THE RIGHT-TO-DIE: State Policymaking and the Elderly

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ABSTRACT: *The life prolonging power of medical technology and traditional ethics which require the maintenance of life have generated growing political demand for new law to regulate the use of lifesaving equipment and techniques, and to establish the rights of individuals to determine the course of their own treatment. This research maps the politics of the right-to-die through an analysis of state legislation and appellate court decisions and interviews with political participants in three states. It also examines the role of interest groups of and for the elderly in shaping this policy. The research has discovered that, with an important exception, state law has become more supportive of patients' rights since the earliest legislation, but that state courts and legislatures often compete in policymaking. However, the elderly have not substantially sought to influence this policy in either branch of government. The political potential of the elderly is examined.*

The specter of a lingering death increasingly confronts Americans since advances in medical technology in the past several decades have made it possible to keep elderly, terminally ill and comatose patients alive through respirators, cardiac resuscitation, artificial feeding, drug treatment and other procedures. Modern medical tools are valued lifesavers for accident victims and those suffering from reversable serious illness or undergoing surgery, but the new technology also can be a threat to the elderly and the hopelessly ill who inevitably will die, but not quickly or easily because the same machines which preserve life also keep others from death.

The life prolonging power of medical technology, traditional medical ethics which require the maintenance of life, and fear of liability for disconnecting life support systems have generated growing political demand for new law to regulate the use of lifesaving

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equipment and techniques and to establish the rights of individuals to determine the course of their own treatment. The galvanizing event which stimulated the rising chorus of concern is the Karen Quinlan case (*In the Matter of Karen Quinlan* 355 A.2d 647, 1976). Then, a young woman in a coma, but not brain dead, was placed on a respirator in "an altered state of consciousness" with no hope of recovery. Her parents pressed attending physicians to remove the respirator so that she could die, but were refused. The New Jersey Supreme Court, relying on an expansive interpretation of the constitutional right to privacy and the right of parents to act as guardians, finally ordered the respirator removed. Although the respirator was withdrawn, Karen Quinlan was fed artificially and lived for another ten years. The case inaugurated new policy for allowing patients and/or their families to make decisions concerning the use of life prolonging medical treatment. Through the end of 1989, dozens of appellate court cases have been decided in 15 states affecting the use of life support systems and other treatment for the terminally ill. Generally, the states have endorsed the policy produced in the *Quinlan* decision, but other courts have produced distinctive policies.

But litigation has not been the only avenue taken to create a right-to-die. Also in 1976, California enacted the nation's first living will law, followed in 1977 by similar laws in 7 additional states. By the end of 1988, 37 states and the District of Columbia had enacted living will legislation.[1] Living will laws allow individuals to specify in advance of a terminal illness their directions concerning the kind of medical treatment they wish to receive. In contrast, the court cases generally deal with terminally ill or permanently comatose patients who have not executed living wills and where there is doubt concerning a patient's wishes or doctors require a court order to disconnect equipment. However, certain court cases have interpreted legislation and on occasion have sanctioned the validity of living wills in the absence of legislation.

As part of a comprehensive examination of state policymaking concerning medical treatment for terminally ill and seriously injured patients, I have collected and coded data from all legislation and state supreme court decisions, and intermediate appellate court decisions in states in which the highest court has not heard a case in this field.[2] I also have interviewed political participants in California, Florida and Massachusetts in order to obtain insights into the politics of setting governmental agendas and political conflict over enacting living will laws. These three states were selected because they illustrate three distinctive models in right-to-die politics. As indicated, California was first to enact a living will law in 1976; Florida had the first bill proposing a living will, but strong opposition prevented adoption until 1984; and Massachusetts has no living will legislation.

In addition to exploring the variable content of this policy, the purpose of the research is to identify innovations, trace their diffusion and examine the ways that state political institutions apply each other's policies. The research has discovered that early legislative and judicial innovations are produced by certain familiar leading states, but it also reveals that courts and legislatures develop distinctive streams of policy within this broad field which have substantially different impacts on how this issue is handled by the states. Finally, interest groups have been crucial in determining how legislation has fared and they play an important role in litigation as well. Special attention is given to the role of advocates for and associations of the elderly in this policy field.

LEGISLATION AND LITIGATION

Early Proposals

The right-to-die has been on state political agendas for a long time, although laws and appellate court cases did not appear until 1976. The Euthanasia Society of America (renamed the Society for the Right-To-Die in 1974) endorsed a model living will in 1967, and Dr. Walter Sackett, a medical doctor and a representative in the Florida legislature, is credited with introducing the first state right-to-die proposal in 1968. Dr. Sackett's interest in living will laws is typical of the process by which new issues are placed on legislative agendas. Legislators frequently become aware of and sensitive to an issue due to personal exposure and experiences or the impact of one or more constituents' personal plight (Kingdon 1983, pp. 53-56; Kingdon 1984, pp. 100-101).

Struck by what he perceived as the hopeless condition of seriously retarded patients in state institutions and the lingering deaths of many elderly hospital patients, Dr. Sackett embraced the right-to-die as his personal political agenda. In 1968, he introduced a short constitutional amendment giving every citizen the right-to-die with dignity. Lacking advance planning and coalition building, however, it received no support. Then, in 1970, he proposed a living will law which contains some of the same provisions found in the laws adopted later by other states. However, Dr. Sackett's bill also included provisions allowing severely retarded patients housed in state institutions to die if they contracted infections or otherwise treatable illnesses. Scorned by interest groups representing the retarded and the disabled, the Catholic Church and others as advocating nazi-like euthanasia, Dr. Sackett's bill received a hostile legislative reception. In 1973, a bill limited to living wills passed the house of representatives, but recollection of his earlier bill and characterization of his proposal as the first step on a "slippery slope" to active euthanasia probably contributed to the failure of the 1973 bill and Florida's delayed enactment of a living will law (1984).

Court Cases

Criminal cases involving mercy killings have appeared in American courts for decades (Humphrey and Wickett 1986), but judicial policy concerning the right-to-die first appeared in *Quinlan* in 1976 and was followed by a Massachusetts case the following year. New Jersey and Massachusetts policy leadership is not surprising since these two states also place high in other aggregate measures of judicial reputation and are two of several courts which are cited most often by others in formal written opinions (Caldeira 1983, 1985). In addition, these two states have many characteristics which are likely to stimulate innovation. They are heavily urban, industrial, with high median incomes and education and with substantial political competition, all environmental characteristics which are likely to produce novel political ideas and new public issues (Walker 1969; Caldeira 1985; Atkins and Glick 1976).

