

Implementing Prospective Autonomy

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Alberto B. Lopez & Fredrick E. Vars, [Wrongful Living](#), 104 *Iowa L. Rev.* 1921 (2019).

Advance directives are often recommended, but rarely used. The latter fact is an alarming one, and Professors Alberto Lopez and Fredrick Vars tackle this problem in their Article *Wrongful Living*. After identifying the root causes of this state of affairs, they provide innovative practical and conceptual proposals for implementing the wishes of those who have taken the time to exercise their prospective autonomy. They argue for a tripartite solution to the persistent problem of advance directive underutilization. First, they recommend creating a nationwide registry of advance directives. Second, they suggest that attorneys be exposed to professional discipline and malpractice liability for failing to enter advance directives into said registry. Third, they reconceptualize the nature of the damages that flow from medical interventions that lead to undesired continued life, making wrongful living claims potentially more cognizable to courts. This holistic analysis of advance directives is admirable for providing a realistic blueprint for law reform, and the Article is a must-read for those scholars working in the areas of incapacity planning, health law, and torts.

Lopez and Vars first perform some necessary brush clearing by discussing the historical and philosophical background of advance directives. They detail the legal history of the device, including its origins in informed consent doctrine, the flurry of state and federal legislative activity that allowed and promoted its use, and the high-profile cases of Karen Ann Quinlan and Nancy Cruzan. They then turn to the thornier philosophical issues around advance directives, focusing on the Ronald Dworkin-Rebecca Dresser debates on their utility or normative desirability. They conclude, unsurprisingly, that advance directives do protect important autonomy or dignity interests, creating a need to analyze how best to legally implement them.

With this conceptual foundation, they turn to examining why advance directives fail to influence medical treatment decisions. One culprit is the current law, which places the onus on the declarant (their term for the person who filled out the advance directive) to notify medical institutions of the existence of the directive. Even when this is done, however, advance directives are often not placed in the medical record in a way that will make them operative in a medical setting. States and the private market have attempted to ameliorate this situation by offering advance directive registries, but these face several practical problems. First, the placement in a registry does not necessarily make the advance directive easily accessible to medical personnel at the moment of decision, as it might require passwords that only the declarant has. Second, there are significant costs to starting up such registries, explaining why many states have not endeavored to create them. Finally, the proliferation of private registries to make up for the lack of public ones actually further complicates the efforts of medical personnel, as it increases search costs to find the registry that houses a particular patient's legal documents.

This leads to their first proposal: a national centralized registry for advance directives. There are two features that Lopez and Vars identify as must-haves for this registry. First, it must be searchable without needing information from the declarant, as she might not be in a condition to communicate or may have forgotten a login password. Second, the registry must be completely online, which allows for immediate viewing of the relevant documents. This is important as often medical decisions are made in emergency situations, and there is not time for the directive to be mailed or faxed. Lopez and Vars justify such a registry primarily on the basis that it reduces the costs of finding and using advance directives as well as saving on costs due to economies of scale. In response to critics who say that they are merely proposing another government bureaucracy, they point to the relatively successful Organ Procurement and Transplantation Network, a similar database used in emergency situations by medical professionals that is maintained by the Department of Health and Human Services.

But having a registry is only part of the solution. It must be populated with advance directives in order to be effective. To illustrate this point, Lopez and Vars draw an interesting analogy between advance directives and wills, noting that the former is only useful if they are accessible quickly and during the life of the declarant, whereas the latter are only operative and needed some time after death. Thus, their second proposal: Attorneys who safeguard advance directives for their clients must adequately preserve them as they would other client property. The simplest and best way to do this would be to enter the advance directive into the national registry. Failure to do so could (and should, they argue) subject an attorney to both professional discipline and a legal malpractice action, thus creating an incentive for attorneys to comply. Here, the authors analogize registration to the attorney recordation of deeds after a real estate transaction, both of which put third parties on notice of the client's interests.

Once the registry exists and is populated with a sufficient number of advance directives, the final part of the puzzle is getting medical professionals to use the registry and obey their patients' memorialized commands. Their third proposal targets medical professionals, who might be subject to various claims for failing to comply with advance directives, specifically ones that require the discontinuation of life-sustaining treatment. Courts have been wary of wrongful life claims, primarily because they find it difficult to conceptualize continued life as a harm, as compared to nonexistence. In a clever move, Lopez and Vars reconceptualize the nature of the harm not as continued life but as a loss of enjoyment of life. The authors note that life-threatening medical events—if survived—are often followed by poor quality of life as compared with life before the medical event. This poor quality of life, in turn, is precipitated by a wrongful medical intervention caused by ignoring the dictates of an advance directive. Thus, the correct measure of damages is the difference between the quality of life in that previous state as compared to the diminished state that a person might find herself in after the wrongful medical intervention.

Whether courts will buy this particular conceptualization of damages is an open question. The harm of ignoring advance directives is more likely an injury to some type of dignity or prospective autonomy interest of the patient. However, as the authors note, courts are just as reluctant to expand dignity torts as they are to accept wrongful life claims. Therefore, the authors may provide a more realistic doctrinal route to recognition of the harms of not honoring advance directives. Coupled with their other proposals for a centralized registry and attorney incentives, we may have a path forward for making advance directives useful and effective.

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