

# After The Cruzan Case: The Primary Care Physician And The Use Of Advance Directives

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**Abstract:** In the case of Nancy Cruzan, involving an incompetent patient's right to have artificial feeding withdrawn, the Supreme Court of the United States upheld the State of Missouri's right to set evidentiary standards prior to the discontinuation of care. The "clear and convincing" standard of the Cruzan ruling highlights the primary care physician's importance in proactively addressing advance directives with patients in the outpatient setting. Primary care physicians need to familiarize themselves with and discuss with patients such advance directives as the living will and the durable power of attorney. Physicians also need to understand the legal requirements of advance directives, as well as the implications of the clear and convincing standard in their own state. (J Am Board Fam Pract 1992; 5:201-6.)

While the decision of the US Supreme Court in the case of Nancy Cruzan has important implications for primary care physicians, commentary on the case has been potentially confusing and without specific clinical recommendations. Before the Supreme Court ruling on 25 June 1990, commentators focused primarily on whether artificial nutrition and hydration could be withdrawn by proxy on behalf of a patient in a persistent vegetative state.<sup>1-8</sup> Since the ruling, the focus has been upon legal ramifications, especially on proxy decisions and advance directives.<sup>9-16</sup>

As a result of the Cruzan case, the primary care physician might well ask, "How should I address the needs of incompetent patients? What role can advance directives play in my practice?" To answer these questions, we need first to review the facts of the case, then briefly look at the pertinent points made by the court, and finally address practical concerns. These issues remain important as more patients ask about living wills in the wake of the publicity surrounding the Cruzan case.<sup>17</sup>

## Case Synopsis

On the night of 11 January 1983, 23-year-old Nancy Cruzan lost control of her car. Paramedics in Jasper County, Missouri, discovered her lying

face down in a ditch and without detectable pulse or respiration, apparently having been anoxic for 12 to 14 minutes. Cardiopulmonary resuscitation was successful, but Cruzan never regained consciousness and ultimately remained in a persistent vegetative state.<sup>18</sup> A gastrostomy tube was placed, and Cruzan was eventually transferred to a state rehabilitation center.

When, after several years, her parents realized the hopelessness of her prognosis, they requested that artificial feeding and hydration be discontinued to allow her to die. The hospital refused to do so without court approval, and the lower court, citing precedent cases in 16 states, agreed with the parents' request. The case was, however, appealed to the Missouri Supreme Court, which reversed the lower court by a 4 to 3 vote. Relying heavily on legislative intent as evidenced by the Missouri living will statute, indicating a very strong state interest in the preservation of life, the Missouri Supreme Court ruled that the presumption in favor of life could be overturned only by clear, convincing, and reliable evidence of Cruzan's intent to refuse treatment in her present state. Informal wishes expressed to her parents and roommate, which had satisfied the lower court, were rejected by the Missouri Supreme Court as insufficient for this standard. The court added that nutrition and hydration should be viewed as basic life support and not as medical therapy.<sup>19</sup>

When the Cruzan case came before the US Supreme Court in oral arguments on 6 December 1989, most of the discussion centered on several concerns: (1) whether nutrition and hy-

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dration are medical therapy or basic comfort care, (2) whether family members can refuse nutrition and hydration on behalf of the incompetent patient, and (3) whether states can set evidentiary standards or thresholds of proof before acknowledging the validity of the proxy refusal for an incompetent patient.

### **The US Supreme Court Majority Decision**

On 25 June 1990, a 5-member majority of the US Supreme Court affirmed the Missouri Supreme Court decision, while disagreeing with some of their reasoning. The basic points made in the US Supreme Court's first ruling in a so-called "right to die" case were:

1. Competent patients have a right under the US Constitution to refuse medical therapy.
2. The state has an interest in preserving life.
3. When a patient is competent, the constitutional right to refuse therapy takes precedence over the state's interest. When the patient is incompetent, however, the state can exercise its interest in preserving life by requiring a standard of evidence that a proxy must meet before being allowed to refuse life-prolonging treatment on the patient's behalf.
4. Upon stating the above, the US Supreme Court therefore had to answer only one question: Does anything in the US Constitution prohibit the State of Missouri from applying a strict standard that requires clear and convincing evidence of the patient's actual wishes (a standard previously required in only one other state)? The 5-member majority concluded that there was no such prohibition and that the Missouri ruling should stand. Furthermore, the majority refused to follow the Missouri court in holding that artificial nutrition and hydration were distinguishable from other forms of medical therapy.

