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DEATH WITH DIGNITY LAWS: A PLEA FOR UNIFORM LEGISLATION

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Introduction

Abe Perlmutter became ill with amyotrophic lateral sclerosis in January, 1977, at the age of seventy-two.[1] His physician informed him that there was no cure for the disease, and that he should not expect to live beyond two years. Perlmutter was hospitalized in Florida, and his condition deteriorated rapidly until he became almost unable to move and so dependent upon a respirator for his breathing that it was estimated he would die in less than an hour without it. Although speaking became extremely difficult and painful, he remained mentally competent throughout his illness.

After a time, Perlmutter expressed to his family the misery he felt in his condition, and his desire to have the respirator disconnected. He attempted to detach himself, but an alarm sounded and the machine was quickly re-attached by the hospital staff. Unable to exercise his right to decide the course of his own treatment, Perlmutter finally sought a court order restraining the hospital and treating personnel from interfering with his decision to discontinue use of the respirator. At a bedside hearing, he told the trial judge that he was willing to accept the consequences of removal of the respirator, because "it can't be worse than what I'm going through now."[2] The trial court granted the order in *Satz v. Perlmutter*.[3]

The District Court of Appeals affirmed,[4] and, in view of the "exigencies of [the] situation,"[5] declined to certify the matter for review by the

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[1] Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

[2] *Id.* at 161.

[3] *Id.*

[4] *Id.* at 164.

[5] *Id.*

Florida Supreme Court.[6] Nonetheless, the State applied for review.[7] Perlmutter died during the Supreme Court proceedings. On January 17, 1980, the Florida Supreme Court adopted the opinion of the District Court of Appeals.[8]

Although the Florida Supreme Court ultimately gave its blessing to the trial court's decision, it also made the following observation:

> Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.[9]

It is important to note that Mr. Perlmutter languished for some time while the courts considered his request. One need not be a scholar to appreciate the considerable suffering and expense borne by Mr. Perlmutter and his family during this period.

Della Dockery, forty-one years old, was admitted to Erlanger Hospital in Tennessee on November 12, 1976, with a collapsed lung, asthmatic bronchitis, and pulmonary emphysema.[10] She was placed on a respirator while still conscious, but soon afterward she suffered cardio-respiratory arrest from a massive pulmonary embolism. Although her vital signs returned after six minutes of heart massage, she suffered cortical brain damage and lapsed into a coma. Her condition was described as follows:

> Mrs. Dockery lies in a comatose condition in the Intensive Care Unit of Erlanger Hospital; her limbs are limp; she requires constant attention; her lungs must be drained at two-hour intervals; and she must have regular turning in bed. Two tubes are placed inside of the chest wall to create a vacuum in the chest cavity. A tube hooked to the respirator is inserted through an incision in the neck to the hole in the windpipe. A tube for feeding is inserted into the stomach through an incision in the abdominal

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[6] *Id.*

[7] Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980).

[8] *Id.*

[9] *Id.* at 360.

[10] Dockery v. Dockery, 559 S.W.2d 952, 953 (Tenn. Ct. App. 1977).

> wall. A catheter is inserted into her bladder. Through a tube into the vein of her arm she is given 500 cc's fluid daily (5% dextrose). She is given Garamycin daily for infection. Periodic blood transfusions are required. Enemas are performed, and a heart monitor is attached to three locations on her body by adhesive.[11]

Upon learning that her condition was irreversible, Mrs. Dockery's husband and family asked the attending physician to discontinue use of the respirator.[12] The physician refused,[13] and the Dockery family instituted court proceedings in chancery court, seeking, among other things, to have Mrs. Dockery's husband appointed guardian with authority to have the respirator removed.[14]

The Dockerys prevailed in the lower court,[15] but the guardian ad litem appealed the decision.[16] Mrs. Dockery died while the appeal was pending.[17]

The Tennessee Court of Appeals declined to take advantage of the opportunity to provide some guidance for future cases in the area, but did rule on the physician's cross-appeal of the trial court's assessment of the costs of the proceedings against him.[18] Despite its recognition of the applicable rule of law—that where costs are awarded, they ordinarily are assessed against the losing, not the prevailing, party—the Court of Appeals reversed the trial court's award, declaring that "the equities require that *all costs,* including the guardian ad litem's fee, be paid by the [Dockerys] who began the action for declaratory judgment, even though they obtained the declaration sought."[19]

The facts and procedural history of these two cases make it clear that litigation is not a promising option for a terminally ill patient who wishes to refuse extraordinary, life-prolonging medical treatment.

Chief Justice Richard J. Hughes, writing for a unanimous New Jersey Supreme Court in the landmark decision *In re Quinlan*,[20] commented upon the negative factors associated with litigation in this area:

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[11] Dockery v. Dockery, No. 51439, slip op. at 3 (Tenn. Ch. Ct., Hamilton County Feb. 11, 1977).
[12] *Id.*
[13] *Id.* at 4.
[14] *Id.*
[15] *Id.* at 14-15.
[16] 559 S.W.2d 952 (Tenn. Ct. App. 1977).
[17] *Id.* at 953.
[18] *Id.* at 955-56.
[19] *Id.* at 956 (emphasis added).
[20] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied,* 429 U.S. 922 (1976).

> We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome. Such a requirement is distinguishable from the judicial overview traditionally required in other matters such as the adjudication and commitment of mental incompetents. This is not to say that in the case of an otherwise justiciable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure.
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> . . . .
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> If there could be created not necessarily this particular system but some reasonable counterpart, we would have no doubt that such decisions, thus determined to be in accordance with medical practice and prevailing standards, would be accepted by society and by the courts, at least in cases comparable to that of Karen Quinlan.[21]

Quinlan also noted that:

> there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients.[22]

Other courts have held that "[p]revailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances."[23]

Despite the availability of non-treatment as an acceptable medical alternative, doctors and hospitals are often understandably reluctant to withhold or withdraw life-prolonging medical care without prior judicial authorization.[24]

Adequate legislation is capable of solving many of these problems. Legislation has traditionally reduced the role of litigation in the resolution of societal disputes, and is, without doubt, the best available "reasonable

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[21] *Id.* at 50-51, 355 A.2d at 669.

[22] *Id.* at 49, 355 A.2d at 668.

[23] Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743, 370 N.E.2d 417, 426 (1977); Satz v. Perlmutter, 362 So. 2d at 163 (quoting *Saikewicz*).

[24] *See* Satz v. Perlmutter, 362 So. 2d at 162, discussing the fear of civil and criminal liability by health personnel.

counterpart''[25] in the area of decision-making for terminally ill patients. The legislative grant of immunity from civil or criminal liability is certainly not a new phenomenon in the law, and such provisions are the cornerstone of legislation governing termination of treatment for patients suffering from irreversible, terminal diseases.[26]

This article will, after briefly reviewing the doctrinal foundation supporting the right to refuse treatment, examine "death with dignity" legislation in detail. The need for such legislation is apparent. Indeed, some courts have questioned whether they have the authority to act in this area in the absence of such legislation.[27] In response to this need, eleven states have enacted legislation,[28] and bills are pending in several others.[29] Generally, they clarify the right of the terminally ill patient to refuse treatment, and set forth guidelines for physicians regarding the termination of life-support systems. All include some provision for the utilization of the "living will," an advance declaration of an individual's wishes with regard to treatment in the event he is incapable of expressing them at the time the treatment decision must be made. Living wills and implementing legislation are designed, in part, to reduce the number of situations in which someone other than the patient must make treatment decisions. Because the decision frequently needs to be made when the individual is no longer capable of speaking for himself, living will legislation permits and encourages patients and prospective patients to express their desires while still competent to do so.

Incompetent patients present peculiar problems for doctors, lawyers, and judges. Such patients are unable to provide any input in the decision-making process, and there are some who have never been competent to decide anything. Legislation is especially important for preservation of the well-being of these individuals. The decision of the New York Court of Appeals in *In re Storar*,[30] involving a fifty-two year old "profoundly retarded" inmate in a state development center, is the most recent case dealing with a person unable to make his own treatment decisions. It underscores the complexity of decision-making in this context, and serves

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[25] *In re* Quinlan, 70 N.J. at 50, 355 A.2d at 669.

[26] *See* pp. 133-37 *infra*.

[27] *See, e.g.*, Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334, 1345-46 (Del. 1980); Eichner v. Dillon, 73 A.D.2d 431, 451, 426 N.Y.S.2d 517, 533-36 (App. Div. 1980), *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

[28] *See* note 78, *infra*.

[29] *See* note 79, *infra*.

[30] 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

as compelling evidence of the need for living will legislation for the benefit of the incompetent. For this reason, it will be discussed at length later in this article.[31]

Another contention that will be made is that a state-by-state legislative approach may not be adequate for the task of implementing a system of fair, equitable decision-making. As is the case with decision-making in a number of medico-legal areas,[32] there is a demonstrable need for uniformity throughout all the states of the Union. Consequently, it will be argued that uniform legislation is a potent legislative solution available to the states at this time.[33]

An examination of these factors leads to the conclusion that legislation defining the rights and duties of physicians and patients is essential, not only because judicial decision-making has been erratic, confusing, and inadequate, but also because the right to refuse life-prolonging treatment in an advanced technological age is of sufficient dimension to require the affirmative and comprehensive protection that only the legislative process can provide.

Background

A. Informed Consent

The doctrine of informed consent is the common-law foundation for the exercise of a patient's right to refuse life-prolonging medical treatment. Like the constitutionally-based right to privacy, the right to refuse medical treatment rests on the belief that every individual has a right to determine what shall be done with his own body.[34] In the context of the doctor-patient relationship, this has come to mean that the patient is entitled to be informed of all material facts pertaining to his condition and of any reasonably likely risks involved in proposed procedures.[35] Similarly, the patient is generally entitled to be consulted before any new unanticipated procedure is undertaken.[36]

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[31] *See* pp. 115-19 *infra*.

[32] These areas include the practice of making anatomical gifts, or considerations of the treatment and rehabilitation of persons with drug dependency problems. *See* p. *infra*.

[33] *See* pp. 137-40 *infra*.

[34] *See, e.g.*, Schloendorff v. Soc'y of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).

[35] *See, e.g.*, Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *opinion on denial of motion for rehearing*, 187 Kan. 186, 354 P.2d 670 (1960).

[36] *See, e.g.*, Wall v. Brim, 138 F.2d 478 (5th Cir. 1943); Perry v. Hodgson, 168 Ga. 678, 148 S.E. 659 (1929); Franklyn v. Peabody, 249 Mich. 363, 228 N.W. 681 (1930).

