

# DEATH WITH DIGNITY AND THE "LIVING WILL": A COMMENTARY ON LEGISLATIVE DEVELOPMENTS

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By 1977, eight states had enacted legislation to assure "natural death," "death with dignity" or the "right to die." At least 59 other bills are pending in 42 states which purport to advance the same interests.<sup>1</sup>

The statutes so far enacted in California, Arkansas, North Carolina, New Mexico, Texas, Nevada, Idaho and Oregon<sup>2</sup> do not allow "mercy killing"; they specifically forbid it, thus reflecting a social consensus in opposition to any public policy that might, even by inference, demean the value of all born human life, even if senile or infirm. Generally, these statutes provide that the terminally ill patient may execute a legally enforceable directive or "will" which prohibits the physician from initiating or continuing heroic or extraordinary treatment under certain circumstances.

The laws of Texas, Idaho and Oregon are substantially similar to California's Natural Death Act, the first legislative incursion into this heretofore private area. The Nevada law is similar to California's in most respects, though the terms and definitions are not the same. New Mexico's law is modeled closely after the draft legislation promoted by the Society for the Right to Die,<sup>3</sup> a social action unit of the Euthanasia Foundation, with a few provisions borrowed from the California statute and the addition of a provision for the termination of heroic treatment for minors. It is the only state law in this area based directly on the euthanasia group's model law. North Carolina, unlike the other states, has included a definition of brain death. The Arkansas statute is the briefest, least complex and most radical, providing for the execution of a directive by one person on behalf of another and with no time limit upon the legal force of the executed directive.

The extent to which such "right to die" legislation in fact serves its purported purpose—"a dignified" or "natural" death—is open to serious question.

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1. Euthanasia: 1977 Legislative Review (National Conference of Catholic Bishops, 1977).
2. Ark. Stat. Ann. §§82-3801 to -3804 (Supp. 1977); Cal. Health & Safety Code §§7185-7195 (West Supp. 1977); Idaho Code §§39-4501 to -4508 (Supp. 1977); N.C. Gen Stat. §§90-320 to -322 (Supp. 1977); Nev. Rev. Stat. §§449.540 - .690 (1977); Tex. Health Code Ann. art. 4590h (Vernon Supp. 1977); An Act Relating to Medical Treatment of Terminally Ill Patients, 33rd Leg., 1st Sess., ch. 287, 1977 N.M. Laws.
3. Society for the Right to Die, *Draft State Natural Death Act* (250 W. 57 St., New York, NY 10019).

The thesis of this article is that such legislation as currently exists in this sensitive area is counterproductive, confusing and inhibitory—that it obscures rather than solves the problem of a humane and dignified death.

A competent adult may refuse medical treatment unless countervailing interests of other persons or the state would be jeopardized by this refusal.<sup>4</sup> This general principle flows from the common law rule, which requires no statutory recognition, that any unconsented touching is a battery. The *Quinlan*<sup>5</sup> and *Saikewicz*<sup>6</sup> cases have added a constitutional dimension by finding within the constitutional right of privacy a right to refuse medical treatment. The rare exceptions to this general principle occur only when courts find sufficient public interest at stake to order compulsory treatment. This court-mandated medical treatment takes place when public health might be adversely affected,<sup>7</sup> when children become abandoned wards of the state,<sup>8</sup> or when a woman is pregnant.<sup>9</sup>

A patient may reject medical treatment as a matter of choice, and this choice can be respected by the attending physician, without any state "living will" statute. Thus, for the adult who remains competent through terminal illness, and for his physician, "living will" legislation is legally superfluous.

