FIXED INTENTIONS: WILLS, LIVING WILLS, AND END-OF-LIFE DECISION-MAKING

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Contemporary trusts and estates law is built on the premise that individuals can and should have fixed intentions with respect to the disposition of their property at death. These intentions can and should be fixed in a written document, and that document can and should be fixed against other outside evidence of intention. Experience with end-of-life health care decision-making gives reason to question these premises. In the health care context, intentions have proven to be fluid, and the documents purporting to record individuals' wishes have often proved unreliable.

This Article examines the implications for wills of the literature on end-of-life health care decision-making. Advance health care directives and property wills are alike pre-commitments, attempts in the present to bind the future, but studies in the end-of-life health care decision-making context show there are serious issues with this process.

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Individuals simply do not care to decide about post-competency treatment, those who do make such decisions often change their minds, and cognitive biases operate to limit individuals' ability to predict accurately in the present what they will want in the future. Many of these issues arise also in the context of end-of-life property decision-making and unsettle many of wills law's fundamental premises about intention.

The final part of the Article suggests avenues for further empirical study and explores the practical significance of this potential research for estates law, particularly the potential to displace the vision of the estates attorney as a passive scrivener who simply asks what the client wants and writes it down. It may be that the wishes expressed in a will may be formed in response to, and shaped by, the attorney's questions rather than being brought out by those questions. The Article concludes by asking whether there might be a way to honor fluid intentions in the property context that does not destroy the utility of testamentary documents as a safe harbor.

INTRODUCTION

Contemporary trusts and estates law is built on the premise that individuals can and should have fixed intentions with respect to the disposition of their property at death. These intentions can and should be fixed in a written document, and that document can and should be fixed against other outside evidence of intention. Experience with end-of-life health care decision-making gives reason to question these premises. In the health care context, intentions have proven to be fluid, and the documents purporting to record individuals' wishes have often proved unreliable.

This Article examines the implications for wills of the literature on end-of-life health care decision-making. Advance health care directives and property wills are alike pre-commitments, attempts in the present to bind the future, but studies in the end-of-life health care decision-making context show there are serious issues with this process. Individuals simply do not care to decide about post-competency treatment, those who do make such decisions often change their minds, and cognitive biases operate to limit individuals' ability to predict accurately in the present what they will want in the future. Many of these issues arise also in the context of end-of-life property decision-making and unsettle many of wills law's fundamental premises about intention.

The literature on end-of-life health care decision-making teaches that many patients cannot and do not make once-and-for-all decisions about treatment at the end of life, and therefore, they should not be expected or required to. But both academic and practitioner literature on end-of-life property decision-making begins from the assumption that testators are rational in more or less the way posited by classical economics, coolly able to decide at the time they make their wills how they will want their property distributed when they die. No one seems to question this assumption even though the facts of the reported cases show that, over and over again, testators informally "revise" their estate plans by marking up their wills,[1] writing letters containing instructions inconsistent with the terms of their wills,[2] or executing holographs to bring their wills into alignment with changed family circumstances.[3] These adjustments may or may not be legally effective,[4] but that is beside the point. What is interesting about the cases is that they depict a universe of testators whose thinking seems quite similar to those of patients facing end-of-life health care choices. These testators, like those patients, are irresolute.[5]

The wills of testators who do not conform to the fixed-intention paradigm reflect serious problems. These wills are not signed at all;[6] or contain confusing marginal notations;[7] or are contradicted by other, informal instruments written closer to the time of death.[8] These problems—problems of irresolution—are not reached by recent legal reforms permitting courts to correct minor, inconsequential errors that affect such testators' wills, such as a signature in the wrong place

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[1] *See In re* Estate of Windham, No. 287937, 2010 WL 293064, at *1 (Mich. Ct. App. Jan. 26, 2010).

[2] *See In re* Estate of Smoke, No. 273114, 2007 WL 4415499, at *1–3 (Mich. Ct. App. Dec. 18, 2007).

[3] *See* Minton v. Minton, 374 S.W.3d 818, 819 n.2 (Ark. Ct. App. 2010).

[4] *See In re* Windham, 2010 WL 293064, at *2–3 (handwritten markings on will did not constitute effective revocation); *In re* Smoke, 2007 WL 4415499, at *3 (letters insufficient to prove that testator intended to replace, amend, or revoke his will). *But see Minton*, 374 S.W.3d at 822 (two handwritten notes admissible to probate as a holographic codicil).

[5] On the general issue of irresolution in wills law, see generally Jane B. Baron, *Irresolute Testators, Clear and Convincing Wills Law*, 73 WASH. & LEE L. REV. 3 (2016).

[6] *See, e.g.*, *In re* Estate of Anton, Jr., No. BER-P-335-15, 2015 WL 6085394, at *3 (N.J. Super. Ct. Ch. Div. Oct. 6, 2015); Brown v. Fluharty, 748 S.E.2d 809, 810–11 (W. Va. 2013).

[7] *See, e.g.*, Eckstein v. Estate of Dunn, 816 A.2d 494, 499 (Vt. 2002).

[8] *See, e.g.*, *In re* Estate of Beebee, 258 P.2d 1101, 1103–04 (Cal. Ct. App. 1953).

or a word or line omitted when an earlier draft of a document is revised.[9]

Some might argue, of course, that such problems need not be addressed at all. Today, it is virtually unthinkable that the instructions in a written testamentary document would be overridden or ignored in favor of more recent informal statements made by the testator or new perceptions by one holding the testator's durable power of attorney—solutions taken seriously in the literature on end-of-life health care decision-making. But should it be unthinkable? Preferences about end-of-life property distribution, like preferences about end-of-life health care, may be affected by new information, changed circumstances, or altered wishes. Rather than pushing testators to foresee the unforeseeable and come to painfully final decisions fixed in documentary form, perhaps we might learn from end-of-life health care decision-making to conceptualize end-of-life property decision-making as fluid. That conceptualization might lead to the exploration of alternative strategies designed both to create reliable evidence of intent and also to respond to changes of mind and of circumstance.

This Article begins that exploration. Part I briefly reviews the turn in end-of-life health care decision-making first toward, and then against, the model of a final dispositive document or set of documents stating the patient's wishes. Both federal and state lawmakers did all that they could to support the creation of such documents, but their efforts were ineffective. Yet the underlying values of autonomy and self-determination remained constant even as the fixed-intention, documentary model for achieving them changed.

Part II takes up the questions that supported the turn away from the fixed-intention model in the health care context and examines their implications for end-of-life property planning. Many of these questions have unsettling implications for wills law.[10] What if a significant number of individuals simply do not care to provide specific

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[9] *See* UNIF. PROBATE CODE § 2-503 (2010); RESTATEMENT (THIRD) OF PROP.: WILLS AND DONATIVE TRANSFERS § 3.3 (AM. LAW INST. 2003) (excusing harmless errors in will execution); *see also* John H. Langbein, *Excusing Harmless Errors in the Execution of Wills: A Report on Australia's Tranquil Revolution in Probate Law*, 87 COLUM. L. REV. 1, 27–29 (1987) (explaining the basis for this reform). These provisions are discussed further *infra* text accompanying notes 152–58. Related reforms permit judicial correction of erroneous terms in a will or trust. *See* UNIF. PROBATE CODE § 2-805 (2010); RESTATEMENT (THIRD) OF PROP. § 12.1 (AM. LAW INST. 2003).

[10] For the sake of economy, I use the term "wills law" in this Article to refer to the law of trusts and estates and estate planning generally, and I use the term "will" to refer to any testamentary document including inter vivos trusts.

directions about the post-death distribution of their property? Or what if those who do make such decisions often change their minds? What cognitive biases operate to limit individuals' ability to predict accurately in the present the property distributions they will want in the future? These questions have received extensive empirical examination in the health care context. It is at least worth considering, in light of the findings in that context, whether extant understandings of the will-making process are accurate and how we might know.

Part III explores the practical significance of this potential research for wills law. In the current, fixed-intention paradigm the attorney is situated as a passive scrivener who asks what the client wants and writes it down. But the literature on end-of-life health care decision-making challenges this vision and suggests that the wishes expressed in a will may be formed in response to, and shaped by, the attorney's questions rather than being brought out by those questions. Part III then asks whether there might be a way to honor fluid intentions in the property context that does not destroy the utility of testamentary documents as a safe harbor.

In the end, the literature on end-of-life health care decision-making raises the uncomfortable possibility that "intent" about health care choices at the end of life is fictive because competent patients cannot meaningfully know what they will want when they are incompetent, and incompetent patients cannot meaningfully choose. If the same were true in the property context, there would be reason to question the existing architecture of wills law. In some important ways, the institutional context of end-of-life property decision-making is different from the health care context—simpler, less emotionally charged, and risking less financial ruin. Intentions about property might thus be less fictive. And if they are, then perhaps the current wills law paradigm of individual choice remains appropriate. Yet the work on end-of-life health care decision-making suggests that in meaningful ways this paradigm is questionable. At the very least, more work needs to be done to determine whether the wills law we have now is the wills law we need.

I. FROM "LIVING WILLS" TO "ADVANCE CARE PLANNING" IN MEDICINE

The term "living will" seems to have first appeared in a 1969 article by Luis Kutner tellingly titled *Due Process of Euthanasia: The*

Living Will, A Proposal.[11] Kutner, an international human rights lawyer, examined the legal treatment of so-called mercy killings, technically proscribed regardless of motive.[12] "From another perspective," Kutner noted, "the current state of the law does not recognize the right of the victim to die if he so desires," even if the victim is suffering unbearably.[13] "Such a denial," Kutner argued, "may well infringe upon an individual's right of privacy."[14] This right, coupled with patients' "rights to decide" what they wanted with respect to end-of-life health care, gave competent patients a concomitant right to declare in advance what treatments they would accept if terminally ill and unable to express their own wishes. Kutner described the advance declaration document in explicitly testamentary terms, as "a living will, a declaration determining the termination of life," and a "testament permitting death."[15] "Living wills" would be executed with roughly the same formality necessary for property wills—they would be in writing, signed, witnessed, and notarized—and like ordinary wills they could be revoked at any time before the patient's death.[16] The underlying concept was that treatment decisions at the end of life should reflect the autonomous choices of the patient, not the doctor or the hospital.[17]

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[11] Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 552 (1969). For a more detailed legal history of advance health care directives, see generally Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211 (2010). On physician compliance with advance directives, see generally Alberto B. Lopez & Fredrick E. Vars, *Wrongful Living*, 104 IOWA L. REV. 1921 (2019).

[12] *See* Kutner, *supra* note 11, at 540.

[13] *Id.* at 543.

[14] *Id.*

[15] *Id.* at 551. Kutner also suggested that a living will gave rise to a trust relationship:

> The *living will* is analogous to a revocable or conditional trust with the patient's body as the *res*, the patient as the beneficiary and grantor, and the doctor and hospital as the trustees. The doctor is given authority to act as the trustee of the patient's body by virtue of the patient's consent to treatment. He is obligated to exercise due care and is subject to liability for negligence.

Id. at 552.

[16] *Id.* at 551.

[17] *Id.* at 552. Kutner stated:

> [T]he patient in giving consent to treatment is limiting the authority the doctor and other medical persons may exercise over his body. . . . The patient may not be compelled to undergo treatment contrary to his *will*. He should not be compelled to take certain drugs, receive innoculations [sic] or therapy or undergo

A trilogy of legal cases arising in the decades after the publication of Kutner's article highlighted the potential utility of the living will to effectuate autonomy values. Karen Ann Quinlan,[18] Nancy Beth Cruzan,[19] and Theresa Marie Schiavo[20] were all relatively young patients in a persistent vegetative state who had failed to document in writing their wishes with respect to sustained life.[21] In the absence of such documentation, family members fought with doctors, each other, or the patients' spouses over whether to terminate treatment/life support.[22] The medical community viewed these cases as cautionary tales.[23] How much friction could have been avoided, how many legal and medical costs saved, doctors argued, if the patients had only recorded their wishes for doctors, hospitals, and family members to read?[24]

States encouraged the production of documents stating patients' wishes with respect to end-of-life health care by passing statutes authorizing and setting out requirements for living wills and health care proxy designations.[25] Many of the requirements are close to those

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> surgery without his express assent. At any point he may stop treatment or he may change physicians.

Id. On the centrality of autonomy in thinking about advance directives, see Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEX. L. REV. 1823, 1827 (2003) ("Scholars defending the authority of advance directives assign a high value to autonomy. . . . They assert that a patient's prior competent decisions should control treatment even if the person can no longer appreciate or understand the beliefs and concerns that motivated the earlier decisions."); Sabatino, *supra* note 11, at 219 ("[A]dvance directives have become public policy's choice for championing patient autonomy in the face of incapacity.").

[18] *In re* Quinlan, 355 A.2d 647, 651 (N.J. 1976).

[19] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 265, 267–68 (1990).

[20] Schiavo *ex rel.* Schindler v. Schiavo, 403 F.3d 1223, 1225 (11th Cir. 2005).

[21] *See supra* notes 18–20.

[22] *See generally* cases cited *supra* notes 18–20.

[23] *See* Sabatino, *supra* note 11, at 213–14.