However, despite their similar prestige and reputations for innovation, the early leading courts in the right-to-die produced different streams of policy which had different impacts on other courts. A summary of the major elements of judicial right-to-die decisions is presented in Table 1. As mentioned earlier, in its 1976 *Quinlan* decision, the New Jersey Supreme Court relied on the principle of the right to privacy

TABLE 1
Elements of Right-to-Die Judicial Policy

Case	Substantive Issue[a]	Decision[b]	Major Policy Content[c]
Quinlan, NJ 1976	withdraw resp.	+	I. extends const. right to privacy; no judicial intervention required
Saikewicz, MA 1977	withhold treatment	+	I. accepts right to privacy, but judicial supervision required
Dinnerstein, MA 1978	withhold resuscit.	+	F. judicial approval not required in all cases
Perlmutter, FL 1/80	withdraw resp.	+	F accepts const. right to privacy for competent patients; extensive call for legislation
Spring, MA 5/80	withdraw treatment	+	F. interprets Saikewicz; court approval required, but policy left unclear
Severns, DE 9/80	withdraw resp.	+	F. grants authority to trial court; no general policy, extensive call for legislation
Storar, NY 3/81	withhold resp.	−	F. limits decision to a case by case approach; court approval required
Eichner, NY 3/81	withdraw resp.	+	F. facts in each case will determine outcome; requires unequivocal evidence of patient's wishes
Colyer, WA 3/83	withdraw resp.	+	F. endorses Quinlan; guardian required
Barber, CA[d] 10/83	withdraw resp. & food hydration	+	I. extends basis beyond State Nat. Death Act for terminating life support systems
Leach, O.[d] 5/2/84	withdraw resp.	+	F. endorses Saikewicz
Bludworth, FL 5/2/84	withdraw resp.	+	F. endorses Quinlan and Colyer but allows family decisionmaking; validates living wills
LHR, GA 10/84	withdraw resp.	+	F. endorses Quinlan but allows family decision making
Hamlin, WA 11/1/84	withdraw resp.	+	F. interprets Colyer; no guardian required
Torres, MN 11/2/84	withdraw resp.	+	F. endorses Quinlan
Bartling, CA[d] 12/84	withdraw resp.	+	F. endorses Barber and Quinlan
Conroy, NJ 11/85	withdraw food/hydr.	+	I. no distinction between "ordinary" and "extraordinary" procedures; provides rules; extensive call for legislation
Bouvia, CA[d] 6/86	withdraw food/hyd.	+	F. endorses Bartling
Brophy, MA 9/86	withdraw food/hyd.	+	F. endorses Conroy
Farrell, NJ 6/24/87	withdraw resp.	+	F. endorses Quinlan and Conroy
Jobes, NJ 6/24/87	withdraw food/hydr.	+	F. endorses Quinlan and Conroy
Peter, NJ 6/24/87	withdraw food/hydr.	+	F. endorses Quinlan and Conroy

(continued)

TABLE 1
(continued)

Case	*Substantive Issue*[a]	*Decision*[b]	*Major Policy Content*[c]
Rasmussen, AZ 7/87	withdraw food/hydr.	+	F. endorses Hamlin and Torres and Quinlan
Gardner, ME 12/3/87	withdraw food/hydr.	+	F. limits decision to case by case; living will law does not apply
Grant, WA 12/10/87	withdraw resp. & food & hydr.	+	F. endorses Colyer
Prange, IL[d] 2/88	withdraw food/hydr.	+	F. endorses several other decisions
Dradick, CA[d] 4/88	withdraw food/hydr.	+	F. endorses numerous other decisions
Westchester, NY 10/88	withdraw food/hydr.	−	F. endorses Storar
Cruzan, MO 11/88	withdraw food/hydr.	−	I. rejects other states' decisions; interprets living will law to require artificial food and hydration
McConnell, CO 1/31/89	withdraw food/hydr.	+	I. interprets restrictive living will law to permit withdrawal of artificial food and hydration

[a] Withdraw or withhold respirator, other treatment or food and hydration.
[b] + = In favor of requirest to withdraw or withhold.
− = Against request to withdraw or withhold.
[c] I = Innovative.
F = Follows own or other state's precedent.
[d] Intermediate court of appeals decision.

and established the power of families as guardians, in consultation with doctors, to make decisions on behalf of incompetent patients. It permitted the withdrawal of a respirator without requiring prior judicial approval. The *Quinan* policy is significant because it has been embraced by most other courts and is cited more frequently by them (in 80 percent of subsequent cases) than any other state court decision. This decision has become the model for most states as well as for the most recent changes in judicial policy. In *Superintendant of Belchertown State School, et al.* v. *Joseph Saikewicz* (370 N.E. 2d 417, 1977), the Massachusetts Supreme Judicial Court adopted New Jersey's right to privacy view; however, the court required prior judicial approval before medical treatment could be withheld. In contrast to *Quinlan,* this decision was greeted with great confusion and concern among lawyers and doctors who worried what the court intended that prior court approval be required in *all* cases involving the removal or withholding of life sustaining treatment. Numerous articles in legal and medical journals focused on the anticipated financial and emotional burdens which the decision would impose on patients, families and medical institutions and personnel (Doudera and Peters 1982). The Massachusetts court later modified, but never abandoned, this policy. Significantly, it has been followed only by the Ohio Supreme Court.

Other states also produced distinctive policies within the broad context of earlier rulings, but with little impact on other courts. The New York Court of Appeals

contributed two of the three court cases decided against patients and in 1981 produced a policy requiring extensive proof of a patient's prior wishes before life sustaining treatment could be withdrawn or withheld. This policy has been followed only by the Maine Supreme Court. The California decisions all were produced by intermediate courts of appeals and relied solely upon prior California precedent. Finally, in 1988, the Missouri Supreme Court deviated from all others by flatly refusing to grant permission for the withdrawal of artificially administered food and hydration from a permanently comatose patient (*Cruzan* v. *Harmon,* 760 S.W. 2d 408, 1988). This decision has been approved by the U.S. Supreme Court in 1990, setting the first national precedent in the right-to-die.

All but 5 of the 15 states which have produced appellate judicial policy concerning the right-to-die have followed the general *Quinlan* model of permitting the withdrawal or withholding of various forms of medical treatment without requirements for prior judicial approval or extraordinary proof of patient's wishes. More on the content of judicial policy will be presented below.

Legislation

It may appear that the *Quinlan* case stimulated California legislators to enact their 1976 living will law, since the *Quinlan* case was in the New Jersey trial courts in 1975 and it received enormous news coverage in the *New York Times* and other media.[3] It was visible to any interested reader nationwide. California is among the early innovators in many areas of policy and it seems plausible that California would have been cued by the *Quinlan* litigation to enact a law permitting advance directives for medical treatment. But this is not the case. First, as indicated earlier, a living will law would not have addressed Karen Quinlan's situation. Not only was she a young woman, who did not and probably would not have executed a living will, her condition was not terminal as specified by most living will laws. Instead of following *Quinlan* in a direct cause and effect fashion, unrelated political developments in California culminated at about the same time as the *Quinlan* litigation. And, both the New Jersey and California events paralleled a rising curve of public interest in living will laws developing throughout the nation. Consequently, support for laws and litigation came simultaneously from many different sources and directions and reflects the likely interaction of numerous ideas, proposals, experiences and literature (Kingdon 1984, pp. 17-18).

Articles on death and euthanasia had appeared in various journals for decades, indicating that related issues had a place on the public agenda. However, the number of medical journal articles on treatment for the terminally ill and the right-to-die began to significantly increase in 1968 and they appeared with greater frequency in popular periodicals in 1971, reflecting a pattern in which professional literature leads the popular media and provides it with information (Nelson 1984).