Such legislation ostensibly provides an opportunity for a written and enforceable expression of patient choice should the person become incompetent during terminal illness. To justify living will legislation upon this ground alone, however, presumes that the physician would be liable for failure to extend heroic treatment in the absence of a specific refusal by the patient. But short of abandonment, the physician is under no obligation to initiate or continue extraordinary means of life support. Indeed, it is customary for physicians, with familial consent, to discontinue or fail to initiate such treatment without violating the ethical norms of the community or their profession; there is as yet no reported case, civil or criminal, in which liability has been attached for discontinuance of treatment for the terminally ill.<sup>10</sup>

An opportunity to provide for a written directive of refusal of heroic treatment might be desirable, it is said, to supply the physician with knowledge of the patient's preference of which he might not otherwise be aware. In addition, it can be argued that such legislation may relieve the family of an otherwise difficult decision. These "living will" statutes, however, provide no new substantive rights for the patient or immunities for the physician. What they do supply is a procedure for implementation of patient choice and, in some instances, penalties for the physician who fails to abide by it. If "living will" legislation has value to the extent it clarifies patient choice, or educates the terminally ill patient about his rights and interests, or relieves the family and physician from decision-making, that value must ultimately be balanced

4. Robert M. Byrne, *Compulsory Life Saving Treatment for the Competent Adult*, 44 *Fordham L. Rev.* 1 (1975). Such a decision cannot properly be construed to be euthanasia. See Germain Grisez, "Suicide and Euthanasia," in *Death, Dying and Euthanasia* 742 (1977).
5. *In Re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). See also Dennis J. Horan, "The Quinlan Case," in *Death, Dying and Euthanasia* 525 (1977).
6. *Superintendent of Belchertown v. Saikewicz*, - Mass. -, 370 N.E.2d 417 (1977).
7. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
8. *Application of President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 985 (1964).
9. *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964).
10. Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 *Notre Dame Law.* 1202 (1973).

against possible confusions, opportunities for excess, and impediments to humane treatment of the dying created by the statutes themselves.

"Living will" legislation obscures the question of a patient's right to decline extraordinary means of medical treatment. It increases rather than decreases the decisional burden upon the physician. In addition, the statutes do not clarify the area of greatest need—those patients who reach the terminal stage while comatose or incompetent and who have never executed a living will. If current statistics concerning the number of people who die without wills are relevant, then we must realize that the area of greatest need is for a better understanding of the law by the patient and his physician. Most people will reach the terminal stage without a living will. It is for these patients and their physicians that current legislation creates problems.

### THE MINOR AND INCOMPETENT

Only the Arkansas and New Mexico statutes deal with the area of presumed legal confusion which provided media attention and much of the impetus for such legislation in the first place: the problem of the incompetent adult or the minor as in the litigation involving Karen Ann Quinlan.

Section 3 of the Arkansas act provides for the issuance of a directive to terminate treatment for an incompetent adult who had not issued his own directive, or for a minor by a third party in a manner closely analogous to testamentary disposition of property and according to identical formalities. The highest priority lies in the spouse or parent of a minor. If the spouse is unwilling or unable to act, his "child" 18 years or older may then issue the directive. If there is more than one child over 18, however, the majority of the children determine whether treatment shall continue. Whether death shall be "dignified" or not may thus be determined by the casting of ballots upon the failing body of the family progenitor. No mention is made of procedures in the event of a tie vote. Unaccountably, the Arkansas statute makes no provision for evaluation of the possible unwritten preferences of the patient, much less examination of the possible ill will on the part of his relatives, or whether his best interests are at stake in the relatives' decision. Since one supposes that "right to die" legislation is primarily intended to preserve *patient* prerogatives, these are indeed strange and abusive omissions.

New Mexico provides that parents or family may consent to refuse to initiate or continue extraordinary means through execution of a directive.<sup>11</sup> The family decision is apparently not open to judicial review as the *Saikewicz*<sup>12</sup> case holds, or to inspection of a medical ethics board as in the *Quinlan*<sup>13</sup> case. Normally, whether the physician obtains the consent of the family or kin is a separate problem from termination of heroic treatment. The former is an exercise of business judgment—action to avoid suit; the latter is an exercise in sound medical judgment—determining that continued treatment is useless. As a matter of prudence the physician should obtain consent of the family to terminate a form of treatment which will be followed by death, if only to preclude maintenance of an action by all who consented. Permission of the family has not, however, been a legal prerequisite to a medical decision to

11. An Act Relating to Medical Treatment of Terminally Patients, 33rd Leg., 1st Sess., ch. 287, 1977 N.M. Laws, §4.

12. Superintendent of Belchertown v. Saikewicz, *supra* note 6.

13. In Re Quinlan, *supra* note 5.

refuse to initiate or continue treatment that prolongs death. Because of unwillingness of the family to confront such decisions, this provision might defeat its intent.