[24] *See, e.g.*, Ana Tuya Fulton & Joan M. Teno, *Advance Care Planning: Focus on Communication and Care Planning Rather than on Building the Perfect Form*, *in* ADVANCE CARE PLANNING: COMMUNICATING ABOUT MATTERS OF LIFE AND DEATH 33, 33 (Leah Rogne & Susana Lauraine McCune eds., 2014); Anne M. Wilkinson, *Advance Directives and Advance Care Planning: The US Experience*, *in* ADVANCE CARE PLANNING IN END OF LIFE CARE 189, 192–93 (Keri Thomas & Ben Lobo eds., 2011); Peter H. Ditto et al., *Imagining the End of Life: On the Psychology of Advance Medical Decision Making*, 29 MOTIVATION & EMOTION 481, 482 (2005); Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211, 213 (2010).

[25] *See* ALA. CODE §§ 22-8A-1 to -17 (West 2019); ALASKA STAT. §§ 13.52.010–395 (West 2019); ARIZ. REV. STAT. ANN. §§ 36-3261–3297 (West 2019); ARK. CODE ANN. §§ 20-6-101 to -117 (West 2019); CAL. PROB. CODE §§ 4600–4806 (West 2019); COLO.

required for wills—writing, signature, witnesses, and notarization.[26] States also created default rules for naming proxies where none had been designated.[27] To facilitate state lawmaking, the National Conference on Uniform State Laws promulgated a Uniform Health Care Decision Act in 1993, providing a template for state laws.[28] On

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REV. STAT. §§ 15-18-101 to -113 (West 2019); CONN. GEN. STAT. §§ 19a-570 to -580i (West 2019); DEL. CODE ANN. tit. 16, §§ 2501–2518 (West 2019); FLA. STAT. ANN. §§ 765.101–404 (West 2019); GA. CODE ANN. §§ 31-32-1 to -14 (West 2019); HAW. REV. STAT. ANN. §§ 327e-1 to -16 (West 2019); IDAHO CODE ANN. §§ 39-4501 to -4515 (West 2019); 755 ILL. COMP. STAT. ANN. 35/1–40/65 (West 2019); IND. CODE ANN. §§ 16-36-4-1 to -6-21 (West 2019); IOWA CODE ANN. §§ 144A.1–A.12 (West 2019); KAN. STAT. ANN. §§ 65-28,101–109 (West 2019); KY. REV. STAT. ANN. §§ 311.621–643 (West 2019); LA. STAT. ANN. §§ 40:1151–40:1151.9 (West 2019); ME. REV. STAT. tit. 18-C, §§ 5-801 to -817 (West 2019); MD. CODE ANN., HEALTH–GEN. §§ 5-601 to -626 (West 2019); MASS. GEN. LAWS ch. 201D, §§ 1–17 (West 2019); MICH. COMP. LAWS ANN. §§ 333.5651–5685 (West 2019); MINN. STAT. ANN. §§ 145b.01–145c.16 (West 2019); MISS. CODE ANN. §§ 41-41-201 to -229 (West 2019); MO. REV. STAT. §§ 190.600–621, 404.800–872, 459.010–055 (West 2019); MONT. CODE ANN. §§ 50-9-101 to -10-107 (West 2019); NEB. REV. STAT. §§ 20-401–416 (West 2019); NEV. REV. STAT. ANN. §§ 449A.400–739 (West 2019); N.H. REV. STAT. ANN. §§ 137-J:1 to 37 (West 2019); N.J. STAT. ANN. §§ 26:2H-53 to -78, 26:2H-102 to -140 (West 2019); N.M. STAT. ANN. §§ 24-7A-1 to -18 (West 2019); N.Y. PUB. HEALTH LAW §§ 2960–2994-u (West 2019); N.C. GEN. STAT. ANN. §§ 32A-15 to -27 (West 2019); N.C. GEN. STAT. ANN. §§ 90-320 to -323 (West 2019); N.C. GEN. STAT. ANN. §§ 130A-465 to -471 (West 2019); N.D. CENT. CODE §§ 23-06.5-01 to -19 (West 2019); OHIO REV. CODE ANN. §§ 2133.01–26 (West 2019); OKLA. STAT. tit. 43A, §§ 11-101 to -113 (West 2019); OKLA. STAT. tit. 63, §§ 3101.1–3118, 3131.1–.14 (West 2019); OR. REV. STAT. § 127.002–.995 (West 2019); 20 PA. CONS. STAT. §§ 5421–5488 (West 2019); R.I. GEN. LAWS §§ 23-4.10-1 to 4.11-15 (West 2019); S.C. CODE ANN. §§ 44-66-10 to -80, 44-77-10 to -78-65 (West 2019); S.C. CODE ANN. §§ 62-5-504 to -518 (West 2019); S.D. CODIFIED LAWS §§ 34-12C-1 to -12D-29, 34-12F-1 to -9 (West 2019); TENN. CODE ANN. §§ 32-11-101 to -113, 68-11-1801 to -1815 (2018); TEX. HEALTH & SAFETY CODE ANN. §§ 166.001–209 (West 2019); UTAH CODE ANN. §§ 75-2a-101 to -125 (West 2019); VT. STAT. ANN. tit. 18, §§ 9700–9731 (West 2019); VA. CODE ANN. §§ 54.1-2981 to -2996 (West 2019); WASH. REV. CODE ANN. §§ 70.122.010–925 (West 2019); W. VA. CODE ANN. §§ 16-30-1 to -25, 16-30C-1 to -16 (West 2019); WIS. STAT. ANN. §§ 154.01–155.80 (West 2019); WYO. STAT. ANN. §§ 35-22-301 to -509 (West 2019).

[26] *See, e.g.*, N.H. REV. STAT. ANN. § 137-J:14 (West 2019) ("The advance directive shall be signed by the principal in the presence of either . . . [t]wo or more subscribing witnesses . . . or [a] notary public . . . .").

[27] *See, e.g.*, ALA. CODE § 22-8A-11 (West 2019) (setting forth a hierarchy of persons eligible to serve as surrogate, along with their rights and responsibilities, when no health care proxy is appointed by principal).

[28] UNIF. HEALTH-CARE DECISIONS ACT (UNIF. LAW COMM'N 1994). Interestingly, this statute would recognize oral as well as written declarations of intention. *See id.* § 2(a). However, only seven states adopted this statute. *See* A. KIMBERLY DAYTON ET AL., ADVISING THE ELDERLY CLIENT § 33:22 (2015). On the

the federal side, Congress passed the Patient Self-Determination Act in 1990, requiring health care institutions accepting Medicare or Medicaid to advise patients of their rights, under state law, to formulate and document their wishes and to record in patients' charts whether they had executed such a document.[29]

Yet even as the law moved to encourage and regulate the production of documents reflecting individuals' choices with respect to end-of-life health care, the medical world quickly came to understand the limits of such documents[30]—which were pointedly renamed "advance directives." Relatively few patients executed advance directives.[31] The documents that were executed were often not known or available to the treating physician at the site of care.[32] They were too vague to provide guidance,[33] they were not seen as applicable in the particular circumstances, and/or they were contradicted by the patient or the patient's proxy.[34] For their part, proxies were reluctant

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statute generally, see Charles P. Sabatino, *The New Uniform Health Care Decisions Act: Paving a Health Care Decisions Superhighway?*, 53 MD. L. REV. 1238 (1994).

[29] Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388–204 (codified as amended at 42 U.S.C. §§ 1395cc, 1396a (1994)). For an overview, see Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997).

[30] *See* Lauren G. Collins et al., *The State of Advance Care Planning: One Decade After SUPPORT*, 23 AM. J. HOSPICE & PALLIATIVE MED. 378, 379 (2006) ("Advance directives were promoted by the Patient Self Determination Act (PSDA) of 1990 as a way to preserve patients' ability to control their own medical care in the event of mental or physical incapacity; however, this promotion of advance directives preceded evidence of their effectiveness.").

[31] *See* Susan P. Shapiro, *Advance Directives: The Elusive Goal of Having the Last Word*, 8 NAELA J. 205, 206 (2012) ("Despite repeated campaigns for decades, coupled with regulations that require all hospitals to offer advance directives to patients upon admission, a substantial majority of Americans have not executed advance directives.").

[32] *See* Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 HASTINGS CTR. REP. 30, 35 (2004).

[33] *See* Shapiro, *supra* note 31, at 216; *see also* Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 J. AM. MED. ASS'N 3288, 3289 (1989) ("[T]he most important operational terms—'no reasonable expectation of . . . recovery,' 'heroic measures,' 'life prolonging procedures,' etc—are open to multiple interpretations on when to act and on what interventions the patient would desire."); Shapiro, *supra* note 31, at 220–21 (describing how the specific directions in the living will might not apply in the patient's particular circumstance, while more general directions ("I do not want to be a vegetable") are too abstract to give guidance about particular decisions about, for example, administering antibiotics or connecting briefly to a ventilator).

[34] *See* Shapiro, *supra* note 31, at 223.

to make decisions, and when they overcame that reluctance, they were shown to be quite unable to assess accurately what the patient wanted.[35]

Advance directives adherents' first approach to solving these problems was to face each obstacle individually. Interventions were designed to, for example, encourage more individuals to execute the necessary documents, to word the documents less vaguely, and to educate health care proxies about their role. However, a large, rigorous study supported by the highly respected Robert Wood Johnson Foundation and published in 1995 showed that these interventions were largely ineffective.[36] Efforts to improve the rate at which patients executed pertinent documents, and to make those documents more useful when they were needed, were unfruitful.[37]

The level of disenchantment with advance directive documents is reflected in the title of an influential article published in 2004, forty-five years after Kutner introduced the living will concept: *Enough: The Failure of the Living Will.*[38] Reviewing the extant literature, the authors wrote:

> What would it take for a regime of living wills to function as their advocates hope? First, people must have living wills. Second, they must decide what

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[35] *See* Peter H. Ditto et al., *Advance Directives as Acts of Communication: A Randomized Controlled Trial*, 161 ARCHIVES INTERNAL MED. 421, 424–25 (2001) (documenting the inaccuracy of proxies' understanding of patients' wishes and the difficulty of improving the accuracy of proxies' judgements); Peter H. Ditto & Nikki A. Hawkins, *Advance Directives and Cancer Decision Making Near the End of Life*, 24 HEALTH PSYCHOL. S63, S67 (2005) (describing errors in surrogates' decision making).

[36] Alfred F. Connors, Jr. et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591, 1591 (1995).

[37] *See* Carl E. Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 439 (2006). Schneider stated:

> Were first-generation living wills laughably vague? Strive for completeness. Were second-generation living wills laughably complex? Solicit statements of "values." Were third-generation living wills laughably opaque? Claim that they provoke conversations with physicians or families. Do physicians fail to talk with patients about care after incompetence? Educate them better. Do physicians fail to respond to education? Educate them some more, yea, unto seven times seventy. At some point, shouldn't repeated failure lead you to ask why your program is not working and whether it can ever work?

Id.

[38] Fagerlin & Schneider, *supra* note 32, at 30.

> treatment they would want if incompetent. Third, they must accurately and lucidly state that preference. Fourth, their living wills must be available to people making decisions for a patient. Fifth, those people must grasp and heed the living will's instructions. These conditions are unmet and largely unmeetable.[39]

In light of the persistent problems posed by the documentary model, medical academics began to see the merit of a process larger than the execution of a single advance directive, the process of "advance care planning" (ACP). Such planning includes the preparation of an advance directive and the naming of a health care proxy decision maker, but these documents are not the central focus of the ACP process.[40] Rather than creating or perfecting a document, medical experts argue that ACP should start and continue a conversation designed to "help people to articulate their values, goals, and preferences, and [to] provide a framework to facilitate discussions with others."[41] Ideally, that conversation will begin when the patient is healthy and mentally sharp, focusing on values. It will perhaps become more focused on medical decisions as the patient ages or otherwise confronts illness.[42] Most significantly, it will continue

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[39] *Id.* at 32.

[40] *See* Arianne Brinkman-Stoppelenburg et al., *The Effects of Advance Care Planning on End-of-Life Care: A Systematic Review*, 28 PALLIATIVE MED. 1000, 1020 (2014) ("Nowadays, ACP is seen as a process of communication between patients and professional caregivers that may include (but is not limited to) the completion of written agreements and advance directives." (citation omitted)); Ana Tuya Fulton & Joan M. Teno, *Advance Care Planning: Focus on Communication and Care Planning Rather than on Building the Perfect Form*, *in* ADVANCE CARE PLANNING: COMMUNICATING ABOUT MATTERS OF LIFE AND DEATH 33, 34 (Leah Rogne & Susana McCune eds., 2013) ("Advance directives . . . should be the product of a larger, more complex process—advance care planning (ACP)—and are one of many communication tools to accomplish this process . . . .").

[41] Douglas K. Martin et al., *Planning for the End of Life*, 356 LANCET 1672, 1673 (2000); *see also* Sabatino, *supra* note 11, at 227 ("The essence of advance care planning is captured by a broader concept of patient-centered care and the quality of communication among the individual, family, and health care providers," which cannot be measured by the existence of an advance directive.).

