The Linacre Quarterly

Volume 46 | Number 1 Article 12

February 1979

The 'Right to Die': Legislative and Judicial Developments

Dennis J. Horan

The 'Right to Die': Legislative and Judicial Developments

Dennis J. Horan

Mr. Horan is chairman of the Right to Live/Right to Die Committee of the American Bar Association and gave this talk to the medicine and law committee of the Association at its annual meeting in 1977.

One of the legal dilemmas of our electronic age is too much unnecessary legislation enacted too soon and in response to too many non-problems. This is especially true in the legal-medical area where physicians are slowly being hemmed in by such legislation and are finding themselves unable to practice their art and to exercise their best judgment in doing so. Living Will or Natural Death legislation is a typical example of that phenomenon.

California recently passed a Living Will provision entitled "The Natural Death Act."[1] Seven other states have followed suit, but with variable approaches.[2] Although hailed by many as a necessary and important piece of legislation giving another fundamental freedom to persons and protection to physicians, in fact, it gives nothing to persons which they do not already possess under the law, nor does it add any additional legal protection to doctors which they do not already possess. The immunity granted by the bill may be of doubtful constitutional validity and is certainly a doubtfully meritorious statement of public policy when one considers that there exist no reported cases of either criminal or civil liability against doctors arising out of the termination of treatment to terminal patients. If anything, the California bill adds officious burdens to the death bed, encumbers medical decisions with unnecessary additional consultations and creates, rather than clarifies, legal problems.

The California Act does not allow or hasten mercy killing, which is strictly prohibited either by active means or by mere omission. Some have argued that living will legislation is the opening wedge towards the ultimate legalization of euthanasia.[3] Since this legislation, in itself, adds nothing to the legal rights people already possess under the law, nor gives physicians additional protections not already possessed (presuming an absence of homicidal intent), there may be some truth in this charge. For example, Prof. Yale Kamisar points out in his famous article[4] that the living will may be the first step towards the ultimate legalization of mercy killing. On the other hand, however, one can also

argue that since *this* legislation adds nothing which does not already exist in the law it cannot, therefore, be considered such an opening wedge but is, rather, a mere codification for clarification purposes of the existing state of the law. Between these extremes lies the truth.

Adult persons of sound mind have a right to refuse medical treatment unless some equal and countervailing rights of other persons would be substantially jeopardized by such a refusal.[5] For example, it has been consistently held by the courts that the right of a pregnant woman to refuse medical treatment must give way to the unborn child's right to life. Under those circumstances, courts have consistently overruled the mother's right to refuse medical treatment, even when it may flow from a First Amendment protection — namely, the free exercise of religion.

Consequently, adult persons of sound mind may reject medical treatment even though the result may be their own death. Such a decision has not been construed either as suicide or euthanasia by most commentators in spite of the consistent confusion that the concept of passive euthanasia causes.[6] The problem becomes particularly difficult in the situation where the person is either not competent to give consent, or is comatose or unconscious and unable to consent. These issues were recently litigated in three cases: the Quinlan case,[7] the Saikewicz case[8] and the Dockery case.[9] In each of these cases the courts ultimately held that refusal to accept the treatment could be made on behalf of the unconscious or incompetent by the next of kin who had been appointed conservator or guardian. No statutory authority or guidelines existed in any of these three states where these cases were litigated. The courts made such decisions based upon the application of traditional rules of equity and their understanding of the medical-legal principles involved.

States Pass Legislation

In 1977, eight states attempted to close what is felt to be a legislative gap by passing legislation variously described as Natural Death Acts or Living Will Acts or Right to Die Acts. There are at least 59 other bills pending in 42 states. The purpose of this paper will be to analyze the eight bills which have been thus far passed in order to help clarify some of the issues and to determine whether or not such legislation is beneficial as a solution to this problem.

My own view is that the legislation is not beneficial and is indeed counter-productive. I say this because I see the solution as lying in the area of the patient-physician relationship — a highly personal relationship and an area in which I do not like legislative intrusion unless it is absolutely impossible to otherwise solve or circumscribe a legal problem, which I do not believe to be the case.

