focal point of several myths that may interfere with good medical decision making and practice. Many of these commonly heard myths are both wrong and internally inconsistent. The best interests of both medical professionals and their patients compel a critical analysis and refutation of some of the more prominent ones.

The Myth of Simplicity

First, decision making concerning life-sustaining technologies is expected to be clear, unambiguous, and straightforward, and legal interference in medical affairs is thought to make that process unnecessarily and counterproductively complex, uncertain, and difficult. The short answer to this attitude is that irreversible life-and-death decisions are and should be agonizing and gut-wrenching, dealing as they do with the most basic of human values and concerns. Such decisions should never become commonplace, facile, or matter of fact (Meier and Cassel 1983). "The awesome and unsettling power to influence when death comes to another human being should be exercised with the greatest care" (Dresser and Boisubin 1985).

To a certain extent, a degree of ambiguity in the law is unavoidable

and healthy. There are no absolute guarantees in law, any more than there are perfect guarantees in medical care. Here, as elsewhere, law and medicine operate in parallel. Uncertainties exist in all parts of life; we can to a large extent identify, soften, and prepare for those uncertainties, but we can never completely eliminate them. If medical professionals refused to proceed in the face of clinical uncertainty, no patient would ever be treated; every intervention involves medical risk. Similarly, every intervention involves legal risk as well, but the risk is reasonable and manageable. Particularly in a part of the universe as dependent on human value judgments as our legal system is, some risk can never be obliterated, nor should it be. To the extent that the law contributes to a careful and cautious consideration of all relevant issues and perspectives, to the extent that the law poses questions that would not otherwise have been posed, it makes a valuable and positive contribution to sound decision making (Baron 1984; Burt 1984).

The Myth of Intrusion

One widely shared belief is that gratuitous, unwanted, inappropriate legal involvement pervades and intrudes into virtually every aspect and instance of decision making concerning life-sustaining technologies. While it is true that every aspect and instance of medical care (and of every other human activity in complex modern society) entails potential legal implications to which participants must be sensitive, legal intrusion in this sphere cannot fairly be characterized as either gratuitous or pervasive.

First, it is understandable that a few well-publicized legal cases, especially when they yield seemingly conflicting conclusions, are capable of generating substantial anxiety and overcautiousness and increasing the medical professional's normal propensity to practice defensively. An examination of the numbers, however, belies the paranoia. Such cases are indeed few and far between (Annas and Glantz 1986; Helm 1985). Given the predictable regularity with which decisions concerning life-sustaining technologies are made every day in hospitals and nursing homes across the country—when treatment is either instituted, continued, withheld, or withdrawn—the number of situations in which the legal system becomes actively involved is relatively small. The possibility of a physician, nurse, or health care administrator becoming

an involuntary litigant based on a decision concerning life-sustaining treatment of a patient pales in comparison to the ordinary malpractice exposure encountered in standard, run-of-the-mill medical practice.

On the criminal side, both case law and scholarly commentary opine that there is little realistic risk of prosecution or liability whether life-sustaining treatment is or is not given, as long as the decision leading to that result has been made in good faith and according to reasonable professional standards and judgment⁷ (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983; Oakes 1982; Wilson 1985; Annas and Glantz 1986). Much media attention surrounded the only criminal prosecution brought against physicians for withdrawing life-sustaining treatment from a comatose, terminally ill patient (discussed earlier),⁸ but many seem to forget that this case ended in complete legal vindication for the accused physicians and an admonition that criminal prosecution was inappropriate.

The bulk of litigated cases fall within the civil sphere. Few involve an after-the-fact allegation of professional malpractice and a demand for substantial monetary damages (but see *Estate of Leach v. Shapiro*).⁹ Instead, most civil cases involving life-sustaining technologies treat the rare situation of unreconciled differences between participants as to the appropriate course of conduct to follow, and take the form of before-the-fact actions for declaratory and injunctive relief brought by physicians or health care administrators to obtain advance legal prophylaxis or by patients or their families to compel providers to take or to refrain from taking certain actions.

In this regard, it is important to remember that the law is not a self-initiating or enforcing process; it does not simply "happen." Judges do not randomly roam the halls of intensive care units in sweeping black robes with law books under their arms looking for new cases to decide. On the contrary, a tradition of judicial deference is well established, and a court becomes involved only when an issue is brought to it by an interested party. In many respects, resort to

⁷ *In the Matter of Spring*, 405 N.E. 2d 115 (Mass., 1980).

⁸ *Barber and Nejdil v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983).

⁹ *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 469 N.E. 2d 1047 (Ohio Ct. Appeals, 1984).

the courts represents a regrettable failure of informal means of resolving such deeply personal dilemmas (Rothenberg 1982), and challenges responsible medical professionals, patients, and families to devise and implement better means of informal communication, cooperation, and issue resolution (Hofmann and Smoot 1985; Mariner 1984). In the vast majority of situations, such procedures are not only achievable, but are already being carried out daily (American Geriatrics Society 1985; Bollet 1985; U.S. Congress. Office of Technology Assessment 1984).

It should also be noted that, even for the small percentage of disputes about life-sustaining technology that become legal cases, not all involve the debilitated elderly. Many have involved young or middle-aged adults, or minors whose parents have refused treatment for them (Classen 1985).¹⁰ In fact, older persons are vastly underrepresented as malpractice plaintiffs generally, since their cases present difficult evidence problems regarding damages and causation.

There will be some circumstances where differences involving issues that raise fundamental values, rights, and interests cannot be satisfactorily reconciled by the parties themselves. Impasses may result from a clash between sincere but uncompromising positions held by different parties, or because of hidden agendas promoted by persons who do not have the patient's best interests foremost at heart. In either case (and such impasses are relatively rare), the judicial system may be the most appropriate decision-making forum of last resort—not because judges are automatically imbued with greater wisdom than others, but because the courts can provide a degree of objectivity, fairness, and authority that is unmatched by any other societal or individual formal arena of issue resolution (Baron 1984; Dresser 1985).

