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NOTE

Living Wills in the United States and Canada: A Comparative Analysis

"Vex not his ghost. O, let him pass! He hates him that would upon the rack of this tough world stretch him out longer."¹

I. INTRODUCTION

In the past few decades, modern medical technology has made it possible, and society has made it acceptable, to keep patients "alive" longer and longer. Some believe that patients are frequently kept alive "beyond the point dictated by humane medical practice."² Others state that patients remaining on life support systems become, in a sense, "prisoners of medical technology."³ In its most basic sense, technological advancement has changed the treatment of illness and injury. Scientific research has helped us to maintain heartbeat, breathing, and nutritionally supplied bodily activities long after the brain ceases to function. Today, an estimated eighty percent of all deaths occur in an institutional setting.⁴ Although the definition of legal death is a point of contention among both medical and legal scholars, the majority of jurisdictions now point to "brain death" as the pivotal point in the analysis.⁵ "Brain dead" per-

¹ William Shakespeare, *The Tragedy of King Lear*, in WILLIAM SHAKESPEARE: THE COMPLETE WORKS 923 (Stanely Wells et al. eds., 1986).

² NORMAN L. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING ix (1987).

³ *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988). In an amicus brief, the American Academy of Neurology referred to Ms. Cruzan as a "prisoner of medical technology." *Id.* at 423 n.19.

⁴ Christopher J. Condie, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 105, 105 (1988); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 17 (1983).

⁵ The controversy surrounds the point at which brain death actually renders the patient dead. For a discussion of this ambiguity, see generally Stuart Youngner, *'Brain Death' and Organ Retrieval: A Cross-Sectional Survey of Knowledge and Concepts Among Health Professionals* 261 J. AM. MED. ASS'N 2205 (1989). The article points out that irreversible loss of all brain function is required for a patient to be declared brain dead, while irreversible loss of all cortical function alone does not render the individual legally dead. *Id.* at 2208. See also PRESIDENT'S COMMISSION FOR THE

sons may now be kept alive through the use of artificial means for a number of years.⁶

As technology changes the face of medical treatment, many people realize that they do not want to be kept alive by artificial means. Many factors may go into the decision to request a natural death; thereby requesting that caregivers and family members be instructed to withhold life-sustaining procedures. Living wills serve the purpose of articulating and publicizing this decision. The living will has been defined as "[a] directive to [one's] family and physician acknowledging [his or her] preference for a dignified death as opposed to an artificial or mechanical prolongation of life when no hope of recovery remains."⁷ In directing instructions to the physician, a living will indemnifies the physician against malpractice liability should he comply with its demands.⁸ On an emotional level a living will offers comfort to the patient's family by assuring family members that the patient's desires will be met. Although problems of ambiguity and inconsistency of interpretation do arise, and the implementation of advance directives under living wills can be emotionally charged, living wills clearly serve several fundamental purposes. The creation of a living will provides an opportunity for the commencement of open communication between the patient, his family, and the attending physician. Because death is often a difficult and emotionally weighted topic of conversation, this communication allows those involved to calm their anxieties and to discuss possible alternatives at length. Most of us fear death. We have a tendency to repress this frightening subject. That fear of our own death may cause this repression is obvious, but we must remember that adults may also suppress thoughts of their parents' death; thereby avoiding the issue of their own mortality.

Once the lines of communication are opened, living wills provide a clear and documented testimonial of the patient's decision. No ambiguities or controversies in opinion as to what the patient actually decided will occur *if* the patient employs adequately precise language. Stress surrounding a life-threatening illness can be reduced if these issues are attacked and resolved before critical decisions must be made in the face of an emergency.

Courts and state legislatures throughout the United States have begun to recognize the benefits of decision-making by proxy and through

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

⁶ Condie, *supra* note 4, at 105.

⁷ Shari Lobe, *The Will to Die: Survey of State Living Will Legislation and Case Law*, 9 PROBATE L. J. 47 (1989), quoted in Parks H. Wilson Jr., *The Living Will—Death with Dignity or Mechanical Vitality*, 10 CUMB. L. REV. 163, 164 (1979).

⁸ See generally Lobe, *supra* note 7.

the mechanism of living wills. Canada's reaction has not been quite as accepting. This note will first outline the present status of living wills in the United States. In doing so, characteristic state legislation will be investigated, as well as relevant case law. Next, the status of living wills in Canada will be analyzed. Comparisons between the two countries will ultimately be drawn. Evidence that Canada, in effect, follows U.S. precedent will be set forth and discussed. Also, the various factors influencing the effectiveness of living wills will be articulated: both pros and cons of their acceptance will be recognized. As a way of conclusion, this note will recommend that Canada follow the example set by the United States, which has adopted specific legislation vital in the treatment of living wills.

II. WHY THIS COMPARISON?

The topic of living wills has been in the forefront of U.S. social and political arenas for the past several years. The states vary greatly regarding their acceptance of advance directives. The issues, however, continue to be openly debated. The controversy is recognized as having far-reaching consequences; it raises both the issue of constitutionally mandated privacy rights and the issue of states' interest in preserving human life. Medical experts and emotionally charged families aside, the controversy concerning whether to allow an individual to make the decision to terminate life-support systems becomes quite political. No clear and unanimous decision has yet been reached, but there is a growing trend in favor of continued support and reinforcement for advance directives.

The questions in Canada are quite different for several reasons. Constitutional issues do not play such a symbolic and intensely political role in the Canadian arena. Additionally, health care in Canada is characteristically more socialized.⁹ Thus the question remains whether a consensus on the topic of living wills is imperative in Canada. Although Canadians struggle with the issues of the right to natural death and the right to make an unencumbered decision about the fate of one's body in an unconscious and terminally ill situation, authority regarding these issues is yet undeveloped in the Canadian context. Because Canadian provinces have yet to deal overtly with these issues, Canada is a true *tabula rasa* in the area of living wills laws. In effect, those involved in health care decisions for the terminally ill now follow the U.S. model. So Canada's proximity to the United States cannot be ignored. Canada can and does look over our mutual border and gathers guidance from our political and judicial infrastructure. The United States is not a quiet, introverted neighbor. In facing these dilemmas, we are loud and aggres-

⁹ See generally LORNE E. ROZOVSKY, *THE CANADIAN PATIENT'S BOOK OF RIGHTS* (1980) (see particularly Chapter 2 which discusses hospital insurance and medicare).

sive, often oscillating between sides as political interest groups rally for support and ultimate victory on the issues. Canada's temptation to imitate our model is thus extreme. One illustration of this temptation is the fact that Canada has adopted our approach to living wills laws.

Thus, in the area of living will laws, Canada has subtly adopted a system identical to that developed in the United States. It has done so even though it does not, on its own, have any statutory or common law authority on point. Physicians, health care practitioners, and even judges have been silently persuaded that the U.S. response is valid and should be followed. Where Canada lacks consensus on the topic of living wills, it takes American precedent as its own.

This practice by Canada is unsafe. Canada should ensure that the framework *it* sets into place remains stable; thereby granting to physicians and family alike the freedom to follow advance directives without fear of liability or emotional repercussions. The first step is to adopt provincial legislation recognizing the validity of living wills. This step is recommended to guard against the unfortunate possibility that the system implemented in the United States is suddenly destroyed. The American response, although impressive, is still tenuous, and Canada should begin building its own guidelines to which those faced with the controversy can look for concrete answers.

III. STATUS IN THE UNITED STATES

A. Statutory Response

Louis Kutner first proposed the living will concept in the 1930's.¹⁰ A few decades later, a New York educational institution known as "Concern for Dying" began to produce and distribute living will forms.¹¹ In 1976, California was the first state to enact a statute recognizing the validity of living wills.¹² Between 1976 and 1979, ten states adopted similar legislation.¹³ The period from 1981 to 1984 saw twelve additional states and the District of Columbia adopt Natural Death Acts.¹⁴ But between 1985 and 1986 there was "an acceleration in lawmaking that exceeded any other period in the history of 'living will' legislation."¹⁵ Sixteen

¹⁰ PHIL WILLIAMS, *THE LIVING WILL SOURCE BOOK* 7 (1986); Condie, *supra* note 4, at 105.

¹¹ WILLIAMS, *supra* note 10, at 7. The wills were distributed primarily in 1968.

¹² Lobe, *supra* note 7, at 47.

¹³ SOCIETY FOR THE RIGHT TO DIE, *HANDBOOK OF LIVING WILL LAWS* 5 (1987) [hereinafter *SOCIETY HANDBOOK*]. States included: Arkansas, California, Idaho, Kansas, Nevada, New Mexico, North Carolina, Oregon, Texas and Washington. *Id.*

¹⁴ States included: Alabama, Delaware, Florida, Georgia, Illinois, Louisiana, Mississippi, Vermont, Virginia, West Virginia, Wisconsin and Wyoming. *Id.* See also *HANDBOOK OF LIVING WILL LAWS* (1981-84) [hereinafter *HANDBOOK*].