[42] *See, e.g.*, INST. OF MED., DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE 118 (2015) (describing a life-cycle approach to ACP in which "ideally, . . . discussions would start early in adulthood, addressing global values and the identification of potential surrogate decision makers, and focusing on more specific treatment preferences for older persons and those facing serious illness. With changes in health status, they would take on increasing specificity"); Sabatino, *supra* note 11, at 225 ("Advance care planning is an

through the patient's last days, and if the patient's oral instructions regarding care contradict those in the advance directive, the conversation, not the document, will control.[43] Documents can be a useful part of the process, but they are not the determinative part.[44]

Kutner's original model for advance health care directives—the "living will"—contemplated a finalized intention fixed once and for all in a document. The parallel to property wills is clear. It is perhaps not surprising that a lawyer would propose such a model. It is perhaps equally unsurprising that, over time, the medical community began to move away from the fixed-intention documentary model. Whether or not doctors believed that patients had fixed intentions, they confronted serious practical problems, not to mention litigation risks, in implementing living wills. Today, the medical community sees end-of-life health care decision-making as a conversational process ongoing over time. Even the terminology has shifted—from "living wills" to "advance directives" to "ACP." Living wills may have begun

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iterative process over time to discern the individual's priorities, values, and goals of care and to engage a proxy and others who may participate in the health care decision making process in the future.").

[43] *See, e.g.*, Sabatino, *supra* note 11, at 225.

[44] *See, e.g.*, Karen M. Detering et al., *The Impact of Advance Care Planning on End of Life Care in Elderly Patients: Randomized Control Trial*, 340 BMJ 847, 854 (2010) ("[T]he focus of advance care planning needs to be on improving communication between patients, their families, and doctors. . . . [D]ocumentation alone is unlikely to improve outcomes."); Gary S. Winzelberg et al., *Beyond Autonomy: Diversifying End-of-Life Decision-Making Approaches to Serve Patients and Families*, 53 J. AM. GERIATRICS SOC'Y 1046, 1048 (2005) ("Completing an advance directive should therefore not be considered the criterion standard of advance care planning. Instead, communication that seeks to achieve patients' and families' desired balance between their autonomy and physicians' control over treatment should become the standard."). One document that continues to find favor in the medical community is the Physician Order for Life-Sustaining Treatment, or POLST. The POLST, meant for patients in the last year of expected life, details the patient's choices with respect to five specific medical interventions, incorporates those choices into presently applicable medical orders, and ensures that the orders will follow the patient from home to hospital and back. On the promise of POLSTs, see Sabatino, *supra* note 11, at 228–31; *What is "POLST"?*, NAT'L POLST, https://polst.org/professionals-page/?pro=1 (last visited May 30, 2020). For general treatments of POLSTs in the legal literature, see Keith E. Sonderling, *POLST: A Cure for the Common Advance Directive—It's Just What the Doctor Ordered*, 33 NOVA L. REV. 451, 458–59 (2009); Robert B. Wolf, Marilyn J. Maag & Keith Bradoc Gallant, *The Physician Orders for Life Sustaining Treatment (POLST) Coming Soon to a Health Care Community Near You*, 40 REAL PROP., TR. & EST. L.J. 57 (2014). For critiques, see Stanley A. Terman, *It Isn't Easy Being Pink: Potential Problems with POLST Paradigm Forms*, 36 HAMLINE L. REV. 177, 179 (2013); Robert J. Santoro, Note, *Giving POLST a Pink Slip: Why Connecticut Was Right to Reject the National POLST Paradigm*, 28 QUINN. PROB. L.J. 411, 412 (2015).

as testaments of sorts, but end-of-life health care decisions are no longer thought about in fully testamentary terms.

II. HEALTH CARE DECISIONS AND PROPERTY DECISIONS AT THE END OF LIFE

As the brief history offered in Part I attests, end-of-life health care planning has moved away from the fixed-intention, one document paradigm. Wills law, in contrast, remains wedded to that paradigm. The obvious explanation for the divergence is that end-of-life health care decision-making is just different from end-of-life property decision-making. This Part tests that proposition, examining differences and similarities between end-of-life decision-making in the health care and property contexts. The two contexts are not entirely alike but share enough to make the literature on end-of-life health care decision-making salient for property wills. This Part then goes on to describe the findings of studies in the end-of-life health care context and their troubling implications for wills law.

A. Differences and Similarities

Let us begin with differences:

First, advance directives deal with treatment choices at the end of life, choices that may affect whether a patient lives or dies, or what quality life the patients might have—whether they will be tethered to a machine, whether they will live or die in pain.[45] Wills, in contrast, deal with property. Decisions in the former category seem more consequential than decisions in the latter category, for they affect the patient themselves, whereas the testator will not during their lifetime feel the effects of their testamentary disposition. Arguably, life and death are more important than property and should be dealt with differently.

Second, individuals seeking to control the care they will receive when incompetent confront an almost limitless variety of possibilities of illnesses, health states, and treatment options.[46] Moreover, health

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[45] *See supra* Part I.

[46] *See, e.g.*, Fagerlin & Schneider, *supra* note 32, at 32 (describing how difficult it is "to conjure up preferences for an unspecifiable future confronted with unidentifiable maladies with unpredictable treatments"); Kenneth E. Rosenfeld et al., *End of Life Decision Making: A Qualitative Study of Elderly Individuals*, 15 J. GEN. INTERNAL MED. 620, 620 (2000) ("Patients often lack sufficient knowledge of health states, interventions, and prognoses to make informed treatment choices."); Laura Vearrier, *Failure of the Current Advance Care Planning Paradigm: Advocating for a*

care decision-making is fluid; the effectiveness of one intervention will determine whether another is needed, the patient's level of comfort or discomfort will change from day to day, and experience with a course of treatment will help clarify whether a longer course is worthwhile.[47] By contrast, property owners know what they own, and because property does not take a limitless variety of forms,[48] they can pretty easily imagine what they might own and what they will want to do with what they own in the future. Unlike health states, assets are not subject to frequent change. Thus, it is arguable that, relative to end-of-life health care decision-making, end-of-life property decision-making is uncomplicated and stable.

Third, much of end-of-life health care decision-making is about proxies. If patients were guaranteed to be able to make their own real-time decisions about their health care at the end of life, there would be little need for advance directives. Patients would simply determine in the moment what care they did or did not want and instruct their family and caregivers accordingly. But, at the time treatment is needed, a patient may be unconscious or otherwise mentally incompetent. In these circumstances, others—doctors, members of the patient's family—will have to make decisions for the patient. Ideally, the advance directive dictates who should make those choices in the patient's stead and guides the surrogate in what choices the patient wants. The decisions made by the proxy will affect the patient while he or she is still alive. But wills operate at death, not incompetence, and do not affect the testator. They are not instructions to others about how or what to decide but direct commands from the testator.[49]

Communications-Based Approach, 28 HEC F. 339, 344 (2016) ("Studies have reported that patients have a very poor understanding of [end of life] therapies and terminology, raising ethical concerns regarding the informed decision-making of [advance directives].").

[47] *See* James A. Tulsky, *Beyond Advance Directives: Importance of Communication Skills at the End of Life*, 294 J. AM. MED. ASS'N 359, 361 (2005) (describing how new information affects choices and noting in this light how "[t]ime-limited trials of therapy can be very useful to assess whether particular interventions are effective while defining an end to that treatment if goals are not met").

[48] *See* Thomas W. Merrill & Henry E. Smith, *Optimal Standardization in the Law of Property: The Numerus Clausus Principle*, 110 YALE L.J. 1, 3 (2000).

[49] These differences can be overblown. Consider the argument that more is at stake in health care than in property decisions. It is true that when wills take effect, at death, the testator is no longer able to experience the consequences of his or her earlier decisions, but this seems also to be true of the patient who, after he or she becomes incompetent, will also not experience the consequences of his or her earlier decisions. The reason that decisions about end-of-life health care need to be made *in advance* is because the individual will be incapable of making decisions for themselves

Conceding that these are important differences,[50] there are significant similarities as well. Many people who could benefit from having a will—to arrange custody of minor children, to create an accurate chain of title for a family home—do not have them, just as many patients do not have advance directives.[51] Many people who do

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at the relevant time. Decisions affecting quality of life and death may indeed be more significant than those affecting property but not necessarily to the decision maker.

Or consider the notion that health care decisions are complicated, while property decisions are simple. It is hard to deny the complexity and fluidity of health care decision making. Property decisions do seem to be simpler. It is not clear, however, that they are uncomplicated. Wills are about property, but they are also about death and family and "legacy," the mark that a testator wishes to make after he or she dies or wishes he or she made in life. None of these matters are straightforward. The cases involving attempts to change wills illustrate how, when feelings change, desires about property distributions change as well.

Finally, the literature on advance care planning does indeed focus on proxy decision making, highlighting the importance of designating a proxy and of educating the proxy about the principal's values. Underlying this focus is concern that proxies will not accurately determine what their principals want and thus will make treatment choices different from their principals'. But this concern about "rogue" proxies operates with respect to end-of-life property decision-making as well. It would hardly be consistent with the intent-effectuation policy of trusts and estates law to allow executors or family members to substitute their wishes for those of the testator. This is one reason why wills are required to be in writing.

[50] There are other, less important, differences between advance directives and property wills. For example, advance directives often are not physically available to decision makers at the relevant time because the document is at the patient's home when he or she is at the hospital or is in a hospital chart rather than at the nursing home. *See* Fagerlin & Schneider, *supra* note 32, at 35 (describing these problems). Although occasionally a will may be difficult to find, rarely is the document needed immediately, so there will be time to search for and find it, wherever it might be. Another difference between advance directives and property wills is that, in the case of the former, it is often unclear whether the document is relevant to the situation at hand. An advance directive may, for instance, state that a particular treatment regimen is to be foregone "if my condition is terminal," but physicians may be unsure whether the patient's illness is, in fact, terminal. *See, e.g.*, Emanuel & Emanuel, *supra* note 33, at 3289 ("[T]he most important operational terms—'no reasonable expectation of . . . recovery,' 'heroic measures,' 'life prolonging procedures,' etc—are open to multiple interpretations on when to act and on what interventions the patient would desire."); Joan M. Teno et al., *Role of Written Advance Directives in Decision Making: Insights from Qualitative and Quantitative Data*, 13 J. GEN. INTERNAL MED. 439, 439 (1998) (one reason that advance directives had limited impact is that "patients were not considered hopelessly ill, so the directive was never seen as applicable"). Wills, in contrast, speak at the testator's death, about which there is rarely ambiguity.

[51] *See* ROBERT H. SITKOFF & JESSE DUKEMINIER, WILLS, TRUSTS, AND ESTATES 125 (10th ed. 2017) ("For a parent with a minor child . . . an important reason to make a will is to designate a guardian of the person for the child."); William F. Kehoe, *A Practical Guide to Drafting Massachusetts Wills*, 14 NEW ENG. L. REV. 486, 489 (1979)

have wills, like many who have advance directives, do not understand the document they have signed.[52] Many people whose wills grant powers of appointment to other persons, like many people who name health care proxy decision makers, do not adequately inform the holder of the power of their wishes.[53] Peoples' wills, like their advance directives, may take effect long after the document was executed and may reflect wishes that the testator no longer has.[54] Property or family circumstances, like health status, may change radically over

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(citing appointment of guardian for minor children as reason parents with young children need a will); Palma Joy Strand, *Inheriting Inequality: Wealth, Race, and the Laws of Succession*, 89 OR. L. REV. 453, 491–501 (2010) (discussing how intestacy laws create barriers to obtaining clear title for heirs' property); *2020 Estate Planning and Wills Study*, CARING.COM, https://www.caring.com/caregivers/estate-planning/wills-survey (last visited May 30, 2020) (finding 84% of adults ages 18 to 34, 73% of adults ages 35 to 54, and 52% of adults over age 55 do not have a will); *see also* Kuldeep N. Yadav et al., *Approximately One in Three US Adults Completes Any Type of Advance Directive for End-Of-Life Care*, 36 HEALTH AFF. 1244, 1244 (2017) (finding approximately 37% of American adults have completed an advanced directive, with almost 30% having a living will).

[52] *See* Kent Greenawalt, *A Pluralist Approach to Interpretation: Wills and Contracts*, 42 SAN DIEGO L. REV. 533, 549 (2005) ("[P]eople often may not understand complex provision in their own wills."); Thomas S. Word, Jr., *A Brief for Plain English Wills and Trusts*, 14 U. RICH. L. REV. 471, 471–72 (1980) (arguing to eliminate "legalese" in wills and trust documents to foster better client understanding); *see also* Lesley S. Castillo et al., *Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care*, 154 ANNALS INTERNAL MED. 121, 122–23 (2011) (explaining that almost half of the U.S. population cannot understand the complex legal language of advance directive forms).

[53] *See* Susana Lauraine McCune & Leah Rogne, *Planning for End-of-Life Care: Where Are We and How Did We Get Here?*, *in* ADVANCE CARE PLANNING, *supra* note 40, at 21 ("[P]atients frequently did not discuss their wishes with their proxies, with only 16% to 55% of patients having talked with their proxy about their [end-of-life] concerns."); *see also* Ditto et al., *supra* note 35, at 421 (documenting the inaccuracy of proxies' understanding of patients' wishes and the difficulty of improving the accuracy of proxies' judgements); Vincent Bonazzoli, *The Family Meeting: An Essential Part of the Estate Planning Process*, ESTATEPLANNING.COM (Jan. 20, 2010), https://www.estateplanning.com/Communicating-Your-Estate-plan-to-the-Family/ ("Many clients do have a conversation with the [fiduciary] which usually includes a humble request to act as [fiduciary] and an honored response by the [fiduciary] of their willingness to help in any way. This is typically the extent of their conversations. The estate plan and the individual fiduciary's role are rarely discussed or revisited until after the death of the client.").