The roots of the informed consent doctrine date back to the fourteenth century.[37] As one court declared: "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment."[38]

Yet until the very recent advent of a trend toward increasing judicial and societal acceptance of the concept of a "good death,"[39] courts *had* inhibited the realization of patient self-determination in large part, by exhibiting an extreme deference toward the medical profession's purported need for unfettered discretion in the treatment of patients. This reasoning is illustrated by a 1971 case, *John F. Kennedy Memorial Hospital v. Heston*,[40] in which the mother of an automobile accident victim refused to consent to a blood transfusion:[41]

> When the hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards. The solution sides with life, the conservation of which is, we think, a matter of State interest.[42]

Although the *Heston* case has not been expressly overruled, there is little doubt that its reasoning, that the purportedly conflicting interests of physician and patient should be resolved on the side of the physician, has been thoroughly rejected by courts which have addressed the issue in other contexts over the past several years.[43] But because of increasing judicial recognition of the applicability of the constitutionally-based privacy doctrine to treatment decisions by dying patients,[44] the viability of the common-law informed consent doctrine has not received adequate attention

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[37] I. de S. et Ux. v. W. de S., Y.B. Lib. Assis., folio 99, pl. 60 (1348), cited in PROSSER, TORTS 38 n.96 (4th ed. 1971).

[38] Natanson v. Kline, 186 Kan. at 406-07, 350 P.2d at 1104.

[39] This is the literal translation of "euthanasia"; however, it is used here in the broader sense of a person's right to die with dignity.

[40] 58 N.J. 576, 279 A.2d 670 (1971).

[41] Ironically, this case was decided by the same court, the Supreme Court of New Jersey, that decided the landmark *Quinlan* case less than five years later; *see* 70 N.J. 10, 355 A.2d 647 (1976).

[42] 58 N.J. at 583, 279 A.2d at 673.

[43] *See, e.g.*, Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

[44] *Id.*

in the recent court decisions involving the withdrawal of life-prolonging treatment, with a few notable exceptions.[45]

In the past several years a trend has developed toward increased recognition of the patient's right to self-determination. This trend is reflected in a number of recent informed-consent decisions, involving allegations of medical malpractice.[46] The landmark case is *Canterbury v. Spence*,[47] a 1972 decision by the United States Court of Appeals for the D.C. Circuit. The patient in *Canterbury* underwent a laminectomy for a suspected ruptured disk. This dangerous operation caused partial paralysis.[48] In the patient's subsequent action for malpractice, a factual question arose concerning the content and adequacy of the doctor's disclosure of the risk of paralysis. After acknowledging the majority rule, which mandated reference to the medical custom and standard of care in the area,[49] the court held that the patient's cause of action was not "dependent upon the existence and nonperformance of a relevant professional tradition."[50] Rather, "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."[51] Furthermore, it declared that "[t]he physician's privilege to withhold information. . . must be carefully circumscribed, . . . for otherwise it might devour the disclosure rule itself."[52]

Although the shift away from a "standard of due care" has occurred in only the minority of jurisdictions following the *Canterbury* approach,[53]

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[45] *See, e.g., In re* Eichner, 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), *aff'd as modified sub nom.* Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (App. Div. 1980), *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

[46] *See generally* cases cited in note 53 *infra*.

[47] 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

[48] *Id.* at 777.

[49] *Id.* at 783.

[50] *Id.*

[51] *Id.* at 784.

[52] *Id.* at 789.

[53] The standard announced in *Canterbury*, that part of the physician's overall duty to his patient is an obligation of reasonable disclosure of available choices with respect to proposed therapy, and the inherent and potential dangers of each choice, in order that the patient may make his own treatment decisions, is now followed in thirteen states. *See, e.g.*, Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Percle v. St. Paul Fire & Marine Ins. Co., 349 So. 2d 1289 (La. Ct. App.), *writ denied*, 350 So. 2d 1218 (La. 1977); Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962); Fogal v. Genesee Hosp., 41 A.D.2d 468, 344 N.Y.S.2d 552 (App. Div. 1973); Congrove v. Holmes, 37 Ohio Misc. 95, 308 N.E.2d 765 (C.P. Ross County

the courts espousing this view have laid the legal groundwork for the modern common-law right to refuse life-saving medical treatment. In a 1972 case adopting the *Canterbury* standard, the California Supreme Court declared: "Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected. . . . In sum, *the patient's right of self-decision is the measure of the physician's duty to reveal.*" [54]

One positive by-product of the *Canterbury* line of cases is that reference to the patient's wishes, as a legal standard, reduces the physician's sometimes excessive concern about liability. The physician is encouraged to respect the wishes of his patient and under the *Canterbury* standard he will be said to have acted with due care if those wishes are followed.

B. The Right of Privacy

The United States Supreme Court has not taken the opportunity to decide whether the right of privacy is applicable to terminally ill patients.[55] Four state supreme courts have held, however, that the constitutional guarantee of privacy is clearly the central factor in any judicial decision-making process involving a refusal of life-prolonging treatment.[56]

All of these courts have identified several state interests which must be considered in determining whether the right of privacy will compel

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1973); Scott v. Bradford, 606 P.2d 554 (Okla. 1979); Getchell v. Mansfield, 260 Or. 174, 489 P.2d 953 (1971); Cooper v. Roberts, 220 Pa. Super. Ct. 260, 286 A.2d 647 (1971); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Small v. Gifford Memorial Hosp., 133 Vt. 552, 349 A.2d 703 (1975); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (Ct. App. 1974), *aff'd per curiam,* 85 Wash. 2d 151, 530 P.2d 334 (1975); Scaria v. St. Paul Fire & Marine Ins. Co., 68 Wis. 2d 1, 227 N.W.2d 647 (1975). The *Canterbury* standard gives the concept of self-determination distinctly greater evidentiary weight, and implicitly upholds the patient's right-to-know. The modification of the doctrine has certainly worked to reduce the number of cases of abuse of medical discretion on the issue of informed consent. It helps to avoid the analytical dilemmas presented in cases where treatment is complicated and some information is communicated by the doctor. Curiously, a legal standard having the patient's needs as a central reference also serves to limit the possibility of wrong opinion by judges and lawyers, as well as doctors. As litigators say, it becomes a "question of fact," not susceptible to faulty judicial analysis.

[54] Cobbs v. Grant, 8 Cal. 3d 229, 243, 245, 502 P.2d 1, 10, 11, 104 Cal. Rptr. 505, 514, 515 (1972) (emphasis added).

[55] For example, the United States Supreme Court denied certiorari to the New Jersey *Quinlan* decision. *See* 429 U.S. 922 (1976).

[56] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied,* 429 U.S. 922 (1976); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980). *See also In re* Spring, 1980 Mass. Adv. Sh. 1209, 405 N.E.2d 115, 123 (1980) (clarifying *Saikewicz*).

termination of treatment in a particular case. They include: 1) preservation of life; 2) protection of innocent third parties, such as dependent children and fetuses; 3) protection of incompetent patients; and 4) maintenance of the integrity of the medical profession.[57]

Discussion of these issues is beyond the scope of this article. It must be emphasized, however, that the legislative process, although considerably more deliberative, must take account of these factors in moving toward an efficacious solution. Each of the courts mentioned has concluded that the constitutional right of privacy will mandate termination of treatment in any situation where the prognosis is terminal and degree of suffering is great.[58]

C. The Right to Refuse Treatment

Whether drawn from the law of informed consent or from constitutional guarantees of individual self-determination, it is clear that there now exists a firmly recognized right to refuse medical treatment.

Erickson v. Dilgard,[59] a 1962 decision by a lower New York court, presaged this trend and is often cited as the first case recognizing the right. The court in *Erickson* declined to accept the prosecutor's argument that the patient's unexplained refusal to consent to a blood transfusion amounted to suicide under the penal law. The court reasoned that Dilgard's act was not suicide; it noted that, although Dilgard refused the transfusion, he was willing to undergo the surgery without the transfusion. It declared that "it is the individual who is the subject of a medical decision who has the final say and . . . this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires."[60] The court upheld the refusal as a legally protected right, and stressed the fact that the patient was at all times competent to make the decision.[61] The fact that recent

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[57] *See Quinlan*, 70 N.J. at 40-55, 355 A.2d at 663-72; *Saikewicz*, 373 Mass. at 741-44, 370 N.E.2d at 425-28; *Severns*, 421 A.2d at 1340-44; *Satz*, 362 So. 2d at 162-64. (The *Satz* citation is to the reasoning of the trial court's opinion, which was affirmed by the Florida Supreme Court.) There may be considerable overlap in analysis of the issues, depending upon the facts of the case. *Saikewicz* and *Satz* also mention an interest in the prevention of suicide, but this interest is just another way of expressing the state's concern with the preservation of life.

[58] *See Quinlan*, 70 N.J. at 39, 355 A.2d at 663; *Saikewicz*, 373 Mass. at 737-38, 743-44, 370 N.E.2d at 423, 426-27; *Severns*, 421 A.2d at 1341-42, quoting *In re* Spring, 405 N.E.2d at 119; *Satz*, 379 So. 2d at 360.

[59] 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

[60] *Id.* at 28, 252 N.Y.S.2d at 706.

[61] *Id.*

decisions have been based on *Erickson* is an indication of the farsightedness of its reasoning.[62]

D. The Never-Competent Patient

John Storar, age fifty-two, was, according to the facts adduced in *In re Storar*,[63] a lifelong resident of the Newark (New York) Developmental

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[62] *See also In re* Brooks' Estate, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re* Osborne, 294 A.2d 372 (D.C. 1972). Many of the cases decided since *Erickson* have involved Jehovah's Witnesses, thereby raising, in addition to the common law consent doctrine, the 1st Amendment right to the free exercise of one's religious beliefs. On one hand, the patients in these cases are in a stronger legal position because their refusal is raised to a constitutional level; on the other hand, they are often victims of accidents who would be restored to vigorous long life by the disputed treatment, rather than victims of terminal illness, in which the treatment would offer no more than a temporary delay of death. Many courts have drawn a significant distinction between these two conditions. It is also more likely that the accident victim will have dependent children. Thus, decisions involving refusals to consent to treatment for religious reasons vary widely from jurisdiction to jurisdiction, and depend upon the particular facts. *In re* Brooks' Estate, 32 Ill. 2d 381, 205 N.E.2d 435, decided in 1965, involved a female Jehovah's Witness who refused a transfusion necessary for treatment of a peptic ulcer. The Supreme Court of Illinois vacated a lower court transfusion order, *post facto*, on 1st Amendment free exercise grounds. The court emphasized the patient's awareness of the consequences of the decision, the strength of her religious belief, and the court's reluctance to impose value judgments concerning that belief. In 1972, a panel of the D.C. Appellate Court upheld a patient's right to refuse treatment on 1st Amendment religious grounds, even though two minor children would lose their sole provider as a result. (There were assurances given, however, that the children would be adequately provided for by the patient's wife and family). [*In re* Osborne, 294 A.2d 372 (D.C. 1972)]. Since then, several courts have upheld the right, as a religious one, although with language indicating that the result might have been different if it had involved injury to third parties (*i.e.*, children), or danger of conduct contrary to the general welfare of society. Most recent decisions have, however, held against the exercise of the religious right, reasoning that the preservation of life and the protection of incompetents are sufficiently important societal concerns to warrant compulsory treatment even in the face of an attempted good-faith exercise of religious belief.