¹⁵ *SOCIETY HANDBOOK*, *supra* note 13, at 5.

states enacted statutes within sixteen months.¹⁶ A common purpose of these statutes was to "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."¹⁷

At present, forty-five states and the District of Columbia have applicable legislation.¹⁸ Although the format of these statutes varies significantly from state to state, there are some elements common to all of them.¹⁹ In addition, various states have chosen differing titles for these statutes.²⁰

A Durable Power of Attorney was often a major element of these living wills laws as they began to develop. In a Durable Power of Attorney situation, a proxy is designated to make any and all decisions for the patient once he becomes incompetent. Given general instructions by the patient, the proxy is afforded broad authority in making medical decisions. Establishing the authority of a proxy is the next best scenario to acceptance of living wills — while a living will instructs medical personnel to implement the patient's instructions directly, a proxy is given authority to act on behalf of the patient generally to implement the patient's wishes. As of August 31, 1991, forty-eight states have included provisions providing specific power of attorney decision-making

¹⁶ *Id.* States included: Alaska, Arizona, Colorado, Connecticut, Hawaii, Indiana, Iowa, Maine, Maryland, Missouri, Montana, New Hampshire, Oklahoma, South Carolina, Tennessee and Utah. *Id.*

¹⁷ BARNEY SNEIDERMAN ET AL., CANADIAN MEDICAL LAW: AN INTRODUCTION FOR PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS 314 (1989). The statutes enable a mentally competent adult to anticipate a state of incompetency during terminal illness, and should that situation arise, exercise control over his own medical decisions. *Id.*

¹⁸ These states include: Alabama, Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Ohio, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

Note that eleven states have enacted statutes substantially similar to the Uniform Rights of the Terminally Ill Act (of 1985 and amended in 1989). These states include: Alaska, Arkansas, Iowa, Maine, Missouri, Montana, Nevada, North Dakota, Ohio, Oklahoma, and Rhode Island. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 96, 116 (Supp. 1992) [hereinafter UNIFORM RIGHTS ACT].

¹⁹ See discussion of the elements of living wills, *infra* notes 40-112 and accompanying text. For a general comparative overview see SOCIETY FOR THE RIGHT TO DIE, REFUSAL OF TREATMENT LEGISLATION: A STATE BY STATE COMPILATION OF ENACTED AND MODEL STATUTES (1991).

²⁰ California's statute, for example, is entitled "Natural Death Act." CAL. HEALTH & SAFETY CODE § 7185 (West Supp. 1992). Arizona's statute is entitled the "Medical Treatment Decision Act." ARIZ. REV. STAT. ANN. tit. 36, ch. 32 (Supp. 1991). Some are more direct, having been entitled, for example, "Removal of Life Support Systems," CONN. GEN. STAT. ANN. tit. 19a, ch. 368w (West Supp. 1991), while others portend the action, such as the "Right to Decline Life-Prolonging Procedures Act." FLA. STAT. ANN. § 765 (Supp. 1992).

procedures.²¹

In general, living will legislation provides the following items: (1)

²¹ There are several different types of health care power of attorney statutes including: (1) those specifically designed for the purpose of authorizing the appointment of an agent for health care decision making; (2) general durable power of attorney statutes containing a provision expressly permitting the designation of an agent to make health care decisions; (3) provisions of living will or surrogate decision making statutes permitting the appointment of an agent to make health care decisions; and (4) general durable power of attorney statutes which, although not mentioning health care decision making, have been judicially construed to permit the appointment of an agent to make health care decisions or may be used to appoint an agent for that purpose because another statute (such as a living will statute or surrogate decision making statute) specifically authorizes such use. ALAN MEISEL, *THE RIGHT TO DIE* 217 (Supp. 1992). A combination of these includes: ALASKA STAT. §§ 13.26.356 (Supp. 1991); ARIZ. REV. STAT. ANN. § 36-3204.B (Supp. 1991); ARIZ. REV. STAT. ANN. § 14-5501 (1975); ARK. CODE ANN. § 20-17-202(b) (Michie 1991); CAL. CIV. CODE §§ 2430-2444 (West Supp. 1992); COLO. REV. STAT. §§ 15-14-501 to 502 (Supp. 1991); 1991 Conn. Legis. Serv. Pub. Act 91-283 (S.H.B. 7184) (West, June 26, 1991); DEL. CODE ANN. tit. 16, § 2502(b) (1983); D.C. CODE ANN. §§ 21-2201 to 2213 (1989); FLA. STAT. ANN. §§ 641.61-.72 (West Supp. 1991); FLA. STAT. ANN. § 709.08 (West Supp. 1991); FLA. STAT. ANN. § 765.04(1) (West 1986); GA. CODE ANN. §§ 31-36-1 to -13 (Michie 1990); HAW. REV. STAT. § 327D-26 (Supp. 1991); IDAHO CODE § 39-4505 to 4509 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, paras. 804-1 to -12 (Smith-Hurd Supp. 1992); IND. CODE ANN. § 16-8-12-6 (Burns 1992); IOWA CODE ANN. §§ 144B.1-.12 (West 1992); IOWA CODE ANN. § 633.705 (West 1992); IOWA CODE ANN. § 144A.71 (West 1989); KAN. STAT. ANN. §§ 58-625 to -632 (Supp. 1990); KY. REV. STAT. ANN. §§ 311.970-.986 (Baldwin Supp. 1991); LA. CIV. CODE ANN. art. 2997 (West Supp. 1991); LA. REV. STAT. ANN. § 40:1299.58; 3(C)(1) (West Supp. 1992); ME. REV. STAT. ANN. tit. 18A, § 5-501 (West Supp. 1991); ME. REV. STAT. ANN. tit. 18A, § 5-702(c) (West Supp. 1991); MD. EST. & TRUSTS CODE ANN. §§ 13-601 to -602 (1974); MASS. GEN. LAWS ANN. ch. 201D, §§ 1-17 (West Supp. 1992); MICH. COM. LAWS § 700.496 (Supp. 1992); MINN. STAT. ANN. § 145B.06.2 (West Supp. 1991); MISS. CODE ANN. § 41-41-151 to -183 (1991); MO. ANN. STAT. §§ 404.800 -.865 (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-103(1) (1987), *amended by* 1991 Mont. Laws ch. 391 (H.B. 635) (Apr. 8, 1991); MONT. CODE ANN. § 72-5-501 to -502 (1989); NEV. REV. STAT. ANN. § 449.800 -.860 (Michie Supp. 1989); NEV. REV. STAT. ANN. §§ 449.540 -.690 (Michie 1987), *amended by* 1991 Nev. Stat. ch. 258 §§ 6, 27 (S.B. 442) (June 6, 1991); N.H. REV. STAT. ANN. § 137-J:1 -16 (Supp. 1991); 1991 N.J. Sess. Law Serv. ch. 201 (S.B. 1211) (West, July 11, 1991); N.J. STAT. ANN. § 46:2B-8 (West 1989); N.M. STAT. ANN. §§ 45-5-501 to 502 (Michie 1989); N.Y. PUB. HEALTH LAW § 2980-2994 (McKinney Supp. 1992); N.C. GEN. STAT. §§ 32A-1 to -2 (1987); 1991 N.D. Laws 266, §§ 1-18; OHIO REV. CODE ANN. §§ 1337.11 -.17 (Anderson Supp. 1990), *amended by* 1991 Ohio Laws File 36 (S.B. 1) (July 11, 1991); OR. REV. STAT. § 127.505 -.585 (1991); PA. STAT. ANN. tit. 20, §§ 5601-5606 (Supp. 1990); R.I. GEN. LAWS §§ 23-4.10-1 to -2 (1989); S.C. CODE ANN. §§ 62-5-501 to -502 (Law. Co-op. Supp. 1991); S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1991), *amended by* 1991 S.C. Acts 149, 5 (H.B. 3090) (June 12, 1991); S.D. CODIFIED LAWS ANN. §§ 59-7-2.1 to -2.8 (Supp. 1992); TENN. CODE ANN. §§ 34-6-201 to -214 (Supp. 1991), *amended by* 1991 Tenn. Pub. Acts ch. 344 (H.B. 956) (May 14, 1991); TEX. PROB. ANN. art. 36A (West 1992); UTAH CODE ANN. § 75-2-1106 (Supp. 1991); VT. STAT. ANN. tit. 14, §§ 3451-3467 (Supp. 1991); VA. CODE ANN. § 54.1-2984 (Michie 1990); VA. CODE ANN. § 54.1-2986 (Michie 1991); VA. CODE ANN. § 37.1-134.4D (Michie 1991); VA. CODE ANN. §§ 11-9.1 to -9.4 (Michie 1989); WASH. REV. CODE ANN. §§ 11.94.010 -.040 (West Supp. 1992); W. VA. CODE §§ 16-30A-1 to -20 (1992); WIS. STAT. ANN. §§ 155.01 -.80 (West Supp. 1991); WYO. STAT. §§ 3-5-201 to -214 (1991), *amended by* 1991 Wyo. Sess. Laws 80; WYO. STAT. § 35-22-102(d) (1991).

recognition of an *adult* individual's advance directive;²² (2) immunity from liability for medical practitioners honoring directives; (3) a *suggested* form of declaration;²³ (4) definition of terms;²⁴ (5) procedures for execution of declarations;²⁵ (6) a provision outlining an unlimited term of effectiveness;²⁶ (7) a requirement that declaration be made part of the medical record; (8) a requirement that physicians who are unwilling or unable to honor declaration make a reasonable effort to transfer the patient;²⁷ and (9) a declaration that nothing in the statute impairs or supercedes other rights or responsibilities.²⁸

In an attempt to make state laws uniform in purpose and form, the National Conference of Commissioners on Uniform State Laws enacted its Uniform Rights of the Terminally Ill Act in 1985.²⁹ The Act, which focuses on patient autonomy, suggests a simple form outlining the patient's desires and loosens restrictions concerning witnesses. As originally drafted, the Act lacked two significant provisions, one allowing for the appointment of a proxy and one providing procedures to be followed in the event that the patient has no declaration or has not appointed a proxy.³⁰ Since its inception, however, the Act has added these two provisions.³¹ The Uniform Act is significant because it reveals support for living wills among politicians and decision-makers.³²

²² SOCIETY HANDBOOK, *supra* note 13, at 15. Note that only an adult, and not a minor, may execute an advance directive.