In each of the cases I have previously mentioned, the reasons given

by the court for the necessity of intruding into this physician-patient relationship in order to solve this problem are the fear of physicians and hospitals of malpractice suits and criminal prosecution. Yet, today, there are no reported cases of either criminal or civil liability being assessed against the doctor or hospital arising out of the termination of treatment for terminal patients.[10] Why then do we have this extraordinary spate of legislative activity in an area where no liability exists on the books? Is it because liability is deemed probable and suits may be filed, or is it because of the activities of special interest groups such as the Euthanasia Society or the Society for the Right to Die?

The Society for the Right to Die has been very active in pursuing the enactment of living will statutes throughout the nation. Perhaps this accounts for the fact that such legislation during 1976 and 1977 was introduced into almost all 50 state legislatures. The Society for the Right to Die publishes a legislative manual containing its own model statute which has been introduced into many legislatures. The manual also contains copies and analyses of the statutes introduced into the various states.

The Society for the Right to Die is closely connected to the Euthanasia Society and the Euthanasia Educational Council. It is this close relationship which has prompted many people to see the living will as the first step towards the ultimate legalization of euthanasia, which is currently classed as homicide. However, putting such speculation aside for the present, let us return to an analysis of the legislation involved.

As in the execution of any will, the major problem and cause for litigation (other than interpretation of the will itself) is the voluntariness of the execution or the consent. Such is also the case for the living will as we will discuss shortly.

A far more important problem created by these acts and one which would probably surprise its sponsors is that, in my opinion, living will legislation will inhibit rather than increase the physician's ability to solve with dignity and grace the problem of the dying patient. Anytime a statute is passed regulating conduct and creating rewards and punishments for non-compliance, such an act has the effect of chilling or inhibiting similar conduct otherwise legal but now not in conformity with the act. Consequently, the effect of these acts will be to chill and inhibit otherwise lawful conduct of a physician in withdrawing life-sustaining means unless such a living will has been made by the patient. If even 20% of the populace executes such living wills — a figure I doubt will be attained — still another 80% will reach the terminal never having executed such a document.

The physician will probably assume that he cannot now withdraw life-sustaining measures unless he has a directive from the patient in compliance with the act. California has sought to avoid this problem by including Section 7193, which indicates that the act does not

impair or supersede any legal right or responsibility a person may have to effect the withdrawal of life-sustaining procedures in a lawful manner. Few of the other statutes have dealt with the problem.

A better approach of the legislature would have been to pass an act stating that life-sustaining measures may be withdrawn when this may be done in the judgment of the attending physician under usual and customary standards of medicine. Here is an example:

> Life-sustaining measures may be terminated by the attending physician when, in his judgment, based upon a reasonable degree of medical certainty according to usual and customary standards of medicine, it is proper to do so.

This would constitute an affirmative statement by the legislature that physicians can terminate useless treatment and thus presumably dispel the medical confusion on this point.

It is understood that hospital aides, nurses or technicians who act upon a lawful order of a physician are not liable for doing so, and it is not necessary to say so in the statute. If the order itself constitutes malpractice, mayhem or murder and should have been known to be so by the aide or nurse, or is carried out by them negligently, then that is another matter.

The grant of immunity to the treating physician, which is a universal aspect of these statutes, is most curious in these days of seeming mistrust of the medical profession. Immunity is probably granted to ensure physician support of these bills, but not even sacred immunity has been able to make the medical profession support such legislation. I think the reason is that most doctors handle terminally ill situations now without any of the mess or fuss brought about by this legislation. Most feel qualified to handle the situation and, if hospital cooperation and family support can be obtained, will have no difficulty — indeed, less difficulty with such situations without a statute than with one.

In addition, customary methods and standards in medicine change continuously. There is no way that particularized medical practice can be legislated. Will we pass statutes saying when and under what circumstances an appendix may or must be removed? The better approach seems to me to leave the determination of the customary standards of medicine in the hands of the physicians. If they overstep the bounds of what is proper, legally or morally, then society should act to correct this condition. The physician's judgment must be relied upon by society in these matters. Elements of that judgment can be controlled by statutes prohibiting unwanted conduct such as Section 7188 of the California Act which "prohibits" mercy killing. But the homicide laws do this anyway. It is a misunderstanding of the current status of medical-legal principles which causes the confusion. Unfortunately the California Natural Death Act has compounded those problems rather seriously.