Senator Barry Keene, the sponsor of all but one of California's living will bills and amendments, has reported that he became interested in living wills before his election to the legislature in 1972. His first sensitizing experience was as an attorney helping a neighbor resist unwanted medical treatment for terminal cancer, and later during his mother-in-law's battle with cancer. He introduced a living will bill in 1974, which failed

TABLE 2
Dates of Adoption of Living Will Legislation

1976	*1977*	*1978*	*1979*	*1980*	*1981*	*1982*	*1983*	*1984*	*1985*	*1986*	*1987*	*1988*
CA	AR		KS		AL	DE	IL	FL	AZ	AK		
	ID		WA		DC	VT	VA	GA	CO	HI		
	NV							LA	CN	SC		
	NC							MS	IN			
	NM							WV	IA			
	OR							WI	ME			
	TX							WY	MD			
									MO			
									MT			
									NH			
									OK			
									TN			
									UT			

to pass, but during the following two years, Keene obtained the support of many groups, especially the California Catholic Conference and the California Medical Association, by compromising on many features of his bill. Keene asserts that *Quinlan* did not cause California to adopt the law, but it did provide a political boost—a window of opportunity—for getting the bill through the legislature (Kingdon 1984).

Following *Quinlan* and the California law, living will laws received tremendous attention, although few states enacted laws until 1984. The Society for the Right-to-Die (1988) reports that 61 living will bills were introduced in 42 states in 1977, clearly placing living wills on the official governmental agenda throughout the country (Cobb and Elder 1972; SRD 1988). However, between 1978 and 1983, only 7 states and the District of Columbia joined the ranks of the early innovators with living will laws, but in 1984 and 1985, 20 additional states adopted legislation. Three more adopted in 1986 and 2 more in 1989, bring the nation's total to 41.[4] The distribution of states adopting living will laws by year is found in Table 2.

THE EVOLUTION OF POLICY

Although there has been an enormous increase in the number of states creating right-to-die policy, either through legislation or court cases, the content of policy has not been the same in all of the states. Indeed, legislation has varied from the earliest days, and, although the court cases generally address similar factual circumstances, the direction and content of judicial policy also has been altered over the years. The concept of *policy re-invention* has been used to characterize a process in which policy undergoes change during the period when new adopters, such as courts and legislatures, produce their own laws and decisions (Rogers 1978 and 1983).

Court Cases

From 1976 to 1985, the substantive issue presented to most state supreme courts concerned the withdrawal or withholding of respirators and other medical treatment from terminally ill, incompetent patients.[5] Only 10 percent of the cases involved competent patients and all courts upheld the right to refuse medical treatment in these instances. As indicated earlier, judicial policy varied on several dimensions, particularly whether prior judicial approval was required before medical treatment could be withheld or withdrawn and the amount of proof required to determine that a patient had expressed prior wishes concerning medical treatment.

However, besides creating distinctive policies to deal with traditional treatment decisions, the courts also faced new issues as right-to-die policy evolved. Certain comatose patients, such as Karen Quinlan, do not require artificial respiration, pacemakers or similar medical treatment and continue to live for months or years because they are supplied artificially with food and water through intravenous, nasogastric or implanted stomach tubes. Therefore, the withdrawal or withholding of certain traditional forms of medical treatment does not result in their death. Recent litigants have argued that artificial food and hydration should be considered part of medical treatment, rather than ordinary care, and should be governed by the same principles enunciated in previous decisions.

This issue first appeared before the New Jersey Supreme Court in 1985, and the court ruled that artificial food and hydration was part of medical treatment and also could be withdrawn, allowing a terminally ill or permanently comatose patient to die (*In re Conroy,* 486 A.2d 1209). The New Jersey court relied on and expanded its prior *Quinlan* policy to apply to artificial food and hydration and established general rules which were to apply to similar conditions. The Court also issued an extensive call for comprehensive state legislation. With one exception (also in New Jersey) every case which followed *Conroy* raised identical issues, either separately or in conjunction with the request for a removal of a respirator.

The *Conroy* decision probably simulated additional litigation concerning identical issues and, with few exceptions, courts reached similar conclusions. The *Conroy* decision also has been discussed more heavily in the subsequent opinions of other courts than any other right-to-die case. Significantly, the Massachusetts Supreme Judicial Court, which produced the early *Saikewicz* policy of requiring court approval before treatment could be withheld or withdrawn, also endorsed the New Jersey decision in its own food and hydration case. Like New Jersey, it did not distinguish between food and hydration and other forms of medical treatment, but also did not require prior judicial approval for its removal (*Brophy* v. *New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 1986).

Overall, the state appellate courts have been permissive concerning the withdrawal or withholding of medical treatment, including the artificial administration of food and hydration, both for competent and incompetent patients. Competent patients may refuse medical treatment and incompetent patients may indicate their wishes in advance or have family or court appointed guardians act on their behalf to obtain the end of medical treatment. Missouri's *Cruzan* decision is an exception.

Legislation

Not only has the content of judicial policy changed over time, legislation also differs among the states. Overall, recent legislation is more responsive to patients' right than earlier law, but certain provisions are very restrictive. I have coded legislation on a scale of *living will facility* which reflects the ease of producing and carrying out the provisions of these advance medical directives. The scale is based on eighteen legal provisions covering four main areas of law: drafting; executing (signature and witnessing requirements); coverage of medical contingencies; and enforcing a living will.[6] A higher total score indicates that a state has a living will law which makes it easier for patients and their families to control medical decisionmaking and treatment in the final days of life. The scoring technique is similar to that used in much policy research in which the provisions of state law are content analyzed and coded in order to tap the particular requirements or coverage of various state policies (Bingham 1976; Fairbanks 1980; Glick 1981).

The scores for each state are presented in Table 3. Theoretically, the highest possible score is 28; however, no state reaches that level since all have some restrictive provisions. Substantial variation exists among the states, ranging from a high facility score of 20 to a very restrictive score of 6. Clearly, while these states have adopted living will laws, the exact nature of their policies is different. Most significant for this analysis, many of the states which were among the early adopters—the chronological innovators—have produced legislation which is much more restrictive than that of many recent adopters. Of the eight earliest adopters (Table 2), seven have scale scores below the mean and several have the lowest scores in Table 3: California scores eight, Idaho six and Texas seven. Correlation analysis confirms that there is a positive relationship between the date of adoption of original laws and the content of policy ($r = .384$; sig.$= .05$). Recent adopters generally have enhanced patient control while earlier laws restricted it.

TABLE 3
State Living Will Facility Scores

State	*Score*	*State*	*Score*	*State*	*Score*
Alaska	20	Hawaii	13	Colorado	10
Maine	20	Indiana	13	Illinois	10
Montana	20	Iowa	13	Miss.	10
		Tennessee	13	N. Carolina	10
Louisiana	18	W. Virginia	13	Wisconsin	10
Virginia	18				
		Missouri	12	Nevada	9
D.C.	16	New Mexico	12	N. Hampshire	9
Maryland	16	Washington	12	S. Carolina	9
		Wyoming	12		
Florida	15			California	8
Utah	15	Arkansas	11	Oklahoma	8
		Delaware	11		
Kansas	14	Oregon	11	Georgia	7
		Vermont	11	Texas	7
Alabama	13				
Arizona	13			Connecticut	6
				Idaho	6

Mean = 12.2 Std. Dev. = 3.7

An illustration of the important difference between state scores is found in the contrast of California (1976) and Montana (1985) legislation. In California, a valid living will can be executed by a patient no sooner than two weeks after he/she has been diagnosed as terminally ill. In Montana, a valid living will can be created any time. A survey of California doctors found that as many as fifty percent or more patients are not diagnosed as terminally ill until after they have become permanently comatose, making it impossible for these patients ever to execute a valid living will. Therefore, this one provision alone has drastic consequences on the usefulness of this law to California residents. (*The California Natural Death Act,* 1979). In California, a living will cannot be created on behalf of a patient who is unable to sign for him or herself; Montana has such a provision. In California, living wills are valid for no longer than five years whereas Montana has no time limit. California imposes complicated and restrictive witnessing requirements, while Montana does not. In California, a living will is invalid if the patient is pregnant while in Montana the document is invalid only if it is clear the fetus will develop if life-sustaining treatment is given to the patient. In California, a doctor who refuses to comply with a living will faces no penalties while in Montana a doctor who refuses to carry out a patient's wishes to withdraw or withhold life-sustaining treatment is subject to criminal prosecution. Overall, Montana's recent law makes it much easier for patients or their families to control final medical treatment and enforcement provisions are likely to compel doctors to comply with their wishes.