In states other than New Mexico and Arkansas which have passed such legislation, no provision is made for refusal or discontinuance of treatment for minors. Minors, of course, cannot execute a will, "living" or otherwise. In states other than Arkansas, an incompetent adult is dealt with only insofar as he satisfies the provisions of the statutes prior to a determination of incompetence.

### INFORMED AND VOLUNTARY CONSENT

The statutes employ a variety of officious requirements designed to assure the competent, voluntary and informed consent of the patient at the time the directive is executed. Competent and voluntary consent is, of course, the major question in determining the validity of any will. Unfortunately, however, these statutes merely tend to compound confusion in an already difficult area of law.

For example, Sections 7186 and 7188 of California's Natural Death Act<sup>14</sup> appear to condition the directive upon the voluntary consent given when a patient is of "sound mind." But Section 7191(b) establishes a *conclusive* presumption that the will is valid if a "qualified patient" executed it within 14 days or more after the patient is advised that he or she has a terminal illness. A "qualified patient" in accord with Section 7187(e) is one found to be terminally ill, competent or not. Section 7191(b) determines that the physician is guilty of "unprofessional conduct" if he does not abide by the will, or refer the patient to another physician who will discontinue life-sustaining procedures. Section 7190 provides for physician immunity from any criminal or civil liability for discontinuance of treatment only if he complies with the act.

Thus, on the face of the statute, evidence of unsound mind at the time of execution cannot rebut the conclusive presumption of validity, even though there might be good reason to suppose that judgment might be impaired simply because a directive to which a conclusive presumption is attached must be executed by a patient recently informed of terminal illness. One presumes that the entire will—conclusive presumption and all—is without force where the patient is without "sound mind" at its execution. But how will the attending physician know whether the patient was competent? Should or must he conduct an investigation? Since the directive might operate under a conclusive presumption for as long as five years, how is an investigation even feasible in most situations?

As Professor Yale Kamisar of the University of Michigan Law School has pointed out,<sup>15</sup> even reasonable assurance of informed and voluntary consent in this area meets almost insurmountable difficulties. The statutes so far enacted confront the problem of consent either clumsily or not at all; apparently content with gross declarations of principle and sentimental evocations of an ideal death. Where exceptions are made in view of circumstances where the directive might not fully represent informed consent, they tend to defeat entirely the original intent of the statute.

14. Cal. Health & Safety Code §§7186, 7188 (West Supp. 1977).

15. Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 Minn. L. Rev. 969 (1958).

For example, Section 7191(c) of the California act provides that when a patient becomes "qualified" *after* he has executed the will, the physician is to give "weight" to the directive. He may also consider other factors, such as preferences of family and even the "totality of circumstances." For the probable majority of persons who execute the directive—those who do not execute or re-execute after notification of terminal illness or injury—the will thus becomes a mere piece of paper with little or no legal significance. The patient might have accomplished as much through a handwritten letter or even oral instruction to physician or family, which would probably mean a great deal more to them than would a formal directive.

### THE PHYSICIAN'S ROLE

Ironically, though such legislation is intended to relieve physicians from decision-making responsibilities in relation to heroic treatment, it accomplishes the opposite. All the enacted legislation ostensibly provides immunity for the physician for discontinuance or failure to initiate heroic treatment, despite the fact that civil or criminal liability has never been attached in any case. But in so doing, it is implied that there *is* liability in absence of a directive or when the directive is invalid. Further, instead of making a medical decision based upon whether treatment would be heroic or useless, and conferring with the patient and family as to whether it should be pursued anyway, the physician is to become embroiled in issues outside his competence and in endlessly frustrating procedural controversies.