The Myth of Unreasonableness

Another myth holds that the law surrounding decision making about life-sustaining technologies is basically inconsistent with sound clinical judgment, reason, and ethical imperatives; that it is formulated in a

¹⁰ *In re Quinlan*, 70 N.J. 10, 355 A. 2d 647, cert. denied, 429 U.S. 922 (1976); *Brophy v. New England Sinai Hospital*, No. 84-4152, Mass. Sup. Jud. Ct. Sept. 11, 1986.

vacuum, based solely on abstract theory, and out of touch with clinical realities. The assumption is that "changes in the law" (generally unspecified) are needed to allow more ethically and clinically reasonable care (Sherlock and Dingus 1985). One author prefaced her call for such changes with the phrase: "Since [the law] does not consider patient sensibilities or base decisions on individual need and sound bioethical principles . . ." (Whiteneck 1985).

We hear voiced a lack of faith in the ability of the political system (e.g., hospice statutes and regulations) and the common law (law as announced by courts in the context of individual lawsuits, with decisions based on general societal principles, customs, traditions, and legal precedent in similar factual cases) to adapt reasonably to emerging issues concerning the use of life-sustaining technologies. It is not unusual today to hear criticisms by medical professionals, in response to their interpretations of legal decisions, that the law, legal system, and lawyers act as an essentially negative force in medical decision making, a force that often flies in the face of good clinical judgment, sound ethical principles, and human compassion (Connery 1980). We often hear complaints about the unnecessary cost and turmoil of "defensive medicine" and the need to "treat the attorney" rather than the patient or the family. One influential group of physicians who are quite familiar with life-sustaining technology issues has written that "fear of legal liability often interferes with the physician's ability to make the best choice for the patient" (Wanzer et al. 1984).

Certainly, in the area of life-sustaining technologies, the state of the law is not definitively settled, and anomalous legal decisions may occur in any sphere of developing, evolving social policy. For the most part, though, the developing law concerning life-sustaining technologies appears to be highly consistent with, and supportive of, clinical judgment, reason, shared ethical precepts, and compassion for the emotional and spiritual well-being of all participants in this human drama (Ball 1984; Baron 1984; Lo 1984; Dresser 1985; Dresser and Boisabuin 1985).

To begin, judges recognize that good law, as well as good ethics, depends in the first instance on the collection and analysis of good facts. Particularly in a scientifically sophisticated field such as life-sustaining technologies, therefore, courts look carefully and respectfully to the clinicians most directly involved in a patient's care to inform the legal process concerning relevant clinical facts about the patient's condition and prognosis. Courts use provider-supplied clinical data

as the basic building blocks upon which legal rules and social policy are constructed, as the legal process strives to draw legally and ethically meaningful analogies and distinctions among cases presenting different facts. Some of the most recent judicial decisions have been well-publicized as inconsistencies—for example, the purportedly conflicting results in the *Bartling* (Scherer 1985; Lo 1986)¹¹ and *Bouvia*¹² cases, both of which involved a competent adult, and the inconsistent legal outcomes between the *Barber* case¹³ and the *Conroy* intermediate appellate decision¹⁴ (which, as many overlook, was later reversed on appeal) (Cantor 1985; Curran 1985),¹⁵ both of which involved withdrawal of tube feeding from an incompetent person. But these may be due not to the respective courts being ignorant of the clinical realities, but precisely to those courts being attuned to the differing physical and mental conditions of the involved patients and the different types of proposed medical interventions (Annas 1983).

One illustration of the use of clinical data in judicial decision making is the way that courts handle the highly controversial “quality of life” issue. Courts that have considered this issue have unanimously rejected the concept as a valid criterion in treatment decision making for an incompetent patient, maintaining that each person’s life is of infinite worth. Most judicial opinions in this area, however, implicitly consider this factor anyway, but in the guise of the patient’s “persistent vegetative state”¹⁶ or irreversible absence of cognition or sapience. In other words, the same issue is framed in medical, rather than moral, terms, for psychological reasons. Regardless of how the issue is described, the courts need and use clinical data in order to arrive at just, humane conclusions.

The problem faced by the courts here is the same as that encountered

¹¹ *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 163 Cal. App. 3d 186 (1984).

¹² *Elizabeth Bouvia v. County of Riverside*, Superior Court of California, County of Riverside, No. 159780 (1983). This was the first *Bouvia* case. For a different result, see *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. App. 1986).

¹³ *Barber and Nejdal v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983).

¹⁴ *In re Conroy*, 464 A. 2d 303 (N.J. App., 1983).

¹⁵ *In re Conroy*, 98 N.J. 321, 486 A. 2d 1209 (N.J., 1985).

¹⁶ *In re Quinlan*, 70 N.J. 10, 355 A. 2d 647, cert. denied, 429 U.S. 922 (1976).

by clinicians, patients, and families—namely, good facts upon which to build good law and good ethics may at times be exceedingly difficult to obtain. Making and communicating diagnoses and prognoses in the context of life-sustaining technologies is frequently an uncertain and imprecise process more dependent on art than on science (Meier and Cassel 1983; Lo 1984; Billings 1985) and incapable of giving the courts clear and unequivocal facts for their decisions. Nonetheless, courts faced with difficult decisions concerning the care of critically ill patients uniformly turn to clinicians for an account of the clinical data to be considered in fashioning sound remedies and rules.