Arkansas provides another contrast with California and most early adopting states. Arkansas enacted a restrictive living will law in 1977 with a facilitative score of 11, higher than California's but still well below the scores of later adopters. However, in 1987, Arkansas substantially amended its law, which has become the ideal model for the Society for the Right-to-Die.[7] Arkansas's total score increased to 25, the highest in the nation. It differs from the Montana law in four important ways. First, unlike most other state laws which limit living wills to patients declared to be in a terminal condition, the Arkansas legislation applies also to patients who are in a permanent comatose state. Arkansas also allows for creating living wills on behalf of minors and permits the designation of a proxy decision maker in a living will. It also includes a procedure for terminating life support systems for patients who lack a living will. This latter provision exceeds the coverage of many other laws and it applies to circumstances usually found only in state court policies. Thus it is much more comprehensive legislation than most.

However, while many recent adopters have created considerably more facilitative laws, not all states have done so. As indicated earlier, an exceptionally controversial provision concerns the artificial administration of food and hydration. Political activists in the three case study states volunteered that this is the most controversial issue on the right-to-die governmental agenda. Right-to-die advocacy and various other groups maintain that food and hydration should be viewed as a form of medical treatment that may be refused, withheld or withdrawn, but the Catholic Church and right-to-life groups are opposed and have lobbied for provisions in living will laws which would prevent the withdrawal or withholding of artificial food and hydration from any patient.

The entry of new and controversial issues, such as food and hydration, is likely to lower overall state facility scores if legislatures respond to groups which want to limit the scope of living will laws. Additional analysis confirms that food and hydration

provisions correlate negatively with date of adoption, i.e., food and hydration provisions become more restrictive over time.[8] With the food and hydration provision eliminated, the correlation between date of adoption and overall facility score improves from .354 to .493 (sig. = .01). Thus, without the food and hydration provision included in state scores, there is a stronger relationship between date of adoption and the facilitative content of state law.

Seventeen states have amended their living will laws.[9] However, seven produced only technical changes which did not affect their facility scores, but ten others made modest to major substantive changes. Most important, all ten made their laws more facilitative, in keeping with the trend established during the 1984-1985 wave of original adoptions. Amending states changed their scores from one to 14 points, but the median change in score was 2.5, indicating that most changes were relatively modest ones. In six of the ten states, legislatures adopted both more facilitative and more restrictive provisions, but nevertheless increased their overall facility scores. All but one restrictive amendment concerned food and hydration and pregnancy, and reveal that these states adopted restrictive provisions favored by state Catholic conferences and right-to-life organizations. Amendments reduce the correlation between date of adoption and facility scores to zero. Most early adopters increased their scores in varying degrees, but they fall within the range of scores established by the later adopters. Overall, then, with the main exception of food and hydration, state legislation has become more supportive of patients' rights to end life prolonging treatment in terminal and other hopeless circumstances.

INTERACTION OF LEGISLATIVE AND JUDICIAL POLICYMAKING

State legislative and judicial policies interact. First, preliminary evidence indicates that an increase in the volume of litigation in the appellate courts has affected the frequency of living will law enactments. Second, the content of judicial and legislative policy has provided new items for each institution's agendas. Legislatures have responded to the generally permissive content of judicial rulings, and courts have had opportunities to interpret the meaning and application of living will laws. Finally, interest group politics has affected both the content of statutes and the resistence of certain states to living will laws. However, some of the states without legislation have produced important right-to-die judicial decisions.

Rising Volume of Policy

The relationship between the frequency of court decisions and the adoption of legislation is portrayed by the graph in Figure 1. It charts the number of appellate court cases and living will laws enacted from 1976 to 1988. The figures suggest that an increase in the number of cases precedes an increase in the number of laws enacted in the 1980-1981 and 1983-1984 periods. To test the hypothesis that litigation has stimulated legislation, I have correlated the dates of appellate court cases lagged for one year with the dates of adoption of living will laws. The results are as hypothesized, although the correlation is marginally statistically significant, due probably to the small number of court cases in the sample ($r = .43$; $p = .10$). However, additional support for this

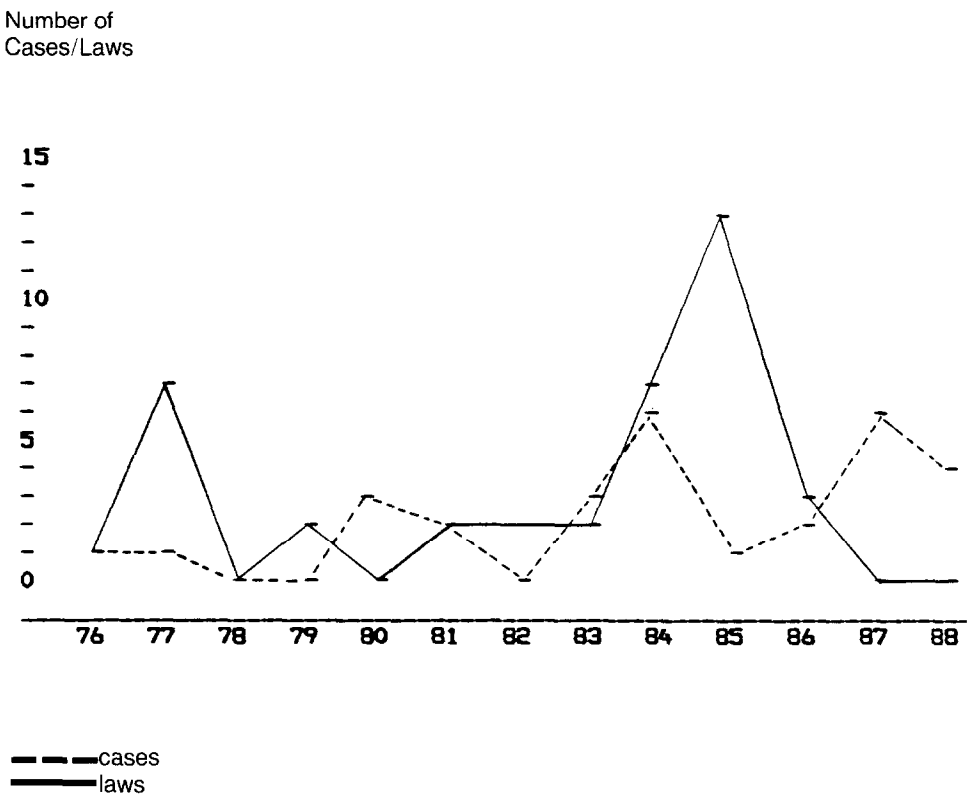

FIGURE 1
Frequency of Appellate Court Cases and Legislation, 1976-1988

hypothesis is provided by the lack of strong correlations for alternative relationships. There is no support for the hypothesis that rates of litigation and enactment of living will laws occur simultaneously ($r = -.08$, n.s.), or the hypothesis that the lagged adoption of living will laws precedes increases in litigation ($r = -.16$, n.s.). While there are other social forces and events which stimulated state legislatures to act, there is support for the view that legislatures have responded to litigation.