Resolution of 1st Amendment questions involving the free exercise of one's religious beliefs triggers application of a balancing test: the state's interest in life and public order are weighed against the right of the individual to the free exercise of his religion. Since this is an analytical framework that permits courts to speculate on and express their own views of societal concerns, American courts have repeatedly held that the state may regulate religious practice. Particularly, where religious practice may touch upon fundamental societal concerns and threaten life, most courts have not hesitated to condemn and prohibit the practice, especially in cases affecting minor children. *Osborne* and its progeny have, however, continued to play an important role in the shaping of the law. Where refusal is on 1st Amendment grounds alone, the patient and his legal representative should be aware of individual factors which may distinguish their case from others previously adjudicated. *See, e.g.*, Reynolds v. United States, 98 U.S. 145 (1879); Jacobson v. Massachusetts, 197 U.S. 11 (1905); Cude v. State, 237 Ark. 927, 377 S.W.2d 816 (1964); State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962); Raleigh Fitkin-Paul Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

[63] *In re* Storar, 106 Misc. 2d 880, 433 N.Y.S.2d 388 (Sup. Ct.), *aff'd*, 78 A.D.2d 1013, 434 N.Y.S.2d 46 (App. Div. 1980) (memorandum order), *rev'd*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

Center, an institution operated by the New York State Office of Mental Retardation and Developmental Disabilities. Storar had always been profoundly mentally retarded. His IQ was assessed at between 10 and 20, with a corresponding mental age of between one and one-half and two years. At the time of trial, in November of 1980, he was only able to express himself by grunts and growls and completely unable to adhere to daily routines, thereby requiring round-the-clock supervision.

In July, 1979, Storar's physicians determined that he was suffering from invasive, transitional carcinoma of the bladder. On March 17, 1980, his condition was diagnosed as terminal and incurable. Between March and November, the patient's condition substantially deteriorated. The cancer metastasized to Storar's lungs, and testimony indicated probable metastasis to his liver and brain as well. Lesions of the bladder caused extensive bleeding.

On May 13, 1980, Storar's attending physicians ordered blood transfusions to counteract his massive blood loss. After the blood transfusions commenced, Storar's condition continued to worsen, and by November could only be described in the most tragic terms:

> Although he is still ambulatory and can feed himself, Storar's physical condition has steadily deteriorated. In March, 1979, he weighed 150 pounds. In August, 1980 his weight was down to 108 pounds. He is pale, has diminished appetite and is subject to frequent attacks of nausea and emesis (vomiting). He naps frequently and spends most of his time in his room, either in bed or on the commode. . . . In contrast to his behavior prior to the commencement of the transfusions, Storar now very seldom ventures outside his room. . . . Even after blood transfusions he remains weak.
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> In addition, and as a direct result of the transfusions, there is frequent clotting in Storar's urine which makes urination quite painful. The clots increase in both size and number and he bleeds extensively after a transfusion. Each time he goes to the bathroom, the blood and clotting are present. He becomes very upset when he urinates blood, particularly because it seems that he has made a primitive connection between the blood going in and the blood coming out.
>
> There is no question but that Storar's illness causes him intense pain and discomfort. . . . One physician described it as a "strangling pain," characterized by frequent involuntary con-

> tractions of the bladder in an attempt to expel the cancerous mass. The pain and the need for medication increase as the cancer spreads.[64]

The trial court's decision authorizing termination of blood transfusions was affirmed by the New York intermediate appellate court,[65] but the orders of both these courts were stayed and the transfusions continued during the entire appeals process.[66] In a startling opinion, the Court of Appeals reversed both lower courts.[67] Perhaps it was fortunate, under the circumstances, that John Storar died during the pendency of the matter in the Court of Appeals.[68]

Storar must have suffered tremendously during this period. His mother, seventy-seven years old and his guardian, persisted in her efforts to terminate the treatment. Although Storar was deceased at the time of the Court of Appeals decision, the Court decided to address the issues.[69]

A careful reading of the opinion leaves one with the impression that the court will refuse to order termination of treatment in any case involving a never-competent patient.[70]

Storar is similar to the *Saikewicz* decision of the Massachusetts Supreme Judicial Court,[71] in that it involved a patient who had never been

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[64] 106 Misc. 2d at 882-83, 433 N.Y.S.2d at 392.

[65] 78 A.D.2d 1013, 434 N.Y.S.2d 46 (App. Div. 1980), *rev'd*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

[66] 52 N.Y.2d 363, 369, 420 N.E.2d 64, 66, 438 N.Y.S.2d 266, 268 (1981).

[67] 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

[68] *Id.* at 369, 420 N.E.2d at 66, 438 N.Y.S.2d at 268.

[69] The court decided that the matters were not moot. *Id.* at 369-70, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.

[70] Although this was not so stated *explicitly*, the court did declare that "[m]entally John Storar was an infant and that is the only realistic way to assess his rights in this litigation. . . . A parent or guardian has a right to consent to medical treatment on behalf of an infant. . . . The parent, however, may not deprive a child of lifesaving treatment, however well intentioned." *Id.* at 380, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. Whether the court's holding in *Storar* absolutely precludes termination of treatment for never-competent patients depends upon its definition of "extraordinary life-prolonging" measures. By terming the blood transfusions in question "analogous to food" (52 N.Y.2d at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275), the court seemed to indicate that the transfusions were *not* the equivalent of a life-prolonging measure, such as the use of a respirator. The court made no attempt, though, to define "extraordinary" treatment, nor did it make an effort to give guidelines for future litigation. The term "extraordinary" care, as used in this article, may be defined as that kind of treatment which offers no reasonable hope of benefit to the patient and cannot be utilized without severe pain or undue expense.

[71] Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). Saikewicz was a profoundly retarded inmate of the Belchertown State School who contracted

competent to make fundamental decisions. Unlike *Saikewicz*, though (which, by using a "substituted judgment" standard, reached an opposite conclusion), the *Storar* court never attempted to address the constitutional issues involved. Relying instead on New York case law,[72] the court held that "it is unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent."[73]

Analogizing Storar's situation to that of an infant, the Court concluded that to allow termination of transfusions would be allowing the patient to "bleed to death"[74] and that "[i]f it is desirable to enlarge the role of the courts in cases involving discontinuance of life sustaining treatment for incompetents . . . the change should come from the Legislature."[75]

The *Storar* opinion provides no guidance for guardians, lawyers, physicians, family members, and lower courts, all more intimately involved with the plight of incompetent terminally-ill patients than are appellate-level courts. A proliferation of litigation will doubtless be the result. Furthermore, the court's opinion is likely to generate the same kind of critical commentary which followed the *Saikewicz* decision in 1977.[76]

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acute myeloblastic monocytic leukemia. Although the court addressed the constitutional issues raised by the parties and decided them in the patient's favor, the decision was interpreted as mandating litigation in every case involving incompetent patients. This interpretation caused a groundswell of litigation in the lower Massachusetts courts. *See In re* Dinnerstein, 1978 Mass. App. Ct. Adv. Sh. 736, 380 N.E.2d 134 (Mass. App. 1978); Lane v. Candura, 1978 Mass. App. Ct. Adv. Sh. 588, 376 N.E.2d 1232 (Mass. App. 1978). The matter was not resolved until the Massachusetts Supreme Judicial Court decided *In re* Spring, 1980 Mass. Adv. Sh. 1209, 405 N.E.2d 115 (1980). The *Spring* court cautioned:

> Neither the present case nor the *Saikewicz* case involved the legality of action taken without judicial authority, and our opinions should not be taken to establish any requirement of prior judicial approval that would not otherwise exist. The cases and other materials we have cited suggest a variety of circumstances to be taken into account in deciding whether there should be an application for a prior court order with respect to medical treatment of an incompetent patient.

1980 Mass. Adv. Sh. at 1215, 405 N.E.2d at 120-21.

[72] *In re* Hofbauer, 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979); *In re* Sampson, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972); *In re* Vasko, 238 A.D. 128, 263 N.Y.S. 552 (App. Div. 1933).

[73] 52 N.Y.2d at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

[74] *Id.* at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

[75] *Id.* at 382-83, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

[76] *See, e.g.*, Annas, *Judges at the Bedside: The Case of Joseph Saikewicz*, 6:1 MEDICOLEGAL NEWS 10 (Spring 1978); Legislative Research Council, THE DEFINITION OF DEATH AND THE "LIVING WILL," MASS. H. REP. NO. 5380 at 26, 39-45 (March 8, 1978); Curran, *Law-Medicine Notes: The Saikewicz Decision*, 298:9 N. ENG. J. MED. 499 (1978); Relman, *The Saikewicz Decision: Judges as Physicians*, 298:9 N. ENG. J. MED. 508 (1978).

Although the opinion clearly identifies the need for legislation, it also effectively closes the courthouse door in New York to guardians and relatives of incompetent patients who may seek relief from a physician's refusal to terminate life-prolonging treatment. It is against this backdrop that living will legislation will be considered.

Legislation

It is clear that legislation is the only concrete approach available to our legal system in dealing with problems associated with the terminally ill. Judge-made rules of decision in such a complex area of the law cannot keep pace with changing societal conceptions of life and death and the sophisticated technological innovations spawned by rapid advances in the medical sciences. Modern medicine can now "miraculously prolong the life of terminal patients with its arsenal of respirators, heart-lung machines, pacemakers, antibiotics, difibrillators, chronic dialysis, hypothermia, and artificial or transplanted organs. Modern technology . . . can also ventilate a corpse or prolong death when life as we know it has long passed."[77]

Courts are not fully equipped to deal with controversies involving such far-reaching political, moral, and ethical dimensions. Legislation has always been the more appropriate response to the societal need for resolution of difficult questions. The legislative process is considerably more deliberative and allows legitimate input from most segments of society. Living-will statutes are, therefore, an appropriate legislative solution to some of the problems created by the bio-medical technology available today. These statutes, in various forms, have been enacted in eleven states.[78] Given the number of bills now being considered in state legislatures, it is reasonable to assume that many more legislative proposals will

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[77] Akers, *The Living Will: Already a Practical Alternative,* 55 TEX. L. REV. 665, 666 (1977).