²³ *Id.* In most states, the form can be varied with personal directions.

²⁴ Terms such as "life-sustaining procedure" and "terminal condition" are defined. Misunderstandings frequently arise, however, because the definitions are ambiguous. *Id.*

²⁵ *Id.* These include witnessing procedures and requirements for revocation. Note that the revocation rules, for the most part, are easily met.

²⁶ California recently amended its statute to allow for this unlimited term. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1992).

²⁷ SOCIETY HANDBOOK, *supra* note 13, at 16. This provision, in some states, includes a penalty for violation of the transfer requirement. *Id.*

²⁸ This clarifies that a statutory declaration is one easily effectuated way of exercising rights but is not the exclusive method. *Id.*

²⁹ See generally, UNIFORM RIGHTS ACT *supra* note 18.

³⁰ UNIFORM RIGHTS ACT, *supra* note 18. When a patient becomes incompetent and has not created a living will or appointed a proxy, guidelines for medical decision-making are crucial. Varying standards make decisions in this scenario difficult and time consuming. It is in these situations, too, where speedy and concise decisions must be reached. Often the patient is in severe pain, or his condition is costing a great deal in medical bills — both of which are factors warranting quick resolution of the issue of whether or not to continue life-sustaining measures.

³¹ The provision allowing for appointment of a proxy can be found at UNIFORM RIGHTS ACT, *supra* note 18, § 2. The provision establishing procedures to be followed in the absence of a declaration can be found at UNIFORM RIGHTS ACT, *supra* note 18, § 7.

³² The Uniform Laws are compiled by the National Conference of Commissioners on Uniform State Laws, which was organized in 1892. The Conference is made up of Commissioners from each state, who in most cases are appointed by the governor or by the legislature. The membership is primarily lawyers, judges, legislators, and law school professors. 9B U.L.A. III (1987).

Despite criticism of the variety of statutes which have been enacted, support for living will legislation is widespread. One author notes that "millions of people have already signed some kind of living will."³³ In a 1986 poll taken for the American Medical Association, 1,100 out of 1,500 people said they favored "withdrawing life-support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it."³⁴ Further, a poll taken after following a nationally televised conference, moderated by Ted Koppel, on, "Who Lives, Who Dies, Who Decides?" found that:

[t]he American people want to have uniform living will provisions in every state, durable power of attorney provisions in every state, and an ongoing national public education program in place to make the public aware of the nature and availability of these documents.³⁵

But some feel that living wills are limited and evanescent.³⁶ Professor Leslie Francis explains that living wills, like testamentary wills, are plagued with ambiguities. Although she does not specify what kinds of ambiguities, she may be referring to such things as formalities which are inflexible and thus can be confusing in situations where detailed interpretation is required. Francis states that living wills are not "performative,"³⁷ and concludes that the "current treatment of living wills assures only relatively limited and fragile changes in the medical treatment of an individual."³⁸

Although reaction is divided, the fact remains that forty-five states and the District of Columbia have now enacted some sort of Natural Death Act, Rights of the Terminally Ill Act, or "living will" legislation.³⁹

1. Who May Execute a Living Will?

The person executing a living will, or similar statutorily recognized advance directive, must be a competent adult.⁴⁰ This means that the adult must be alert and aware (of sound mind and body) *at the time the declaration is made*.⁴¹ Further, competency implicately means that the

³³ Condie, *supra* note 4, at 105.

³⁴ SOCIETY HANDBOOK, *supra* note 13, at 13.

³⁵ *Id.* Note that a later survey illustrates less convincing statistics. In a 1989 poll, 9% of Americans were said to execute advance directives. See MEISEL, *supra* note 21, citing Emanuel & Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document* 261 J. AM. MED. ASS'N 3288 (1989).

³⁶ Leslie P. Francis, *The Evanescence of Living Wills*, 14 J. CONTEMP. L. 27, 50 (1988).

³⁷ *Id.* at 30. There is no dictionary definition of the word "performative." In the context of her analysis, "performative" seems to mean that living wills "change very little." *Id.*

³⁸ *Id.* at 27.

³⁹ See *supra* note 18 and accompanying text.

⁴⁰ Lobe, *supra* note 7, at 48. See also Condie, *supra* note 4, at 108.

⁴¹ This is an extremely strict standard. If the declarant is incompetent at the time the living

individual is able to make significant decisions such as whether or not he wishes to be kept on life-sustaining measures. In addition, the individual must understand the consequences of those decisions; he must be aware that death is ultimately involved. The statutes generally define "competent person" as "an individual who is able to understand and appreciate the nature and consequences of a decision to accept or refuse treatment,"⁴² or a person "possessing the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a purposed treatment decision."⁴³ In the absence of evidence to the contrary, the presumption is in favor of competency.⁴⁴ In most jurisdictions, the individual making a living will must be terminally ill (whether by reason of disease or injury).⁴⁵ Ambiguity arises here, however, because most states fail to define what constitutes "terminal illness."⁴⁶ Despite the lack of clear definition, twenty-five

will is executed, or if there is a question concerning his competence at that time, the advance directive will be invalidated.

⁴² See, e.g., TENN. CODE ANN. §§ 32-11-103(1) (Supp. 1991).

⁴³ See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 672.002(2) (West 1992).

⁴⁴ Lobe, *supra* note 7, at 48.

⁴⁵ Condie, *supra* note 4, at 111. See also, Lobe, *supra* note 7, at 60-61. Lobe notes that to be qualified to execute a living will, a patient must be afflicted with a "terminal condition." *Id.* Arkansas is the only state which does not require that the patient's illness or injury be terminal. ARK. CODE ANN. § 20-17-201(7) (Michie 1991). See also Condie, *supra* note 4, at 111 n.43.

Those statutes requiring that the patient be terminally ill include: ALA. CODE § 22-8A-3(5) (1990); ALASKA STAT. § 18.12.010 (1991); ARIZ. REV. STAT. ANN. § 36-3201(5) (Supp. 1991); CAL. HEALTH & SAFETY CODE § 7186(h) (West Supp. 1992); COLO. REV. STAT. § 15-18-104 (1991); CONN. GEN. STAT. ANN. § 19a-571 (West Supp. 1991); FLA. STAT. ANN. § 765.03(5) (West Supp. 1992); DEL. CODE ANN. tit. 16, § 2503(a) (1983); D.C. CODE ANN. § 6-2421(5) (1989); GA. CODE ANN. § 31-32-3(a) (Michie 1991); HAW. REV. STAT. § 327D-3(a) (Supp. 1991); IDAHO CODE § 39-4503(2) (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 702(g) (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-8-11-14 (West 1992); IOWA CODE ANN. § 144A.3 (West 1989); KAN. STAT. ANN. §§ 65.28.101 & 65.28.102(e) (1991); KY. REV. STAT. ANN. § 311.624 (7) (Baldwin 1991); LA. REV. STAT. ANN. § 40:1299.58.2(8) (West 1992); ME. REV. STAT. ANN. tit. 18-A, § 5-701(7) (West Supp. 1991); MD. HEALTH-GEN. CODE ANN. § 5-601(f) (1990); MINN. STAT. ANN. §§ 145B.03. Subd. 1 & 145B.04 (West Supp. 1992); MISS. CODE ANN. §§ 41-41-105 & 41-41-107 (1991); MO. ANN. STAT. §§ 459.010-.459.015 (Vernon Supp. 1992); NEV. REV. STAT. §§ 449.600, 449.610 (1987); N.H. REV. STAT. ANN. § 137-H:2v (Supp. 1991); N.M. STAT. ANN. § 24-7-3 (Michie 1991); N.C. GEN. STAT. § 90-321(b) (1987); N.D. CENT. CODE § 23-06.4-03 (1991); OKLA. STAT. ANN. tit. 63, § 3102(7) (West Supp. 1992); OR. REV. STAT. § 127.605(5) (1991); S.C. CODE ANN. §§ 44-77-10 to 44-77-20(1) (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. § 34-12D-1(7) (Supp. 1991); TENN. CODE ANN. §§ 32-11-103(1), 32-11-104 & 32-11-105 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.002(8) (West 1992); UTAH CODE ANN. §§ 75-2-1103(3) & 75-2-1104(4) (Supp. 1991); VT. STAT. ANN. tit. 18, § 5253 (1991); VA. CODE ANN. § 54.1-2982 (Michie 1991); WASH. REV. CODE ANN. § 70.122.020(6)-(8) (West 1992); W. VA. CODE §§ 16-35-2 & 16-30-3 (Supp. 1991); WIS. STAT. ANN. § 154.01(6) (West 1989); WYO. STAT. § 35-22-101(a)(v) (Supp. 1991).

