The development of new, life-prolonging medical technologies in the 1970s aroused concern among Americans about the indiscriminant use of aggressive, life-prolonging treatments. Highly public cases such as those of Karen Ann Quinlan and Nancy Cruzan drew attention to the importance of end of life care planning for healthy adults. Advance directives were developed as a way for people to retain control over their medical care by specifying their treatment values and choices and by naming someone to make medical decisions once they were no longer able to do so. Over the past several decades, it has become clear that statutory advance directives alone have not been as successful as originally hoped in giving patients control over their end of life care. However, the initial goal of advance directives was laudable and is worth preserving. Promising new models have evolved from practice and research that move us closer to achieving the original intent of advance directives.

Most traditional advance directives, such as statutory living wills and surrogate appointments, were created by legislative processes that set specific requirements about content and established rules regarding their use to define the rights of adults to forgo medical treatment, to protect providers who honor these decisions, and to appoint an authorized surrogate decision-maker. Statutory living wills are a tool for patients to express preferences about medical treatments that can be used if a person is no longer able to make his or her own decisions. These documents typically focus on potentially life-prolonging treatments in a very limited set of circumstances, such as when a person is faced with “imminent death regardless of treatment” or is in a “persistent vegetative state.” In most states, a person can also designate a surrogate to make decisions in the event the patient loses decisional capacity. Depending on state law, a surrogate may be called a health care proxy or agent, medical power of attorney, or durable power of attorney for health care.

Limitations of Traditional Advance Directives

Despite the hope that traditional advance directives would ensure that patient preferences are honored, numerous studies have found that only a minority (20 to 30 percent) of American adults have an advance directive and that these documents have limited effects on treatment decisions near the end of life, though more recent research suggests use may be higher at the end of life. In addition to a low completion rate, there are many reasons why traditional advance directives are less successful than originally hoped. These reasons include the following:

1. The focus is often on a patient’s legal right to refuse unwanted medical treatments, reflecting the legislative origins of traditional advance directives. Those who complete such documents generally do not receive assistance in understanding or discussing their underlying goals and values.

2. The instructions given in these documents and the scenarios provided for discussion are generally either too vague to be clear (for example, “If I am close to death”) or too medically specific to be helpful in com-