An important catalyst for new legislation as a response to court decisions appears to be a decision by many Catholic lobbyists to change their political strategy. Late in 1981, certain Catholic clergy recommended that the Catholic Church reverse its opposition to living will laws (Paris and McCormick 1981). In their view, state courts increasingly were producing policies which promoted the right-to-die at a level well beyond that which state legislatures probably would approve if state Catholic conferences lobbied for restrictive provisions and participated actively in bill drafting.[10] The National Conference of Catholic Bishops officially endorsed this view in 1984, and certain, but not all, state Catholic conferences adopted this view.

Courts as Alternative Policymakers

While many states have enacted living will laws, others have not. The difference is linked in part to varied Catholic political strategies in the states. As indicated above, some Catholic leaders have calculated that they needed to participate in drafting legislation in order to stave off or limit increasingly liberal judicial policy. Interviews confirm that this was the case in California and Florida. In California, the Catholic Conference concluded that since, in its view, the prestigous and powerful California Medical Association had agreed to support a living will law, legislation probably would pass in 1976, and the Church needed to cooperate in order to obtain compromises favorable to its pro-life position. Catholic officials also acknowledged that the California Catholic Church hierarchy and related institutions are more liberal than those in the east and midwest and that they saw no conflict between a limited living will law and Catholic doctrine. However, recent efforts to amend California's very limited living will law have been defeated through gubernational veto. A right-to-life mail campaign, with tacit California Conference support, is given credit for persuading the conservative governor to reject the legislature's amendments.

In Florida, the Catholic Conference resisted living will legislation until the state supreme court was about to issue an opinion anticipated to legalize living wills. As soon as the decision was imminent, the Conference abandoned its opposition and actively lobbied for a compromise bill. But in Massachusetts, the Catholic Conference has resisted all efforts to enact legislation and participants there believe there is little chance for a bill to pass in the foreseeable future. All agree that the conservative Catholic Church is very powerful and that key Catholic legislative leaders can prevent full legislative consideration of living will bills.

In addition to information gained from interviews and legislative bill files, I have tested the effect of the political power of the Catholic Church on living will law enactments for all of the states. An indirect indicator of interest group political strength is the size of its membership. I have correlated the percentage of the Catholic population in each of the states with the dates of adoption of living will laws. The results suggest that larger Catholic populations are associated with the absence of living will legislation or with late adoptions ($r = -.47$; $p = .001$). Other social and political forces which also might be hypothesized to affect the adoption of this policy—the size of the states' elderly population, urbanism, state policy liberalism, and others—have no independent effect in a multiple regression model of living will law enactments. Only the size of the states' Catholic population remains a significant factor affecting the adoption of this policy. (Additional discussion on the role of the elderly follows below). States with large Catholic populations generally are found in the northeast which often are among the highly innovative states in other fields of policy. But on living will laws it appears that the strength of the Catholic Church puts these states in the laggard category on policy innovation.

While heavily Catholic New Jersey, New York and Massachusetts lack living will laws, they have been among the leaders in judicial right-to-die policy. As indicated earlier, these states possess many of the social characteristics that promote innovation, but powerful interests can prevent particular issues from being enacted. However, while it might successfully oppose or limit legislation, the Catholic Church and other groups

cannot prevent individual citizens from putting an issue on the judicial agenda. The courts also are much less likely to be influenced by interest groups, which can affect court cases directly only by submitting *amicus curiae* (friends of the court) briefs. Since right-to-die cases are not plentiful, it also is unlikely that an interest group can have much indirect effect, such as stimulating sustained high levels of public interest which might transfer to judicial elections. But even in this regard, many judges, particularly in the northeast, are appointed to office for life or for very long terms and never face the pressure of re-election. Moreover, elected judges are rarely defeated at the polls. Consequently, the courts are much more insulated from direct political influence than state legislatures and, as we have seen, generally have responded favorably to claims of privacy and patient or family control over medical treatment in the right-to-die cases.

Judicial Interpretation of Legislation

Courts have interpreted and applied living will laws in slightly more than half of the state appellate cases. As in all areas of law, when cases and legislation abound, the growing body of law gives judges numerous choices about which law to use and how to apply it. In addition, while the facts in many right-to-die cases are similar, judges frequently emphasize certain ones more than others and fit the law differently to those facts. The right-to-die cases support a policymaking model of judicial behavior: like legislators, judges are oriented to a particular policy or result and find law or interpret law and facts which support the conclusion they wish to reach. Thus, courts are important policymaking institutions in their own right. One interview respondent summarized this view well when he said that state supreme courts and legislatures are competitors and go their own way in making policy.

Courts have revealed their policymaking power concerning state legislation in several ways. First, state courts have viewed living will laws as only one avenue for determining the right-to-die. Patients with or without living wills do not give up other rights. The first appellate case involving a substantive interpretation of a state living will law is a 1983 California intermediate appellate court decision (*Barber* v. *Superior Court,* 195 Cal. Rptr., 484). The court concluded that the withdrawal of all medical treatment from terminally ill and comatose patients, including food and hydration, was within the normal practice of medicine and could be done with the wishes of the patient or surrogate decisionmaker, and that such decisions were not limited by the state's living will law (the Natural Death Act) or the brain death statute. It added that few people have executed living wills and it criticized as inhibiting the California statute which requires a 14 day waiting period after a patient has been declared terminally ill before a valid living will can be executed.

The Maine Supreme Court and a Florida intermediate court of appeals produced similar decisions in 1986 and 1987 (*Corbett* v. *D'Alessandro,* 487 So. 2d 368 and *In re Joseph Gardner,* 534 A. 2d 947). They condoned the withdrawal of artificial feeding and hydration from permanently comatose patients despite state living will statutory language which could be interpreted to require the administration of artificial food and hydration for "comfort care and to alleviate pain." Both courts added that state statutes were but one of several ways that patients' rights in these circumstances could be defined and that statutes could not limit the constitutional right to refuse medical treatment.

Thus, these decisions vastly extended the right-to-die beyond the states' living will laws and created an independent role for appellate courts in states with legislation.