[78] Alabama: Natural Death Act, ALA. CODE §§ 22-8A-1 to -10 (Cum. Supp. 1981); Arkansas: Death with Dignity, ARK. STAT. ANN. §§ 82-3801 to -3804 (Cum. Supp. 1981); California: Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Cum. Supp. 1980); Idaho: Natural Death Act, IDAHO CODE §§ 39-4501 to -4508 (Cum. Supp. 1980); Kansas: Natural Death Act, KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1980); Nevada: Withholding or Withdrawal of Life Sustaining Procedures, NEV. REV. STAT. §§ 449.540 to .690 (1979); New Mexico: Right to Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (1978); North Carolina: Right to Natural Death; Brain Death, N.C. GEN. STAT. §§ 90-320 to -323 (1981); Oregon: Rights with Respect to Terminal Illness, OR. REV. STAT. §§ 97.050 to .090 (1979); Texas: Natural Death Act, TEX. REV. CIV. STAT. ANN. art. 4590h §§ 1 to 11 (Vernon Cum. Supp. 1980-1981); Washington: Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010 to .122.905 (West Cum. Supp. 1980).

soon become law.[79] This is not meant to suggest that the proposed bills will have an easy time in the various legislatures.[80] The eleven statutes now on the books became law primarily because of continued public awareness and concern with the issue, including that of legislators who have had personal contact with the dying. These efforts will continue, with new legislation the undoubted result.

In considering the legal impact of legislation in this area, the role that state legislation has played in relation to medical practice will be briefly discussed, and then living-will legislation will be contrasted with other types of medico-legal statutes. Secondly, an analysis of the current statutory law, with particular emphasis upon the problems of the incompetent patient, will be offered. Finally, some recent legislative proposals will be examined, and the question of whether uniform legislation might be a viable alternative in this area will be considered.

Conceptually, living-will statutes can be grouped into three categories: binding if executed after terminal diagnosis,[81] binding whenever executed,[82] and non-binding (advisory).[83] This analysis will show that the competence or incompetence of the patient can be a decisive factor in determining the form of decision-making process to be followed under

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[79] Thirty-seven pieces of Death with Dignity legislation were introduced in 21 legislatures (including the District of Columbia) during the 1981 legislative session. *See* NEWSLETTER OF THE SOCIETY FOR THE RIGHT TO DIE [hereinafter SOCIETY] Spring 1981. *See also* SOCIETY, 1981 HANDBOOK (1981); SOCIETY, HANDBOOK OF ENACTED LAWS (1981).

[80] Time Magazine on October 11, 1976 reported:

> [i]t has become a profoundly perplexing question for doctors and, indeed, all of society: Should heroic measures—respirators and other marvels of modern medical technology—be used to prolong the lives of the dying who no longer want to live? Last week California gave its answer. It became the first state to legalize the right of the terminally ill to decree their own deaths.
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> . . . .
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> Passed by a 43-to-25 vote in the California assembly after a bitter fight, the bill gained significant support in the wake of the case of Karen Anne Quinlan, the New Jersey girl who slipped into an apparently irreversible coma. Karen's parents spent six months battling for the right to die with dignity. Though the California bill specifically disavows "mercy killing" and allows anyone designated by the patient to rescind the death directive, California's pro-life forces strenuously opposed the measure as the first step toward euthanasia. Said one Democratic assemblyman, Vincent Thomas: "The trend seems to be to get rid of the senile, insane and crippled people. Our next move will be to get rid of everyone."

TIME, Oct. 11, 1976, at 101 (footnote omitted).

[81] California, Idaho, Oregon, and Texas. *See* pp. 125-28 *infra*.

[82] Alabama, Arkansas, Kansas, New Mexico, and Washington. *See* discussion of this category of legislation at pp. 130-33 *infra*.

[83] Nevada and North Carolina. *See* note 104 *infra* and accompanying text.

each of the three statutory schemes. The most recently enacted legislation represents a qualitative improvement in lawmaking over the eight death with dignity statutes passed in 1976 and 1977.[84] With two exceptions,[85] all of the earlier bills contain many unduly restrictive provisions.[86] These provisions tend to work to the disadvantage of the incompetent patient, especially one who has made a prior written expression of wishes. Using this conceptual framework a comparison of more recently enacted legislation with the older bills will be made, and an indication of the direction legislatures seem to be taking will be given.

Increasing Regulation of Medical Practice

The legal status of the doctor-patient relationship is a creature of the common law; it has consistently been defined by reference to prior cases, custom, usage, and traditional medical practice. Although medical practice has always to some extent been regulated by governmental authority, for example, by The Code of Hammurabi,[87] abortion statutes,[88] and Medical Licensing Acts,[89] lawmakers generally have not concerned themselves with the day-to-day practice of the physician. If an instance of negligence, battery, or other breach of the physician's obligation should arise, the state legislatures are content to allow the courts and professional boards to use a case-by-case approach.

In recent times, the legislative attitude has changed somewhat. This is due, at least in part, to social change. Our society becomes more

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[84] Statutes in Washington, Kansas, and Alabama, all having been signed into law since March of 1979, are the most recently enacted bills. *See* note 78 *supra*. Each of these statutes would give substantial relief to an incompetent patient, since directives signed in those states are binding and enforceable under all circumstances, provided the declarant is competent when the directive is executed.

[85] Arkansas' Death with Dignity Law, ARK. STAT. ANN. §§ 82-3801 to -3804 (Cum. Supp. 1981), and New Mexico's Right to Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (1978), cannot be considered restrictive in any real sense. (*See* notes 137 to 144 and accompanying text at pp. 131-32 *infra*.) They are the only statutes containing provisions for execution of directives on behalf of minors and incompetents. ARK. STAT. ANN. § 82-3803; N.M. STAT. ANN. § 24-7-4.

[86] *See* discussion of the California Natural Death Act at pp. 125-28 *infra*. The California Act served as a model for most of the bills passed before 1978.

[87] THE BABYLONIAN LAWS 6, 78-81 (Driver & Miles ed. 1955).

[88] *See, e.g.*, KY. REV. STAT. §§ 311.710 to .990 (1977 & Supp. 1978); CONN. GEN. STAT. ANN. §§ 53-29 to -31b (West 1960 & Supp. 1981).

[89] *See, e.g.*, N.J. STAT. ANN. §§ 45:9-1 to -58 (West 1978 & Supp. 1981) (Medicine & Surgery); N.J. STAT. ANN. §§ 45:6-1 to -69 (West 1978 & Supp. 1981) (Dentistry); PA. STAT. ANN. §§ 35-6801 to -6805 (Purdon 1977 & Supp. 1980) (Emergency Medical Technicians). *See also* Bruns v. Department of Registration and Educ., 59 Ill. App. 3d 872, 376 N.E.2d 82 (App. Ct. 1978) (discussing license revocation procedures).

impersonal, complex, and fraught with hidden danger as a result of inattention from our fellow human beings. Hospital practices have become increasingly cold and routinized, with little thought given to the personal, human needs of the patient.[90] In the urban depersonalized setting, the family doctor has all but disappeared. It is no longer unusual for patients to consult a complete stranger about life and death matters. Consequently, state legislatures have passed many laws regulating the physician's conduct in cases where fundamental interests are involved. For example, doctors are now required by law to keep scrupulous records and notify the proper authorities whenever they witness a birth or death,[91] treat a case of contagious disease,[92] or suspect a case of child abuse or neglect.[93] Many states have enacted statutes defining the nature and content of the disclosure required where surgery or emergency procedures are medically indicated.[94] In states where "good samaritan" statutes are on the books, the physician is encouraged to render aid at the scene of an accident or other emergency, without fear of liability.[95]

These statutes are legislative responses to particularized societal needs, and they all make some attempt to supply needed codification and enforcement of the fiduciary obligation of the physician in critical situations. Perhaps the most striking example of such a codification may be found in the Uniform Anatomical Gift Act, a recently proposed statutory scheme governing organ transplants, now law in all fifty states and the District of Columbia.[96] Any physician or hospital designated as donee or recipient of an organ cannot, under the law, "participate in the procedures for removing or transplanting" the body part, for obvious reasons.[97] Similarly, the physician who attends the donor at death and the physician who certifies death may not be involved in the organ transfer.[98]

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[90] *See, e.g.*, Netsky, *Dying in a System of "Good Care": Case Report and Analysis*, 39:2 THE PHAROS 57 (April 1976).

[91] *See, e.g.*, N.J. STAT. ANN. § 26:8-30 (West Supp. 1981).

[92] *See, e.g.*, N.J. STAT. ANN. §§ 26:4-15 to -26 (West 1964).

[93] *See, e.g.*, N.J. STAT. ANN. §§ 9:6-8.8 to .20 (West 1976 & Supp. 1981).

[94] *See, e.g.*, PA. CONS. STAT. ANN. § 40:1301.103 (Purdon Supp. 1980); N.Y. PUB. HEALTH LAW § 2805-d (McKinney 1977); OHIO REV. CODE ANN. § 2317.54 (Page Supp. 1979). One study has asserted that passage of these statutes was a direct response by state legislatures to the "medical malpractice crisis" of the mid-1970's. Meisel and Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 410 (1980).

[95] *See, e.g.*, N.J. STAT. ANN. §§ 2A:62A-1 to -2 (West Supp. 1981); N.Y. EDUC. LAW. § 6527 (McKinney 1972).

[96] UNIFORM ANATOMICAL GIFT ACT, §§ 1-11, 8 UNIFORM LAWS ANN. 15-44 (1979 & Supp. 1980).

[97] *Id.* at § 4(c).

[98] *Id.* at § 7(b).

Although there is some doubt as to whether the statute goes far enough in protecting patients, it is clear that such a regulation is bound to have a salutory effect upon the conduct of physicians. Given the ease with which certain transplants are now accomplished, the abdication of legislative responsibility in this area would almost certainly have caused chaos in hospitals, and voluminous litigation in the courts.

Death With Dignity Legislation

Eleven states have undertaken a similar responsibility with respect to terminally ill patients[99] by passing right-to-die legislation. These statutes also alter the traditional common law status of the physician-patient relationship by codifying and enforcing the physician's fiduciary obliga- his patient and to society at a critical moment in the patient's life. There is no other time in life when the patient's wishes, desires, comfort, and dignity are more paramount than when he is about to die. Although cold indifference shown by the physician at such a time might not be actionable malpractice, it is clear that a doctor who does not seek to comfort the patient during his last moments breaches a fiduciary duty to the patient and the trust placed in him by society. The rote, mindless administration of death-prolonging "extraordinary" medical measures to the dying patient amounts at least to insensitivity to the patient's needs, and arguably to a breach of the hospital's and physician's duty in that regard.

Living will statutes, like the Anatomical Gift Acts, serve evidentiary and protective functions[100] for the patient, family, doctor, and the community at a crucial time when the doctor's fiduciary obligation is subject to influence from many directions. Typically, each state's statute allows for a written directive, commonly known as a "living will," to be executed by the patient before at least two witnesses, while he is competent, directing the attending physician, in the event of terminal illness, to conduct the course of treatment in a particular manner.[101] All of the

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[99] Alabama, Arkansas, California, Idaho, Kansas, Nevada, New Mexico, North Carolina, Oregon, Texas, Washington.