In a separate concurring opinion, Justice O'Connor noted that few patients have actually executed advance directives and thus provided "clear and convincing" evidence as to their wishes. She reviewed state statutes providing for both living wills and durable powers of attorney (DPA) for health care and suggested that either mechanism could meet the clear and convincing

evidence requirement. The other 4 justices in the majority, however, simply put DPA aside as not applicable to the Cruzan case.

### **The Dissent**

Two dissenting opinions were written in which three major points were raised. First, the minority wrote that the Missouri clear and convincing standard works against itself by excluding important (even if informal) information about the patient's own wishes. The clear and convincing standard is opined as not really a standard of evidence at all, but an evidentiary mask concealing an ideological stance on the preservation of life. Second, the minority argued that the majority opinion unduly disenfranchises family members as appropriate proxies for incompetent patients. They cited that even were the family not acting in the best interest of the patient, numerous legal safeguards are already in place to prevent harm. Third, while the state's interest in preserving life is properly owed to individual human beings, it is not similarly owed to biological life in the abstract. The minority wrote that no such interest exists to justify keeping Nancy Cruzan alive against her own wishes (as best as can be determined) when there is no discernible benefit to her or to her family.

### **Aftermath and Controversies**

Six months after the US Supreme Court's decision, the case of Nancy Cruzan returned to the lower court in Missouri in December 1990, as her parents claimed that the publicity had brought forward other witnesses who could testify as to their daughter's previous wishes. The same lower court judge who had approved their original petition to discontinue the gastrostomy tube heard this new testimony and declared that the clear and convincing standard had now been met. The state attorney general claimed no interest in appealing this new ruling. Subsequently, the gastrostomy tube was removed, and Nancy Cruzan died on 26 December 1990.

The impact of the US Supreme Court ruling has been widely reviewed.<sup>9-16</sup> Because the ruling focuses narrowly on the rights of states to set evidentiary requirements for proxy consent, the ruling basically leaves unaltered whatever standards presently exist in each of the 50 states. Some controversy has arisen over aspects of the ruling.

Conservative scholars have noted that the equation of nutrition and hydration with other forms of medical therapy is an assumption rather than a holding of the court and so carries less authority as precedent. Others interpret that the clear and convincing standard prevents families from discontinuing life-sustaining therapy either prematurely or in disregard for the incompetent patient's welfare.

In what follows, we focus on implications for primary care physicians; in our view, these aspects of the ruling are the least controversial. Moreover, what we suggest is also in keeping with well-accepted guidelines of medical ethics.<sup>20,21</sup> In suggesting action steps for primary care physicians, we make three assumptions about the nature of primary care (which we take to be relatively implicit in the role of the physician for our present purposes):

1. That primary care physicians are primarily patient advocates and only secondarily advocates for various specific forms of medical therapy. Primary care physicians value an ongoing therapeutic relationship, based on the patient's interest and desires, above the application of medical technology.
2. That primary care physicians have the opportunity to know the patient well over time and to become familiar with the patient's preferences and values regarding life-sustaining therapeutic interventions. This relationship gives the primary care physician both a special opportunity and a special responsibility regarding advance directives.
3. That primary care physicians are prevention minded. In ethical decision making, prevention takes the form of early action to record patient wishes and values, rather than waiting for a crisis with a newly incompetent patient whose wishes are poorly understood.