Although most courts have endorsed and expanded the right-to-die, courts can interpret legislative language either to restrict or expand patients' rights. Two recent state supreme court decisions reveal the enormous significance of judicial interpretations of legislative language and the importance of state court decisions as part of state policymaking in the right-to-die. First, Connecticut's living will law explicitly excludes the *mechanical* administration of food and hydration from medical treatment which may be withdrawn. The statute also calls for comfort care and alleviation of pain *in all cases* and the provision of nutrition and hydration for *all patients* who are not terminally ill. Therefore, removing food and hydration from patients in a permanent vegetative state seems to be prohibited. But, in keeping with the overall trend toward expanding patients' rights, the Connecticut Supreme Court, in *McConnell* v. *Beverly Enterprises* (539 A. 2d 596, 1989), interpreted the language of the law to achieve the opposite result. The court reasoned that individual provisions of the law had to be considered within the context of the purpose and meaning of the entire statute—giving the judges considerable latitude to interpret and apply other words and phrases. An additional sentence of the statute refers to the provision of "beneficial medical treatment," which, the court decided, did not include artificial technology to assist in nutrition and hydration. Normal eating and drinking by mouth are required, but artificial feeding and hydration are not. Therefore, the seemingly clear food and hydration provision of the state's living will law did not require the artificial administration of food and hydration.

The earlier *Cruzan* decision of the Missouri Supreme Court is a striking illustration of the use of similar law to achieve a result opposite the general trend. In denying the withdrawal of all forms of life sustaining medical treatment, the Court cited *every* right-to-die precedent, which overwhelmingly promote patients' rights, but rejected all prior decisions in favor of a reference to the state's living will law which includes a pro-life statement in its preamble. The Court concluded that the living will preamble revealed the intent of the Missouri legislature concerning the right-to-die. It also ruled that the legislation applied to the patient in this case—an auto accident victim in a permanently comatose condition—even though the court also determined that the patient was not terminal and had not signed a living will, both of which seemingly are required by the legislation. Thus, the Missouri Supreme Court had available an identical set of judicial precedents, which it rejected, in favor of its own distinctive interpretation and application of statutory law.

Many other state laws have identical or similar food and hydration and other restrictive clauses in them. Presumably state courts may interpret them in various ways. Possibly, supreme courts in the generally liberal northeast and far west will follow the Connecticut model while those in the conservative south and midwest may opt for the Missouri route. As mentioned earlier, the U.S. Supreme Court has approved the Missouri supreme court's stringent evidence requirements concerning patients' wishes regarding medical treatment, and it urged individuals to record their wishes in living wills, durable power of attorney for health care forms or similar documents. However, the Court has not required other states to follow the Missouri model, but allows them to chart their own course. The Supreme Court's decision will become an additional ruling that the states

may use in future decisions. Undoubtedly, courts will continue to interpret precedent and legislation and legislatures will draft and amend living will laws as well as other related policies as society grapples with this difficult and contentious social problem.

ASSOCIATIONS OF THE ELDERLY AND THE RIGHT-TO-DIE

Many interest groups have participated in the creation of state right-to-die policy, both in courts and legislatures. However, advocates for the elderly and associations of the elderly generally have not been prominent in drafting or supporting legislation nor have they influenced the formation of judicial policy.

In legislatures, interest groups have been engaged in the full range of lobbying activities, including bill drafting, locating bill sponsors and opponents, testifying at committee hearings, contacting individual legislators and urging members to write public officials. In courts, interest groups have filed *amicus curiae* briefs in which they express their support for one side or the other in the case. Interest groups may not offer verbal arguments. A large number of briefs submitted on behalf of both sides in a court case reveals intense interest group conflict in the courts, albeit a silent and largely invisible one.

Living Will Laws

As indicated in the previous discussion, state Catholic Conferences universally are the most prominent interest groups affecting living will laws. The case studies indicate that early interest in these laws originates with individual legislators whose personal experiences or contacts with constituents have sensitized them to the need for new policy. They and their staffs frequently draft bills and sometimes they have sought additional input from a variety of groups. But rarely have organizations supporting living will laws matched the activity level of organizations which oppose legislation or seek to limit the scope of new policy. Legislative bill files indicate that many organizations, including the elderly, testify at committee hearings when a bill is being considered, but this activity typically comes at the final stages of the legislative process, long after bills have been drafted and key sponsors and opponents have been identified. Testimony at this stage puts a variety of groups and individuals on record as favoring or opposing a bill, but most of them have not had a large part in drafting the legislation or securing its position in the legislature.

Of the three states studied, the elderly have been most active in California. The original 1976 law was passed primarily due to compromises between the bill sponsor, the state Catholic Conference and the California Medical Association. Associations of the elderly and others indicated their support, usually through letters written to the bill sponsor and legislative committees, but they were not active in drafting the bill or rounding up support in the legislature. The first indication of active senior involvement appeared in 1985 when the Gray Panthers urged Senator Keene to introduce the uniform living will law of the National Conference Commission on Uniform State Laws (NCCUSL) in the California legislature. This organization planned to coordinate support among other seniors' groups, including the American Association of Retired Persons (AARP), Older Women's League and others. However, no

amendments to California's law were introduced until 1987, and since then the Gray Panthers appear to have moved on to other issues. Among the elderly, the AARP reportedly has indicated the greatest current interest in obtaining amendments to the law. Although seniors have been more active in California than in other states, and recent concerns may indicate more interest in the future, there has been little evidence of a sustained effort supporting living will laws, lobbying on behalf of changes in California's law, or in arousing large numbers of seniors to contact public officials.

The level of involvement of the elderly in living will laws has been even lower in Florida and Massachusetts. In Florida, the Silver Haired Legislature once placed the right-to-die on its agenda, but it never considered policy alternatives and it has not endorsed legislation. The state chapter of the AARP has only recently indicated interest in living will laws, but there is no evidence that it has been active on this issue in the legislature. Another organization, the American Association of Retired Citizens, lobbied against a living will bill during one year, but otherwise has not been active. In Massachusetts, the dominance of the Catholic Church has shaped the political conflict and overshadowed the power of all other groups. As in Florida, in one particular year, the Silver Haired Legislature and the state secretary of elder affairs each endorsed a living will bill, but they have not engaged in active lobbying. Political activists maintain that living will proposals have so sharply divided the state along religious lines that it is difficult for any other group to influence legislation or even to provide perspectives on living will legislation which differ from the themes established by opposing religious organizations. Overall, the elderly are not perceived as important politically in this area of policy.

Court Cases

Interest groups and public policy almost always evoke images of lobbying in the legislature, but interest groups also are important in litigation. Going to court sometimes is an alternative to the legislature, in which losers hope to win in a different branch of government. The most widely used measure of interest group activity in the courts is the frequency of filing *amicus curiae* briefs (O'Connor and Epstein 1981-1982, 1983). Interest groups have filed briefs in right-to-die cases and their involvement in litigation has increased over the years. In the 1970s and early 1980s, it was uncommon for interest groups to submit briefs, and only three cases prior to 1984 attracted *amici.* But since 1984, as many as ten organizations have submitted arguments for both sides in a single case, and all but a few cases have involved interest groups. In all, interest groups have submitted 83 briefs in 60 per cent of the appellate cases studied between 1976 and 1989. However, approximately 75 per cent of all *amici* briefs were submitted between 1984 and 1989. Clearly, by the mid 1980s, the right-to-die had become very salient to a variety of interest groups and many believed that state appellate courts were having an important impact on the content of the law.