[100] Living will statutes are analogous to testamentary wills statutes as well. In New Jersey, the basic purpose of the [Testamentary] Wills Act [N.J. STAT. ANN. §§ 3A:2A-3 to -32 (West Supp. 1981)] was to safeguard the testamentary act against fraud by the living upon the dead. *See In re* Taylor, 28 N.J. Super. 220, 100 A.2d 346 (App. Div. 1953). Just as many people die intestate, many people also die without benefit of a living will. No one would dare argue that state law should not include a testamentary wills act because people will continue to die intestate. Where the dying do attempt to give directions, society *must* impose rules in order to prevent instances of fraud, and to provide some semblance of uniformity for those who wish to memorialize their last intentions.

[101] *See, e.g.*, OR. REV. STAT. §§ 97.050 to .090 (1979); WASH. REV. CODE ANN. §§ 70.122.010 to .122.905 (West Cum. Supp. 1980).

statutes except Arkansas' require a pre-withdrawal diagnosis of terminal illness by a physician. Nine of the statutes specify that some certifiable record of the diagnosis be made after mandatory consultation with one or more other physicians.[102]

The directive, put simply, is nothing more than a written memorialization of the patient's instruction to his doctor. It defines the nature and extent of the patient's consent to medical treatment; it allows for the specification of various treatment alternatives in the event that certain foreseeable complications occur. Its contents can be pondered and debated at a time, hopefully, when the patient is not racked with pain or heavily sedated. A living will can serve as definitive evidence of a patient's prior wishes, removing any doubt in the minds of those who might question the representations of next of kin. Perhaps the most important benefit to be derived from the living will is its ability to eliminate costly and time-consuming litigation. It is true that those who have been incompetent for all of their lives will never be able to execute a living will. It should be noted, however, that five out of the seven plaintiffs seeking termination whose cases have reached the highest state courts were people who had been competent prior to the onset of the terminal illness.[103] Binding legislation and the existence of a valid directive from the patient would probably have eliminated litigation in each of those five cases. Curiously, two states, North Carolina and Nevada, do not require compliance with the directive by the physician, but, rather, allow him to consider the directive as an advisory communication from the patient, to be considered in light of all the surrounding circumstances.[104] Those statutes which do make such a directive binding on a physician fall into two groups: those requiring execution or re-execution after a diagnosis of terminal illness has been entered in the medical record,[105] and those declaring the directive to be binding regardless of when the period of terminal illness begins.[106]

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[102] Idaho allows certification by one doctor alone. IDAHO CODE §§ 39-4501 to -4508 (Cum. Supp. 1981).

[103] Karen Ann Quinlan: *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); Abe Perlmutter: Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); Earle N. Spring: *In re* Spring, 1980 Mass. Adv. Sh. 1209, 405 N.E.2d 115 (1980); Mary Reeser Severns: Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); Brother Joseph Fox: *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

[104] NEV. REV. STAT. § 49.640 (1979); N.C. GEN. STAT. § 90-321(b) (1981).

[105] California, Idaho, Oregon, and Texas. *See* discussion pp. 125-28 *infra*.

[106] Alabama, Arkansas, Kansas, New Mexico, and Washington. *See* discussion pp. 130-33 *infra*.

Binding If Executed After Diagnosis

California, Idaho, Oregon, and Texas permit the withdrawal or withholding of life-sustaining medical care for terminally ill patients if, and only if, the document authorizing such action is executed by the patient after a terminal diagnosis has been made and communicated to the patient. Idaho's "Natural Death Act"[107] allows the attending physician to make such diagnosis alone. All others require confirmation of the diagnosis by at least one other physician. California and Oregon impose a fourteen-day "waiting period," during which time the patient must remain in a terminally ill condition before executing or re-executing the document.[108] Under Idaho and Texas law, withdrawal can be effectuated at any time after diagnosis and entry of the diagnosis in the medical record.[109] (The Texas statute was recently amended so as to remove the fourteen-day provision.)

The fourteen-day so-called "waiting period" is the centerpiece of the California and Oregon statutes. It is a good example of how the legislature's desire to enact protective provisions can place tremendous obstacles in the path of the patient and the patient's family. The "waiting period" is supposed to insure that the patient is, in fact, terminally ill, and thereby assure finality of decision. In point of fact, however, many dying patients do not live that long, even *with* the assistance of life-prolonging devices; in those cases the fourteen-day prohibition can only serve to prolong suffering and accumulate needless medical costs.

The California Natural Death Act was enacted on September 30, 1976, and became effective on January 1, 1977, the first "death with dignity" bill enacted in the United States. Idaho, Oregon, and Texas followed suit within a year. The California statute set the pattern for all of these early bills.

Its objectives were worthy and commendable, and the statute attempted to solve many of the problems raised in the cases and thereby end needless and expensive litigation. The California legislature, in my opinion, deserves considerable credit for having exhibited courage and boldness when other state legislatures were tentative and cautious in the face of criticism from organized medicine and various religious interest

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[107] IDAHO CODE §§ 39-4501 to -4508 (Cum. Supp. 1981).

[108] CAL. HEALTH & SAFETY CODE § 7191(b) (West Cum. Supp. 1980); OR. REV. STAT. § 97.075(2) (1979).

[109] IDAHO CODE § 39-4504 (Cum. Supp. 1981); TEX. REV. CIV. STAT. ANN. art. 4590h § 3 (Vernon Cum. Supp. 1980-1981).

groups.[110] By 1977, dying patients in eight states[111] could claim legal protection which, prior to that time, came only as a result of vigorous advocacy by the patients, their attorneys, guardians, and families: the California statute paved the way for these developments.

As noted, however, the fourteen-day waiting period has proven to be somewhat counter-productive. The California statute, like those of Oregon and Texas, depends upon the concept of the "qualified" patient—one who has been diagnosed and certified by two doctors as terminally ill.[112] The clear intent evidenced by the language of the statutory waiting period provision would seem to require the patient to remain a "qualified" patient during the entire fourteen-day period. Therefore, any purely temporary remission, if not diagnosed as such, could threaten the effectiveness of the directive and require a cautionary re-execution with witnesses, or perhaps a refusal by the doctor to honor the directive. This will especially be true in California, where the responsibility for determining the validity of the directive is placed upon the physician.[113] Of course, a valid will executed by a patient who has remained "qualified" for fourteen days must be followed.

A recent survey of physicians' practices conducted under the auspices of Stanford Law School and the Santa Clara County (Calif.) Medical Society bears out this conclusion.[114] Although doctors in the County were generally aware of the Act, only twenty-two percent of the 284 out of 920 contacted physicians who responded claimed to know the circumstances under which directives are binding or non-binding.[115] When asked to define "imminent" death, responses varied. Most physicians held that an imminent death was one likely to occur within one week; others said death must occur in less than twenty-four hours[116]–hardly a heartening response for patients in California, since death must be imminent before treatment may be withdrawn or withheld.[117] The statute does not define "imminent" death. Not surprisingly, the survey indicated that roughly one-half

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[110] *See* note 80 *supra*.

[111] Arkansas, California, Idaho, Nevada, New Mexico, North Carolina, Oregon, and Texas.

[112] CAL. HEALTH & SAFETY CODE § 7187(e) (West Cum. Supp. 1980); OR. REV. STAT. § 97.050(5) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h § 2(5) (Vernon Cum. Supp. 1980-1981).

[113] CAL. HEALTH & SAFETY CODE § 7191 (West Cum. Supp. 1980). *See generally* Meyers, *The California Natural Death Act: A Critical Approach,* 52 CALIF. ST. B.J. 326 (1977).

[114] *The California Natural Death Act: An Empirical Study of Physicians' Practices,* 31 STAN. L. REV. 913 (May 1979).

[115] *Id.* at 930.

[116] *Id.* at 933.

[117] CAL. HEALTH & SAFETY CODE § 7188 (West Cum. Supp. 1980).

of the patients who executed and delivered California directives died before the fourteen-day waiting period expired.[118] These results are stark testament to the need for clarifying amendments to the California Natural Death Act.

The "binding if executed after diagnosis" legislative scheme also presents problems for withdrawal of terminal care of incompetent patients, whether there is a "waiting period" or not. Problems will be exascerbated, however, in those states which impose the fourteen-day condition. Just as some may die prior to the expiration of the statutory period, others may become unconscious, comatose, or otherwise uncommunicative before they are able to execute or re-execute a directive.

Those statutes which require re-execution after terminal diagnosis tend to be unduly restrictive, because they require the patient to be competent at the time of re-execution. Thus, if a thirty-year-old wife and mother executes a living will on July 1, 1978, and three years later is involved in an automobile accident which leaves her in a chronic vegetative state, the doctor would not be statutorily bound to honor the previously executed directive, because the patient would not be competent to re-execute it. Under Oregon and Idaho law, there is no statutory authority for withdrawal in these circumstances. The Texas and California legislatures seemed to recognize the problem, and to attempt a solution.

Texas' Natural Death Act provides:

> (c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently re-executed the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justifies effectuating the directive. No physician, and no health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.[119]

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[118] *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 Stan. L. Rev. 913, 928 (May 1977).

[119] TEX. REV. CIV. STAT. ANN. art. 4590h § 7(c) (Vernon Cum. Supp. 1980-1981).

Section 7191(c) of the California Natural Death Act is exactly the same as the Texas statutory provision.[120] Apparently, physicians in California and Texas may, if the "totality of circumstances" justifies it, give effect to a directive *even though* the patient is unable to re-execute it after the onset of the terminal condition. Despite the ambiguity of these words, this provision does offer some measure of protection for patients who become incompetent and therefore unable to re-execute the document. Thus, in California and Texas, the living will that has not been re-executed becomes an advisory communication, much like those sanctioned by North Carolina and Nevada.

North Carolina: A Special Case

Perhaps the most far-reaching of the death with dignity laws is North Carolina's statutory scheme.[121] Originally passed on June 29, 1977, it gives coverage to the concept of brain death,[122] as well as legitimating the use of the living will. The statute follows the general format found in most other states—two unrelated witnesses are required;[123] the terminal diagnosis must be confirmed by a second physician;[124] a suggested form of directive is included, as well as forms for acknowledgment by witnesses.[125] The directive can be executed at any time. Doctors who comply with such directives are immune from civil or criminal liability;[126] the will is advisory only.[127]

Section 90-322 of the statute was amended, effective May 30, 1979, to allow withdrawal of extraordinary care even in the absence of a written

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[120] CAL. HEALTH & SAFETY CODE § 7191(c) (West Cum. Supp. 1980).

[121] N.C. GEN. STAT. §§ 90-320 to -323 (1981).