Whether treatment is extraordinary and the patient is terminally ill are decisions which still must be made. But in California, for example, the responsible physician confronted with a directive would also be concerned with whether the patient was of sound mind when the will was executed, whether the will had been revoked at any time, and whether the patient was "qualified" at the time of execution. He would confer with his private attorney to solicit an opinion about immunity, the hospital attorneys to discover whether they disagreed (or vice-versa), and then offer the issue to the hospital ethics committee to determine whether they agreed with the lawyers. Then, if it is decided the patient was "qualified," the physician must weigh the will together with the "totality of circumstances" surrounding execution so that he might "justify executing the directive." In accord with Section 7191(a), the physician would then determine whether the directive complies with the law, whether the patient is competent, and whether the action contemplated is in "accord with the desires" of the patient before action is taken. In other words, if the patient is presently competent, the doctor is to disregard the document and obtain the customary consent to termination of treatment.

To further illustrate the burden placed upon the physician, consider that Section 7191(a) of the California act states that, prior to withdrawal or withholding of life-sustaining procedures from a qualified patient, the physician must determine whether the directive complies with Section 7188. Section 7188 determines the correct form for execution of the directive and requires that it be signed by the declarant in the presence of two witnesses not related by blood or marriage and who would not be entitled to any portion of the estate under any will or codicil of the declarant or, at the time of the issuance of the directive, by operation of law. Why not simply convene probate court? How can the physician possibly know such things? Presumably Section 7191(a)

applies to the patient who is competent (whereupon the physician must obtain present informed consent in any case) or where witnesses are available to comment upon their relationship or status under the patient's will. But why should the physician become involved in such matters when his task is surely to attend to the care of a dying human being? In what sense is the dignified natural death thereby assured? The safeguard procedures are potentially so complex that the physician is likely to either disregard the will where the patient was qualified upon execution, or mechanically comply in all circumstances upon the presumption that the will is always legally binding.

Such legislation is likely to inhibit the physician's effort to treat the dying patient with dignity, grace and a measure of humanity in yet another way. Whenever a statute is enacted regulating conduct, especially where punitive sanctions are available for non-compliance, the effect is to chill and inhibit similar conduct otherwise legal but not now in conformity with the requirements of the act. Thus, physicians may be reluctant to withdraw or withhold life-sustaining treatment unless a directive has been executed by the patient, even though there is no legal obligation to extend heroic or useless care. If even 20% of the population executed a living will within the requirements of the given statute—an optimistic figure in view of the small percentage who execute testaments for disposition of property—the remaining 80% must suffer the consequences. California attempted to mitigate this problem through Section 7193 which indicates that its Natural Death Act does not impair or supercede any prior right or responsibility the person possesses to effect the lawful withdrawal of life-sustaining procedures. The most deleterious impact of such legislation—and one of the reasons why it is often opposed by medical societies—is that it tends to subtract an important area of medical practice from the usual legal principles by which physician conduct is controlled. In recent litigation to terminate heroic treatment—in the Quinlan,<sup>16</sup> Dockery<sup>17</sup> and Saikewicz<sup>18</sup> cases—the reason offered by the courts for intrusion into the physician-patient relationship was fear by the physicians and hospitals of potential malpractice suit or criminal prosecution.<sup>19</sup> But far from relieving the physician from fear of liability in this regard, such legislation for the first time not only implies that the physician may be subject to civil or criminal prosecution for withdrawal or failure to initiate treatment that prolongs death, it provides penalties where the physician fails mechanically to comply with a directive.

Rather than permitting standards of medical practice to develop in this area in the traditional manner, such legislation attempts the impossible task of particularizing medical decision-making. A better, more flexible and ultimately more humane approach would be to permit the determination of customary standards to remain in the hands of the medical profession. Only if physicians overstep the bounds of legal or ethical propriety should society intervene.

16. In Re Quinlan, *supra* note 5.

17. Dockery, et al. v. Dockery, No. 51439, Chancery Court, part 2 for Hamilton County, TN. In July, 1977, the Court of Appeals for the Eastern District of Tennessee declined to rule on the merits, on the ground that the issue was not of substantial public interest since Mrs. Dockery had died pending appeal.