[54] *See* Mark Glover, *The Timing of Testation*, 107 KY. L.J. 221, 221 (2018); Adam J. Hirsch, *Text and Time: A Theory of Testamentary Obsolescence*, 86 WASH. U. L. REV. 609, 609 (2009).

time, such that the previously executed document is out of date when it takes effect.

More fundamentally, advance health care directives, like property wills, are pre-commitments, attempts in the present to bind the future. Among the reasons that the medical community moved away from the fixed-intention documentary model is that it recognized that there are serious issues with pre-commitment in the end-of-life health care decision-making context. Many of these issues arise also in the context of end-of-life property decision-making and have important implications for wills law.

The remainder of this Part describes findings from the health care literature and the implications of those findings for wills law. The literature on end-of-life health care decision-making raises important questions about intentions at the end of life that are worth considering in the end-of-life property planning context.

B. Do People Want to Plan for the End of Life?

In the United States and western Europe, people now routinely live longer than was historically the case.[55] Longer life spans raise the discomforting possibility that a person might lose mental capacity prior to the time that end-of-life health care decisions need to be made. At the same time, advances in medical technologies can prolong life in ways never previously imaginable, and if one lacks capacity to decline medical interventions an unrewarding life might be extended indefinitely. Advance directives seem a fitting solution to these problems, for they allow individuals, while competent, to make decisions about what can and should be done if they are later incompetent or if illness otherwise renders them unable to decide for themselves. Thus, advance directives allow patients to control in the present what they may be unable to control in the future.[56]

Kutner and the early adherents of advance directives clearly believed that individuals would want this control. It thus came as something of a surprise that, even after the enactment of state and

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[55] *See* CTR. FOR DISEASE CONTROL, TREND TABLES, UNITED STATES 1–3 (2017), https://www.cdc.gov/nchs/data/hus/2017/015.pdf; *Life Expectancy at Birth, Total (Years) – European Union*, WORLD BANK, https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=EU (last visited May 30, 2020).

[56] On the connection between chronic illness, medical technology, and advance directives, see generally ANNE WILKINSON ET AL., LITERATURE REVIEW ON ADVANCE DIRECTIVES (2007), https://aspe.hhs.gov/system/files/pdf/75141/advdirlr.pdf.

federal statutes specifically authorizing advance directives, a relatively low percentage of individuals executed these instruments.[57]

Low execution rates may have been caused in part by the legal requirements set forth in the authorizing statutes themselves. Conceptualizing advance directives as health care wills, legislators commonly imposed on advance directives many of the formal requirements familiar to property wills—writing, witnesses, and so forth.[58] However functional such formal requirements may be for end-of-life property decision-making,[59] in the context of end-of-life health care decision-making, they have a number of disadvantages. Signatures and notarization requirements are "barrier[s] to completion, keeping people from documenting even the most basic plans."[60] Moreover, the "legal model diverts important health care planning from doctors' offices to lawyers' offices," where patients are less likely to receive pertinent information or have their wishes recorded in electronic health records.[61] "Legalization" of advance directives presents particular problems for individuals with few economic resources, who may not be able to afford lawyers, and for individuals with less literacy or proficiency in English, who may struggle to understand the language in which advance directives are typically written.[62]

Additional resources—money, time, information, and effort—might solve these problems. A major study conducted in the mid-1990s attempted this solution, studying whether, *inter alia*, targeted interventions by trained medical personnel conducted for the specific

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[57] *See* Linda L. Emanuel, *Advance Directives and Advancing Age*, 52 J. AM. GERIATRICS SOC'Y 641, 641 (2004) ("[W]hen [Kutner] first proposed the notion of a 'living will'. . . . The idea of planning ahead for medical decisions . . . must have seemed a solid one," but he did not foresee how the idea would be challenged.).

[58] *See supra* note 26 and accompanying text.

[59] *See* Ashbel G. Gulliver & Catherine J. Tilson, *Classification of Gratuitous Transfers*, 51 YALE L.J. 1, 5–6 (1941) (discussing how will formalities protect testators' intentions by providing safeguards to ensure evidence of testamentary intent is reliable and permanent when testator is unavailable to testify). *But see* Jane B. Baron, *Gifts, Bargains, and Form*, 64 IND. L.J. 155, 157 (1989) (questioning this rationale for formality).

[60] Joshua A. Rolnick et al., *Delegalizing Advance Directives — Facilitating Advance Care Planning*, 376 NEW ENG. J. MED. 2105, 2106 (2017); *see also* Castillo et al., *supra* note 52, at 122 (enumerating legal obstacles to completion); Bernard Lo & Robert Steinbrook, *Resuscitating Advance Directives*, 164 ARCHIVES INTERNAL MED. 1501, 1501 (2004) ("Many legal requirements and restrictions concerning advance directives are counterproductive.").

[61] Rolnick et al., *supra* note 60, at 2106.

[62] *See* Castillo et al., *supra* note 52, at 122–23.

purpose of facilitating conversations about, and execution of, advance directives would increase the rate at which patients would create these documents.[63] The results were disappointing; the interventions were found to be "completely ineffectual."[64] Time has not solved the problem. Execution rates to this day remain quite low.[65]

Other studies suggest that low execution rates may be less a function of resources than of inclinations. The patients in these studies did not want "the standard approach to advance care planning whereby healthy individuals record their preferences for specific life-sustaining treatments in writing."[66] Patients instead "expressed a desire to convey [their wishes] verbally to designated decision makers."[67] Nor did patients want to provide specific, precise instructions of the sort that might be most helpful to medical personnel.[68] Even people with "positive attitudes about advance directives in general . . . do not seem to desire the kind of specific control over end-of-life care implied in the stereotypical image of the individual completing a detailed living will[,]"[69] and they have "little desire to micromanage their own end-of-life medical treatment."[70] Many patients prefer to express general wishes, values, or goals,[71] and to express these in a conversation rather than a document.[72]

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[63] Connors, Jr. et al., *supra* note 36, at 1592. The study also showed that even those who did create advance directives did not want them followed at the relevant time. *Id.* at 1594.

[64] *Id.* at 1596.

[65] *See supra* notes 31, 51 and accompanying text. *But see* Maria J. Silveira et al., *Advance Directives and Outcomes of Surrogate Decision Making Before Death*, 362 NEW ENG. J. MED. 1211, 1217 (2010) (reporting an increase in use of advance directives since the SUPPORT study was first issued).

[66] Nikki Ayers Hawkins et al., Micromanaging Death: Process Preferences, Values, and Goals in End-of-Life Medical Decision Making, 45 GERONTOLOGIST 107, 113 (2005).

[67] *Id.*

[68] *Id.*

[69] Peter H. Ditto & Nikki A. Hawkins, *Advance Directives and Cancer Decision Making Near the End of Life*, 24 HEALTH PSYCHOL. 63, 65 (Supp. 2005).

[70] Peter H. Ditto et al., *Imagining the End of Life: On the Psychology of Advance Medical Decision Making*, 29 MOTIVATION & EMOTION 481, 498 (2005); *see also* Winzelberg et al., *supra* note 44, at 1047 (providing that "[s]ome individuals think in terms of care goals," such as avoiding pain, "rather than [in terms of] individual treatments").

[71] Ditto et al., *supra* note 70, at 498 (encouraging documentation of "'process preferences,' such as how much leeway people want surrogate decision makers to have and the general values people want to guide decisions about their end-of-life care").

[72] *See* Hawkins et al., *supra* note 66, at 113 (noting that "patients consistently appear to place a high priority on communicating their preferences verbally"). This

Even those who do overcome the procedural and emotional obstacles to executing an advance directive may not actually want the instructions in that document to be given effect. In one study, a third of the patients wanted their physician or surrogate to have "complete leeway" to override their advance directive.[73] Moreover, "over half the subjects would allow very specific advance directives to be overridden."[74] Thus, even those who create documents may not want the instructions in the instrument to be given effect automatically.[75]

As with advance directives, the percentage of Americans who have executed wills is quite low.[76] The formal requirements for will execution operate in the property context as they do in the health care context, as a barrier to will creation.[77] Some estate planning scholars

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preference has played a significant role in calls for reducing emphasis on the completion of advance directives and increasing attention to a larger and broader process of advance care planning. *See* Castillo et al., *supra* note 52, at 125; Fagerlin & Schneider, *supra* note 32, at 31; Rebecca L. Sudore & Terri R. Fried, *Redefining the "Planning" in Advance Care Planning: Preparing for End-of-Life Decision Making*, 153 ANNALS INTERNAL MED. 256, 257–58 (2010); Vearrier, *supra* note 46, at 348–49.

[73] Ashwini Sehgal et al., *How Strictly Do Dialysis Patients Want Their Advance Directives Followed?*, 267 JAMA 59, 61 (1992).

[74] *Id.* at 62; *see also* Hawkins et al., *supra* note 66, at 113 (observing that "91% of our sample desired that surrogate decision makers be allowed at least some leeway to override their written directives if the surrogates believed it would be best").

[75] *See, e.g.*, Silveira et al., *supra* note 65, at 1217 ("Surrogates frequently override previously stated preferences . . . and data indicate that patients want it that way." (citation omitted)).

[76] Yadav et al., *supra* note 51, at 1247 (finding approximately 37% of American adults have completed an advanced directive, with almost 30% having a living will); *2020 Estate Planning and Wills Study*, *supra* note 51 (finding less than 32% of American adults have an estate planning document).

[77] *See* Langbein, *supra* note 9, at 3–4 (illustrating how strict compliance with Wills Act formalities commonly frustrates decedents' intent (citing *In re* Groffman [1969] 1 W.L.R. 733, 739–40 (Eng.) (admitting that invalidating will for testator's failure to sign or acknowledge in the presence of two witnesses frustrated decedent's intent))); *see also* Bruce H. Mann, *Formalities and Formalism in the Uniform Probate Code*, 142 U. PA. L. REV. 1033, 1036 (1994) ("Courts have routinely invalidated wills for minor defects in form even in uncontested cases and sometimes even while conceding—always ruefully, of course—that the document clearly represents the wishes and intent of the testator.").

The barrier is lower in states recognizing holographic wills, which are easier for testators to write themselves and have no witness attestation requirement. Around half of the U.S. states currently permit some form of holographic will. *See* Reed Kress Weisbord & David Horton, *Inheritance Forgery*, 69 DUKE L.J. 855, 867 (2020). Of those states that recognize holographic wills, ten require the will be "entirely" or "wholly" in the testator's handwriting. *See* ARK. CODE ANN. § 28-25-104 (West 2019); KY. REV. STAT. ANN. § 394.040 (West 2019); LA. CODE CIV. PROC. ANN. art. 2883 (West 2019);

regard these barriers as a feature rather than a bug insofar as they channel testators to attorneys, who are more likely to record testamentary wishes accurately in words well understood in the law and to ensure that the proper execution procedures are followed.[78] Yet many individuals do not know an attorney or believe they can afford one. And even testators advised by attorneys may not fully comprehend the legal language putatively expressing their wishes and thus may not be able to evaluate the accuracy of the documents they have executed.[79] Thus, the specific requirements for will execution and the customary language of wills alike may discourage individuals from making wills.

More troubling for wills law is the possibility that individuals might not want to leave the detailed instructions with respect to their property that would be most helpful after death. This possibility is not much discussed in academic literature on wills law, which focuses largely on the potential of various rules to carry out (or frustrate) actual or imputed intent.[80] The very purpose of wills law, this

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MISS. CODE ANN. § 91-5-1 (West 2019); N.C. GEN. STAT. § 31-3.4 (West 2019); OKLA. STAT. tit. 84, § 54 (West 2019); TEX. EST. CODE ANN. § 251.052 (West 2019); VA. CODE ANN. § 64.2-403 (West 2019); W. VA. CODE ANN. § 41-1-3 (West 2019); WYO. STAT. ANN. § 2-6-113 (West 2019). Six states require the testator's signature and "the material provisions" of the will to be in the testator's handwriting. *See* ARIZ. REV. STAT. ANN. § 14-2503 (West 2019); CAL. PROB. CODE § 6111 (West 2019); IDAHO CODE § 15-2-503 (West 2019); NEB. REV. STAT. ANN. § 30-2328 (West 2019); NEV. REV. STAT. ANN. § 133.090 (West 2019); TENN. CODE ANN. § 32-1-105 (2018). Ten states require the testator's signature and "the material portions" of the will to be in the testator's handwriting. *See* ALASKA STAT. § 13.12.502(b) (West 2019); COLO. REV. STAT. § 15-11-502(2) (West 2019); HAW. REV. STAT. ANN. § 560:2-502(b) (West 2019); ME. REV. STAT. ANN. tit. 18-C, § 2-502 (West 2019); MICH. COMP. LAWS ANN. § 700.2502(2) (West 2019); MONT. CODE ANN. § 72-2-522 (West 2019); N.J. STAT. ANN. § 3B:3-2(b) (West 2019); N.D. CENT. CODE § 30.1-08-02(2) (West 2019); S.D. CODIFIED LAWS § 29A-2-502(a) (West 2019); UTAH CODE ANN. § 75-2-502(2) (West 2019). Finally, Pennsylvania only requires the testator's signature to be handwritten; any will in writing and subscribed by the testator is valid without requiring witnesses' attestation. *See* 20 PA. STAT. AND CONS. STAT. ANN. § 2502 (West 2019). Despite relieving the testator of one formality—attesting witnesses—these various statutory requirements still pose barriers to effectiveness. *See* SITKOFF & DUKEMINIER, *supra* note 51, at 208–10 (describing how three generations of statutory holographic will requirements each attempted to reduce barriers to validity).