Beyond the evolving law's general consistency with such clinical data as are available, there also appears to be a strong congruency between the great bulk of published legal opinions and the emerging (although not unanimous) ethical consensus (see discussion of voluntary guidelines later in this article) on issues concerning life-sustaining technologies. The ethical emphasis on patient autonomy and self-determination in medical decision making is at the heart of every judicial decision in this area, as courts have held that the right to make decisions about one's own medical care is embodied in both the common law right to bodily integrity and the constitutional right to privacy (and, in some cases, in the constitutional protection of religious freedom as well). Except for a few cases where the interests of third parties were deemed compelling,¹⁷ the courts have consistently ruled that mentally competent adults possess the right to decline even life-saving medical interventions, while the autonomy of incompetent patients has been safeguarded by application of the "substituted judgment" test that asks what the individual would have wanted if personally capable of deciding. There is nothing unsound, unreasonable, or unethical about this legal approach.

Procedurally, the courts¹⁸ have overwhelmingly—with the notable exceptions of the *Saikewicz* case, which was severely limited by subsequent Massachusetts decisions,¹⁹ and of the *Eichner* and *Storar* cases²⁰ in New

¹⁷ *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A. 2d 670 (1971).

¹⁸ *In the Matter of Spring*, 405 N.E. 2d 115 (Mass., 1980); *Leach v. Akron General Medical Center*, 426 N.E. 2d 809 (Ohio Ct. Common Pleas, 1980); *Severns v. Wilmington Medical Center, Inc.*, 421 A. 2d 1334 (Del. Sup., 1980).

¹⁹ *In the Matter of Spring*, 405 N.E. 2d 115 (Mass., 1980).

²⁰ *In re Eichner*, 52 N.Y. 2d 363, 420 N.E. 2d 64 (1981); *In re Storar*, 52 N.Y. 2d 363, 420 N.E. 2d 64 (1981).

York, which allow for no substitute decision makers—recognized and encouraged the vital role of family members and attending clinicians in exercising an incompetent patient's rights on his or her behalf. (On the importance, including the legal value, of encouraging family involvement in medical decision making for an incompetent patient, see Brody 1985; Erstling 1985; Sherlock and Dingus 1985; see also American College of Physicians Ad Hoc Committee on Medical Ethics 1984, on why the family has no legal status in decision making when the patient is competent.)

Substantively, the judiciary has adopted guidelines for the surrogate exercise of such rights according to the generally endorsed ethical principle of proportionality or benefit/burden ratio. It cannot credibly be claimed that these legal developments constrain desirable decision making concerning life-sustaining technologies or that they compel the opposite, although cases like *Saikewicz*, *Eichner*, and *Storar* do foster the medical profession's impression of the law as inconsistent and complex.

In addition, the law affirmatively encourages, and in an increasing number of states expressly enables, cooperation and collaboration among patient, family, and care givers in a process of advance health care planning designed to avoid many of the difficult and emotion-laden dilemmas that arise in critical care medicine where adequate advance planning has not occurred. Most deaths today happen in health care institutions and a majority of these deaths are expected by physicians (Tolle, Elliot, and Girard 1985). Legal enablement of advance health planning takes the form of legislative and/or judicial recognition of legal instruments such as living wills and durable powers of attorney to effectuate the wishes of a once-competent patient in the event of subsequent incompetence (Buchanan and Brock 1986; see also President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983; Kapp and Bigot 1985). Again, such legal developments are well in line with the weight of current professional judgment, ethical analysis, and public opinion.

The Myth of Inflexibility

The common lament that legal requirements are too simpleminded, rigid, and inflexible to accommodate easily to clinical realities and contingencies is the flip side of the previously discussed myth that

the law is too ambiguous and nondefinitive to provide sufficient guidance to participants involved in decisions concerning life-sustaining technologies. The inflexibility myth misjudges both the intent and the effect of the law in general, and in this sphere particularly.

It is true that legal rules that are too rigidly and inflexibly drawn and interpreted will necessarily fail, for at least two reasons. First, it is not humanly possible for a lawmaking body (or a medical professional) to anticipate all contingencies that might arise concerning life-sustaining technologies (or any other matter) and to draft definitive laws comprehensive enough to cover them directly. Any attempt to do so would impose unnecessary constraints without corresponding benefits. Second, excessively inflexible legal requirements erode the exercise of discretion and judgment by the actors, and thus impinge on the autonomy of patient and family and on the professionalism of the care givers. It is by asking for cut-and-dried, risk-free legal answers that medical professionals risk forfeiting their ethical and clinical freedom (Whiteneck 1985).

Legislators and jurists are cognizant of these inherent limitations of the law. What is developing, therefore, is the legal setting of broad boundaries, beyond which lies conduct that most people would agree is unacceptable, but within which the participants are afforded substantial leeway to exercise judgment and discretion based on personal values and aspirations (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983). For medical professionals, the crux is not to curse the law for manufactured defects, but rather to know its limits and to acknowledge and embrace the discretion that the law permits and even promotes among medical professionals, patients, and families. While it is the role of law to establish societal rules, it is ordinarily the physician's role, in consultation with patient and family, to apply society's rules to particular circumstances.

The Myth of Lethargy

The final myth explored in this article is the claim that the law is too slow and lethargic in responding to emerging clinical controversies. This is the mirror image of the complaint that the legal system is too anxious and quick to intrude gratuitously into private, personal matters. Many who eagerly criticize the ubiquitous presence and ex-

panding role of attorneys in contemporary society are the same persons who shout that "there ought to be a law" as a means to "escape from [the] freedom" (Fromm 1941) that is imposed by the awesome responsibility to exercise judgment and discretion in life-and-death affairs. It is a paradox that no one wants to be told what to do, but everyone desires the security that comes with clear prescriptions and proscriptions.