### **What Can the Primary Care Physician Do?**

How can the primary care physician protect adult patients from having beneficence-based therapies imposed upon them against their prior expressed preferences? Based upon the above premises, the primary care physician's advocacy role well suits him or her to facilitating the autonomy-based informed consent (or refusal) by patients to life-sustaining treatment. Using such a prophylactic

bioethics approach, primary care physicians have a variety of advance directives at their disposal to allow any adult patient to express preferences on termination of care therapies.<sup>22</sup>

In terms of when to hold these discussions, the facetious adage "vote early and vote often" lends itself well as "voice [your advance directives] early and voice often." All competent persons at the age of majority or older are candidates for informed consent to advance directives. Further, these discussions should be periodically reviewed throughout the patient's life to ascertain whether changing health care values have altered advance directive choice.

Discussing the now well-publicized Cruzan case with patients, using layman's terms, helps illustrate the importance of stating advance directives for termination of care or persistent vegetative states. Such discussions can enhance patient autonomy by eliciting the values and advance directives prior to their need. The Cruzan case, therefore, has significant importance to primary care physicians and patients as a negative example of how beneficence-based treatment plans can interfere with well-intended, but poorly documented, autonomous preferences.

Two prevailing methods of advance directives currently address the need of patients to help document their preferences. The first method, the living will, allows for the articulation of the patient's preference to withhold or withdraw life-sustaining treatment in the face of terminal disease. While patients apparently are well acquainted with living wills, it is not common for patients to sign living wills, much less write down specific details regarding their preferences. Part of the difficulty is the perception of some physicians that the patient should always initiate these discussions, thereby waiting for their patients to start the consent process.<sup>23</sup> As to the nine states that do not yet have living will statutes, generic living wills, such as those offered by the Society for the Right to Die, are helpful in documenting the autonomous refusal to life-sustaining therapy.

The DPA is another valuable form of advance directive, allowing for flexibility in decision making when medical circumstances change, particularly when these circumstances are unforeseen by patients. It is, however, incumbent upon patients to discuss their preferences in advance with the person who is assigned as the DPA, so that pa-

tients will have a living record of what they would want, given a variety of medical circumstances. Only 30 states and the District of Columbia have passed a DPA statute specifically for health care, but all states have general DPA statutes that potentially lend themselves to directing medical care for incompetent patients.

What, then, should be the primary care physician's position on discussing advance directives? Such a decision will depend on whether the patient under consideration is presently incompetent or competent. If the patient is competent, it seems prudent to advise him or her to consider executing an advance directive, preferably a living will and a DPA, with additional exploration of the patient's health care values and explicit statements of treatment preferences, as offered in the Values History by Doukas and McCullough.<sup>22</sup> This advice is not merely defensive in case the physician's state later chooses to legislate a stricter evidentiary standard. Advance directives have a valid medical utility distinct from their legal status by helping physicians to understand patient preferences more accurately and helping physicians and families to avoid disputes over what the formerly competent patient preferred.

In the Cruzan case, though, the eliciting of an advance directive was never possible because Ms. Cruzan was comatose upon her admission. If one were caring for a patient such as Nancy Cruzan — for whom all the available evidence creates a reasonable presumption that she would have wished to refuse treatment — then currently accepted ethical guidelines suggest that the physician should abide by her wishes as voiced by her legal proxy (i.e., DPA). If no clearly defined proxy has been legally appointed, then the health care team can enlist the assistance of the family and friends (preferably as a group) to attempt to reconstruct the patient's preferences for treatment in the specific context of the illness at hand. To do this "values reconstruction" of the patient, asking the following question can prove helpful to these family and friends: "Knowing what you do of A's values and health preferences, what might A say about treatment X, given the present prognosis?" A values reconstruction could then be used by the health care team as a reflection of the patient's autonomous preferences (albeit through a third party conduit) unless a specific state statute or court ruling forces the team to do otherwise. Such

attempts, however, have important legal standing, for no physician in the United States has been held legally liable for withdrawing life-sustaining treatment in good faith when following the patient's wishes, as best determined by a written advance directive or proxy. Indeed, the Cruzan ruling made no mention about physician liability.