[122] *Id.* at § 90-323. Application of "brain death" criteria to a patient involves a conceptually distinct analysis, from both medical and legal standpoints. Under a brain death statute, a patient may be declared dead if he meets the medical criteria set forth by the Harvard Medical School Ad Hoc Committee to Examine the Definition of Brain Death, *Report: A Definition of Irreversible Coma*, 205 JOURNAL OF THE AMERICAN MEDICAL ASS'N 337 (1968). *See also* UNIFORM BRAIN DEATH ACT §§ 1 to 2, 12 UNIFORM LAWS ANN. 15-16 (Supp. 1980), now adopted in four jurisdictions. Between 1970 and 1978, 19 other states enacted legislation recognizing the concept of brain death. *Commissioners' Prefatory Note* to UNIFORM BRAIN DEATH ACT, *id.* at 15. The UNIFORM BRAIN DEATH ACT was superseded by the UNIFORM DETERMINATION OF DEATH ACT, 12 UNIFORM LAWS ANN. 187-88 (Supp. 1980), adopted by the National Conference of Commissioners on Uniform State Laws in August, 1980.

[123] N.C. GEN. STAT. § 90-321(c)(3) (1981).

[124] *Id.* at § 90-321(b)(2).

[125] *Id.* at § 90-321(d).

[126] *Id.* at § 90-321(h).

[127] *Id.* at § 90-321(b).

declaration.[128] If the patient is (a) comatose, (b) not reasonably expected to return to a cognitive sapient state, (c) incurable, and (d) terminal, physicians in North Carolina *may* discontinue life support systems at the request of spouse, guardian, or a majority of relatives of the first degree, in that order. A majority of a three-physician committee must confirm the attending physician's diagnosis before withdrawal may take place.

This procedure is a significant legislative step which will clearly assist the families of many patients and their doctors in reaching a decision. It is unreasonable to expect every patient in North Carolina to see a doctor or lawyer and execute a living will. In most states, even those with right-to-die legislation, the patient without a living will might suffer for an undetermined amount of time, or, if withdrawal is effected, the physician might wonder if he will be sued by some disgruntled relative or charged by a zealous prosecutor. The North Carolina procedure substantially reduces the likelihood of prolonged suffering and eliminates any fear of liability on the part of the physician.

Section 90-322 should, therefore, act to curtail litigation on behalf of comatose patients in situations similar to that of Karen Quinlan.[129] There has been much concern expressed recently concerning the question of whether court intervention should be required in all cases involving incompetents.[130] This question is of particular importance where the patient has not executed a declaration, or where there is no strong evidence of prior wishes. Most courts, when confronted with an incompetent, unconscious patient requesting termination of care through parent or guardian, will, as did the *Quinlan*,[131] *Saikewicz*,[132] and *Eichner*[133] courts, engage in a fairly extensive fact-finding and appellate process, often lasting several years. Ultimately, in most of the recent cases, the patient's right to die was upheld. The North Carolina procedure is less costly, less time-consuming, and will undoubtedly prevent a good deal of needless suffering and litigation.

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[128] *Id.* at § 90-322(b).

[129] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

[130] *See* Paris, *Sounding Boards—The N.Y. Court of Appeals Rules on the Rights of Incompetent Dying Patients*, 304 N. ENG. J. MED. 1424 (1981).

[131] *In re* Quinlan, 137 N.J. Super. 227, 148 A.2d 801 (Ch. Div. 1975), *rev'd*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

[132] Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

[133] *In re* Eichner, 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), *aff'd as modified sub nom.* Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (App. Div. 1980), *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). The Court of Appeals, deciding the *Eichner* matter in tandem with *Storar*, affirmed the trial court's order and distinguished Eichner's

Although the North Carolina statute substantially codifies the suggestions made by the *Quinlan* court by allowing the physician to act in accordance with family wishes and accepted medical practice without fear of liability,[134] it still suffers from limitations. There is no provision for the trial and punishment of those who falsely execute, alter, or otherwise tamper with a living will. The directive is advisory only. The doctor is not bound to follow it. Paradoxically, the attending doctor is allowed to terminate extraordinary care, at his "discretion," if no family is "available" to make the decision. What kind of discretion should be allowed to the physician in these circumstances? The "no-family" situation presents the courts with the most vexing and difficult cases. Should physicians be entrusted with this kind of authority? Is the concurrence of two other physicians enough to validate this decision? What is meant by the word "available"? A physician, acting in compliance with the North Carolina law, would be well advised to document *thoroughly* his search for "available" family members before deciding to discontinue extraordinary care.

The statute is barely four years old. It will be several years before a significant number of living wills are disseminated throughout the state. Use of the procedure outlined in section 90-322 will eliminate a significant amount of litigation and facilitate the medical profession's acceptance and orderly implementation of the wishes of patients and their families.

The North Carolina amendment allowing withdrawal in the absence of written directive[135] is, in spite of the statute's ambiguity, a tremendous legislative advance.

Binding Whenever Executed

Alabama, Arkansas, Kansas, New Mexico, and Washington[136] permit effectuation of living wills no matter when they are executed, provided that the patient is shown to be terminally ill.

Generally, under this formulation, it is likely that patients who have executed a directive and then fallen comatose as a result of sudden terminal illness or injury will be protected and their wishes honored. This will be a tremendous boon to incompetent patients who have previously signed living wills. The directive is binding under all circumstances and must be followed, or the patient must be transferred to another physician.

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situation from that of Storar on the basis of Eichner's clear expression of prior wishes in favor of termination.

[134] N.C. GEN. STAT. § 90-322(d) (1981).

[135] *Id.*

[136] ALA. CODE § 22-8A-2 (Cum. Supp. 1981); ARK. STAT. ANN. § 82-3802 (Cum. Supp. 1981); KAN. STAT. ANN. § 65-28, 105 (1980); N.M. STAT. ANN. § 24-7-3 (1978); WASH. REV. CODE ANN. § 70.122.010 (West Cum. Supp. 1980).

The Arkansas and New Mexico statutes also contain several specific provisions with respect to those who have never been competent to decide.[137] The Arkansas Death with Dignity bill, enacted in 1977, is extremely vague and open-ended in many places, yet its provision on incompetent or minor patients is quite specific. It provides:

> If any person is a minor or an adult who is physically or mentally unable to execute or is otherwise incapacitated from executing either document, it may be executed in the same form on his behalf:
>
> (a) By either parent of the minor;
>
> (b) By his spouse;
>
> (c) If his spouse is unwilling or unable to act, by his child aged eighteen or over;
>
> (d) If he has more than one child aged eighteen or over, by a majority of such children;
>
> (e) If he has no spouse or child aged eighteen or over, by either of his parents;
>
> (f) If he has no parent living, by his nearest living relative; or
>
> (g) If he is mentally incompetent, by his legally appointed guardian.
>
> Provided, that a form executed in compliance with this Section must contain a signed statement by two physicians that extraordinary means would have to be utilized to prolong life.[138]

The legislature's concern for the incompetent patient is commendable. As to the question of whether this provision will prevent litigation, to date there have been no reported cases in Arkansas concerning this issue. Unfortunately, section 82-3803 is no clearer than the balance of the statute. Who has the right in Arkansas to execute a living will on behalf of an adult mental incompetent? A first reading of the statute would seem to suggest that the family, in the designated order, has the right. Yet, section 3803(g) suggests that *only* a legally appointed guardian may exercise the right. What happens if there is a dispute between parents, or between parents and spouse? Litigation is the most likely result, since the statute does not prefer one class of relatives over another. Since such disputes usually find their way into the courthouse anyway, Arkansas'

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[137] ARK. STAT. ANN. § 82-3803 (Cum. Supp. 1981); N.M. STAT. ANN. § 24-7-4 (1978).

[138] ARK. STAT. ANN. § 82-3803 (Cum. Supp. 1981).

failure to give preferences among relatives is probably inconsequential if the primary objective of the statute is to prevent litigation. On the other hand, doctors may become perplexed concerning the proper and legal course to be followed, even after a reading of the statute, and petition a court for guidance, thereby delaying the decision-making process and ultimately increasing the costs and suffering involved.

The most interesting feature of the New Mexico statute is its provision allowing execution of a document for the benefit of a terminally ill minor.[139] The Act permits the minor's spouse, if the latter is adult, or, if there is no adult spouse, then either the parent or guardian, to execute a directive, provided that the minor has been certified as terminally ill. The declarant is required to petition the local district court for "certification" of the document, as well. The statute does not set out any procedural guidelines, but apparently the court proceeding is similar to that undertaken by courts when probating a testamentary will. Little discretion is given to the trial judge; the court's only task is to grant certification if it is "satisfied that all requirements of the Right To Die Act have been satisfied, that the document was executed in good faith and that the certification of the terminal illness was in good faith."[140] The certification of terminal illness must appear on the face of the document.

Only the state of Arkansas has enacted a similar provision,[141] and New Mexico, like Arkansas, has apparently not had any problem in implementing the procedure. Unlike California, New Mexico does not impose a waiting period; therefore, a directive can be effectuated any time after execution, and, in the case of a minor, after certification by the district court.[142]

The New Mexico statute also provides that a spouse, parent, or guardian of a minor may not execute a document on his behalf where the declarant "has actual notice of contrary indications by the minor" or "has actual notice of opposition by either another parent or guardian or spouse. . .."[143] Any declarant who executes a document after receiving actual notice of contrary intent from the minor, or opposition from a parent or guardian, is declared guilty of a second-degree felony.[144]

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[139] N.M. STAT. ANN. § 24-7-4 (1978).
[140] *Id.*
[141] ARK. STAT. ANN. § 82-3803 (Cum. Supp. 1981).
[142] N.M. STAT. ANN. § 24-7-4(D) (1978).
[143] *Id.* at § 24-7-4(B)(1) and (2).
[144] *Id.* at § 27-7-10(C).

These penal provisions have real teeth, and should make every person who executes a directive for a minor act carefully and prudently. The New Mexico statutory provisions concerning minors strike a careful balance between the rights of parents of terminally ill minors and the right of the state, as *parens patriae,* to insure protection for the welfare of children.

Physician Immunity

All of the right-to-die statutes immunize the physician from civil and criminal liability if he, in good faith, follows the dictates of the patient's directive authorizing the termination of treatment.[145] The immunity provisions of these statutes are, in many respects, far more important than other items, since they encourage physicians to act in situations where the fear of liability might otherwise be inhibiting. Elimination of the risk of liability promotes the probability that the patient's directions will be followed in appropriate circumstances.

Unfortunately, the immunity provisions vary in scope and specificity from state to state. The most interesting (and perhaps most extreme) example is California's scheme. Section 7190 grants immunity to any physician, health facility, or licensed health professional who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of the act.[146]

Standing alone, section 7190 offers the same safe harbor as do all the other subsequently-enacted statutes. However, the California act goes further. Section 7191(b) provides:

> (b) If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. *No physician. . . .shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision.* A failure by a physician to effectuate the directive of a qualified patient pursuant to this

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[145] *See* ALA. CODE § 22-8A-7 (Cum. Supp. 1981); ARK. STAT. ANN. § 82-3804 (Cum. Supp. 1981); CAL. HEALTH & SAFETY CODE § 7190 (West Cum. Supp. 1980); IDAHO CODE § 39-4507 (Cum. Supp. 1981); KAN. STAT. ANN. § 65-28,106 (1980); NEV. REV. STAT. § 449.630 (1979); N.M. STAT. ANN. § 24-7-7(B) (1978); N.C. GEN. STAT. § 90-321(h) (1981); OR. REV. STAT. § 97.065(2) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h § 6 (Vernon Cum. Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.050 (West Cum. Supp. 1980).