18. Superintendent of Belchertown v. Saikewicz, *supra* note 6.

19. This is so though the physicians testified to the contrary, and in spite of the fact that withdrawal of extraordinary treatment is generally in accord with standard medical practice. It is important to point out, again, that no civil or criminal cases have arisen on account of withdrawal where the patient is terminally ill.

### TIMELINESS

Along with the regulation of voluntary and informed consent, and the burden placed upon the physician, the third important element in such legislation is the schedule upon which the directive becomes effective. Time and qualification limitations upon operation of the statute insulate the patient from decisions which are not relevant to present state of mind or physical condition. They tend to prevent the effect of a directive from being purely automatic or from being amended in practice to foster mercy killing.

The California act provides that the patient's "living will" directive shall have legal force only if the patient is terminally ill, defined as a "condition caused by injury, disease or illness" to which "application of life-sustaining procedures . . . serve only to postpone the moment of death of the patient."<sup>20</sup> It further provides that the directive shall be effective for only five years.<sup>21</sup> Such carefully restrictive qualifications should be compared to Arkansas' statute, which provides merely that the person shall have the right by directive to refuse any "artificial, extraordinary, extreme or radical" treatment calculated to prolong life with no time limit upon the directive's force.<sup>22</sup> Such loose treatment of an important decision simply invites self-serving definitions of "artificial" treatment,<sup>23</sup> and contempt for the concept of consent, since such general permission cannot reasonably be conceived to anticipate the particular options available in the context of particular disease or injury over the lifetime of a declarant.

With the exception of Arkansas, the qualification restrictions are generally defined as restrictively as in the California act: the directive becomes effective (in the sense it may be put to actual use) only upon terminal illness and only when the use of extraordinary means of medical care would prolong death. This latter qualification is a reasonable time, if time there must be, for living will statutes to become effective.

### CONCLUSION

"Living will" legislation presents the attending physician with a welter of procedural guidelines, thresholds, timetables and qualifications before he or she may terminate extraordinary or useless care for a dying patient and be granted the immunity such statutes grant. It does not guarantee that the choice of the patient will be followed, but merely shifts the grounds upon which the decision of the attending physician must be made. As a result of the penalties provided, and as the majority of patients will not execute the directives, these state laws might inhibit withdrawal of extraordinary means in many instances where treatment would serve little purpose but to prolong death, discomfort and pain. Perhaps worse, the presentation of an officious document to a

20. Cal. Health & Safety Code §§1187(c), 1187(f) (West Supp. 1977).

21. Cal. Health & Safety Code §7189.5 (West Supp. 1977).

22. An Act to Permit an Individual to Request or Refuse in Writing Medical or Surgical Means or Procedures Calculated to Prolong His Life; and to Authorize Such Request or Refusal by Others on Behalf of One Incompetent or Under 18; and for Other Purposes, H. 826, 1977 Ark. Laws, act 879, §1; Ark. Stat. Ann. §82-3801 (Supp. 1977).

23. The nature and definition of extraordinary treatment may radically change over the lifetime of a declarant.

physician with neither the time nor inclination to investigate the circumstances of execution, when coupled with penalties for non-compliance, could result in mechanical implementation without regard to delicate personal and medical options confronted in particular situations. In practice, the latter circumstance presents sufficient opportunities to amend such legislation as to constitute forms of mercy killing, which is all the more insidious because intent is shrouded by a web of supposed procedural safeguards and formalities.

Death is not ennobled by merely transferring decisions which encompass it to printed paper in a form determined by the state so the person might be dispatched in the manner of a used auto. It is apparently imagined that such legislation represents new maturity—heroic confrontation with the mysteries of death which, in the past, we have supposedly shunned in fear and anxiety or shrouded in euphemism, legend and symbol. In fact, it simply adds a layer of burdensome procedure and legal fiction to the medical gadgetry and jargon which perhaps too often now attend the end of life.