Family Consent a Separate Problem

Whether or not a physician obtains a consent from the family or next of kin for terminating life-sustaining measures is a separate problem involving freedom from potential suit. This is entirely distinct from the exercise of the physician's judgment in determining that the life-sustaining method should be terminated, or in obtaining an informed voluntary consent from the patient himself for the termination of treatment. As a matter of prudence, the physician should obviously obtain such consents from the family when the patient is unable to voluntarily consent. Such a consent at least precludes those who gave consent from maintaining an action.

Voluntary consent is the difficult problem and the California statute does not make that problem any easier. In fact, it compounds it by 1) using, in Sections 7186 and 7188, language that conditions the validity of the directive to a voluntary consent given when the patient was of sound mind (How in the world can a physician know that?), and 2) not clarifying in Section 7191(b) that the conclusive presumption may not be rebutted by evidence of the unsound mind of the declarant at the time the directive was executed. In addition, Section 7190 conditions its immunity grant on compliance with the act. Presumably, failure to follow the act vitiates the immunity.

Section 7191(c) aggravates the problem further by only giving "weight" to the directive (when the patient becomes a qualified patient subsequent to executing the directive) as evidence of the patient's directions, but then indicates that he "may" (read must now) consider other factors such as information from the family and even the totality of the circumstances. This section [7191(c)] destroys the entire utility of the act in its present form as far as the apparent intent of the legislature is concerned. This section is the one that will probably be applicable to most patients dying in a hospital. That is, most of these will be patients who have executed the directive previously, but have not re-executed it since becoming a qualified patient. For all these patients the directive will merely be a piece of paper indicating the desires of a patient with little or no legal significance. That is no more (and less effective) than what the patient could have accomplished anyway with a hand-written letter to a loved one. Such a letter would probably mean more to the attending physician anyway. A formalized directive will cause him endless worry and frustration wondering whether the declarant was of sound mind when the directive was executed, worrying about whether the directive has ever been revoked, calling his personal attorney for an opinion on his immunity, conferring with the hospital attorneys and discovering that they disagree with his personal attorney (or vice versa), conferring with the hospital ethics committee only to discover that they disagree with the lawyers, and last, but not least, learning to his chagrin that the statute

requires him to consider the totality of the circumstances surrounding execution of the document so that he can "justify effectuating the directive." In addition, Section 7191(a) mandates that the physicians determine that the directive complies with the law and if the patient is mentally competent, and the action to be taken is in "accord with the desires of the qualified patient," then the action may be taken.

In plain language, this means that if the patient is competent and alert the doctor should disregard the directive and obtain an informed consent from the patient to terminate the treatment. If the patient is not competent and alert, then 7191(c) requires the physician to make an inordinate investigation into the surrounding circumstances concerning the execution of that directive. Who needs such a statute? Certainly not the doctors. Nor does it help the patient or his concerned family.

As an example of the complexity thrust upon the shoulders of the attending physician by the California act, let me pose one illustration. Section 7191(a) states that prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with Section 7188. Section 7188 is the section which determines the correct form for the execution of the document and the form of the document itself. This section requires that the directive "shall" be signed by the declarant in the presence of two witnesses who are not related to him by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing, or, at the time of the directive, by operation of law then existing. How in the world is any physician supposed to know that the witnesses are not related to the declarant, nor are they getting any portion of his or her estate when he or she dies? Presumably Section 7191(a) applies to a patient who is competent and can discuss such things with the physician or the witnesses are available to do so. In any event, why should the attending physician be involved in matters of this sort when his job is to take care of a human being who is in a terminal condition — certainly the most psychologically difficult time of most people's lives? This intrusion into the patient-physician relationship seems totally unwarranted and cannot, in the long run, help raise the quality of medical care or the relationship between physician and patient.

Other States Passed Law

The other seven states which have recently passed such legislation are Arkansas, North Carolina, New Mexico, Nevada, Texas, Idaho and Oregon.

The Arkansas law differs substantially from the California Act. The Arkansas law contains only four sections. The first declares that every

person has a right to die with dignity and a right to refuse and deny the use or application of artificial, extraordinary, extreme, or radical medical or surgical means or procedures calculated to prolong life. Alternatively every person has a right to request that such means be used to prolong his life as long as possible. Section 2 allows the execution of a will containing such a directive.