[146] CAL. HEALTH & SAFETY CODE § 7190 (West Cum. Supp. 1981).

> division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.[147]

The practical effect of this provision is to prohibit criminal action or civil litigation for damages against a physician who refuses either to effectuate a binding directive or to transfer a patient to another physician so that the directive might be carried out. Although such conduct is deemed to be unprofessional, the only sanction available is through the professional licensing boards, a sometimes hollow remedy. In this respect, dying patients are deprived of a common law remedy they would otherwise retain; the physician who ignores the law in California is now no longer liable for conduct which would have heretofore rendered him liable in damages.

Unlike California, New Mexico does not provide its physicians with blanket immunity from civil and criminal liability.[148] Rather, section 7 of the New Mexico statute confers a presumption of good faith, provided the physician relies on a properly-executed document with no actual notice of revocation or contrary indication. The statute expressly allows anyone to allege and prove, presumably in a civil action, that the physician's actions violated the "standard of reasonable professional care and judgment under the circumstances."[149]

These provisions grant the physician the familiar "qualified immunity" from civil liability frequently accorded public officials who are required to make a good-faith effort to discharge certain duties arising under case law, statutes, codes, and ordinances.[150] This is a much more

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[147] *Id.* at § 7191(b) (emphasis added).

[148] N.M. STAT. ANN. § 24-7-7 (1978).

[149] *Id.* at § 24-7-7(B).

[150] Dean Prosser, in his hornbook on Torts, noted that:

> There are a number of classes of defendants upon whom the law, for various reasons of policy, has in the past conferred immunity from tort liability to a greater or less extent. An immunity differs from a privilege, or justification or excuse, although the difference appears to be largely one of degree. The privilege avoids liability for tortious conduct only under particular circumstances, and because these circumstances make it just and reasonable that the liability shall not be imposed, and so go to defeat the existence of the tort itself. An immunity, on the other hand, avoids liability in tort under all circumstances, within the limits of the immunity itself; it is conferred, not because of the particular facts, but because of the status or position of the favored defendant; and it does not deny the tort, but the resulting liability. Such immunity does not mean that conduct which would amount to a tort on the part of other defendants is not still equally tortious in

sensible and realistic way to handle the immunity problem. The scheme reassures the competent physician and encourages him to act, while affording the family some protection against misdiagnosis, or worse, actions taken in bad faith by the physician. The New Mexico legislature has again achieved a balancing of two strong competing interests in a fashion which does not elevate the position of any particular actor.

Most of the other statutory immunity provisions fall somewhere between those of California and New Mexico. Like California, Arkansas grants immunity to "any person, hospital, or other medical institution which *acts or refrains from acting* in reliance on and in compliance with"[151] a living will. Nevada, Texas, and Washington immunize the physician from criminal or civil liability "for failing to effectuate the directive of the qualified patient."[152] On the other hand, Oregon's Right-to-Die Act, while immunizing the physician who in good faith participates in withdrawal or withholding of treatment,[153] provides that nothing in the Act "shall impair or supersede any legal right *or legal responsibility* which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner."[154] Presumably, if a living will is properly executed, witnessed, and delivered to a physician in Oregon, he would not have the luxury to ignore it. Other sections of the Oregon Act clearly provide that, although the physician cannot be forced to participate in the decision, he must make a reasonable good-faith effort to transfer the patient to someone who will give effect to the directive.[155] If the physician does not make such an effort, he will be exposed to civil liability for battery, negligence, and false imprisonment, as well as a charge of unprofessional conduct by the Oregon medical licensing board.[156] Thus, the Oregon statute expressly preserves the pa-

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character, but merely that for the protection of the particular defendant, or of interests which he represents, he is given absolution from liability.

PROSSER, TORTS 970 (4th ed. 1971) [footnote omitted]. The "qualified immunity" is usually one which is conditioned upon the defendant's exercise of good faith. Additionally, the defendant is charged with constructive knowledge of the "settled" or "undisputed" law. *See generally* Pierson v. Ray, 386 U.S. 547 (1967); Wood v. Strickland, 420 U.S. 308 (1975).

[151] ARK. STAT. ANN. § 82-3804 (West Cum. Supp. 1981) [emphasis added].

[152] NEV. REV. STAT. § 449.640 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h § 6 (Vernon Cum. Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.060(2) (West Cum. Supp. 1980).

[153] OR. REV. STAT. § 97.065(2) (1979).

[154] *Id.* at § 97.085(2) [emphasis added].

[155] *Id.* at § 97.070(3)(a) and (b).

[156] *Id.* at § 97.990(5) to (7).

tient's common law right to hold a physician liable in damages for failure to transfer the former to someone better able to effectuate treatment, or, as here, to authorize nontreatment, pursuant to the directive.

Idaho's Natural Death Act, while not imposing a statutory duty to transfer, provides:

> This chapter shall have no effect or be in any manner construed to apply to persons not executing a directive pursuant to this chapter nor shall it in any manner affect the rights of any such persons or of others acting for or on behalf of such persons to give or refuse to give consent or withhold consent for any medical care, neither shall this chapter be construed to affect chapter 43, title 39, Idaho Code, in any manner.[157]

Chapter 43, title 39 of the Idaho Code defines the parameters of the informed consent doctrine and codifies the physician's common-law responsibilities thereunder.[158] The Idaho law is therefore quite similar to Oregon's in that the common-law action sounding in battery for failure to obtain consent is preserved.

The Kansas and North Carolina statutes are silent on the question of preservation of the patient's common-law rights. Kansas, while granting immunity to the physician who participates,[159] expressly deems a refusal to act to be unprofessional conduct under the Kansas Medical Licensing Acts,[160] but says nothing more on the subject. North Carolina's silence on the issue is somewhat less significant, by virtue of the fact that a directive in that state is no more than an advisory communication in any case.[161]

In dealing with questions of immunity, courts have generally denied the existence of an immunity from civil liability, unless such immunity clearly appeared in the legislation or was an established precedent at common law.[162] Neither of those two conditions seems to be the case in Kansas or North Carolina. It is appropriate, therefore, to conclude that the patient's common law right of action for battery is probably preserved in these two states.

In sum, it is apparent that the statutory immunity provisions now in place in at least three of the states under consideration are in need of

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[157] IDAHO CODE § 39-4508(1) (Cum. Supp. 1981).

[158] *Id.* at §§ 39-430 to -443.

[159] KAN. STAT. ANN. § 65-28,106 (1980).

[160] *Id.* at § 65-28,107.

[161] N.C. GEN. STAT. § 90-321(b) (1981).

[162] *See, e.g.*, Owen v. City of Independence, 445 U.S. 622 (1980).

redrafting.[163] It may be argued that the results reached after analysis of the effect of these provisions are substantially in accord with the intent of the various legislatures. However, no statement exists which would lead one to believe that the legislatures intended to immunize physicians from the moment they received a living will, no matter what their course of action was. This obviously would be an untenable situation. It would seem that the legislative purpose in authorizing immunity for those physicians who fail to act was to prevent the legal condemnation of those who, for whatever reasons, could not in good conscience terminate life-prolonging care. Because of the use of ambiguous and somewhat truncated language, the statutes in question reach beyond the intended result and thereby encourage behavior contrary to the announced public policy of the states.

This situation also points up the need for uniform legislative treatment of the problem. The doctor is liable in Oregon for acts for which he would *not* be liable in California. This might be a tolerable situation, were we able to be solely dependent upon the common law courts for resolution. It has been shown, however, that litigation is certainly not a desirable result and should be avoided. It seems, therefore, that lawmaking must be uniform in order to avoid midnight ambulance rides across state borders.

The Need for Uniformity

The foregoing review of these selected statutes has highlighted the more commendable features of each, and pointed to a few glaring infirmities. There are many areas where statutory reform and definitional refinement would serve useful purposes. Every state enacting a right-to-die measure should allow for withdrawal of extraordinary care from minors and incompetents, either upon certification by a court where there is no family, or upon request of family or guardian, after confirmation by a committee of physicians. The New Mexico concept of "contrary indication"[164] could well be incorporated into every statutory scheme, provided that the term "actual notice" is adequately defined and the doctor's responsibility to notify relatives clarified.

The physician-immunity provisions are in need of substantial rewriting. Several statutes immunize a physician whether he follows the direc-

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[163] Arkansas: ARK. STAT. ANN. § 82-3804 (Cum. Supp. 1981); California: CAL. HEALTH & SAFETY CODE § 7190 (West Cum. Supp. 1980); Washington: WASH. REV. CODE ANN. § 70.122.050 (West Cum. Supp. 1980).

[164] N.M. STAT. ANN. § 24-7-6 (1978).

tive or not. A physician is immunized, therefore, from the moment the executed directive is delivered. Difficult questions are thus raised. Is the doctor liable for misdiagnosis? Shouldn't the doctor be liable for battery if he continues treatment after a lawful directive to cease? If he fails to comply with all the act's terms, does that failure completely vitiate immunity? How serious must his failure to comply be? Would the answers to these questions depend upon local state law?

Prof. Yale Kamisar makes an argument[165] which proves persuasive to some courts. In an attempt to refute contentions advanced by Prof. Glanville Williams in *The Sanctity of Life and the Criminal Law*,[166] Kamisar makes the following observation:

> Williams champions the "personal liberty" of the dying to die painlessly. I am more concerned about the life and liberty of those who would needlessly be killed in the process or who would irrationally choose to partake of the process. Williams' price on behalf of those who are *in fact* "hopeless incurables" and *in fact* of a fixed and rational desire to die is the sacrifice of (1) some few, who, though they know it not, because their physicians know it not, need not and should not die; (2) others, probably not so few, who, though they go through the motions of "volunteering", are casualties of strain, pain or narcotics to such an extent that they really know not what they do. My price on behalf of those who, despite appearances to the contrary, have some relatively normal and reasonably useful life left in them, or who are incapable of making the choice, is the lingering on for awhile of those who, if you will, in fact have no desire and no reason to linger on.[167]

This argument is reinforced by way of an example involving a brilliant diagnostician, Dr. Richard Cabot:

> He was given the case records [complete medical histories and results of careful examinations] of two patients and asked to diagnose their illnesses. . . . The patients had died and only the hospital pathologist knew the exact diagnosis beyond doubt, for

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[165] Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958). *See, e.g., In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 4, 71, 438 N.Y.S.2d 266, 273 (1981); Eichner v. Dillon, 73 A.D.2d 431, 450 n.13, 426 N.Y.S.2d 517, 533 n.13 (App. Div. 1980), *modified sub nom. In re* Storar, *Id.*

[166] WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1957).