The law does react slowly to emerging clinical controversies, but this is not a sign of lethargy. Rather, it is (at least ideally) an indication of deliberation and care. Such a methodically paced process is more likely to produce better legal outcomes, allowing for a greater opportunity to gather evidence, hear arguments from interested parties, and engage in more thoughtful analysis of and reflections about competing points and perspectives (Siegler and Weisbard 1985). Too, the law generally attains a larger degree of public acceptance and respect when it follows and codifies a widespread ethical consensus on a sensitive issue. Problems with public respect for the law often arise when the law makes the error of moving out ahead of the general community too far and too fast in the absence of substantial ethical agreement. We can avoid or minimize the harm of this happening in the realm of life-sustaining technologies by withholding criticism of the law for patiently and cautiously embodying, rather than trying to anticipate, the growing ethical consensus surrounding the delivery or termination of various types of medical care to critically ill persons. The law must react when needed, not preempt merely for the sake of activity.

One further point is in order. While the law is properly deliberate in developing broad rules and policies, expeditious hearings to apply the rules to particular patients can frequently be obtained. For example, hospital attorneys are adept at getting emergency court orders authorizing treatment for incompetent patients or minors.

Influence on Medical Decisions of Perceptions about the Law

Physicians' Responses to Perceptions of the Law

Physician perceptions of the law may influence medical practice. Fears and uncertainty about the law sometimes lead to making decisions

out of public view. Doctors may attempt to avoid justifying or documenting decisions. In a study of DNR orders in San Francisco, physicians, in 4 of the 136 cases, gave oral orders to nurses not to resuscitate patients in case of cardiopulmonary arrest, but deliberately did not write the orders in the medical records. In these four cases, the physicians disagreed with the families of incompetent patients about the decisions (Lo et al. 1985).

In six cases, the physicians gave "limited," "slow," or "partial" code orders (Lo et al. 1985). These orders meant that basic cardiopulmonary resuscitation would be started, but that advanced cardiac life support, such as intubation and mechanical ventilation, would be withheld. Again, these decisions generally were used in cases of disagreement with patients or families. Such limited or oral orders may cause confusion, however, and create legal jeopardy for nurses. In addition, they greatly decrease the likelihood of successful resuscitation. Limited attempts at resuscitation may seek to convince the family that "everything was done." But they provide no benefit to the patient and cause cynicism among the nursing and medical staff (Lo and Steinbrook 1983). Thus, they cannot be justified, unless the patient agrees with them.

Physicians may believe that their risk of liability is decreased if they do not give written orders or discuss their decisions in the medical records. This belief is unsound risk-management policy. Moreover, it violates the ethical ideal that difficult decisions should be made openly and justified.

Another effect of these perceptions about the law is that life-sustaining treatment may be continued on incompetent patients, whether or not it is medically or ethically appropriate. After the *Saikewicz* case in Massachusetts, many incompetent patients had life-sustaining treatment applied or continued. One expert in health law described a dying woman who was resuscitated 70 times in a 24-hour period, a brain-dead patient in whom placement of a cardiac pacemaker was planned, and family members who had to bar the door of a patient's room to prevent resuscitation (Annas 1982). In all cases, the treatment was recommended by hospital counsel. The expert wrote: "Physicians should know at least enough law to be able to tell when the advice their lawyers are giving them is so incredible that it is most likely wrong" (Annas 1982).

Similarly, while Drs. Barber and Nejdil faced criminal charges for

discontinuing intravenous fluids on a comatose patient, many physicians in California were reluctant to discontinue any life-sustaining treatment on incompetent patients. An expert in bioethics said that the prosecution created "terror" among physicians who must decide about life-sustaining treatment for comatose patients (Rohrlich 1983). He cited a case in which physicians refused to disconnect a ventilator from a brain-dead patient, even though this procedure is expressly permitted by California law (and the law of most other states as well).

There are several reasons why physicians generally are less concerned about legal jeopardy for continuing life-sustaining treatment over objections than they are about legal liability for withholding life-sustaining treatment. Hospital administrators similarly seem less concerned about the legal risks of continuing life-sustaining treatment, as discussed earlier. Court proceedings initiated by patients and families to require physicians to withhold or withdraw life-sustaining treatment have not generated much adverse publicity for the physicians. Similarly, the possibility of civil malpractice actions seems remote and unlikely to stigmatize physicians. The public seems willing to accept physicians' justification that in questionable or doubtful cases they should continue life-sustaining treatment rather than allow a patient to die.

Physicians' perceptions of the law may also cause them to practice defensive medicine. They may order additional tests or follow-up visits. The American Medical Association claims that defensive medicine may be costing as much as \$24 billion a year (American Medical Association Special Task Force on Professional Liability and Insurance 1985). But it is difficult to define defensive medicine exactly: "Does the term cover all tests and procedures, however medically defensible, if the principal motivation of the provider in calling for these measures is a fear of litigation? Or, does it, rather, encompass only measures which have no medical justification and, thus, are undertaken solely to guard against legal liability?" (Rosoff 1985). Moreover, there are little good data on the scope of defensive medicine. One 1980 study reported that medicolegal considerations are a contributing factor in only 1 percent of all test orders (Wertman et al. 1980).

Inconsistencies between Law and Medical Practice

Medical practice is inconsistent with the law in fundamental ways. For example, clinical assessment as to whether a patient is mentally

incompetent may differ markedly from legal requirements. Strictly speaking, competence is a legal concept. An adult person is presumed to be competent until the courts declare that person incompetent and appoint a guardian. But in medical practice such legal proceedings are rarely initiated. Instead, if an elderly person is deemed incompetent by care givers, family members are usually asked to make decisions on behalf of the patient. It is not clear why clinical practice so diverges from legal standards. Physicians may be ignorant about the precise legal definition of competency or may regard legal proceedings as too cumbersome and time consuming, with insufficient benefits to justify the costs.