[78] *See* JUSTICE, INT'L COMM'N OF JURISTS, A REPORT BY JUSTICE: HOME-MADE WILLS 4–5 (1971), https://justice.org.uk/wp-content/uploads/2015/01/HomeMadeWills.pdf.

[79] *See* Jane B. Baron, *Intention, Interpretation, and Stories*, 42 DUKE L.J. 630, 633 (1992) (describing a testator's inability to understand the terms of his or her own will).

[80] *Compare* David Horton, *Tomorrow's Inheritance: The Frontiers of Estate Planning Formalism*, 58 B.C. L. REV. 539, 545 (2017) (listing Gulliver, Tilson, and

scholarship argues, is to effectuate the wishes of testators with respect to the disposition of property at death.[81] The assumption is that testators have such wishes. Even discussions of default rules in wills law—for example, intestacy or anti-lapse rules—focus on those rules' alignment with actual or imputed intent.[82]

But what if individuals simply do not want to make choices about, for example, who should receive which items of property or who should inherit if a named beneficiary predeceases the donor? Wills law tends to treat such individuals as unusual (the "ordinary" person will want to decide) and also somewhat irresponsible ("sensible" people will make plans). The literature on end-of-life health care decision-making suggests that the group of individuals for whom conventional wills law is inapposite may be larger than has previously been understood. It similarly suggests that their failure to make wills is not a function of irresponsibility, but of more complex emotions.[83] End-of-life property decisions require people to "confront[] death, property and family in one simultaneous act."[84] As in the case of end-of-life health care, it is not entirely surprising that when faced with these potent forces, many individuals will not actually want to make final decisions.

Fuller as authors who argue that strict compliance with wills formalities provides "concrete proof of the testator's wishes"), *with id.* at 546 (collecting authors who argue that requiring strict compliance with wills formalities frustrates decedents' intent).

[81] *See* Robert H. Sitkoff, *Trusts and Estates: Implementing Freedom of Disposition*, 58 ST. LOUIS U. L.J. 643, 644 (2014) ("[T]he American law of succession facilitates . . . the carrying out of the decedent's intent. Most of the law of succession is concerned with enabling posthumous enforcement of the actual intent of the decedent or, failing this, giving effect to the decedent's probable intent." (citation omitted)); *see also* Daniel B. Kelly, *Restricting Testamentary Freedom: Ex Ante Versus Ex Post Justifications*, 82 FORDHAM L. REV. 1125, 1133 (2013) ("[T]he 'organizing principle' of American succession law is . . . *testamentary freedom*." (emphasis added) (citation omitted)).

[82] *See* Sitkoff, *supra* note 81, at 645–46 (stating that "the primary objective in designing an intestacy statute is to carry out the probable intent of the typical intestate decedent" and "[i]n light of evolving family and family-like relationships, to track the probable intent of the typical intestate decedent, the law of intestacy must likewise evolve"); *see also* Courtney Chaipel Pugh, *The Modern Family: Why the Florida Legislature Should Remodel Its Antilapse Statute for Wills to Reflect the Changing Familial Structure*, 46 STETSON L. REV. 659, 673 (2017) ("Antilapse statutes were created to further the alleged societal presumption that a donor would prefer a gift to fall to a beneficiary's descendants rather than passing by intestate succession." (citation omitted)).

[83] *See supra* notes 66–72 and accompanying text.

[84] Baron, *supra* note 5, at 66–67.

Rules designed to carry out intentions that individuals do not care to formulate seem irrelevant at best and contradictory at worst. Intent-effectuating rules are irrelevant for such individuals, for by hypothesis they have formed no intent that the law can carry out. Wills law tacitly assumes that, in most cases, individuals do have intentions that their testamentary documents express. But the findings of studies of end-of-life health care decision-making unsettle this assumption.

C. Preference Problems

The paradigm of end-of-life health care and property planning alike is simple. Individuals have wishes—preferences—about the medical care they would like to receive (or not receive) in foreseeable circumstances, just as they have wishes about the distribution of their property at death. These preferences can and should be recorded in advance directives or in wills. At the relevant time, decision makers can consult the document to ascertain its author's preferences and then carry out those preferences. Scholarship on end-of-life health care raises questions about the preferences on which this paradigm relies.

1. Are Preferences Stable?

Empirical examination of patients' preferences about health care at the end of life shows that people often change their minds about the care they want.[85] One study found that "treatment preferences elicited during recovery from an important, but not life-threatening, illness were different from those stated both prior to and months after hospitalization."[86] Another study found that, among older patients with serious disease, "the acceptability of functional disability increased with time, whereas the acceptability of severe cognitive

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[85] *See, e.g.*, Jennifer Hopping-Winn et al., *The Progression of End-of-Life Wishes and Concordance with End-of-Life Care*, 21 J. PALLIATIVE MED. 541, 541 (2018) ("[W]e found care preferences often changed over time; ~20% of patients revised their end-of-life preferences after having the facilitated conversation, with most of those patients opting for less intensive care. Most changes to preferences were made verbally in the final setting of care.").

[86] Peter H. Ditto et al., *Context Changes Choices: A Prospective Study of the Effects of Hospitalization on Life-Sustaining Treatment Preferences*, 26 MED. DECISION MAKING 313, 319 (2006).

impairment decreased."[87] The changes were often unpredictable and not simply adaptive to diminishing health status.[88] The "inconsistency in preferences over time"[89] poses clear issues: "[w]hen faced with essentially a 50-50 chance that decisions expressed at any given time will change with changes in an individual's health condition, the task of divining a patient's 'true' end-of-life wishes becomes difficult."[90]

People's preferences about property may be similarly unstable. Case law is replete with instances in which individuals attempt to revise or amend their wills in response to changes in their own health or the health of others,[91] or in response to changes in their own or others' financial circumstances,[92] or in response to changes in their relationships with spouses, children, or other relatives.[93] In many

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[87] Terri R. Fried et al., *Prospective Study of Health Status Preferences and Changes in Preferences Over Time in Older Adults*, 166 ARCHIVES INTERNAL MED. 890, 893 (2006).

[88] *See* Terri R. Fried et al., *Inconsistency over Time in the Preferences of Older Persons with Advanced Illness for Life-Sustaining Treatment*, 55 J. AM. GERIATRIC SOC'Y 1007, 1007 (2007); *see also* Ditto et al., *supra* note 86, at 319 (noting that initial preference changes were "temporary" and "fleeting").

[89] Fried et al., *supra* note 88, at 1010. *But see* Matthijs P. S. van Wijmen et al., *Stability of End-of-Life Preferences in Relation to Health Status and Life-Events: A Cohort Study with a 6-Year Follow-Up Among Holders of an Advance Directive*, 13 PLOS ONE, Dec. 2018, at 1, 2, https://doi.org/10.1371/journal.pone.0209315 (documenting stability of preferences and concluding that "[o]ur results largely dispute criticism concerning usability of advance directives due to lack of stability of preferences").

[90] Ditto et al., *supra* note 86, at 320; *see also* Joseph J. Gallo et al., *Advance Directives, Medical Conditions, and Preferences for End-of-Life Care Among Physicians: 12-Year Follow-Up of the Johns Hopkins Precursors Study*, 57 J. PAIN & SYMPTOM MGMT. 556, 562 (2019) ("[A]mong participants with an advance directive, 20% of the persons who preferred the least aggressive treatment changed over time. This challenges the practice of not incorporating end-of-life preference conversations if an advanced directive is already documented.").

[91] *See, e.g.*, Weedon v. Weedon, 720 S.E.2d 552, 554–55 (Va. 2012) (observing that a testatrix, mother of five children, revised her will before cancer surgery to devise entire estate to caregiver daughter); Pope v. Curry (*In re* Estate of Curry), 988 P.2d 505, 506 (Wash. Ct. App. 1999) (observing that a testatrix originally disinherited one child in will, then revised will after cancer diagnosis to provide for all children equally).

[92] *See, e.g.*, Schultz v. Schultz (*In re* Estate of Schultz), No. 2007AP2940, 2008 WL 2574484, at *1 (July 1, 2008) (observing that the testator attempted to execute a new will in favor of testator's children, but violated post-nuptial agreement, after wife won a casino jackpot).

[93] *See, e.g.*, Gularte v. Pradia (*In re* Estate of Stoker), 122 Cal. Rptr. 3d 529, 532 (Ct. App. 2011) (testator attempted to revoke testamentary gift to former girlfriend); Irving v. Divito, 807 S.E.2d 741, 742–43 (Va. 2017) (testator executed valid will leaving

instances, it is unclear that the later-expressed preferences are more accurate or durable than those expressed earlier. Many of the thornier will execution problems arise where the change is made with less formality than the earlier will—for example, a holographic notation on a typed will—raising issues about whether the testator had come to a new conclusion or whether instead the testator is considering a change that will be formalized later.[94] Other cases involve oral statements inconsistent with those expressed in a formal will.[95] Without further research, it is difficult to determine how typical these cases might be. There is, however, no reason to believe they are entirely unrepresentative. These cases—and who knows how many others of oral deathbed declarations that never reached the courts—raise serious concerns about the stability of preferences recorded in formal testamentary documents.

2. Can Future Preferences Accurately Be Predicted?

Scholars seeking to explain preference instability in the health care context turned to the literature on "affective forecasting," which examines psychological impediments to individuals accurately predicting in the present what they will want in the future.[96] They may, for example, underestimate how well they will adapt to future disability, which would affect their assessment of physical states they will find tolerable or intolerable.[97] Or individuals might overestimate

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part of estate to his children but subsequently made notation on estate documents that he wished to disinherit one child after his marriage to that child's mother ended).

[94] *See* Sola v. Sola (*In re* Estate of Sola), 275 Cal. Rptr. 98, 100–03 (Ct. App. 1990) (determining whether various handwritten notations and interlineations were effective as either a holographic will or a revocation of the formally executed will); *In re* Estate of Kuralt, 15 P.3d 931, 934 (Mont. 2000) (interpreting whether a letter amended testator's will).

[95] *See, e.g.*, Ryan v. Ryan, 642 N.E.2d 1028, 1030–32 (Mass. 1994) (testator's oral promise to former wife to leave two-thirds of estate to their children did not invalidate will provisions that favored testator's second wife).

[96] For an overview, see George Loewenstein & David Schkade, *Wouldn't It Be Nice? Predicting Future Feelings*, *in* WELL-BEING: THE FOUNDATIONS OF HEDONIC PSYCHOLOGY 85 (Daniel Kahneman et al. eds., 1999); Timothy D. Wilson & Daniel T. Gilbert, *Affective Forecasting*, *in* 35 ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY 345, 353 (2003).

[97] For a discussion on adaptive preferences, see generally Daniel T. Gilbert et al., *Immune Neglect: A Source of Durability Bias in Affective Forecasting*, 75 J. PERSONALITY & SOC. PSYCHOL. 617 (1998); Jason Riis et al., *Ignorance of Hedonic Adaptation to Hemodialysis: A Study Using Ecological Momentary Assessment*, 134 J. EXPERIMENTAL PSYCHOL. 3 (2005).

the impact that specific future events will have on them, leading them to misjudge how interested they will actually be in various treatment options at the time they face those choices.[98] This "impact bias"[99] may result in part from people's tendency, when predicting their reactions to future events, to "overweight the event itself . . . and neglect the fact that many other factors beside the event contribute to a person's happiness."[100] Or it may result from people "'project[ing]' their current preferences onto future situations where they may not apply."[101] "Projection bias"[102] is especially problematic "when there is a mismatch between the individual's current state and the state to which s/he is predicting. Thus, people in a 'cool,' unemotional state may have difficulty predicting how they would feel or behave were they in a 'hot,' more emotional state and vice versa."[103]

"[C]ompletion of advance directives typically involves individuals predicting what their treatment preferences will be in states quite different from the one they are in when they make their predictions."[104] A healthy individual making a living will must guess what he or she might want when he or she is ill and experiencing pain, fatigue, anxiety, or depression.[105] A person executing a living will at

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[98] *See, e.g.*, Ditto et al., *supra* note 70, at 490 ("[P]eople often predict that events will have a more intense and longer lasting effect on them than they actually do when experienced." (citations omitted)).

[99] On "impact bias" generally, see Daniel T. Gilbert et al., *The Trouble with Vronsky: Impact Bias in the Forecasting of Future Affective States*, *in* THE WISDOM IN FEELING: PSYCHOLOGICAL PROCESSES IN EMOTIONAL INTELLIGENCE 114, 116–17 (Lisa Feldman Barrett & Peter Salovey eds., 2002); Wilson & Gilbert, *supra* note 96, at 351.