[167] Kamisar, *supra* note 165, at 977.

> he had seen the descriptions of the postmortem findings. Dr. Cabot, usually very accurate in his diagnosis, that day missed both.
>
> The chief pathologist who had selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.[168]

It is certainly true that "[d]octors are only human beings, with few if any supermen among them."[169] Any reading of all the death with dignity laws will show that the physician is immunized for the *act* of withdrawal of treatment (or in some cases, the failure to withdraw), and *not* for any preceding diagnosis or prescription of treatment. Therefore, if it is later shown that the patient died from a curable disease rather than an incurable one, the physician would be liable for misdiagnosis under the normal state law principles of professional negligence.

The argument that the effect of narcotics and pain should be a militating influence against living will legislation can be turned on its head. Many times, those problems are the key factors affirmatively motivating the patient and family to terminate treatment. Who can better determine what is a "normal and reasonably useful life" for the patient than the patient himself and his family?

There is a great need for this kind of legislation in every state where advanced life-prolonging medical technology is available to hospitals and practicing physicians. This need clearly justifies the passage and implementation of death with dignity laws even in these states where problems of statutory interpretation might someday cause occasional litigation, confusion, or delay.

As previously noted, legislatures have begun to respond to the societal need for codification of the responsibilities of physicians in a number of areas. Many of these statutes take the form of uniform laws, drafted and approved by the National Conference of Commissioners on Uniform State Laws.[170] Recently, the President's Commission for the Study of Ethical

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[168] Miller, *Why I Oppose Mercy Killings,* WOMAN'S HOME COMPANION 38, 39 (June 1950), cited in Kamisar, *supra* note 165, at 995.

[169] Wolbarst, *Legalize Euthanasia!* 94 THE FORUM 330, 331 (1935), quoted in Kamisar, *supra* note 165, at 995.

[170] *See, e.g.,* UNIFORM ABORTION ACT §§ 1-12, 9 UNIFORM LAWS ANN. 1-10 (1979) [hereinafter cited as U.L.A.]; UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT §§ 1-38, 9 U.L.A.

Problems in Medicine and Biomedical and Behavioral Research recommended enactment of a Uniform Determination of Death Act.[171]

The reasons for uniform treatment of the subject of determination of death are obvious. Disparate and inconsistent statutory definitions of death are bound to lead to confusion among doctors and even ill-advised transportation of patients from state to state.

The same considerations apply to death with dignity laws, although they deal with a substantively different question: the *right* to die, rather than the question of the *existence* of death. The technology employed to sustain life is generally uniform throughout the country; it is the standard of medical treatment of the terminally ill which varies from state to state. These variations in medical practice may, to some extent, be influenced by the nature and content of living will legislation in those various states. Since the technology is uniform, and improving every day, it would seem that uniform legislation, incorporating all of the best features of the various state laws, is probably the way of the future.[172] Indeed, uniform legislation has eliminated a number of problems in several other areas where medico-legal matters have involved issues of national significance.

57-110 (1979); UNIFORM ANATOMICAL GIFT ACT §§ 1-11, 8 U.L.A. 15-44 (1979 & Supp. 1980); UNIFORM BRAIN DEATH ACT §§ 1-2, 12 U.L.A. (Supp. 1980); UNIFORM PATERNITY ACT §§ 1-18, 9A U.L.A. 623-41 (1979); UNIFORM CONTROLLED SUBSTANCES ACT §§ 101-607, 9 U.L.A. 187-640 (1979); UNIFORM DETERMINATION OF DEATH ACT §§ 1-3, 12 U.L.A. (Supp. 1980); UNIFORM DRUG DEPENDENCE TREATMENT AND REHABILITATION ACT §§ 101-703, 9 U.L.A. 667-741 (1979).

[171] THE PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH: A REPORT ON THE MEDICAL, LEGAL, AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 73 (1981).

[172] The Yale Legislative Services Project has drafted several model bills. The latest, see Appendix, *infra*, is an excellent example of the kind of bill which could well govern procedures in every state. Its immunity provisions and its treatment of the incompetent patient are laudatory. Any uniform legislation should also include a North Carolina-type provision allowing withdrawal even in the absence of a directive, where circumstances warrant. I would also recommend incorporation of provisions similar to those found in the UNIFORM DURABLE POWER OF ATTORNEY ACT §§ 1-10, 8 UNIFORM LAWS ANN. (Supp. 1980). A durable power of attorney is a power which, if the instrument so provides, will survive the incompetency or other disability of the principal. The attorney in fact would thus be empowered to make decisions *on behalf of* the incompetent. In 1979, the Uniform Durable Power of Attorney Act was incorporated into Art. V of the UNIFORM PROBATE CODE, now law in a substantial number of state jurisdictions. *See* U.P.C. §§ 5-501 to -505, 8 U.L.A. 198-201 (Supp. 1980).

Appendix

Medical Treatment Decision Act

The following is the Yale Legislative Services Project's proposed model legislation. The use of * and ** is to indicate alternatives. Comments are at the conclusion of the bill. (This model act is printed with the permission of the Yale Legislative Services Project).

Medical Treatment Decision Act

1. Purpose

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the Legislature hereby declares that the laws of the State of . . . . . shall recognize the right of an adult person to make a written declaration instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

2. Definitions

The following definitions shall govern the construction of this act:

(a) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(b) "Declaration" means a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of Section 3 of this act.

(c) "Life-sustaining procedure" means any medical procedure or intervention which, when applied to a qualified patient, would serve only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care.

(d) "Qualified patient" means a patient who has executed a declaration in accordance with this act and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom shall be the attending physician. (See Comment)

3. Execution of Declaration

Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The declaration shall be signed by the declarant in the presence of two subscribing witnesses *(who are not) **(no more than one of whom may be) (a) related to the declarant by blood or marriage, (b) entitled to any portion of the estate of the declarant under any will of declarant or codicil thereto then existing or, at the time of the declaration, by operation of law then existing, (c) a claimant against any portion of the estate of the declarant at the time of his decease at the time of the execution of the declaration, or (d) directly financially responsible for the declarant's medical care.

It shall be the responsibility of the declarant to provide for filing of the declaration with the agency established by Section 4 of this act. The attending physician of an individual with a terminal condition for whom the decision of whether to utilize life-sustaining procedures must be made shall contact such agency to determine the existence and contents of a declaration.

*(It shall be the responsibility of declarant to provide for notification to his attending physician of the existence of the declaration. An attending physician who is so notified shall make the declaration, or a copy of the declaration, a part of the declarant's medical records).

The declaration shall be substantially in the following form, but in addition may include other specific directions. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable. (See Comment)

Declaration

Declaration made this day of (month, year). I, , being of sound mind, willfully and voluntarily

make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed

City, County and State of Residence

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness

Witness

4. Establishment of Agency for Filing of Declarations

An agency shall be established for the filing of declarations executed pursuant to this act, or this function shall be assigned to an existing state

agency. Such agency shall be staffed at all times by at least one staff member and shall provide information to a physician or health care facility as to the existence of a declaration executed by an individual and as to any specific directions contained in the declaration in addition to those set forth in Section 3.

5. Revocation

A declaration may be revoked at any time by the declarant, without regard to his or her mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his or her presence and by his or her direction.

(b) By a written revocation of the declarant expressing his or her intent to revoke, signed and dated by the declarant. The attending physician shall record in the patient's medical record the time and date when he or she received notification of the written revocation.

(c) By a verbal expression by the declarant of his or her intent to revoke the declaration. Such revocation shall become effective upon communication to the attending physician by the declarant or by a person who is reasonably believed to be acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date and place of the revocation and the time, date and place, if different, of when he or she received notification of the revocation.

(d) By filing a written revocation with the agency established by Section 4 of this act. The absence of a written revocation filed with the agency is not conclusive if the declaration has been revoked in accordance with (a), (b), or (c) above.

6. Physician's Responsibility: Written Certification

An attending physician who has been notified of the existence of a declaration executed under this act shall, without delay after the diagnosis of a terminal condition of the declarant, take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that declarant may be deemed to be a qualified patient, as defined in Section 1(d) of this act.

An attending physician who fails to comply with this section shall be deemed to have refused to comply with the declaration and shall be liable as specified in Section 8(a).

7. Physician's Responsibility and Immunities

The desires of a qualified patient who is competent shall at all times supercede the effect of the declaration.

If the qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures, a declaration executed in accordance with Section 3 of this act is presumed to be valid. For the purpose of this act, a physician or health care facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was of sound mind when it was executed. The fact of an individual's having executed a declaration shall not be considered as an indication of a declarant's mental incompetency. *(Age of itself shall not be a bar to a determination of competency.)

In the absence of actual notice of the revocation of the declaration, none of the following, when acting in accordance with the requirements of this act, shall be subject to civil liability therefrom, unless negligent, or shall be guilty of any criminal act or of unprofessional conduct:

(a) A physician or health facility which causes the withholding or withdrawal of life-sustaining procedures from a qualified patient.

(b) A licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures.

8. Penalties

(a) An attending physician who refuses to comply with the declaration of a qualified patient pursuant to this act shall make the necessary arrangements to effect the transfer of the qualified patient to another physician who will effectuate the declaration of the qualified patient. An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arrangements to effect the transfer shall be civilly liable.

(b) Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without such declarant's consent or

who falsifies or forges a revocation of the declaration of another shall be civilly liable.

(c) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 5, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide.

9. General Provisions

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this act shall not, for any purpose, constitute a suicide.

(b) The making of a declaration pursuant to Section 3 shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or non-profit hospital plan, shall require any person to execute a declaration as a condition for being insured for, or receiving, health care services.

(d) Nothing in this act shall impair or supercede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this act are cumulative.

(e) This act shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

(f) If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the

invalid provision or application, and to this end the provisions of this act are severable.

Comments

With respect to #3, we have not attempted to provide a list of qualifications to assess the competency of an elector. Criteria could be established relative to the common law of the particular state, or relative to statutory remarks in similar contexts (e.g. wills or informed consent) if any. Or, appeal could be made to the criteria employed in the Uniform Probate Code §§ 2-501, 5-101, 1-201.

With respect to #4, among the additional specific directions that can be provided is the appointment of an advisory agent. This person, thought by the patient to be acquainted with the patient and his wishes, can inform the physician as to the patient's treatment preferences in the event of the patient's incompetency. The agent's information, however, is only advisory: it should not be used to defeat the declaration's statement of the patient's wishes. (See Appendix to Part A)

Special Note

Since the writing of this article, the District of Columbia enacted a death with dignity law which became effective February 24, 1982. This increases from eleven to twelve the number of jurisdictions which have enacted death with dignity laws. *See* note 78 *infra.*