The distribution of *amici* briefs submitted by various types of interest groups is present in Table 4. Highest on the list are medical organizations (33 percent), including state medical societies, hospital and nursing home associations, individual hospitals, hospices, medical schools and others. These are followed by: national right-to-die advocacy groups (22 percent), principally the Society for the Right-to-Die and Concern for Dying;

TABLE 4
Types of Interest Groups in Right-to-Die Cases

Group	*% of Briefs (N = 83)*
Medical	33
Right-to-Die	22
Pro-Life	18
Disabled	28
Other	8
Total	99[a]

[a] rounded

pro-life organizations (18 percent), particularly state Catholic Conferences and right to life groups; and advocacy groups or associations of the disabled and retarded (18 percent). Among the 7 briefs included in the 'Other" category (8 percent), only one is by an advocacy organization for the elderly.

Clearly, the right-to-die has not been an important political issue for the elderly. Except for the recent activity of the elderly in California legislative politics, there is little evidence that advocates for the elderly or associations of the elderly have paid much attention to the right-to-die or established a sustained effort to influence state public policy in courts or legislatures.

Why Inactivity?

There are several reasons why the elderly probably have not been active in right-to-die policy. First, the elderly generally have not been prominent in state politics and policy. Advocates and organizations of the elderly have directed most of their attention to national policymaking since the federal government has established the major programs benefiting the elderly, and state and local governments participate through matching funds and parallel government programs and bureaucracies. Many state and local officials and advocates for the elderly have perceived the federal government, not the states, as having responsibility for the elderly (Dobson and Karnes 1979; Dobson and St. Angelo 1979; Browne 1985). There are signs, however, that senior lobbying is increasing in the states. The AAPR, for example, has established state committees to monitor and influence legislation. States with active senior organizations include Michigan, Minnesota, New York and California.[11]

With few exceptions, senior interest in the right-to-die is low in comparison with other state issues, such as tax relief, health care, housing, transportation, and others (Browne 1985; Browne and Ringquist 1985). However, in 1987, the Minnesota Board of Aging—a state agency established to advise the governor on aging—sponsored a living will bill, but a living will law was not enacted until 1989. Lack of interest probably is linked to the specific content of this issue. First, it may reflect the tendency of many citizens—young and old alike—to avoid issues of death and dying. The right-to-die, in particular, deals with medical treatment and hospitalization associated possibly with a prolonged and painful death in which the individual is intruded upon beyond his or her control. Contemplating this issue in personal terms and promoting public policy

regarding the right-to-die is troublesome and unpleasant for many. The right-to-die also competes with other health care and financial issues which have more immediate and compelling importance to the elderly. Similarly, organizations of the elderly often have stressed tangible economic benefits such as discounts on insurance, travel and pharmaceuticals. In addition, living wills may be executed by any person over age 21, making the right-to-die technically unrelated to age, although the elderly can be expected to be more affected than other age groups. A nearly equal number of appellate right-to-die court cases have involved litigants over and under age 65. The over age 65 group is highly over represented, given their ratio in the general population, but the right-to-die often has been publicized and made visible through court cases involving young rather than old patients.

Finally, the elderly divide along political, socio-economic and other lines, and age is not a good predictor of political attitudes or loyalties (Hendricks and Hendricks 1977; Dobson and St. Angelo 1979; Hudson 1980; Binstock 1984). When policies benefit certain groups of elderly differently, political divisions occur and the elderly send mixed and competing messages to public officials. The right-to-die probably cleaves the elderly along similar religious and political lines found in the general population. Elderly Catholics may be equally or even more inclined than younger Catholics to follow Church leaders, and elderly conservative Protestants may share a right-to-life orientation with their younger co-religionists. Consequently, associations of the elderly may be reluctant to take a position on this issue if it might divide the membership. The few organizations of the elderly which have testified for the enactment of living will legislation find it difficult to convince legislators that they widely represent the elderly since opposing groups sometimes make identical claims.

Professional associations which advocate the interests of the elderly might appear to have greater opportunities to influence state legislatures, but since they are advocates *for* the elderly and not *of* the elderly, they probably would not be convincing as genuine representatives of the elderly on this issue (Hudson 1980). Politically appointed government officials who serve as advocates of the elderly also must balance their political security with the interests of the elderly, and strong advocacy on controversial issues sometimes is sacrificed to political survival. Advocacy groups also have organizational interests which do not necessarily coincide with the interests of their clientele or customers. In living will laws, for example, medical, hospital and nursing home associations frequently state that they are deeply concerned with the interests of patients, but the provisions of law which they have addressed most often concern liability for terminating life support systems, dampening efforts to impose civil or criminal penalties for not complying with patients' wishes, or they have opposed all legislation as an interference with traditional doctor/hospital-patient relationships.

Political Potential

Many commentators and researchers perceive enormous political potential for the elderly in state politics, but almost all agree that the potential has not been realized. There is no disagreement that the size of the elderly population is growing rapidly and that the social and political contours of the United States are changing. The proportion of the elderly population in Florida probably will become the model for the rest of

the nation in the next century (Lammers 1983). Many issues concerning the elderly, including the right-to-die, are bound to become more relevant and salient to the elderly and to policymakers alike.

Group size also offers significant potential for influencing state politics. State legislatures may perceive the elderly as a growing and deserving group in need of additional services and support. In turn, increases in benefits and programs for the elderly as a percentage of all government activity reinforce the position of the elderly as an important group in state politics. But the elderly also are likely to be perceived as an increasingly important voting bloc which has to be considered by political candidates. Research both on the American states and among nations indicates that the proportion of the elderly population is an important factor explaining government support for pension and other legislation for the elderly (Browne 1985; Pampel and Williamson 1985, 1988, 1989).

The growing size of the elderly population also creates potential for group cohesion and identification, not just as a demographic category, but as a distinctive entity with particular life-styles, needs, programs, and aspirations. The elderly may congregate more in separate living arrangements and meet increasingly in senior centers—convenient locations for social and political organization (Hendricks and Hendricks 1977; Dobson and St. Angelo 1979). The elderly also remain active in many forms of politics. They continue to vote at levels equal to or higher than other age groups and they participate in other ways, such as paying close attention to political news and information and making campaign contributions. They become less involved, however, in the most active forms of participation, notably talking to and persuading others about politics (Jennings and Markus 1988).

The elderly also generally enjoy a favorable public image and empathy from most other age groups which might enhance their status and access in politics (Hudson 1980; Pampel and Williamson 1989). The middle-aged are most likely to be supportive since they forsee becoming elderly themselves. In contrast, it is more difficult to empathize with the young, an age to which no one can return, or with other racial, religious, gender or sexual groups since people cannot or do not change these characteristics and may be less able to imagine themselves in the position of these others.

But size and empathy are not enough. Active lobbying is necessary for the elderly to obtain legislative victories, especially where their proportion of the population is small. Obtaining gubernatorial support also is crucial, for governors have vetoed legislation favorable to the elderly when expenditures exceed governors' budgets (Browne 1985). Conservative governors in California and Florida and other states also have vetoed living will laws and amendments, so supporters of this legislation must obtain and maintain access to all branches of government in order to better assure political success. Finally, it also is necessary for the elderly to coordinate activities among mass membership organizations and for many groups to devote more of their energies to lobbying. In some states, associations for the elderly are interested mainly in social functions and lobbyists for the elderly report that it is difficult to mobilize the members for political action or other demonstrations of political support (Browne 1985).