[100] Ditto et al., *supra* note 70, at 490. On the problem of "focalism," see Timothy D. Wilson et al., *Focalism: A Source of Durability Bias in Affective Forecasting*, 78 J. PERSONALITY & SOC. PSYCHOL. 821, 822 (2000).

[101] Ditto et al., *supra* note 70, at 491 (citations omitted).

[102] For a discussion of projection bias, see generally George Loewenstein & Erik Angner, *Predicting and Indulging Changing Preferences*, *in* TIME AND DECISION: ECONOMIC AND PSYCHOLOGICAL PERSPECTIVES OF INTERTEMPORAL CHOICE 351, 372–76 (George Loewenstein et al. eds., 2003).

[103] Ditto et al., *supra* note 70, at 491; *see also* Loewenstein & Angner, *supra* note 102, at 372 ("People behave as if their future preferences will be more like their current preferences than they actually will be—as if they project their current preferences onto their future selves."). *See generally* George Loewenstein, *Hot-Cold Empathy Gaps and Medical Decision Making*, 24 HEALTH PSYCHOL. 49 (Supp. 2005) (discussing the consequences of hot and cold empathy gaps on medical decision making).

[104] Ditto et al., *supra* note 70, at 491.

[105] *See id.* In considering whether patient preferences should be honored, Loewenstein and Angner considered the following:

the emotionally intense time when he or she is first encountering a serious illness might misjudge how he or she will feel after he or she has had time to adjust to that illness or approaching death.[106] "To the extent that people are insensitive to how such changes in decision context can affect their preferences for life-sustaining medical treatment, the assumption of prospective insight underlying living wills is severely challenged."[107]

This research has clear implications for end-of-life property decision-making. Individuals' present preferences about property distribution may, but may not, be the ones they have closer to the time of death. They may, for example, make a will in a cool, detached state in which they imagine having children or grandchildren; they might have different, "hotter" preferences later, when they have descendants with whom they do or do not bond emotionally. Or they may make or revise a will in a hot moment of anger or affection—a will they might think twice about later when feelings have cooled.[108]

Of course, wills and advance directives can be changed in response to these changes in preferences. And yet evidence shows that, like the instructions in advance directives, wills are frequently stale.[109] Many factors might explain individuals' failure to revise their end-of-life

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> What if someone when healthy expresses a desire to precommit to not receiving heroic measures? If such a desire reflects a correct perception that powerful emotions evoked by sickness will distort his or her decision making, then perhaps we should allow the individual to precommit. Yet what if this is simply a hot-cold empathy gap—a failure of someone in a cold state who can be cavalier toward the prospect of death because he or she is not facing it—to empathize with the true preferences the person will have once he or she becomes sick?

Loewenstein & Agner, *supra* note 102, at 382.

[106] *See* Ditto et al., *supra* note 70, at 491–92.

[107] *Id.* at 492; *see also* Ditto et al., *supra* note 86, at 321 ("If treatment preferences made by healthy individuals cannot be taken as accurate representations of the treatment choices those individuals would make in actual end-of-life scenarios, then the value of documenting life-sustaining treatment preferences in instructional advance directives is suspect."); Dresser, *supra* note 16, at 1840 ("If an advance directive contains uninformed choices or fails to communicate the individual's actual treatment preferences, the directive lacks the moral weight of an autonomous choice." (citation omitted)).

[108] *See, e.g.*, Gularte v. Pradia (*In re* Estate of Stoker), 122 Cal. Rptr. 3d 529, 532 (Ct. App. 2011) (observing an attempted change in testamentary disposition made in throes of anger); *In re* Estate of Kuralt, 981 P.2d 771, 774 (Mont. 1999) (observing an attempted change in testamentary disposition made when testator was hospitalized for serious, but undiagnosed, illness).

[109] *See* Glover, *supra* note 54, at 243; Hirsch, *supra* note 54, at 611.

health care or property planning, including simple reluctance to repeat a difficult process.[110] But another reason may be that people are unaware of their own changes in preferences and thus do not perceive a need to revise their documents.[111]

3. Which Preferences Are Preferable?

The potential mismatch between individuals' predictions of their end-of-life preferences and their preferences at the end of life is troubling if it is assumed that the later-developed preferences are the "true(r)" preferences. If they are, then reliance on documents executed earlier in time will not carry out individuals' "actual" preferences at the end of life. The view that the later-developed preferences should carry more weight than those developed earlier is based on the belief that, as events unfold, individuals "have available to them relevant information that was not available at the time advanced decisions were made."[112]

But "experience not only brings with it information, but also stress, emotion, and the potential for bias and suboptimal decision making."[113] In other words, the gaps described above between decisions made in "hot" as opposed to "cold" states raise questions about the desirability of relying on decisions made at emotionally intense times.[114] Perhaps, then, it is reasonable to trust the documents made by individuals in advance, in cooler states of mind.[115]

However, some scholars are quite skeptical about the pertinence of preferences expressed in advance. Bioethicist Rebecca Dresser has argued that fidelity to instructions in advance directives reflects the "dubious notion that what was vitally important to incompetent patients when they were competent remains vitally important to them in their incompetent states."[116] This notion is, she argues, unfounded:

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[110] *See* Baron, *supra* note 5, at 66–67.

[111] *See* Dresser, *supra* note 17, at 1835; *see also* Ditto et al., *supra* note 70, at 487 (surveying literature suggesting that people are often unaware of changes in their life-sustaining treatment preferences).

[112] Ditto et al., *supra* note 70, at 497.

[113] *Id.*

[114] *Id.* Concerns such as these underlie the view of the property wills as a "safe harbor," providing testators assurance that their expressed wishes will be respected. On the safe harbor function of wills, see *infra* text accompanying note 149.

[115] *See id.* ("[I]t might be argued that there is no a priori reason to favor contemporaneous over advanced decision making.").

[116] Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 389 (1986).

"Incompetent patients are incapable of appreciating the values and preferences they once held dear."[117] Indeed, "[t]hey have lost the goals and preferences they once espoused."[118] Not only may it be inaccurate to say that earlier expressed preferences apply after incompetency, it may be dangerous, for it would permit treatment decisions that fail to serve incompetent patients' present welfare.[119] Under the guise of following what are actually indeterminate advance directives, doctors and families may invisibly make treatment decisions based not on the patient's best interest, but on inappropriate considerations of economic or social worth.[120]

The potential mistreatment of incompetent persons is less significant in the property context, as a will becomes effective only upon a testator's death and thus has little direct effect on the testator.

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[117] *Id.*

[118] *Id.* Dresser argues, following Derek Parfit, that incompetent persons are not the same individuals as their competent selves. *Id.* at 380. Discussion of this issue is well beyond the scope of this Article. For passionate responses to Dresser's argument, see Norman L. Cantor, *Prospective Autonomy: On the Limits of Shaping One's Postcompetence Medical Fate*, 8 J. CONTEMP. HEALTH L. & POL'Y 13, 31–32 (1992); Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845, 854–58 (1990).

[119] Dresser, *supra* note 116, at 389; *id.* at 390 ("By cloaking treatment choices with such honored labels as self-determination, privacy, dignity, and bodily integrity, the existing treatment standards allow incompetent patients' genuine interests to be quietly and conveniently subordinated to the interests of others." (citations omitted)); *see* Dresser, *supra* note 17, at 1840 ("In sum, the ethical and legal responsibilities to protect an incompetent patient ought not be suspended because that person once requested an intervention that would now be inhumane or refused an intervention that now offers clear benefit. If a patient can no longer appreciate the values that motivated the precommitment choice, treatment decisions should take into account what now matters to the patient."); *see also* Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 633 (1994) ("If heeding a patient's former instructions would harm her in her current state, why must others act as her autonomy automatons?"); David Shaw, *A Direct Advance on Advance Directives*, 26 BIOETHICS 267, 269–72 (2012) (questioning whether following demented patients' advance directives truly serves those patients' autonomous interests).

[120] Dresser argues:

> It is legitimate to worry that physicians and relatives will underrate the benefits that life with dementia and other disabling conditions holds for the patients themselves. But it is wrong to think that the current emphasis on advance directives minimizes such threats. Instead, the scarcity of directives and the deficiencies of the directives that exist leave patients exposed to the same risks. And because decisions based on advance directives and substituted judgment are portrayed as choices coming from the patients themselves, social worth and economic considerations affecting those decisions may go undetected.

Dresser, *supra* note 17, at 1843.

And yet the question of which preferences matter—ones developed early in life or those developed later—is a serious one for wills law. In the property context, it is assumed that the intentions developed earlier in time and expressed in formal documents should prevail over later-developed intentions that are not formally expressed.[121] Yet among those who study advance directives, there is significant disagreement about whether earlier-in-time preferences should be given priority at the end of life.

D. Is Autonomy Realistic?

As noted earlier,[122] autonomy is central to thinking about advance directives for health care. Kutner's idea for the living will was based on the view that each individual should be able to determine for himself or herself what treatment he or she will or will not receive when no longer able to speak for himself or herself, [123] and many contemporary scholars agree.[124] Property wills are similarly rooted in autonomy; Anglo-American trusts and estates law gives the testator the power to decide for himself or herself what will happen to his or her assets at death.[125]

The autonomy furthered by advance directives and wills is that of individuals making their own decisions.[126] But studies of end-of-life

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[121] For a discussion on the formal requirements of will execution, see *supra* note 77 and accompanying text.

[122] *See supra* text accompanying note 17.

[123] *See supra* text accompanying notes 11–17.

[124] *See, e.g.*, J. Andrew Billings & Eric L. Krakauer, *On Patient Autonomy and Physician Responsibility in End-of-Life Care*, 171 ARCHIVES INTERNAL MED. 849, 851 (2011) ("Advance care planning is a method whereby the autonomy of a patient can be respected when the patient lacks decisional capacity." (citation omitted)); Cantor, *supra* note 118, at 20 ("There is no better way to respect future-oriented self-determination than through an advance directive."); *see also* WILKINSON ET AL., *supra* note 56, at 1 ("Advance directives . . . were developed to provide a practical process for ensuring patient autonomy at the end of life." (citations omitted)).

[125] *See* Sitkoff, *supra* note 81, at 643–44 ("The American law of succession embraces freedom of disposition, authorizing *dead hand* control, to an extent that is unique among modern legal systems. . . . The right of a property owner to dispose of his or her property on terms that he or she chooses has come to be recognized as a separate stick in the bundle of rights called property." (citations omitted)); *see also* Kelly, *supra* note 81, at 1133–34 (arguing that testamentary freedom, "the idea that a person has the right to choose who will succeed to things of value left behind at death," is the "organizing principle" of American succession law).

[126] A frequent theme in the health care context is the turn from paternalistic decision-making by physicians toward encouraging patients to make their own choices.

health care decisions show that many individuals do not wish autonomy in this sense.[127] In some ethnic groups, end-of-life decisions are considered the purview of the family, not the individual.[128] Similarly, in some ethnic groups, the individual is expected to consider the family's interests as well as his or her own in making decisions at the end of life.[129] For these groups, the value of deciding for oneself is questionable.

Putting the troubling problem of racial or ethnic differences to one side, there are numerous barriers to autonomy in end-of-life health care decision-making. The way in which options are described—in vivid or less dramatic terms, in negative or positive terms—will have an impact on patients' choices.[130] Not all individuals are comfortable with the hypothetical thinking that advance directives require.[131] The

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See, e.g., Billings & Krakauer, *supra* note 124, at 849. In end-of-life property planning, it is dogma that the testator—and only the testator—should decide. *See* Melanie B. Leslie, *The Myth of Testamentary Freedom*, 38 ARIZ. L. REV. 235, 235 (1996) ("One has a right to distribute property upon death solely according to the dictates of one's own desires, unfettered by the constraints of society's moral code or the claims of others." (citation omitted)). Defining autonomy is well beyond the scope of this paper. *See Autonomy*, BLACK'S LAW DICTIONARY (11th ed. 2019) (defining autonomy as "[t]he right of self-government" and "[a]n individual's capacity for self-determination"). For a detailed discussion of the historical, philosophical, and theoretical underpinnings of autonomy in legal theory, see Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1707–55 (1992). Many patients define autonomy differently than decision-making self-determination. Winzelberg et al., *supra* note 44, at 1047.

[127] WILKINSON ET AL., *supra* note 56, at 49 ("Studies show that for many racial/ethnic groups, autonomy is not always empowering, information about bad news may not be invited, and AD-appointed decision makers may be an unacceptable decision making mechanism." (citations omitted)).

[128] Jaclyn Portanova et al., *Ethnic Differences in Advance Directive Completion and Care Preferences: What Has Changed in a Decade?*, 65 J. AM. GERIATRICS SOC'Y 1352, 1356 (2017) ("[M]embers of ethnic minorities may prefer to make end-of-life care decisions as a family. The individualistic decision-making style that whites generally accept may be one reason why AD completion rates are highest among whites." (citation omitted)).

[129] *See* Susan E. Hickman et al., *Hope for the Future: Achieving the Original Intent of Advance Directives*, HASTINGS CTR. REP., Nov.–Dec. 2005, at S26, S27.