The danger of such informal assessments of competency is that elderly patients may be inappropriately denied control over decisions about their medical care. This possibility is especially worrisome because care givers may apply standards of competency that are quite different from the legal ones. While there are no rigorous studies on the issue, often these assessments of competency are based on the mental status examination, which tests whether the patient is oriented, has intact memory, and can perform simple calculations. If there is a question about a patient's competence, it is far more likely that a psychiatrist will be asked to see the patient and do a more elaborate mental status test than that the courts will be asked to settle the question. But using the mental status test to assess competency may be inappropriate. From a legal and ethical perspective, the correct standard for incompetence is that the patient is unable to comprehend the nature of the tests or treatment, the risks and benefits, the alternatives, and the likely consequences of his or her decision.

A fundamental question is who should make decisions for incompetent patients about life-sustaining treatment. As discussed in the other articles in this issue, the competent patient should make decisions. If the patient is incompetent, a representative of the patient should decide. The presumption is that the family of an incompetent patient should make decisions. In some cases, it is appropriate for the courts to appoint a legal guardian.

Medical practice, however, may be inconsistent with this standard; patients and families often are not involved in decisions about life-sustaining treatment. The study of DNR orders in three San Francisco teaching hospitals illustrates this problem. DNR orders had been considered for 136 of 3,282 patients admitted to the medical services;

18 percent of competent patients did not participate in such decisions. Reasons given by physicians for not involving patients in decisions were family requests that the patient not be involved and the belief that the patients' wishes were already known (Lo et al. 1985). Physicians are unable to determine accurately patient preferences about resuscitation, however, without asking them directly (Bedell and Delbanco 1984). Similarly, in two other studies of DNR orders, 18 to 20 percent of competent patients did not participate in decision making (Evans and Brody 1985).

When patients are considered incompetent, families often do not participate in decisions. In the study of DNR orders in San Francisco, families of incompetent patients participated in decisions in only 81 percent of the cases. Physicians' reasons for not involving families in decisions included a fear that families would disagree with the DNR order, difficulties physicians had talking with families, the belief that medical indications were decisive, and the patient's prior request that the family not be involved (Lo et al. 1985).

Thus, there is a significant discrepancy between legal and ethical guidelines about life-sustaining treatment and actual practice. The lack of involvement by families of incompetent patients in decisions is particularly worrisome because the courts are also not involved in these decisions. In the San Francisco study, the courts were not involved in any of the 136 cases in which DNR orders were considered, even though patients were regarded as incompetent in 56 percent of the cases (Lo et al. 1985).

In some situations, the courts may not need to appoint a guardian to make such decisions regarding incompetent patients. Specifically, several courts have ruled that guardianship proceedings are not required if the patient is in a persistent vegetative state, and if all family members and the physician agree with the decision. It seems that it might be prudent to go to court if there is no family or if family members disagree among themselves or with the physician. (For further discussion of these situations, see the other articles in this issue.)

Once again, medical practice may not be consistent with these legal and ethical recommendations. In one study of DNR orders, 20 cases involving incompetent patients fit these standards for judicial review (Lo et al. 1985). In 12 cases, there was no family. In 4 cases, the family disagreed with the physician, in 2 cases the physicians found it difficult to talk to the families, and in 2 other cases, the family

members disagreed among themselves. Overall, in 20 of 3,282 hospital admissions to the medical service (0.6 percent), ethical and legal guidelines recommend involving the courts. This did not happen, however. Instead, physicians made decisions unilaterally in these cases and in no case was the physician charged with civil or criminal liability. Although it is not clear why these cases were not taken to court, physician concerns about the delays in the legal system probably were an important factor.

Another inconsistency is that certain distinctions traditionally made in the law are not accepted in medical practice. The distinction between stopping treatment and not starting it troubles many care givers, even though philosophers have argued that there is no significant moral difference (Burt 1981; Lo 1986). A reason that justifies not starting a treatment also justifies stopping it. Moreover, accepting this distinction may have unintended and undesirable consequences. Care givers may be reluctant to initiate a potentially useful treatment because they fear that they will have to continue it indefinitely. Recent court decisions also have rejected this distinction.²¹

Ironically, arguments to discontinue treatment may be more compelling than arguments not to initiate treatment. If a treatment has been started and proved unsuccessful, it can be discontinued because it provides no medical benefit to the patient. Care givers, however, are often reluctant to discontinue life-sustaining treatment, even though they would not start the treatment under similar circumstances. They may even feel that stopping treatment is a direct action that kills the patient.

A 1984 case in Washington, D.C., illustrates the reluctance of care givers to discontinue treatment (Weiser 1983). Nurses in the intensive care unit felt uncomfortable discontinuing the ventilator from a young patient whose coma was judged irreversible by the attending physicians and whose family wanted treatment discontinued. The nurses refused physically to discontinue the ventilator; their disagreement required the chief of medicine and the chief of nursing to intervene in the case. After an emergency weekend meeting, the

²¹ *Barber and Nejdal v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983); *In the Matter of Claire C. Conroy*, 486 A. 2d 1209 (N.J., 1985).

attending physician himself had to disconnect the ventilator. Similarly, care givers may be reluctant to discontinue intravenous fluids or tube feeding once they have been started.

The distinction between ordinary and extraordinary care illustrates another difference between clinical practice and law. Clinicians commonly refer to expensive, highly technological, unusual, or experimental treatments, such as artificial hearts, as extraordinary or heroic. In contrast, simpler, more common treatments like intravenous fluids may be considered ordinary care. Recent court decisions have rejected this distinction (Jonsen 1984). In agreement with philosophical arguments, the courts have ruled that all treatments may have both therapeutic effects and side effects. If the burdens of treatment outweigh the benefits to the individual patient, then the treatment is disproportionate and not appropriate.²² Thus, to decide whether a treatment is appropriate we must look at the benefits and burdens to an individual patient, not at the nature of the technology. In other words, one cannot say that a ventilator is "heroic" rather than "ordinary." For some patients, like the postoperative individual, mechanical ventilation is indicated, because its benefits are far greater than the burdens. For an irreversibly comatose patient, however, the benefits of mechanical ventilation are few, and the treatment is usually not indicated.