Section 3 is a radical departure from the California bill in that it allows execution of such a directive by one person on behalf of another. This section allows a person to execute such a directive for a minor or an adult who is incompetent. The statute gives certain priorities as to who may execute such a directive on behalf of a minor or incompetent. It begins by giving the right to either parent of the minor, or to a spouse. If the spouse is unwilling or unable to act, then "his child" age 18 or over may act. However, if he has more than one child age 18 or over, then a decision may be made by a majority of such children. (Can one visualize a family of 7 children over 18 casting ballots on this issue?). If he is mentally incompetent, the directive can be executed by a legally appointed guardian provided that two physicians state that extraordinary means would have to be utilized to prolong his life. The last section of the act grants immunity to the physicians or anyone else assisting.

The North Carolina bill contains an addition to the right to a natural death — a definition of irreversible cessation of brain function. The North Carolina Act allows for withholding extraordinary means upon certain conditions if the declarant is determined to be terminal and incurable. It requires that the document be proved before a clerk or assistant clerk of the Superior Court who certifies that the witnesses appeared before him and swore that they observed the declarant sign this declaration and also swore that they were not related within the third degree to the declarant or to the declarant's spouse and that they would not be entitled to any portion of the estate of the declarant upon the declarant's death and that they were not a physician attending the declarant or an employee of an attending physician, or of a health facility in which the declarant was a patient, or of a nursing home or any group care home and that they had no claim against the declarant. The procedure for proving up the document before the clerk indicates that it may be accepted on the testimony of two witnesses or, if only one witness is available, then upon the testimony of such witness and upon the proof of the handwriting of the witness who is dead or whose testimony is unavailable. The statute, unlike the Arkansas bill, specifically allows for revocation. Once again, the act grants immunity from civil or criminal liability to the physician and all those who assist.

The North Carolina bill, unlike most of the legislation in this area, also includes a definition of brain death.

The New Mexico bill is substantially similar to the model bill promulgated by the Society for the Right to Die. It includes other provisions which were borrowed from the California Act, but basically it, like the other statutes, allows for the execution of a document for the refusal of "maintenance medical treatment." It also contains a section allowing the document to be executed on behalf of a terminally ill minor, but the execution of such document must be done with the same formalities as are required of a valid will under their Probate code. The statute allows for revocation, grants immunity to the physicians and requires two physicians to certify to the terminal illness.

The Nevada bill is similar in some respects to the California statute, but does not use the same terms or definitions. Again immunity is granted to the physician.

The Texas bill is the same as the California bill. The Idaho bill is substantially similar to the California statute, as is the Oregon bill.

Most Important Element

The single most important element of each of these bills is the time when the directive becomes effective. It is this element of the statute which controls the entire act and prohibits the use of such legislation to foster mercy killing. Of course, the statute can be amended on the books at some later date to allow mercy killing, or, worse yet, can be "amended" in practice by those who have a mind to, to allow mercy killing now.

The California Act allows the directive to become operative only when the patient is terminal, which is defined as a condition caused by injury, disease or illness which, regardless of the applications of life-sustaining procedures would, within reasonable medical judgment, produce death and where the application of life-sustaining procedures serves only to postpone the moment of death of the patient. Such a carefully restrictive definition which obviously precludes mercy killing should be compared with the Arkansas bill, which is completely devoid of any such definitions and merely grants to every person a right to reject any means of artificial, extraordinary, extreme, or radical medical or surgical means or procedures calculated to prolong his life.

The remaining acts require a terminal condition, which is usually defined as restrictively as is the California bill.

For all but the Arkansas statute then, the time when the directive becomes effective (in the sense that it may be put into actual use) is the time when a person is in an incurably terminal condition where the use of extraordinary medical means serves only to prolong the moment of death. This definition is a reasonable time, if time there must be, when living will statutes become effective.

REFERENCES

1. Assembly Bill 3060. A copy of this bill is attached as Exhibit A.

2. Arkansas — Act 879 of 1977; North Carolina — Ch. 815 of Session 1977, Senate Bill 504; New Mexico — Ch. 287 of Laws 1977, Senate Bill 16; Nevada — Assembly Bill no. 8, Ch. 393 of Laws 1977; Texas — S.B. 148; Idaho — Idaho Session Laws, Ch. 106, Title 39 of Idaho Code, Senate Bill 1164; Oregon — Ch. 183 of 1977 Session Laws, Senate Bill 438. Since these bills have for the most part only been enacted within the last few weeks or months I was not able to obtain their official citations.