⁴⁶ Condie, *supra* note 4, at 111-112 n.43-44; Lobe, *supra* note 7, at 60. Several states define terminal condition as one which would produce death despite the application of life-sustaining procedures. CONN. GEN. STAT. ANN. § 19a-570(3) (West Supp. 1992) (defining terminal condition as

states require that the attending physician certify in writing that the patient's condition is terminal.⁴⁷ Many states further require that this certification be verified by *another* physician.⁴⁸

Minors present a different problem, as the varying treatment of mi-

the final stage of an incurable or irreversible medical condition, which, in the opinion of the attending physician, will result in death); DEL. CODE ANN. tit. 16, § 2501(e) (1983); D.C. CODE ANN. § 6-2421(6) (Supp. 1988); FLA. STAT. ANN. § 765.03(6) (West 1989); GA. CODE ANN. § 31-32-2(10) (Michie 1991); IDAHO CODE § 39-4504 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 702(h) (Smith-Hurd Supp 1991); KY. REV. STAT. ANN. § 311.624(8) (Baldwin 1991); LA. REV. STAT. ANN. § 40:1299.58.2(10) (West Supp. 1992); MD. HEALTH-GEN. CODE ANN. § 5-601(g) (1990); N.M. STAT. ANN. § 24-7-2 (Michie Supp. 1986); MINN. STAT. ANN. § 145B.02 subd. 8 (West Supp. 1992); MISS. CODE ANN. § 41-41-107 (1) (1991); NEV. REV. STAT. § 449.590 (1987); OR. REV. STAT. § 127.605(6) (1991); TENN. CODE ANN. § 32-11-103(9) (Supp. 1991); UTAH CODE ANN. § 75-2-1103(7) (Supp. 1991); VT. STAT. ANN. tit. 18, § 5252(5) (1991); VA. CODE ANN. §§ 54.1-2982 & 54.1-2984 (Michie 1991); WASH. REV. CODE ANN. § 70.122.020(7) (West 1992); W.VA. CODE § 16-30-2(10) (Supp. 1991); WIS. STAT. ANN. § 154.01(8) (West 1989); WYO. STAT. § 35-22-101 (a)(vi) (Supp 1991). This definition severely limits the group of terminally ill patients able to qualify under these statutes. UNIFORM RIGHTS ACT, *supra* note 18, § 1(9).

Other jurisdictions, however, define a terminal condition as one in which death will result if no life-sustaining measures are used. ALASKA STAT. § 18.12.100(7) (1991); ARK. CODE ANN. § 20-17-201(9) (Michie 1991); ARIZ. REV. STAT. ANN. § 36-3201(6) (Supp. 1991); CAL. HEALTH & SAFETY CODE § 7186(j) (West Supp. 1991); COLO. REV. STAT. § 15-18-103(10) (1991); HAW. REV. STAT. § 327D-2 (Supp. 1991); IND. CODE ANN. § 16-8-11-9 (West 1992); IOWA CODE ANN. § 144A.2(8) (West 1989); ME. REV. STAT. ANN. tit. 18-A, § 5-701(9) (West Supp. 1991); MO. ANN. STAT. § 459.010(6) (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-102(14) (1991); N.D. CENT. CODE § 23-06.4.02(7) (1991); OKLA. STAT. ANN. tit. 63, § 3102(8) (West Supp. 1992); S.C. CODE ANN. § 44-77-20(4) (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. § 34-12D-1(8) (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.002(9) (West 1992).

⁴⁷ ALA. CODE § 22-8A-6 (1990); ARIZ. REV. STAT. ANN. § 36-3202(A) (Supp. 1991); COLO. REV. STAT. § 15-18-103(9) (1991); D.C. CODE ANN. § 6-2421(6) (1989); FLA. STAT. ANN. § 765.03(5) (West Supp. 1992); IDAHO CODE § 39-4504 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 702(g) (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-8-11-14 (West 1992); KAN. STAT. ANN. § 65.28.105 (1991); LA. REV. STAT. ANN. § 40:1299.58.7 (West 1992); MD. HEALTH-GEN. CODE ANN. § 5-604(a) (1990); N.H. REV. STAT. ANN. § 137-H:2V (Supp. 1991); N.M. STAT. ANN. § 24-7-5A (Michie 1991); N.D. CENT. CODE § 23-06.4-03 (1991); OKLA. STAT. ANN. tit. 63, § 3102 7 (West Supp. 1992); OR. REV. STAT. § 127.610 (1991); S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1991); TENN. CODE ANN. § 32-11-105 (Supp 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.002(8) (West 1992); UTAH CODE ANN. § 75-2-1104(4) (Supp. 1991); VA. CODE ANN. § 54.1-2984 (Michie 1991); WASH. REV. CODE ANN. § 70.122.020(6) (West 1992); W. VA. CODE § 16-30-5(a) (Supp. 1991); WIS. STAT. ANN. § 154.01(6) (West 1989); WYO. STAT. § 35-22-101(a)(v) (Supp. 1991).

⁴⁸ ALA. CODE § 22-8A-3(5) (1990); ARIZ. REV. STAT. ANN. § 36-3202 (Supp. 1991); COLO. REV. STAT. § 15-18-103(9) (1991); D.C. CODE ANN. § 6-2421(5) (1989); FLA. STAT. ANN. § 765.03(5) (West Supp. 1992); IDAHO CODE § 39-4504 (Supp. 1991); N.H. REV. STAT. ANN. § 137-H:2V (Supp. 1991); N.M. STAT. ANN. § 24-7-5A (Michie 1991); N.D. CENT. CODE § 23-06.4-03 (1991); OKLA. STAT. ANN. tit. 63, § 3102(7) (West Supp. 1992); OR. REV. STAT. § 127.610 (1991); S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.002(8) (West 1992); UTAH CODE ANN. § 75-2-1104(4) (Supp. 1991); VA. CODE ANN. § 54.1-2982 (Michie 1991); WASH. REV. CODE ANN. § 70.122.020(6) (West 1992); W. VA. CODE § 16-30-2(10) (Supp. 1991); WIS. STAT. ANN. § 154.01(6) (West 1989); WYO. STAT. § 35-22-101(a)(v) (Supp. 1991).

nors among states creates ambiguity. Only five states currently allow minors to make a living will declaration or allow their legal guardian to do so on their behalf.⁴⁹ Aside from the minor, certain individuals (parent, legal guardian, spouse if he/she has reached the age of majority) are authorized by these statutes to execute the living will on the minor's behalf.⁵⁰

Louisiana and New Mexico, further, deem a living will invalid if executed by the minor's parent or guardian if it is opposed by the minor's other parent, guardian, or adult spouse.⁵¹ In an effort to ensure that those involved in a decision to terminate a minor's life-sustaining treatment are acting in good faith, Maryland and New Mexico have added the requirement that a living will executed on behalf of a minor must be certified by a district court judge in order to be valid.⁵²

Most state statutes have special provisions addressing the issue of whether or not a pregnant woman can execute a valid living will.⁵³ A pregnant woman can execute a living will, but these provisions deem the declaration invalid during her pregnancy.⁵⁴ Some statutes, for example,

⁴⁹ Condie, *supra* note 4, at 108. LA. REV. STAT. ANN. § 40:1299.58.6 (West Supp. 1987); N.M. STAT. ANN. § 24-7-4 (Michie 1978); N.Y. PUB. HEALTH LAW § 2967 (McKinney Supp. 1992); N.C. GEN. STAT. § 90-320 (1987) (statute simply identifies the declarant as a "person"); TEX. HEALTH AND SAFETY CODE ANN. § 672.006 (West 1992).

⁵⁰ See, e.g., LA. REV. STAT. ANN. § 40:1299.58.6 (West Supp. 1987).

⁵¹ Lobe, *supra* note 7, at 49 n.20; LA. REV. STAT. ANN. § 40:1299.58.6(B)(2) (West Supp. 1989); N.M. STAT. ANN. § 24-7-4 (Supp. 1986).

⁵² See, e.g., MD. HEALTH-GEN. CODE ANN. § 5-602 (1990); N.M. STAT. ANN. § 24-7-4 (Michie Supp. 1986). See also Lobe, *supra* note 7, at 50.