[130] *See* Mark R. Tonelli, *Pulling the Plug on Living Wills: A Critical Analysis of Advance Directives*, 110 CHEST 816, 818 (1996) ("Clearly, the description of possible scenarios and treatments profoundly affects the supposedly autonomous decisions of patients." (citation omitted)).

[131] Fulton & Teno, *supra* note 40, at 37 ("Hypothetical scenarios are used to have a person delineate what he or she would want to have done . . . . Not everyone is comfortable thinking in this way or is able to envision these scenarios in a realistic fashion . . . .").

framing of the available options will also have an impact.[132] A recurring theme in the literature on advance directives is the way in which the scenarios about which individuals are to make choices are either overly vague (would you want "heroic measures?") or overly specific (do you want a "nasal gastric tube?").[133] "The forms typically focus on extraordinary measures and not the more commonly encountered situations," such as needing intravenous antibiotics.[134] They also tend to be framed in terms of the treatment patients do *not* want.[135]

In addition to these framing issues, patients may lack the information necessary to autonomous decision-making. An often-recounted problem with advance directives is that patients express care preferences at odds with those stated in their living wills,[136] suggesting that many individuals simply do not understand the instructions in their own advance directives.[137] In theory, physicians

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[132] *See* Ditto, *supra* note 70, at 488 ("[P]references for life-sustaining treatment can be altered by the way the questions soliciting the preferences are framed (i.e., in terms of mortality vs. survival rates)."); Fagerlin & Schneider, *supra* note 32, at 33 ("An ocean of evidence affirms that answers are shaped by the way questions are asked. Preferences about treatments are influenced by factors like whether success or failure rates are used, the level of detail employed, and whether long or short-term consequences are explained first." (citations omitted)).

[133] *See* Hickman et al., *supra* note 129, at S26–S27 ("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 common clinical situations (for example, 'If I am in a persistent vegetative state').").

[134] Fulton & Teno, *supra* note 40, at 37.

[135] *See* Barbara J. Messinger-Rapport et al., *Advance Care Planning: Beyond the Living Will*, 76 CLEV. CLINIC J. MED. 276, 277 (2009); *see also* Hickman et al., *supra* note 129, at S26 ("[T]he focus is often on a patient's legal right to refuse unwanted medical treatments . . . ."). This focus may contribute to lower rates of advance directive execution by non-Caucasians who "may view traditional advance directives as contrary to their interests because they may be more concerned about being denied life-sustaining treatments rather than receiving them." Winzelberg et al., *supra* note 44, at 1048.

[136] *See* Friedemann Nauck et al., *To What Extent Are the Wishes of a Signatory Reflected in Their Advance Directive: A Qualitative Analysis*, 15 BMC MED. ETHICS 1, 7–9 (2014) (finding incongruities between verbally expressed preferences and the contents of written advance directives in more than half of study participants).

[137] *See, e.g.*, Fagerlin & Schneider, *supra* note 32, at 34 ("[P]eople do, for instance, issue mutually inconsistent instructions in living wills."); Martin et al., *supra* note 41, at 1675 ("[P]atients do not always understand the medical implications of their documented preferences . . . ."); Henry S. Perkins, *Controlling Death: The False Promise of Advance Directives*, 147 ANNALS INTERNAL MED. 51, 53 (2007); Joan M.

could avoid this problem by providing more information to patients.[138] But this information too will be framed in one way or another, and the physician's choice about what information to offer reintroduces the risk of paternalism that advance directives are meant to counteract.

Some scholars argue that the very framework on which advance directives rest—the notion of autonomous choices governing future events—is inappropriate in the context of end-of-life health care decision-making. "People are reluctant to exercise choice in end of life matters because of cognitive difficulties that inescapably afflict everyone in contemplating the reality of death."[139] In this view, "we may enact a convincing appearance of autonomous choice in contemplating death," but the incomprehensibility of death defeats this attempt.[140] "The very concept of the choice-making self, the construct on which the autonomy principle depends for its coherence, is radically unsettled . . . by the actual, imminent approach of death."[141] Ambivalence about death, these scholars argue, cannot be banished or suppressed by the execution of a document purporting to give power to patients (or proxies) that they cannot not possibly exercise at the relevant moment.[142] Thus "the relentless search for a single decision-maker regarding end of life care" may be fundamentally misguided.[143]

Teno et al., *Do Advance Directives Provide Instructions that Direct Care?*, 45 J. AM. GERIATRIC SOC'Y 508, 511 (1997).

[138] *Cf.* Billings & Krakauer, *supra* note 124, at 851.

[139] Robert A. Burt, *The End of Autonomy*, HASTINGS CTR. REP. (SPECIAL ISSUE), Nov.–Dec. 2005, at S9, S10; *see also* Theresa S. Drought & Barbara A. Koenig, *"Choice" in End-of-Life Decision Making: Researching Fact or Fiction?*, 42 GERONTOLOGIST 114, 118 (2002) ("The notion that individuals have clear-cut preferences about a completely unusual and by definition once in a lifetime experience like dying is never questioned—the existence of preferences is assumed and never validated.").

[140] Burt, *supra* note 139, at S10; *see also* Drought & Koenig, *supra* note 139, at 115 (arguing that it is problematic to assume that "all individuals can routinely, comfortably, and meaningfully confront and consider not just their own mortality, but also the process of their physical decline and dying, in an engaged and rational manner"); Perkins, *supra* note 137, at 54 ("In reality, critical illness thwarts the very purpose of advance directives . . . through the many on-the-spot decisions necessitated by unpredictable, uncertain, and complex circumstances.").

[141] Burt, *supra* note 139, at S10.

[142] *See* Perkins, *supra* note 137, at 54 ("[A]dvance directives simply promise more control than they can deliver . . . . They provide an unrealistic but comforting 'illusion of certainty.'"); *see also* Drought & Koenig, *supra* note 139, at 115 ("The irony of the choice paradigm is that it seems to present a choice that does not exist—the choice not to die of a terminal illness.").

[143] Burt, *supra* note 139, at S13.

Even if these psychological and cognitive difficulties could somehow be overcome, resource constraints may limit patients' ability to be autonomous. "For example, the supply of hospital beds, not patients' preferences, has been shown to be the key determinant of whether terminally ill patients die at home or in the hospital."[144] Moreover, "[d]espite more than 25 years of experience with advance directives, all too often, treatment decisions are made on the basis of insurance coverage, not the needs or desires of patients."[145] For these reasons, patient autonomy may require commitment of material or financial resources that would make patient choice possible.[146]

Many of these issues are pertinent to end-of-life property decision-making. The vividness with which the attorney describes options will determine their salience to the testator and lead the testator to choices he or she might not otherwise have made. Framing will also play a role. For example, if the possibility of a daughter or son-in-law inheriting is presented as a chance that assets will go "outside the family," the testator might well choose a distribution that prevents that outcome. But if the possibility were framed in terms of whether the testator wants to leave anything to "the mother/father of your grandchild," the testator might regard that possibility favorably.

Similarly, just as many patients may not understand the terms of their advance directives, many testators may not understand the terms of the testamentary instruments they sign. For instance, they might not comprehend the connection between their revocable inter vivos trust instrument and their desire to provide flexibly for their family. Nor may they appreciate why they need a will *and* a trust or precisely how the two documents will work in conjunction.

Finally, the incomprehensibility of death may affect property decision-making as it does health care decision-making. It may be that testators cannot determine how they will "really" want their property to be distributed at death any more than patients can determine how they will "really" want to be treated when they are actually dying. The notion that testators have "real" wishes that their wills "really" reflect might be in the property context, as in the health care context, just a comforting fiction.

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[144] Diane E. Meier & R. Sean Morrison, *Autonomy Reconsidered*, 346 NEW ENG. J. MED. 1087, 1087 (2002) (citation omitted).

[145] *Id*; *see also* Drought & Koenig, *supra* note 139, at 116 ("[A]spects of the health care system in which the patient receives his or her care, insurance provides a good example, will control and constrain what choices can even be considered by the patient.").

[146] *See* Meier & Morrison, *supra* note 144, at 1088.

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Wills law's relentless focus on intent-effectuation tacitly relies on a variety of premises. The first is that, if the law creates a mechanism by which individuals can state their preferences about the distribution of their property at death, then people will avail themselves of that mechanism. The second premise is that individuals can accurately predict at an early stage of life their preferences about post-death property distribution and that those preferences are stable and thus should govern at death. The third premise is that end-of-life property decision-making reflects individuals' autonomous choices.

The literature on end-of-life health care decision-making raises questions about each of these premises. In the health care context, individuals do not seem to want to use the mechanisms available to express their wishes about care at the end of life. They are not able to predict reliably at early points in time the care that they will want later. They neither desire nor exercise autonomy at the end of life. Because both end-of-life property and end-of-life health care decisions involve pre-commitments, there is every reason to believe that this literature is germane to wills and unsettles wills law's unstated, but critical, premises.

III. WHERE DOES THIS TAKE US?

The literature on end-of-life health care decision-making suggests two lines of inquiry important for end-of-life property decision-making. The first is the need for more empirical research about property wills. The second is the need to address whether reducing or eliminating the formal requirements for wills would threaten wills' ability to function as safe harbors for testamentary wishes.

A. How Little We Know and Why It Matters

One of the more striking aspects of the literature on end-of-life health care decision-making is its empiricism. Advance directive execution rates, preference stability, accuracy of proxy decision-making—virtually every aspect of advance health care planning has been counted, measured, or surveyed. Although there are often disputes about survey design or sample techniques, there seems to be consensus that, if attitudes, preferences, and so forth are important to the end-of-life heath care planning process, then it is important to know what those attitudes and preferences really are.

It may be that attitudes and preferences about end-of-life property decision-making are very different from those pertaining to end-of-life health care decision-making, but it is difficult to be sure in the absence of data on actual attitudes and preferences in the will making context. Very little is known about the factors that lead individuals to make wills, or to fail to make them. The reported cases involving attempted modifications and revocations demonstrate that at least some testators change their minds about the wills they have made. But here again little is known about the frequency with which or the circumstances under which these changes of mind occur. Perhaps most testators are content with the wills they execute, but it would be useful to know if, at the end of life, individuals re-think the wishes stated in their wills.

Recent trusts and estates scholarship has begun to use empirical methods to examine various issues connected to will execution.[147] Much of this scholarship uses wills that can be found in probate records for its data sets. But those records do not capture attitudes and preferences that affect whether a will is made at all, whether a previously made will accurately reflects the testator's current preferences, or whether and how cognitive bias affects the will-making process. The literature on end-of-life health care decision-making presents a virtual template for research avenues and methods that might be pursued to illuminate some of these questions. There is much work to be done.

This work has immense potential relevance to the practice of wills law. The current fixed intention paradigm situates the attorney as preference elicitor and scrivener: the attorney asks what the client wants and then writes it down. For situations that recur frequently but are not obvious to clients, such as the possibility of lapse, divorce, or adoption, the attorney may have to educate clients about circumstances the clients might not otherwise have foreseen. But the purpose of this education, in the conventional view, is to focus the client's attention so that they will form an intention relevant to the possibility now in view. Once this intention is formed, the attorney's job is to record it. At every step, the attorney is regarded as the neutral

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[147] *See generally, e.g.*, Glover, *supra* note 54; David Horton, *Partial Harmless Error for Wills: Evidence from California*, 103 IOWA L. REV. 2027 (2018); David Horton, *Wills Law on the Ground*, 62 UCLA L. REV. 1094 (2015); Reid Kress Weisbord & David Horton, *Boilerplate and Default Rules in Wills Law: An Empirical Analysis*, 103 IOWA L. REV. 663 (2018); Symposium, *An Empirical Analysis of Wealth Transfer Law*, U.C. DAVIS L. REV. (forthcoming 2020).

vessel through which the client's wishes are first articulated and then written down.[148]

But the literature of end-of-life health care decision-making challenges this vision. It suggests, among other things, that individuals might not want to engage in detailed planning at all and instead would prefer not to decide about who should get what item when they die. They may not have thought about planning at all and would prefer not to have to think about it. Thus, it may be that the wishes expressed in the will are formed in response to the attorney's questioning, rather than being brought out by the attorney's questions.

The way in which the attorney frames possibilities, and the vividness with which those possibilities are presented, may also affect what the testator comes to want. Similarly, the very act of making salient unforeseen events such as the death of a beneficiary prior to the testator may unsettle the testator in ways that cause the testator to think differently about the testator's estate. In all of these respects, the attorney is aptly understood as an active, not passive, agent, and the wishes the attorney records could be understood as being developed in a collaboration between that attorney and the testator, not by the testator alone. Attorneys aware of these forces might conduct their client interviews differently.

Additional studies of preference formation might also affect how attorneys counsel clients. Suppose we examined whether people who engage in estate planning in a "hot" state, just having learned of, say, a serious illness or a new grandchild, might make choices different from those they would make in a "colder" state. Attorneys might make clients aware of this phenomenon, perhaps slowing down the will-making process in consequence. Similarly, if there is evidence that preferences are unstable and change over time, attorneys might advise their clients to revisit and revise their wills more frequently.