Yet, the terms "benefits" and "burdens" are ambiguous and rarely used by clinicians. While care givers may use the terms risks and benefits, these terms are usually applied only to medical effects and complications, such as the risk of bleeding or infection. Clinicians usually do not use "risk" to refer to loss of dignity or privacy, which may be important considerations to many patients.

The belief that artificial feedings, such as through nasogastric or gastrostomy tubes, are "ordinary" care is particularly persistent (Callahan 1983; Lo and Dornbrand 1984; Dresser 1985; Meyers 1985; Siegler and Weisbard 1985). Some care givers may consider feeding to be basic, humane care, like a warm, clean bed, that must always be given. Undoubtedly, feeding has emotional and symbolic significance as nourishment and affection. Some writers acknowledge philosophical

²² *Barber and Nejdil v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983); *In the Matter of Claire C. Conroy*, 486 A. 2d 1209 (N.J., 1985).

arguments against regarding feeding as ordinary care but are reluctant to withhold artificial feeding on a wide scale (Siegler and Weisbard 1985). As noted earlier, however, the courts have rejected the claim that feeding is ordinary care²³ (see also Dresser 1985; Meyers 1985). For each patient, the burdens and benefits of artificial feedings must be weighed. Like any other medical intervention, feedings by nasogastric or gastrostomy tubes or intravenous lines may cause complications. Moreover, for patients with severe dementia or irreversible coma, the benefits may be slim (Lo and Dornbrand 1984).

Another inconsistency between law and medical practice is in the use of ambiguous phrases or slogans (Jonsen, Siegler, and Winslade 1982; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983). These terms cause confusion and misunderstanding because physicians and the law may use them in different ways, or there may be no explicit definition.

The term "terminal illness" presents many problems. As mentioned already, the definition of terminal illness adopted by Medicare (6 months survival) may be impractical because physicians cannot predict a prognosis accurately. There are also more fundamental problems with this term. The Medicare definition is arbitrary and may not be accepted by many care givers or patients. Some people may consider a person who is expected to live 6 months terminal, while others may regard a patient as terminal only when survival is expected to be 1 month or 1 week. Some physicians consider patients terminally ill only when they are moribund and will die in a few days no matter what treatment is given. Some people may consider a patient terminal when cancer is first diagnosed, while others apply this label only after metastases develop or a relapse occurs after treatment.

Although the phrase "terminal illness" is often used in a living will, it is usually not defined. Under the California law, for example, two physicians must certify that the patient is terminal, but the criteria for such certification are not specified. Reasonable people may disagree on these interpretations. For living wills, the most important interpretation may be that of the patient. A patient who feels that

²³ *Barber and Nejdil v. Superior Court*, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1054 (1983); *In the Matter of Claire C. Conroy*, 486 A. 2d 1209 (N.J., 1985).

life is valuable may not regard himself or herself as terminally ill, although others do.

Conclusion

In this article we have argued that physicians and other health care professionals too often perceive legal requirements governing the delivery of life-sustaining treatment to elderly persons in a manner that is erroneous and counterproductive. This is an urgent problem that needs to be addressed cogently by federal and state lawmakers, health professions educators, professional societies, the bar, and the press. An accurate and appropriate understanding of the law in this complex and controversial area is compelled by considerations of public policy, good medical care, and the humane and compassionate treatment of elderly individuals and their loved ones.

References

- American College of Physicians. Ad Hoc Committee on Medical Ethics. 1984. American College of Physicians Ethics Manual (Part II). *Annals of Internal Medicine* 101:265–66.
- American Medical Association Special Task Force on Professional Liability and Insurance. 1985. Policy Statement. *American Medical News*, October 4, pp. 70–79.
- American Geriatrics Society. 1985. *Position on Medical Treatment Decisions Concerning Elderly Persons*. New York.
- Annas, G.J. 1981. Learning to Live with Judges. In *Dilemmas of Dying: Policies and Procedures for Decisions Not to Treat*, ed. C.B. Wong and J.P. Swazey, 151–60. Boston: G.K. Hall.
- . 1982. Reconciling Quinlan and Saikewicz: Decision Making for the Terminally Ill Incompetent. In *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients*, ed. A.E. Doudera and J.D. Peters, 28–62. Ann Arbor: AUPHA Press.
- . 1983. Nonfeeding: Lawful Killing in CA, Homicide in NJ. *Hastings Center Report* 13(6):19–20.
- . 1984. Prisoner in the ICU: The Tragedy of William Bartling. *Hastings Center Report* 14(6):28–29.
- Annas, G.J., and L.H. Glantz. 1986. The Right of Elderly Patients to Refuse Life-sustaining Treatment. *Milbank Quarterly* 64(Suppl. 2):95–162.
- Ball, J.R. 1984. Withholding Treatment: A Legal Perspective. *Journal of the American Geriatrics Society* 32:528–30.