⁵³ See generally Janice MacAvoy-Smitzer, Note, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987). States include: Alabama, Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Mississippi, Montana, Nevada, North Dakota, Oklahoma, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

⁵⁴ ALA. CODE § 22-8A-4(a) (1990); ALASKA STAT. § 18.12.040 (1991); ARIZ. REV. STAT. ANN. § 36-3205D (Supp 1991); ARK. CODE ANN. § 20-17-206(c) (Michie 1991) (declaration is not given effect if patient is pregnant as long as it is possible that the fetus could develop to the point of live birth with the continued application of life-sustaining treatment); CAL. HEALTH & SAFETY CODE § 7189.5(c) (West Supp. 1992); COLO. REV. STAT. § 15-18-104(2) (1991) (limited as in Arkansas); CONN. GEN. STAT. ANN. § 19a-574 (West Supp. 1991); DEL. CODE ANN. tit. 16, § 2503(d) (1983); FLA. STAT. ANN. § 765.08 (West Supp. 1992); GA. CODE ANN. § 31-32-3 (Michie 1991); HAW. REV. STAT. § 327D-6 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 703(c) (Smith-Hurd Supp. 1991) (the declaration will have no effect as long as, in the opinion of the attending physician, it is possible that the fetus could develop to the point of live birth with the continued application of death-delaying procedures); IND. CODE ANN. § 16-8-11-11(d) (West 1992); IOWA CODE ANN. § 144A.6 (West 1989) (limited as in Arkansas); KAN. STAT. ANN. § 65.28.103 (1991); KY. REV. STAT. ANN. § 311.624(7)(b) (Baldwin 1991); MD. HEALTH-GEN. CODE § 5-605(2) (1990); MISS. CODE ANN. § 41-41-107(1) (1991); MONT. CODE ANN. § 50-9-202(3) (1991) (limited as in Arkansas); NEV. REV. STAT. § 449.610 (1987); N.D. CENT. CODE § 23-06.4-03 (1991); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1992); S.C. CODE ANN. § 44-77-70 (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. § 34-12D-10 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.004

remove the status of "qualified patient" in the event the patient discovers that she is pregnant.⁵⁵ Others simply state that the living will form is completely ineffective during the course of the pregnancy.⁵⁶ The main issue is whether or not the child could be delivered while the mother was maintained on a life support system. A states' interest in preserving human life (that of the unborn child) is in direct conflict with the woman's right to force physicians to comply with her living will. If the woman is removed from life support equipment during pregnancy, her baby will most likely die. She will argue that it is her right to make a living will, and that it should be enforced despite her pregnancy.⁵⁷ Meanwhile, the state will argue that the woman, while being able to make decisions concerning the disposition of her body, cannot interfere with the well-established state interest in preserving human life. The related Constitutional arguments regarding a woman's right of privacy have raised a great deal of controversy.⁵⁸ Statutory provisions disallowing the advance directives of pregnant women, thus, will continue to be hotly debated.

2. Execution Formalities

All living will statutes require some degree of formality in execution.⁵⁹ Some formalities are similar to those required for execution of testamentary documents,⁶⁰ while others have more detailed instructions.⁶¹ Six states allow oral declarations.⁶² The remaining states require that the declaration be in writing.⁶³ Further, the living will must be exe-

(West 1992); UTAH CODE ANN. § 75-2-1109 (Supp. 1991); WASH. REV. CODE ANN. § 70.122.030 (West 1992); WIS. STAT. ANN. § 154.03 (West 1989); WYO. STAT. § 35-22-102(b) (Supp. 1991).

⁵⁵ See, e.g., CAL. HEALTH & SAFETY CODE § 7189.5(c) (West Supp 1992).

⁵⁶ See, e.g., HAW. REV. STAT. § 327D-6 (Supp. 1991); S.C. CODE ANN. § 44-77-70 (Law. Co-op. Supp. 1987).

⁵⁷ See *In re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990) (involving substituted judgment and a pregnant woman's right to refuse treatment). See also *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court*, 163, 209 Cal. Rptr. 220 (1984).

⁵⁸ See generally *Griswold v. Connecticut*, 381 U.S. 479 (1965) (protecting the right to privacy in the confines of the marital bedroom); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (striking down a Massachusetts law prohibiting the distribution of contraceptives); *Roe v. Wade*, 410 U.S. 113 (1973) (allowing a woman the right to have an abortion in the first trimester without state intrusion).

⁵⁹ See UNIFORM RIGHTS ACT, *supra* note 18, § 2.

⁶⁰ *Lobe, supra* note 7, at 51.

⁶¹ *Id.*

⁶² FLA. STAT. ANN. § 765.04(1) (West 1986) (oral declaration must be subscribed by witness in declarant's presence); CONN. GEN. STAT. ANN. § 19a-571(4) (West Supp. 1991); LA. REV. STAT. ANN. § 40:1299.58.3(4) (West Supp. 1992); MINN. STAT. ANN. § 145 B.03 subd. 2(c) (West Supp. 1992) (the declaration must be communicated to and then transcribed by one of the witnesses); TEX. HEALTH & SAFETY CODE ANN. § 672.005 (West 1992); VA. CODE ANN. § 54.1-2983 (1991) (two witnesses and the physician must be present).

⁶³ *Condie, supra* note 4, at 113.

cuted "willfully and voluntarily;" it must also be signed, dated and witnessed.⁶⁴ The witnessing requirements vary. In Virginia, an attending physician must be present.⁶⁵ Other statutes specifically disqualify certain persons from serving as witnesses. Many statutes require that the witness have no interest in the declarant's estate or not be financially responsible for the patient's medical costs.⁶⁶ Others prohibit the attending physician or health care providers employed where the patient is being treated from acting as witnesses.⁶⁷ Five states prohibit any other patient in the same facility as the declarant from serving as a witness.⁶⁸ In North Dakota, if the declarant is a resident of a long-term health care facility at the time the declaration is executed, one of the two witnesses must be a recognized member of the clergy, an attorney licensed to practice in the state, or a person as may be designated by the department of human services or the county court.⁶⁹ These witness requirements attempt to safeguard against duress or coercion by those with specific inter-

⁶⁴ *Id.*

⁶⁵ VA. CODE ANN. § 54.1-2983 (Michie 1991).

⁶⁶ ALA. CODE § 22-8A-4 (1990); ARIZ. REV. STAT. ANN. § 36-3202 (Supp 1991); CAL. HEALTH & SAFETY CODE § 7186.5(a) (West Supp. 1992); COLO. REV. STAT. § 15-18-105 (1991); DEL. CODE ANN. tit 16, § 2503(b)(2)-(3) (1983); D.C. CODE ANN. § 6-2422(4)(C)(D) (1984); GA. CODE ANN. § 31-32-3(2) & (4)-(5) (Michie 1991); HAW. REV. STAT. § 327D-3(b) (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-11-11-11(c)(3)-(4) (West 1992); KAN. STAT. ANN. § 65.28, 103 (1991); MD. HEALTH-GEN. CODE § 5-602(a)(4) (1990); MINN. STAT. ANN. § 145B.03 Subdiv. 2(d) (West Supp. 1992); MISS. CODE ANN. § 41-41-107(1) (1991); NEV. REV. STAT. § 449.600(4) (1987); N.D. CENT. CODE § 23-06.4-03 (1991); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1992); OR. REV. STAT. § 127.610 (1991); S.C. CODE ANN. § 44-77-40(2) (Law. Co-op. Supp. 1991); TENN. CODE ANN. § 32-11-104 (Supp. 1991); TEX. HEALTH AND SAFETY CODE ANN. § 672.003(c) (Supp. 1991); VT. STAT ANN. tit. 18, § 5254 (West 1992); WASH. REV. CODE ANN. § 70.122.030(1) (West 1992); W. VA. CODE § 16-30-3(b)(3)-(4) (Supp. 1991); WIS. STAT. ANN. § 154.03 (West 1989); WYO. STAT. § 35-22-102(a) (Supp. 1991).

⁶⁷ Colorado excludes any physician, as well as health care providers employed at the facility where the declarant is a patient. COLO. REV. STAT. § 15-18-105(1)(a)-(b) (1991); *See also* CAL. HEALTH & SAFETY CODE § 7186.5(a) (West Supp. 1992); DEL. CODE ANN. tit 16, § 2503(b)(5) (1983) (excluding all employees of the health care facility where in declarant is a patient); D.C. CODE ANN. § 6-2422(c) (1989); GA. CODE ANN. § 31-32-3(3) (Michie 1991); HAW. REV. STAT. § 327-D-3(4)(C) (Supp. 1991); IDAHO CODE § 39-4505 (Supp. 1991) (excluding any health care provider); MISS. CODE ANN. § 41-41-107 (1) (1991); NEV. REV. STAT. § 449.600 2 (1987); N.H. REV. STAT. ANN. § 137-H:4 (Supp 1991); N.C. GEN. STAT. § 90-321(c)(3) (1987); N.D. CENT. CODE § 23-06.4-03 (1991); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1992); OR. REV. STAT. § 127.610 (1991); S.C. CODE ANN. § 44-77-40(2) (Law. Co-op. Supp. 1991); TENN. CODE ANN. § 32-11-104 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.003(3)-(5) (West 1992); UTAH CODE ANN. § 75-2-1104(4) (Supp. 1991); VT. STAT. ANN. tit. 18, § 5254 (1991); WASH. REV. CODE ANN. § 70.122.030(1) (West 1992); W. VA. CODE § 16-30-3(b)(5) (Supp. 1991); WIS. STAT. ANN. § 154.03 (West 1989).