The elderly have other political disadvantages. Most state legislators do not perceive groups of the elderly as active in state politics nor do many legislators self identify as advocates for the elderly or specialists in aging legislation. Nongovernmental advocates

for the elderly rarely report that they participate in bill drafting or lobbying or serve as lobbyists for the elderly. Many see themselves as guardians and managers of existing federal programs for the elderly and do not encourage further state or local government involvement (Dobson and Karnes 1979; Dobson and St. Angelo 1979; Browne 1985). Most senior citizens' groups do not employ professional lobbyists (Browne 1985). Although some amateur lobbyists have several years of lobbying experience, they often work part-time and lack the breadth and penetration enjoyed by business or other occupational and professional groups which sometimes employ the same professional lobbyists and large staffs for many years. These limitations are compounded since the elderly usually seek to change the political *status quo,* which requires enormous energy and constancy to get new items on crowded legislative agendas, shift the attitudes of legislators and shephard bills into laws. In sharp contrast, a Catholic lobbyist volunteered that he did not find it difficult to defeat living will bills since it always is much easier to kill a bill than to enact a law.

Despite political disadvantages, the elderly usually are cohesive on certain issues, notably health care and income support, and the potential for political solidarity and impact remains. In addition, each generation undergoes distinctive life experiences during different historical periods which influence their political socialization and perceptions and attitudes throughout life. It is likely that future generations of elderly will see social issues differently from those of today. Regarding the right-to-die, as more public attention and public policy focuses on this issue—most of which supports the right-to-die—the current young-old and middle-aged populations are likely to develop more knowledge and sophistication and perhaps will develop similar attitudes toward final health care decision making. And, their attitudes are likely to stay with them as they age. If there is growing interest in this issue and opinion solidarity among the future elderly, lobbyists will be motivated to concentrate on this policy and develop greater legitimacy as representatives of the elderly.

CONCLUSION

Courts and legislatures often compete in setting state right-to-die policy. The impetus for policy innovation is found in the personal experiences or awareness of individual legislators, but interest groups have been important in determining if or when states adopt living will laws and the content of their policies. However, overall, state living will laws have changed or been re-invented during the diffusion period to expand patient control over medical decisionmaking. But certain provisions have moved in the opposite direction. Currently, the most controversial one concerns the exclusion of the artificial administration of food and hydration from medical treatment that a patient can refuse. State courts, however, are much more insulated from the direct pressures of interest groups and most have developed and endorsed policies which promote individual freedom to reject medical treatment, including the artificial administration of food and water.

Policymaking in the right-to-die recently has been elevated to the national level, and the U.S. Supreme Court ruled on the Missouri Supreme Court's restrictive legal interpretation. But this is not the last word on the right-to-die. The lessons from much prior research on the impact of U.S. Supreme Court decisions indicate that high court

decisions are open to various interpretations by lower court judges and other officials since they usually are written as general policy statements designed to cover a wide array of individual circumstances. Consequently, they are implemented by lower courts in a variety of ways. The attitudes and values of state judges and other public officials are crucial in determining exactly how court decisions are translated into practice. In addition, state officials will continue to have a large body of state law to apply to this issue as well. Therefore, continual change or re-invention in the law is bound to occur.

While the right-to-die affects all age groups, the elderly are disproportionately affected by this policy. However, neither the elderly nor their advocates have asserted senior power in defining the content of right-to-die policy. However, the issue is likely to become more important to the elderly and other groups for several reasons. First, the size of the elderly population is projected to increase dramatically in the next few decades, making the issue more immediately relevant to a larger percentage of the population. As more people weigh a prolonged life and the quality of life, the right-to-die is likely to become a more salient issue. Second, collateral health issues are likely to intersect with the right-to-die and expand the issue. As medical science continues to advance, making it increasingly possible to stave off death from a variety of old and new illnesses, ethical questions concerning the balance between health care resources and the value of life-near-death are bound to become more prevalent.

Few individuals or lobbyists testifying before state legislative committees have linked the right-to-die with the high costs of health care at the end of life, concentrating instead on personal tragedies and moral issues. The courts also have stressed legal rights and obligations, not medical costs. But, rising health care costs, the disproportionate share of which come at the end of life, likely will draw the right-to-die into a much more comprehensive health care debate, moving it beyond a conflict over religion, morals and individual rights. A suggestion of the connection between the costs of health care and the right-to-die may be found in a recent New York appellate court decision barring a nursing home from collecting fees for maintaining a patient through the artificial administration of food and hydration against the wishes of her family. The immediate impact of this case may be to propel hospitals and nursing homes to honor living wills or the wishes of family and guardians since they may not be able to demand compensation for unwanted extended care. However, the linkage between health care costs and the right-to-die also suggests a future expansion of the issue beyond the realm of the usual combatants in this policy field.

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NOTES

1. Minnesota and North Dakota enacted laws in 1989, but are not included in the analysis.
2. The cases studied include all state supreme court and several intermediate appellate court cases involving adult right-to-die cases decided from 1976 to 1989. The list of cases was provided by the Society for the Right to Die and confirmed through additional LEXIS analysis.

3. Based on the frequency of articles on the right-to-die in various media tabulated by the author.

4. Discussion of the factors which influenced the rapid adoption of living will laws in 1983 and 1984 is largely beyond the scope of this paper. However, there are four major events which probably stimulated the states to act. First, in the early 1980s, many state appellate courts produced facilitative right-to-die policy and certain Catholic leaders urged the Church to give up its opposition to legislation in favor of laws which might restrict the courts. In 1983, A Presidential Commission issued a report titled *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions.* It endorsed living will laws, state judicial decisions and suggested additional legislation. In 1984, the National Conference of Catholic Bishops reversed its earlier opposition to living will laws in favor active participation in drafting state laws. Also in 1984, the National Conference Commission on Uniform State Laws proposed a uniform state living will law.

5. An exception is *Barber* v. *Superior Court* (195 Cal. Rptr. 484, 1983). However, unlike all other cases, this was a criminal case involving two doctors who removed all life support systems as well as artificial food and hydration from a terminal patient. It also is an intermediate appellate court decision and is less likely to be used by other courts.

6. Other provisions which are uniform in the states are excluded from the scale. They concern: the purchase of life insurance; admission to health care facilities; punishment for forging a document; prohibitions against euthanasia or mercy-killing and the non-applicability of the law to those who have not drafted a living will. A dichotomous code was used for most provisions which distinguish among states which do not have a particular provision and those which have a standardized provision. However, on five items a dichotomy was inadequate for representing the content of state policy. Although this weights certain provisions more than others in the scale, this was an acceptable trade-off for obtaining a more precise representation of variation in living will laws.

7. Communication with the author.

8. Additional analysis identified four of the eighteen provisions found in living will laws which depressed overall facility scores: the regulation of food and hydration; pregnancy provisions; creation of living wills for minors; and provisions permitting interested parties to block the implementation of a living will through court order. However, only the food and hydration provision produced a large and statistically significant negative correlation with date of adoption ($r = -.627$; sig. $= .001$).

9. For a discussion of amendment as part of the policy innovation process, see Eyestone 1977.

10. As discussed above, legislatures often have adopted restrictive food and hydration provisions favored by Catholic and right-to-life lobbyists. Provisions making living wills invalid in the case of pregnancy also are found in certain recent state living will laws, but they are not as plentiful or visible, probably because there are few cases in which pregnancy has been involved in right-to-die decision making. There have been no appellate court cases involving pregnant patients.

11. Based on unpublished research by Douglas St. Angelo, Florida State University.

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