- Baron, C. 1984. The Case for the Courts. *Journal of the American Geriatrics Society* 32:734-38.
- Bedell, S.E., and T.L. Delbanco. 1984. Choices about Cardiopulmonary Resuscitation in the Hospital. *New England Journal of Medicine* 310:1089-93.
- Billings, J.A. 1985. Comfort Measures for the Terminally Ill: Is Dehydration Painful? *Journal of the American Geriatrics Society* 33:808-10.
- Bollet, A.J. 1985. A Bad Court Decision. *Medical Times* 113(4):27.
- Brody, H. 1985. The Family and Terminal Care Decisions. *Journal of Family Practice* 20:343-44.
- Brody, H., and J. Lynn. 1984. The Physician's Responsibility under the New Medicare Reimbursement for Hospice Care. *New England Journal of Medicine* 310:920-22.
- Buchanan A., and D.W. Brock. 1986. Deciding for Others. *Milbank Quarterly* 64(Suppl. 2):17-94.
- Burt, R.A. 1981. Immunizing Physicians By Law. In *Dilemmas of Dying: Policies and Procedures for Decisions Not to Treat*, ed. C.B. Wong and J.P. Swazey, 143-49. Boston: G.K. Hall.
- . 1984. The Ideal of the Community in the Work of the President's Commission. *Cardozo Law Review* 6(2):267-86.
- Callahan, D. 1983. On Feeding The Dying. *Hastings Center Report* 13(5):22.
- Cassel, C.K. 1985. Doctors and Allocation Decisions: A New Role in the New Medicare. *Journal of Health Politics, Policy and Law* 10:549-52.
- Classen, H.W. 1985. The Doctrine of Substituted Judgment in Its Medicolegal Context. *Medical Trial Technique Quarterly* 31:451-67.
- Clayton, D. 1985. Do Not Resuscitate: Writing a No Code Policy. *Canadian Medical Association Journal* 133:62-63.
- Connery, J.R. 1980. Court's Guidelines on Incompetent Patients Compromise Their Rights. *Hospital Progress* 61:46-49.
- Danzon, P.M. 1985. *Medical Malpractice: Theory, Evidence, and Public Policy*. Cambridge: Harvard University Press.
- Dresser, R.S. 1985. When Patients Resist Feeding: Medical, Ethical, and Legal Considerations. *Journal of the American Geriatrics Society* 33:791-94.
- Dresser, R.S., and E.V. Boisauhin, Jr. 1985. Ethics, Law, and Nutritional Support. *Archives of Internal Medicine* 145:122-24.
- Erstling, S.S. 1985. The Shared Burden: When Physicians and Families Decide to Forego Life-Sustaining Treatment. *Journal of Family Practice* 20:393-99.

- Evans, A.L., and B.A. Brody. 1985. The Do-Not-Resuscitate Order in Teaching Hospitals. *Journal of the American Medical Association* 235:2236-39.
- Fraser, I. 1985. Medicare Reimbursement for Hospice Care: Ethical and Policy Implications of Cost-containment Strategies. *Journal of Health Politics, Policy and Law* 10:565-78.
- Fromm, E. 1941. *Escape from Freedom*. New York: Holt, Rinehart and Winston.
- Ginex, G.R. 1982. A Prosecutor's View on Criminal Liability for Withholding or Withdrawing Medical Care: the Myth and the Reality. In *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients*, ed. A.E. Doudera and J.D. Peters, 205-10. Ann Arbor: AUPHA Press.
- Gramelspacher, S.P., J.D. Howell, and M.J. Young. 1986. Perceptions of Ethical Problems. *Archives of Internal Medicine* 146:577-78.
- Green, W. 1984. The View from the D.A.'s Office. *Hastings Center Report* 14(6):9.
- Helm, A. 1985. Final Arrangements: What You Should Know About Living Wills. *Nursing* 85 15(11):39-43.
- Hilfiker, D. 1983. Allowing the Debilitated to Die: Facing Our Ethical Choices. *New England Journal of Medicine* 308:716-19.
- Hofmann, P.B., and F.L. Smoot. 1985. Care of the Comatose Patient: Building Mutual Staff Values. *Health Progress* 66(5):58-59.
- Horsley, J.E. 1984. Who Can Sue You for Not Rendering Care? *Medical Economics* 61(17): 85-95.
- Jonsen, A.R. 1984. What is Extraordinary Life Support? *Western Journal of Medicine* 141:358-63.
- Jonsen, A.R., M. Siegler, and W.J. Winslade. 1982. *Clinical Ethics*. New York: Macmillan.
- Kaplan, S.A. 1984. What You'll Need to Know When It's Your Turn to Be Sued. *Medical Economics* 61(23):101-15.
- Kapp, M.B. 1985a. Ethics vs. Fear of Malpractice. *Generations* 10(Fall): 18-20.
- . 1985b. Medicine and Law: A Symbiotic Relationship? *American Journal of Medicine* 78:903-7.
- . 1986. Decision Making in Critical Care: Is the Law an Impediment or a Scapegoat? *Critical Care Medicine* 14(3):247-50.
- . 1987. Law, Medicine, and the Terminally Ill: Humanizing Risk Management Advice. *Health Care Management Review* 12. (In press.)
- Kapp, M.B., and A. Bigot. 1985. *Geriatrics and the Law: Patient Rights and Professional Responsibilities*. New York: Springer.