⁶⁸ N.C. GEN. STAT. § 90-321(c)(3) (1987); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1992); OR. REV. STAT. § 127.610 (1991); S.C. CODE ANN. § 44-77-40(3) (Law. Co-op. Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.003(6) (West 1992).

⁶⁹ N.D. CENT. CODE § 23-06.4-03 (1991).

ests or biases.⁷⁰ Several states also require notarization as an additional formality.⁷¹ Many also impose a duty on the declarant to notify his or her physician of the document's existence; the physician is then directed to make it part of the patient's medical records.⁷² Hawaii, New Hampshire and Vermont require that anyone possessing the living will of another deliver the will to the declarant's physician — if that person is aware that the patient is in a condition where the living will could potentially be applied.⁷³ While all statutes provide a sample form of a living will, only two states dictate that it must be followed exactly.⁷⁴ Many states, however, have only a general form.⁷⁵ Unfortunately, this provides a possibility for ambiguity, misunderstanding and failure to adequately interpret the declarant's intentions.

3. Definition Section

All state living will statutes contain definition sections.⁷⁶ The definitions common to most statutes include: "attending physician;"⁷⁷ "declaration;"⁷⁸ "health care provider;"⁷⁹ "life-sustaining procedure;"⁸⁰ "physician;"⁸¹ "qualified patient;"⁸² and "terminally ill or injured patient."⁸³ Although these definitions are necessary, they create problems of ambiguity. For example, some statutes prohibit the withdrawal or

⁷⁰ See Lobe, *supra* note 7, at 54-56. See also Condie, *supra* note 4, at 113-114.

⁷¹ Lobe, *supra* note 7, at 57.

⁷² *Id.* Note that in Mississippi, the declarant, rather than notifying the physician, must file the living will with the Bureau of Vital Statistics of the State Board of Health. MISS. CODE ANN. § 41-41-107 (Supp. 1988).

⁷³ HAW. REV. STAT. § 327D-9 (Supp. 1991); N.H. REV. STAT. ANN. § 137-H:8 (Supp. 1991); VT. STAT. ANN. tit. 18, § 5258 (1991).

⁷⁴ OR. REV. STAT. § 127.610 (1991); WIS. STAT. ANN. § 154.03 (1989). California requires only substantial compliance with the sample form. CAL. HEALTH & SAFETY CODE § 7186.5 (West Supp. 1992).

⁷⁵ See UNIFORM RIGHTS ACT, *supra* note 18, § 2.

⁷⁶ Condie, *supra* note 4, at 114.

⁷⁷ See, e.g., ALA. CODE § 22-8A-3(1) (1990).

⁷⁸ See, e.g., ALA. CODE § 22-8A-3(2) (1990).

⁷⁹ "A person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession." CAL. HEALTH & SAFETY CODE § 7186(c) (West Supp. 1992).

⁸⁰ "Any medical procedure or intervention which, when applied to a qualified patient, would serve only to prolong the dying process." ALA. CODE § 22-8A-3(3) (1990).

⁸¹ "A person licensed to practice medicine and osteopathy in the state. . . ." ALA. CODE § 22-8A-3(4) (1990).

⁸² "A patient, who has executed a declaration in accordance with this chapter 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." ALA. CODE § 22-8A-3(5) (1990).

⁸³ "A patient whose death is imminent or whose condition is hopeless unless he or she is artificially supported through the use of life-sustaining procedures." ALA. CODE § 22-8A-3(6) (1990).

withholding of treatment for "comfort or care to alleviate pain."⁸⁴ Here, nutrition and hydration are specifically included in the description of comfort care or care to alleviate pain. Other statutes are not quite as clear: they leave operative questions of whether "comfort care" or "care to alleviate pain" include nutrition and/or hydration.⁸⁵ A second question which arises is whether some procedures utilized to prolong life are actually painful or discomforting.⁸⁶ Another defined term that often presents ambiguity is that of "terminally ill or injured patient."⁸⁷ Some statutes use the words "imminent" or "hopeless."⁸⁸ But in applying these provisions, one encounters difficulties in determining what "immi-

⁸⁴ See, e.g., ME. REV. STAT. ANN. tit. 18-a, § 5-706(b) (West Supp. 1991) "This part does not affect the responsibility of the attending physician or other health-care providers to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain." *Id.*

The Maine statute, in its Comment on the Uniform Rights of the Terminally Ill Act, states:

The Act uses the term "comfort care" in defining procedures that may be applied notwithstanding a declaration instructing withdrawal or withholding of life-sustaining treatment. The purpose for permitting continuation of life-sustaining treatment deemed necessary for comfort care or alleviation of pain is to allow the physician to take appropriate steps to insure comfort and freedom from pain, as dictated by reasonable medical standards. Many existing statutes employ the term "comfort care" in connection with the alleviation of pain, and the Act follows this example. Although the phrase "to alleviate pain" arguably is subsumed within the term "comfort care", the additional specificity was considered helpful for both the doctor and the lay-person.

Id.

⁸⁵ Condie, *supra* note 4, at 115. The Maine statute on point states the following:

[The section regarding comfort care or alleviation of pain] does not set out a separate rule governing the provision of nutrition and hydration. Instead, each is subject to the same considerations of necessity for comfort care and alleviation of pain as are all other forms of life-sustaining treatment. If nutrition and hydration are not necessary for comfort care or alleviation of pain, they may be withdrawn. This approach was deemed preferable to the approach in a few existing statutes, which treat nutrition and hydration as comfort care in all cases, regardless of circumstances, and exclude comfort care from the life-sustaining treatment definition.

ME. REV. STAT. ANN. tit. 18-a, § 7-706 (West Supp. 1991) (Uniform Rights Act comment). The Maine statute goes on to state:

It is debatable whether physicians or other professionals perceive the providing of nourishment through intravenous feeding apparatus or agastric tubes as comfort care in all cases or whether such procedures at times merely prolong the dying process. Whether procedures to provide nourishment should be considered life-sustaining treatment or comfort care appears to depend on the factual circumstances of each case and, therefore, such decisions should be left to the physician, exercising reasonable medical judgment. Declarants may, however, specifically express their views regarding continuation or noncontinuation of such procedures in the declaration, and those views will control.

Id.

⁸⁶ Condie, *supra* note 4, at 115.

⁸⁷ See *supra* notes 45-46 and accompanying text.

⁸⁸ See *supra* note 83 and accompanying text.

ment" or "hopeless" means.⁸⁹

Acknowledging that ambiguities exist is a vital step in the process of employing these living will provisions. Declarants who wish to make their intentions clear have been urged by an organization called "Choice in Dying" to go a step further and define terms fully on their own.⁹⁰ "Choice in Dying" is a nonprofit organization, based in New York, which seeks to educate people regarding their rights to make informed decisions about death and dying.⁹¹

4. Revocation Procedures

The duration of living wills under most state statutes is unlimited.⁹² All states except Connecticut provide that a declaration may be revoked at any time.⁹³ Although differences exist in the required revocation procedures, most require that a declarant revoke by executing a written document, by physical destruction of the living will, or by a verbal or non-verbal communication, indicating intent to revoke.⁹⁴ These requirements, as with the formal requirements of execution, closely parallel the standards for revocation of a testamentary document.⁹⁵

5. Noncompliance

Although a majority of the states provide that living will statutes do not impose liability on the physician for failure to comply with a qualified patient's declaration,⁹⁶ thirty nine (of the forty-six jurisdictions) require that the physician refusing to comply transfer the patient to

⁸⁹ Due to this ambiguity, the drafters of the Uniform Rights of the Terminally Ill Act use "relatively short time" rather than "imminent." 9B U.L.A. § 1-18 (1989)

⁹⁰ See HANDBOOK, *supra* note 14, at 7 (suggesting that the declarant (in those states requiring only that the form be "substantially" followed) add personal instructions).

⁹¹ Note that initially, this organization was called "The Society for the Right to Die." In 1992, however, it changed its legal name to "Choice in Dying" when "The Society for the Right to Die" and "Concern for Dying" merged. Telephone conversation with representative of "Choice in Dying" (Apr. 24, 1992).

⁹² Only one state, Georgia, currently has an automatic revocation provision. GA. CODE ANN. § 31-32-6(a)-(b) (Michie 1991) (providing that living wills executed on or after March 28, 1986, shall be of unlimited duration unless revoked under its statutory procedures *but* that those executed prior to that date will be effective only for a period of seven years).

⁹³ Lobe, *supra* note 7, at 58. See also Condie, *supra* note 4, at 116.