The empirical studies of end-of-life health care decision-making raise questions about the factual assumptions underlying the law of end-of-life property decisions. So much more can be known about the latter. Empirical studies of end-of-life property decisions might

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[148] *See, e.g.*, Deborah S. Gordon, *Reflecting on the Language of Death*, 34 SEATTLE U. L. REV. 379, 406–07 (2011) (describing the lawyer as a "scrivener . . . who must, in effect, translate the words of the only author whose intent matters (the testator)."); Karen J. Sneddon, *Speaking for the Dead: Voice in Last Wills and Testaments*, 85 ST. JOHN'S L. REV. 683, 716 (2011) (explaining the draftsperson's "primary goal . . . is to translate the testator's wishes into a document that 'speaks' for the individual testator").

confirm existing assumptions, but they might not, and either way, it would make a difference—a practical difference—to know.

B. A Conversational Model for Wills?

If research demonstrates that, in most cases, preferences about end-of life property decision-making are indeed fixed, that research would confirm that the wills law we have is the wills law we need. And clearly that is true for some percentage of testators. Some individuals are surely able and willing to make once-and-for-all decisions about what should happen to their property at death and to accurately record those decisions in their wills. For these testators, their wills function as a safe harbor, protecting against their own, perhaps impulsive, changes of mind and also against second-guessing by others who might have ideas of their own about what the testator "really" wanted.[149]

But research might also demonstrate—as the cases suggest—that some people have trouble coming to closure about their property. In ways that are often not legally effective, they fiddle with their wills, revising, annotating, or striking out whole sections. They write letters expressing wishes discordant with those in their wills, or they make oral statements about what they wish they had done, or not done, in their wills. The literature on end-of-life health care decision-making suggests that irresolution is a fairly common phenomenon.[150]

What if in the property context intentions are fluid, preferences fleeting? For individuals whose end-of-life property intentions are fluid, existing wills law is more problematic because it requires that alterations or revocations of previously made instruments be made with testamentary formality. Should wills law in consequence move toward the conversational model now so highly thought of in the end-of-life health care decision-making context?

The obvious danger presented by the conversational model is the potential displacement of the written instrument as the repository of

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[149] *See* Baron, *supra* note 5, at 64–70 (explaining how wills function as safe harbors); Langbein, *supra* note 9, at 4 ("The greatest blessing of the Wills Act formalities is the safe harbor that they create. . . . The testator who complies with Wills Act formalities assures his estate of routine probate in all but exceptional circumstances.").

[150] If only a small percentage of would-be testators is irresolute, perhaps no legal adjustments need be made. And even if the percentage is larger, there might still be a case for the legal regime now in force. If, for example, most post-execution changes of mind are made in "hot states," there is a reasonable case for exercising caution about giving them effect.

the testator's intent. As Gulliver and Tilson famously explained, the writing requirement forces testators to consider carefully what they are deciding and provides reliable evidence of testators' wishes.[151] Yet the conversational model of end-of-life health care decision-making does not eschew documents altogether. It simply posits that the document not be the exclusive focus of planning. The literature argues that too much attention to producing the perfect form may impede rather than facilitate the communication of individuals' end-of-life wishes. If what is needed is information about individuals' actual desires, then the focus should be on that information, not the vehicle through which it is provided. The wisdom is not that a writing is unimportant, but rather that it is not the only important thing.

There is some precedent in contemporary wills law for de-emphasizing writings. Both the Uniform Probate Code[152] and the Restatement of Property[153] have moved away from exclusive reliance on a document in all cases. Under traditional doctrine, errors of form, however inconsequential, were fatal to a testamentary document's effectiveness.[154] However, today, in instances of so-called harmless error, writings that technically violate the Wills Act and therefore would otherwise not have been given legal effect are nonetheless treated as valid if there is clear and convincing evidence that the testator meant the writing to be operative.[155] In these cases, evidence

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[151] Gulliver & Tilson, *supra* note 59, at 3–4.

[152] UNIF. PROBATE CODE § 2-503 (amended 2010).

[153] RESTATEMENT (THIRD) OF PROP.: WILLS & OTHER DONATIVE TRANSFERS § 3.3 (AM. LAW INST. 2015).

[154] *See* John H. Langbein, *Substantial Compliance with the Wills Act*, 88 HARV. L. REV. 489, 489 (1975) ("[O]nce a formal defect [in execution] is found, Anglo-American courts have been unanimous in concluding that the attempted will fails.").

[155] The Uniform Probate Code provides:

> Although a document or writing added upon a document was not executed in compliance with Section 2-502 [stating requirements for valid will execution], the document or writing is treated as if it had been executed with that section if the proponent of the document or writing establishes by clear and convincing evidence that the decedent intended the document or writing to constitute:
> (1) the decedent's will,
> (2) a partial or complete revocation of the will,
> (3) an addition to or an alteration of the will, or
> (4) a partial or complete revival of the decedent's formerly revoked will or of a formerly revoked potion of the will.

UNIF. PROBATE CODE § 2-503; *see also* RESTATEMENT (THIRD) OF PROP. § 3.3 (providing that "a harmless error in executing a will may be excused if the proponent establishes by clear and convincing evidence that the decedent adopted the document as his or her will").

of the testator's intent is supplied by evidence other than the document he or she executed. The harmless error doctrine has already moved wills law away from an entirely documentary model.

A legitimate worry about the conversational model in the end-of-life property decision-making context is that, if effect is given to statements made outside the will itself, individuals will not bother to make wills at all or that unconsidered statements will be given legal effect even when those statements contradict a duly executed instrument.[156] The drafters of the harmless error provisions of the Restatement and the Uniform Probate Code confronted exactly this sort of concern about the risk of a slippery slope. It was thought that the benefits of the formal Wills Act requirements would be eroded if noncompliance could be forgiven.[157] But this danger has not materialized in the many years since the harmless error rule was proposed.[158] Most people still execute their wills with the requisite degree of formality, and courts have not rushed to probate wills with serious defects. This experience is useful for considering what might happen if wills law moved away from the fixed-intention, entirely-documentary model, as it suggests that giving effect to some informal statements need not seriously erode the existing architecture of wills law.

In any event, it is not difficult to imagine safeguards that would reduce the slippery slope concerns. The drafters of the harmless error rule used the "clear and convincing evidence" standard to ensure that

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[156] *See, e.g.*, James Lindgren, *The Fall of Formalism*, 55 ALB. L. REV. 1009, 1027 (1992) ("In the law of wills, the overriding fear is that unattested language will be used to pass property at death.").

[157] *See, e.g.*, Adam J. Hirsch, *Formalizing Gratuitous and Contractual Transfers: A Situational Theory*, 91 WASH. U. L. REV. 797, 829 (2014) ("The harmless error power might tend to encourage carelessness and breed litigation, or open up avenues for fraud." (citation omitted)); C. Douglas Miller, *Will Formality, Judicial Formalism, and Legislative Reform: An Examination of the New Uniform Probate Code "Harmless Error" Rule and the Movement Toward Amorphism*, 43 FLA. L. REV. 599, 705–06 (1991) (arguing that the harmless error rule will compromise existing limits on the issues to be resolved after the testator's death); John V. Orth, *Wills Act Formalities: How Much Compliance Is Enough?*, 43 REAL PROP. TR. & EST. L.J. 73, 80–81 (2008) (arguing that relaxing formalities to determine testamentary intent creates a new avenue for judicial activism).

[158] *See* Langbein, *supra* note 9, at 51 ("[T]he litigation levels have been astonishingly low."); Stephanie Lester, *Admitting Defective Wills to Probate, Twenty Years Later: New Evidence for the Adoption of the Harmless Error Rule*, 42 REAL PROP. PROB. & TR. J. 577, 583–600 (2007) (examining how the harmless error rule and substantial compliance fared in Australia from 1987–2007).

intention be proved to a high level of confidence.[159] While that heightened evidentiary standard may be imperfect,[160] it is nonetheless useful in signaling the need for robust evidence of the testator's final intention. Additional safeguards might include distinguishing between uncorroborated and corroborated third-party reports of the testator's statements. Instructions that completely contradict or alter a prior testamentary document might be considered more suspicious than instructions that are only slightly inconsistent. Changes that the testator has been considering over a long period of time might be taken more seriously than changes that seem sudden.

Whether these measures independently or in combination will be effective will depend in part on what research shows: *Do* testators change their minds frequently? *Do* they make statements about their property at the end of life that contradict the statements in their wills? It is difficult to identify the concerns to guard against in the absence of information about what the problems really are. Still, it is possible to imagine limitations and qualifications that would keep a conversational model from entirely eroding the importance of duly-executed testamentary documents.

In the end, the studies of end-of-life health care decision-making cannot spell out exactly what changes may be required for the rules of will execution, but they do demonstrate a need for a new frontier of research about end-of-life property decision-making. They give reason to wonder about the fixed-intention paradigm on which current wills rules are based. When physicians began to doubt the reliability of formalized advance directives, they experimented with alternative ways of interacting with patients about end-of-life care, ultimately moving to the current ACP model. Perhaps lawyers might similarly experiment with alternative ways of talking to clients and documenting their clients' wishes, and these experiments could lead to a new model that better accounts for irresolution in wills law. Perhaps these experiments will come to naught, but it seems worth opening our minds to the possibility that the current rules cannot and do not work for a significant number of people.

At its furthest reach, the literature on end-of-life health care decision-making raises a disquieting prospect: that "intent" about health care choices at the end of life is fictive. Competent patients

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[159] On the importance of this heightened evidentiary standard for the harmless error reform, see Baron, *supra* note 5, at 15–24.

[160] *See id. passim* (describing problems with the application of the clear and convincing evidence standard).

cannot meaningfully know what they will want when they are incompetent, and incompetent patients cannot meaningfully choose. Talk of intent in these circumstances may play an important role in calming families who must actually make decisions for a loved one and in relieving health care personnel from a sense of responsibility.[161] Yet none of this has anything to do with the actual wishes of the patient. This is why ACP is a process of communication involving not just the patient, but the patient's relatives and caregivers.

The institutional context of end-of-life property decision-making may indeed be different from the health care context—simpler, less emotionally charged, and less financially fraught. Intentions about property might thus be less fictive. And if they are, then perhaps the current wills law paradigm of individual choice remains appropriate. This Article draws attention to the work on end-of-life health care decision-making to help clarify this issue. More work needs to be done to determine whether, and how, wills law needs change.

CONCLUSION

Contemporary trusts and estates law is built on the premise that individuals can and should have fixed intentions with respect to the disposition of their property at death. These intentions can and should be fixed in a written document, and that document can and should be fixed against other outside evidence of intention.

Experience with end-of-life health care decision-making, particularly living wills, gives reason to question these premises. In the health care context, intentions have proven to be fluid, and the documents purporting to record individuals' wishes have often proved unreliable. To be blunt, a will is an advance directive for property. It

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[161] *See, e.g.*, Ditto et al., *supra* note 35, at 498 (noting that advance directives did not preserve patients' ability to control specific treatment decisions, but did provide a general sense of control over the dying process and reduced the burdens on surrogate decision makers); Lois Shepherd, *The End of End-of-Life Law*, 92 N.C. L. REV. 1693, 1725 (2014) (arguing advanced care planning allows family members, surrogate decision makers, and health care providers "to believe that they are not making real-time decisions with life and death consequences, but that these decisions were made by the patient . . . . But this is mostly a fiction"); Douglas B. White & Robert M. Arnold, *The Evolution of Advance Directives*, 306 J. AM. MED. ASS'N 1485, 1485 (2011) ("Advance directives were originally designed to allow patients to determine in advance what treatment they would receive in the event of their incapacity. Instead . . . advance directives work not by making the decisions but by giving surrogates and physicians psychological permission to cease life support at some point.").

documents the present preference of the testator with respect to the future disposition of his or her property. But if, as the studies of end-of-life health care decisions suggest, preferences are unstable and changing, why should the earlier-formed preferences stated in a will control over later-formed preferences not stated in a testamentary document? Why not accept alternative ways of expressing end-of-life property decisions?

These questions may seem outlandish, but if indeed irresolution is common, it has several practical implications. For one thing, we might rethink, as has been done in medicine, whether the formalities of will execution are well-suited to the problem at hand. That problem has conventionally been understood to be about recording wishes, but in many cases the problem seems to be in forming "final" wishes to record. At the very least, the lawyer's role might be different, more "counselor" than "scrivener." For another thing, we might rethink the idea that once a will is executed, it can be put away in a safe place and forgotten until after the testator's death. Perhaps property wills, like living wills, need attention and revision over time.[162] Finally, we might rethink some of our reluctance to consider, in respect of will interpretation, evidence extrinsic to the will itself. It may be that a testator's last words about his or her property are actually more reliable than her earlier-stated instructions.

Ultimately, this Article argues that end-of-life property planning can learn from end-of-life health care planning in two ways. The first is methodological. Medical researchers have studied—and continue to study—such things as the rates at which advance health care directives are executed, the pertinence of their instructions to the situation at hand, and whether the patient's wishes at the moment of treatment match those stated in the patient's advance directive. Wills law would benefit from similar empirical efforts. The second is theoretical. The findings of the studies in the health care context unsettle assumptions about what happens in the property context. If research shows that the two contexts are not materially different, then at least some of trusts and estates law will need reconsideration.

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[162] For proposals to this effect, see Glover, *supra* note 54, at 261; Hirsch, *supra* note 54, at 659.