- Kerschner, P. 1985. Life and Death in Transition: The Withholding Issue. *Journal-American Health Care Association* 11(5):50.
- Law Reform Commission of Canada. 1979. *Sanctity of Life or Quality of Life*. Ottawa.
- Lind, S.E. 1984. Transferring the Terminally Ill. *New England Journal of Medicine* 310:1181-82.
- Lo, B. 1984. The Death of Clarence Herbert: Withdrawing Care Is Not Murder. *Annals of Internal Medicine* 101:248-51.
- . 1986. The Bartling Case: Protecting Patients from Harm While Respecting Their Wishes. *Journal of the American Geriatrics Society* 34:44-48.
- Lo, B., and L. Dornbrand. 1984. Guiding the Hand That Feeds: Caring for the Demented Elderly. *New England Journal of Medicine* 311:402-4.
- Lo, B., and R.S. Steinbrook. 1983. Deciding Whether to Resuscitate. *Archives of Internal Medicine* 143:1561-63.
- Lo, B., G. Saika, W. Strull, E. Thomas, and J. Showstack. 1985. Do Not Resuscitate Decisions: A Prospective Study at Three Teaching Hospitals. *Archives of Internal Medicine* 145:1115-17.
- Mariner, W.K. 1984. Decision Making in the Care of Terminally Ill Incompetent Persons: Concerns About the Role of the Courts. *Journal of the American Geriatrics Society* 32:739-46.
- McIntyre, K.M. 1983. Medicolegal Aspects of Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC). In *Textbook of Advanced Cardiac Life Support*, ed. K.M. McIntyre and A.J. Lewis, 275-91. Dallas: American Heart Association.
- McPhee, S., B. Lo, and G. Charles. 1984. Cost Containment Confronts Physicians. *Annals of Internal Medicine* 100:604-5.
- Meier, D.E., and C.K. Cassel. 1983. Euthanasia in Old Age: A Case Study and Ethical Analysis. *Journal of the American Geriatrics Society* 31:294-98.
- Meyers, D.W. 1985. Legal Aspects of Withdrawing Nourishment from An Incurably Ill Patient. *Archives of Internal Medicine* 145:125-28.
- Miles, S.H., and T.J. Crimmins. 1985. Orders to Limit Emergency Treatment for an Ambulance Service in a Large Metropolitan Area. *Journal of the American Medical Association* 254:525-27.
- Oakes, G.A. 1982. A Prosecutor's View of Treatment Decisions. In *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients*, ed. A.E. Doudera and J.D. Peters, 194-200. Ann Arbor: AUPHA Press.
- Prescott, P.A., and S.A. Bowen. 1985. Physician-Nurse Relationships. *Annals of Internal Medicine* 103:127-33.
- President's Commission for the Study of Ethical Problems in Medicine

- and Biomedical and Behavioral Research. 1983. *Deciding to Forego Life-sustaining Treatment*. Washington.
- Relman, A.S. 1978. The Saikewicz Decision: Judges as Physicians. *New England Journal of Medicine* 298:508–9.
- Rheingold, P.D. 1985. How a Lawyer Decides Whether to Sue You for Malpractice. *Medical Economics* 62:148–66.
- Riccardi, J. 1985. Diary of an Unfounded Malpractice Suit. *Medical Economics* 62:116–22.
- Rohrlich, T. 1983. Prosecutors Sketch Case Against 2 M.D.s. *Los Angeles Times*, Jan. 27.
- Rosoff, A.J. 1985. Private Reform Offers Greatest Likelihood for Resolving Medical Malpractice Dilemma. *Journal of Legal Medicine* 6:259–64.
- Rothenberg, L.S. 1982. The Empty Search for an Imprimatur, or Delphic Oracles Are in Short Supply. *Law, Medicine and Health Care* 10(3):115.
- Scheiderman, L.J., and J.D. Arras. 1985. Counseling Patients to Counsel Physicians on Future Care in the Event of Patient Incompetence. *Annals of Internal Medicine* 102:693–98.
- Scherer, E. 1985. *Bartling v. Superior Court*: The Right to Die, the Right to Heal: Conflicts in the Bartling Decision. *Western State University Law Review* 12:907–15.
- Sherlock, R., and C.M. Dingus. 1985. Families and the Gravely Ill: Roles, Rules, and Rights. *Journal of the American Geriatrics Society* 33:121–124.
- Siegler, M., and A.J. Weisbard. 1985. Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued? *Archives of Internal Medicine* 145:129–31.
- Stone, A.A. 1985. Law's Influence on Medicine and Medical Ethics. *New England Journal of Medicine* 312:309–12.
- Supreme Court of the State of New York. 1983. Report of the Special January Third Additional 1983 Grand Jury Concerning "Do Not Resuscitate" Procedures at a Certain Hospital in Queens County. Clerk of the Court, Supreme Court of New York, Queens County.
- Tolle, S.W., D.L. Elliot, and D.E. Girard. 1985. How to Manage Patient Death and Care for the Bereaved. *Postgraduate Medicine* 78(2):87–89, 92–95.
- Uhlmann, R.F., W.J. McDonald, and T.S. Inui. 1984. Epidemiology of No-Code Orders in an Academic Hospital. *Western Journal of Medicine* 140:114–16.
- U.S. Congress. Office of Technology Assessment. 1984. *Intensive Care Units (ICUs): Clinical Outcomes, Costs, and Decisionmaking*. Health Technology Case Study no. 28. Washington.

- Wanzer, S.H., S.J. Adelstein, and R.E. Cranford. 1984. The Physician's Responsibility to Hopelessly Ill Patients. *New England Journal of Medicine* 310:955-59.
- Weiser, B. 1983. The "Orchestration" of a Death. *Washington Post*, April 19.
- Wertman, B.G., S.V. Sostrin, Z. Pavlova, and G.D. Lundberg. 1980. Why Do Physicians Order Laboratory Tests? *Journal of the American Medical Association* 243:2080-82.
- Whiteneck, M.R. 1985. Florida Law Creates Artificial Sustenance Dilemma. *Health Progress* 66(11):36-37.
- Wilson, C.J. 1985. Health Law: CPR Training Brings Life Support Issues to California Nursing Homes. *Whittier Law Review* 7:591-611.
- Winslow, G.R. 1984. From Loyalty to Advocacy: A New Metaphor for Nursing. *Hastings Center Report* 14(3):32-40.

Address correspondence to: Marshall B. Kapp, J.D., M.P.H., Associate Professor, Department of Medicine in Society, Wright State University, School of Medicine, P.O. Box 927, Dayton, OH 45401.