⁹⁴ Lobe, *supra* note 7, at 58. Note that in Alabama, D.C., Illinois, Kansas, Oklahoma, Utah, West Virginia and Wyoming, a witness to an oral revocation must sign a written statement confirming that the revocation was made. ALA. CODE § 22-8A-5(3) (1990); D.C. CODE ANN. § 6-2424(a)(3) (1989); ILL. ANN. STAT. ch. 110 1/2, para. 705 (Smith-Hurd Supp. 1991); KAN. STAT. ANN. § 65-28, 104(3) (1991); OKLA. STAT. ANN. tit. 63, § 3104 (West Supp. 1992); UTAH CODE ANN. § 75-2-1111(1)(c) (Supp. 1991); W. VA. CODE § 16-30-4(a)(3) (Supp. 1991); WYO. STAT. § 35-22-103 (1988).

⁹⁵ See generally U.P.C. § 2-507.

⁹⁶ See *supra* note 8 and accompanying text.

another physician who will.⁹⁷ Several states do not require a physician to abide by a patient's declaration.⁹⁸ In a sense, this undermines the declaration's effectiveness. Twelve states and the District of Columbia, however, assess penalties to physicians who do not comply with valid declarations.⁹⁹ Typical penalties for non-compliance include: withhold-

⁹⁷ Condie, *supra* note 4, at 118. In many states the transfer requirement is also imposed if hospital or health care facility policy precludes the removal of support systems. *Id.* See, e.g., ALA. CODE § 22-8A-8(a) (1990); ALASKA STAT. § 18.12.050 (1991); ARIZ. REV. STAT. ANN. § 36-3204 (Supp. 1991); ARK. CODE ANN. § 20-17-207 (Michie 1991); CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1992); COLO. REV. STAT. § 15-18-113(5) (1991); D.C. CODE ANN. § 6-24-27(b) (1989); CONN. GEN. STAT. ANN. § 19a (West date); FLA. STAT. ANN. § 765.09 (West Supp. 1992); GA. CODE ANN. § 31-32-8(b)(1) (Michie 1991); HAW. REV. STAT. § 327D-11 (Supp. 1991); IDAHO CODE § 39-4508 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 706 (Smith-Hurd Supp. 1991) (if unable to do so, physician must notify individuals by priority listing); IND. CODE ANN. § 16-8-11(e) (West 1992); IOWA CODE ANN. § 144A.8 (West 1991); KAN. STAT. ANN. § 65.28, 107 (1991); KY. REV. STAT. ANN. § 311.634(1) (Baldwin 1991); LA. REV. STAT. ANN. § 40:1299.58.7 B (West 1992); ME. REV. STAT. ANN. tit. 18-A, § 5-708 (West Supp. 1991); MD. HEALTH-GEN. CODE § 5-604(b) (1990); MINN. STAT. ANN. § 145B.06 (West Supp. 1992) (puts duty on declarant first to seek alternate care); MISS. CODE ANN. § 41-41-115(2) (1991); MO. ANN. STAT. § 459.030 (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-203 (1991); NEV. REV. STAT. § 449.700 (1987); N.H. REV. STAT. ANN. § 137-H:6 (Supp. 1991) (if physician cannot comply with the declaration, he must notify the patient and family and then the patient may request to be referred to another physician); N.D. CENT. CODE § 23-06.4-08 (1991); N.M. STAT. ANN. § 24-7-5B (Michie 1991); OKLA. STAT. ANN. tit. 63, § 3107 (West Supp. 1992); OR. REV. STAT. § 127.625(3) (1991); S.C. CODE ANN. § 44-77-100 (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. § 34-12D-11 (Supp. 1991); TENN. CODE ANN. § 32-11-108 (Supp. 1991); UTAH CODE ANN. § 75-2-1112(2) (Supp. 1991); VT. STAT. ANN. tit. 18, § 5256 (Michie 1991) (physician has duty to inform the patient that he cannot comply and to help the patient find a new physician); VA. CODE ANN. § 54.1-2987 (Michie 1991); WASH. REV. CODE ANN. § 70.122.060(2) (West 1992); W. VA. CODE § 16-30-7(b) (Supp. 1991); WIS. STAT. ANN. § 154.07(c) (West 1989).

⁹⁸ ALA. CODE § 22-8A-8(a) (1990) (physician refusing to comply shall not be liable for his refusal); ARIZ. REV. STAT. ANN. § 36-3204 C (Supp. 1991) (attending physician is not required to comply with a declaration if to do so is contrary to the physician's religious beliefs or sincerely held moral convictions); CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1992); FLA. STAT. ANN. § 765 *et seq.* (West Supp. 1992) (statute has no penalties); GA. CODE ANN. § 31-32-8(b) (Michie 1991) (no person shall be civilly liable for failure to comply); IDAHO CODE § 39-4508 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 706 (Smith-Hurd Supp. 1991) (physicians' responsibilities stated in the affirmative, but penalties apply); IND. CODE ANN. § 16-8-11-14(f) (West 1992); MISS. CODE ANN. § 41-41-115(2) (1991); IOWA CODE ANN. § 144A.9 (West 1989); KY. REV. STAT. ANN. § 311.634(2) (Baldwin 1991); NEV. REV. STAT. § 449.640 (1987) (physician may consider other factors); N.H. STAT. ANN. § 137.H:6 (1991); N.M. STAT. ANN. § 24-7-5B (Michie 1991); OR. REV. STAT. § 127.625(1) (1991); S.D. CODIFIED LAWS ANN. § 34-12D-11 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.016(b) (West 1992); VT. STAT. ANN. tit. 18, § 5256 (1991) (bound to follow as closely as possible the dictates of the document); WASH. REV. CODE ANN. § 70.122.060(2) (West 1992). See generally Condie, *supra* note 4, at 119. Condie argues that these provisions "take most, if not all, of the force out of living wills." *Id.* He further argues that it may be unconstitutional for physicians to disregard living wills. *Id.*

⁹⁹ Condie, *supra* note 4, at 119. States include: Alaska, California, Colorado, Hawaii, Indiana, Kansas, Maine, Missouri, Montana, Oklahoma, South Carolina, Tennessee and the District of Columbia. *Id.* at n.99.

ing compensation for medical services;¹⁰⁰ civil liability;¹⁰¹ criminal liability;¹⁰² disciplinary action for unprofessional conduct,¹⁰³ and revocation of one's license to practice medicine.¹⁰⁴ These penalties show intention on the part of the drafters to ensure that physicians comply. More states should adopt penalties such as these. These penalties add validity and legal weight to the declarant's request. The threat to invoke these penalties will be an effective measure in encouraging physicians to follow advance directives. Furthermore, the example made of those against whom penalties are enforced is a good tool in persuading physicians to comply with the terms of advance directives.

6. Immunity From Liability

Prior to the enactment of these statutes, a physician complying with a declaration could be held liable for murder, manslaughter, aiding suicide, or wrongful death. The statutes, however, provide a "safe harbor" for these physicians. Every state with a living will statute has a provision to the effect that:

No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration . . . shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct.¹⁰⁵

These provisions are vital in protecting complying physicians. Commentators note, however, that so few homicide cases are reported involving euthanasia that the provisions may be unnecessary.¹⁰⁶ This argument is diminished because the potential liability accompanying each case is sub-

¹⁰⁰ Alaska is the only state which currently provides for this explicitly in its statute. ALASKA STAT. § 18.12.070(a) (1991).

¹⁰¹ This does not exceed \$1,000 plus actual costs. See e.g., MD. HEALTH-GEN. CODE ANN. § 5-607 (1990) (civil liability for professionals, but not for non-professionals).

¹⁰² These statutes make it a misdemeanor if the physician fails to record the declaration or to transfer the patient in the event that he is unwilling to comply. ARK. CODE ANN. § 20-17-209(a)-(b) (Michie 1991); CAL. HEALTH & SAFETY CODE § 7191(a)-(b) (West Supp. 1992); ME. REV. STAT. ANN. tit. 18-A, § 710(a)-(b) (West Supp. 1991); MONT. CODE ANN. § 50-9-206(1)-(2) (1991).

¹⁰³ COLO. REV. STAT. ANN. § 15-18-113(5) (West 1991); D.C. CODE ANN. § 6-2427(b) (1989); ILL. ANN. STAT. ch. 110 1/2, para. 708(c) (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-8-11-22 (West 1992); KAN. STAT. ANN. § 65.28, 107 (1991); MO. ANN. STAT. § 459.045 (Vernon Supp. 1992); OKLA. STAT. ANN. tit. 63, § 3107 C (West Supp. 1992); S.C. CODE ANN. § 44-77-100 (Law. Co-op. Supp. 1991); TENN. CODE ANN. § 32-11-108 (Supp. 1991).

¹⁰⁴ TENN. CODE ANN. § 33-11-108 (Supp. 1991).

¹⁰⁵ ALA. CODE § 22-8A-7 (1990).

¹⁰⁶ Condie, *supra* note 4, at 120. See also, Carol Dufraine, *Living Wills—A Need for Statewide Legislation or a Federally Recognized Right*, 1983 DET. C. L. REV. 781, 820 (1983).

stantial. The punishment for homicide under most state criminal statutes is great.¹⁰⁷ Further, unlimited civil liability and severe damage to one's practice renders medical practitioners fearful of implementing living will requests.