3. DeMere, McCarthy, M.D., *Visitor*, April 24, 1977, p. 3; others have seen the legislation as very limited in its effectiveness because of the restrictive definition of terminal illness. See, e.g., *The Medical Tribune*, Feb. 9, 1977, pp. 11, 12.

4. Kamisar, Yale, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation," 42 *Minnesota Law Review*, 969.

5. Byrn, Robert M., "Compulsory Life Saving Treatment for the Competent Adult," 44 *Fordham Law Review*, 1 (1975).

6. Grisez, Germain, "Suicide and Euthanasia," *Death, Dying and Euthanasia*, ed. by Dennis J. Horan and David Mall (Washington, D.C.: University Publications of America, 1977). Also see Byrn, *op. cit.*, ft. 5.

7. *In Re Quinlan*, 70 N.J. 10, 355 A2d 647 (1976).

8. *Jones v. Saikewicz*, No. 711 (Mass. S.J.C. order July 9, 1976), no opinion issued.

9. *Dockery et al. v. Dockery*, No. 51439, Chancery Court, part 2 for Hamilton County; in July, 1977 the Tennessee Court of Appeals declined to rule on the merits on the grounds that the issue was not of substantial public interest since Mrs. Dockery had died pending appeal.

10. Note: "Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations," 48 *Notre Dame Law Review*, 1202.

EXHIBIT A

CALIFORNIA
A.3060 ENACTED 1976

Introduced by Assemblyman Barry Keene, 2/13/76
Passed by Assembly (43-22), 6/17/76
Passed by Senate (22-14), 8/26/76
Signed by Gov. Edmund G. Brown, Jr., 9/30/76

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

NATURAL DEATH ACT

Sec. 7185
This act shall be known and may be cited as the Natural Death Act.

Sec. 7186
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.

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

Sec. 7187

The following definitions shall govern the construction of this chapter:

(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) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section 7188. The directive, or a copy of the directive, shall be made part of the patient's medical records.

(c) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent 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 alleviate pain.

(d) "Physician" means a physician and surgeon licensed by the Board of Medical Quality Assurance or the Board of Osteopathic Examiners.

(e) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

(f) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures, serve only to postpone the moment of death of the patient.

Sec. 7188

Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____(month, year).

I, _____ being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive 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.
3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
4. I have been diagnosed at least 14 days ago as having a terminal condition by _____, M.D., whose address is_____, and whose telephone number is_____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.
5. This directive shall have no force or effect five years from the date filled in above.
6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

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_____

Sec. 7188.5

A directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section 1250 at the time the directive is executed unless one of the two witnesses to the directive is a patient advocate or ombudsman as may be designated by the State Department of Aging for this purpose pursuant to any other applicable provision of law. The patient advocate or ombudsman shall have the same qualifications as a witness under Section 7188.

The intent of this section is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decision making role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive.

Sec. 7189

(a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

1. By being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction.
2. By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he received notification of the written revocation.
3. By a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person 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 received notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

Sec. 7189.5

A directive shall be effective for five years from the date of execution thereof unless sooner revoked in a manner prescribed in Sec. 7189. Nothing in this chapter shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Sec. 7188, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

Sec. 7190

No physician or health facility which, acting in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health professional acting under the direction of the physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

Sec. 7191.

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with Sec. 7188, and, if the patient is

mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient.

(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, and no licensed 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 subdivision. A failure by a physician to effectuate the directive of a qualified patient pursuant to this 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.

(c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted 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 justify effectuating the directive. No physician, and no licensed health professional acting under the directive of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision.

Sec. 7192

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

(b) The making of a directive pursuant to Sec. 7188 shall not restrict, inhibit, or impair 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 nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

Sec. 7193

Nothing in this chapter 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. In such respect the provisions of this chapter are cumulative.

Sec. 7194

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a misdemeanor. Any person who, except where justified or excused by law, falsifies or

forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 7189, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any 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 as provided in Chapter 1 (commencing with Section 187) of Title 8 of Part 1 of the Penal Code.

Sec. 7195
Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.

SECTION 2
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.

SECTION 3
Notwithstanding Section 2231 of the Revenue and Taxation Code, there shall be no reimbursement pursuant to this section nor shall there be any appropriation made by this act because the Legislature recognized that during any legislative session a variety of changes to laws relating to crimes and infractions may cause both increased and decreased costs to local government entities and school districts which, in the aggregate, do not result in significant identifiable cost changes.