### Recommendations

1. Find out which legal standard of evidence for proxy decision making (if any) is in force in your state (hospital counsel or the state law bar can be helpful in this regard).
2. Encourage patients who are concerned about their future control over treatment to execute an advance directive, preferably both a durable power of attorney and a living will. Reassure patients that even should your state later adopt a clear and convincing standard, a well-executed advance directive would still protect their autonomous rights (as much as any document can).
3. Remember that the Cruzan decision upholds only the state's right to set its own standard of evidence; it does not impose the clear and convincing standard on any state that does not presently have one.
4. If the standard of evidence is now in dispute in your state, or if new legislation is proposed in this regard, be cognizant of the potential impact of a standard as strict as that in Missouri, which limits patient and family rights based on the availability of clear and convincing evidence. If you decide to take a social stand on the issue, voice your views to your state specialty society and medical association lobbyists.

### References

1. Bopp J Jr. Choosing death for Nancy Cruzan. *Hastings Cent Rep* 1990; 20:42-4.
2. Gasner MR. Cruzan v Harmon, and in the matter of O'Connor. Two anomalies. *J Am Geriatr Soc* 1990; 38:594-9.
3. Glover JJ. The case of Ms. Nancy Cruzan and the care of the elderly. *J Am Geriatr Soc* 1990; 38:588-93.
4. Orentlicher D. From the Office of the General Counsel. Cruzan v Director of Missouri Department of Health: an ethical and legal perspective. *JAMA* 1989; 262:2928-30.
5. Thomasma DC. Surrogate decisions at risk. The Cruzan case. *J Am Geriatr Soc* 1990; 38:603-4.



6. Wolf SM. Nancy Beth Cruzan: in no voice at all. *Hastings Cent Rep* 1990; 20:38-41.
7. Scofield G. The calculus of consent. *Hastings Cent Rep* 1990; 20:44-7.
8. Ellman IM. Can others exercise an incapacitated patient's right to die? *Hastings Cent Rep* 1990; 20:47-50.
9. Annas GJ, Arnold B, Aroskar M, Battin P, Bartels D, Beauchamp T, et al. Bioethicists' statement on the U.S. Supreme Court's Cruzan decision. *N Engl J Med* 1990; 323:686-7.
10. Annas GJ. Nancy Cruzan and the right to die. *N Engl J Med* 1990; 323:670-3.
11. Weir RF, Gostin L. Decisions to abate life-sustaining treatment for nonautonomous patients. Ethical standards and legal liability for physicians after Cruzan. *JAMA* 1990; 264:1846-53.
12. Orentlicher D. From the Office of the General Counsel. The right to die after Cruzan. *JAMA* 1990; 264:2444-6.
13. Saultz J. Routine discussion of advance health care directives: are we ready? *J Fam Pract* 1990; 31:653-6.
14. Annas G. Nancy Cruzan in China. *Hastings Cent Rep* 1990; 20:39-41.
15. Lynn J, Glover J. Cruzan and caring for others. *Hastings Cent Rep* 1990; 2:10-1.
16. Obade CC. Cruzan and its sequelae: the Supreme Court decides its first "right to die" case. *J Clin Ethics* 1990; 1:242-4.
17. Thomas P. Demand for living wills surges. *Med World News* 1990; Aug:40.
18. Persistent vegetative state and the decision to withdraw or withhold life support. Council on Scientific Affairs and Council on Ethical and Judicial Affairs. *JAMA* 1990; 263:426-30.
19. Cruzan versus Director, Missouri Dept. of Health. 1990 US Lexis 3301 (US June 25, 1990).
20. Baird MA, Doherty W. Risks and benefits of a family systems approach to medical care. *Fam Med* 1990; 22:396-403.
21. Doukas DJ. Autonomy and beneficence in the family: describing the family covenant. *J Clin Ethics*. In press.
22. Doukas DJ, McCullough LB. The values history. The evaluation of the patient's values and advance directives. *J Fam Pract* 1991; 32:145-53.
23. Doukas DJ, Gorenflo DW, Coughlin SS. The living will: a national survey. *Fam Med* 1991; 23:354-6.