The recent case of Dr. Jack Kervorkian is illustrative of the potential penalties that may be ensued. In 1990, a terminally ill patient travelled to Michigan and committed suicide by using a "suicide machine" invented by Kervorkian, a retired pathologist.¹⁰⁸ Dr. Kervorkian was initially charged with first degree murder, but the charges were dismissed on the grounds that Michigan had no law against suicide.¹⁰⁹ In September of 1991, two other woman committed suicide in the same manner.¹¹⁰ Hearings began in early February, 1992 on whether or not Kervorkian should stand trial for murder.¹¹¹ On February 28, 1992, a judge ruled that Kervorkian will go to trial for two counts of first-degree murder.¹¹²

Some physicians may feel that, regardless of whether or not a living will exists, foregoing life-sustaining treatment may not only run contrary to their ethical standards, but may also place them at risk for a homicide conviction. Although a good faith standard may be imposed, the insulation provided by a living will may make the difference, to a physician, between deciding to comply or refusing to do so.

B. Common Law

1. When Common Law Is Used

As noted above, forty-six jurisdictions currently have legislation directly addressing the issue of living wills.¹¹³ However, when statutory requirements are ambiguous or inapplicable (and in those states which lack any legislation on point), the common law provides some clarification. Courts will look to common law as a guide to how other judges have treated the issues. The trend is to base decisions squarely on precedent. The Supreme Court stated in *Cruzan v. Director, Missouri Dept. of Health*,¹¹⁴ that "most state courts have based a right to refuse treatment on the common law right to informed consent . . . or on both that right and a constitutional privacy right."¹¹⁵ The common law right to have

¹⁰⁷ See, e.g., ILL. ANN. STAT. ch. 38, para. 9-1 (Smith-Herd 1992) (allowing for the death penalty in the case of first degree murder.)

¹⁰⁸ Editorial, THE DISCIPLINING OF DOCTOR DEATH, Nov. 28, 1991, at H10.

¹⁰⁹ *Id.* A bill is pending as of November 28, 1991 to make assisted suicide a felony. *Id.*

¹¹⁰ *Id.*

¹¹¹ 20/20: *Dr. Kervorkian to Stand Trial* (ABC television broadcast, Feb. 28, 1992).

¹¹² In Michigan, the crime of first-degree murder carries a mandatory life sentence without parole. *Id.*

¹¹³ See *supra* note 18 and accompanying text.

¹¹⁴ 110 S. Ct. 2841 (1990).

¹¹⁵ *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2843, 2846 (1990). See, e.g.,

one's advance declarations carried out was first articulated on a large scale in *Cruzan*.

2. *Cruzan v. Director, Missouri Dept. of Health*

Cruzan involved a young woman, age twenty-five, who was rendered incompetent as a result of severe injuries sustained during an automobile accident.¹¹⁶ Upon learning that she had no chance of recovering her cognitive faculties,¹¹⁷ her parents petitioned for a court order directing that Nancy's artificial feeding and hydration equipment be removed.¹¹⁸ Testimony was presented by a house-mate and co-worker, who had been a childhood friend, as well as from Nancy's sister, of specific conversations with Nancy regarding her fate should she ever become irreversibly comatose.¹¹⁹ Her guardian ad litem, too, testified that it would be in her best interest to have the tube feeding discontinued.¹²⁰ The Circuit Court, Jasper County [Probate Division] directed that the guardian's request be carried out.¹²¹ Appeal was taken, however, by her guardian ad litem because he felt, as a case of first impression in Missouri, the matter should be pursued to the highest state court.¹²² In *Cruzan v. Harmon*,¹²³ the Missouri Supreme Court reversed; holding that there was not clear and convincing evidence of Nancy's desire to have life-sustaining treatment withdrawn under such circumstances.¹²⁴ The Supreme Court, in affirming this decision, held that Missouri could constitutionally apply the clear and convincing evidence standards.¹²⁵ Recently, however, the Missouri courts have reviewed the evidence and found it to be sufficient to support removal of the tubes.¹²⁶ The probate judge granted the parents' wish on December 14, 1990¹²⁷ (at which time

In re Storar, 420 N.E.2d 84 (N.Y. 1981), *cert. denied*, 454 U.S. 858 (1981); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977).

¹¹⁶ Jerry V. McMartin, "Prisoner of Medical Technology"—A Case Comment on *Cruzan v. Director, Missouri Dept. of Health*, 110 S.C.T. 2841 (1990), available in WESTLAW WL 357780, at 1. The accident occurred in 1983. *Id.*

¹¹⁷ She was in a persistent vegetative state (PVS) defined as "a condition in which 'patients may react reflexively to sounds, movements and normally painful stimuli, but they do not feel any pain or sense anybody or anything. Vegetative state patients may appear awake but they are completely unaware.'" *Id.* at 1-2, citing Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality*, 18 HASTINGS CTR. REP. 27, 28, 31 (1988).

¹¹⁸ *Cruzan*, 110 S.Ct. at 2845.

¹¹⁹ *Id.* at 2846, 2855.

¹²⁰ *Id.* at 2863.

¹²¹ McMartin, *supra* note 116, at 3.

¹²² *Id.*

¹²³ *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988).

¹²⁴ *Id.* at 426-27.

¹²⁵ *Cruzan*, 110 S.Ct. 2841.

¹²⁶ *Cruzan v. Mouton*, No. CV384-9P (Jasper County P. Ct., Mo. Dec. 14, 1990).

¹²⁷ *Id.*

Nancy was age 33 and had been on life-support apparatus for eight years). Nancy died twelve days later.¹²⁸

3. Constitutional Privacy-Right Controversies Are Not New

Historically, at common law, even nonconsensual touching of another without justification was a battery.¹²⁹ As the Supreme Court noted in *Cruzan*, it had held before the turn of the century that “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”¹³⁰ The notion of bodily integrity is essential to the idea of informed consent in medical treatment.¹³¹ Justice Cardozo noted in *Schloendorff v. Society of New York Hospital*,¹³² that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his body.”¹³³

4. Right To Refuse Treatment

The right to refuse treatment is central to the idea of a living will. If a patient is allowed to refuse various other types of medical treatment, then he should similarly be allowed to refuse treatment which is sustaining his life.¹³⁴ The earliest significant decision regarding the “right to die” was *In re Quinlan*.¹³⁵ Although this case did not specifically involve a living will, its result lends theoretical support to living will statutes. Karen Quinlan suffered severe brain damage, after a “coma of unknown etiology,”¹³⁶ and was diagnosed as being in a persistent vegetative state.¹³⁷ Upon her father’s request for judicial approval to disconnect

¹²⁸ Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. TIMES, Dec. 27, 1990, at A1.

¹²⁹ W. PAGE KEETON ET AL., 5 PROSSER AND KEETON ON THE LAW OF TORTS § 9, at 39-42 (5th ed. 1984).

¹³⁰ *Cruzan*, 110 S.Ct. at 2846. See also, *Union Pacific R.R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

¹³¹ *Cruzan*, 110 S.Ct at 2846.

¹³² *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (1914).

¹³³ *Id.*

¹³⁴ Justice Scalia discusses this in his dissenting opinion in *Cruzan*. *Cruzan*, 110 S. Ct. at 2865. He states that this right of refusal is a fundamental right: “But if a competent person has a liberty interest to be free from unwanted medical treatment . . . it must be fundamental.” *Id.*

¹³⁵ 355 A.2d 647 (N.J. 1976).

¹³⁶ *Id.* at 655.

¹³⁷ *Id.* Persistent vegetative state (or “PVS”) describes a “syndrome of diverse etiologies including cerebral, cortical, or brainstem lesions.” PRESIDENT’S COMMISSION 1981, *supra* note 5, at 88. Patients in this condition are often described as “awake but not aware: they often can breathe, chew, swallow and even groan but show no signs of consciousness, perception, cognition, or other higher functions.” *Id.*

Karen's respirator, the New Jersey Supreme Court granted relief.¹³⁸ It held that Karen had a right of privacy grounded in the Federal Constitution which allowed her to terminate treatment.¹³⁹ Although the *Quinlan* court recognized that the patient's interests must be balanced against the asserted state interest, the court sided with Karen.¹⁴⁰ Despite the fact that no clear and convincing evidence of Karen's desires existed, the court was willing to say that she had the right to die.¹⁴¹

5. Right of Informed Consent and the Right to Privacy

This right to refuse treatment, notes Chief Justice Rehnquist in the *Cruzan* opinion, parallels the doctrine of informed consent.¹⁴² Following *Quinlan*, courts have relied on the right of informed consent and the privacy right in their analysis of right-to-die cases.¹⁴³ In *Superintendent of Belchertown State School v. Saikewicz*,¹⁴⁴ the Massachusetts Supreme Court relied on both rights in permitting chemotherapy to be withheld from a profoundly retarded 67-year old man suffering from leukemia.¹⁴⁵ The patient in *Saikewicz* was a patient in a state hospital. Because he was profoundly retarded, he was unable to understand the reason for the pain that the treatment would cause (physical pain as well as nausea and vomiting).¹⁴⁶ The court applied the substituted judgment test.¹⁴⁷ Rehnquist reflects in *Cruzan* that the seeds of the "substituted judgment" standard were laid in *Saikewicz*.¹⁴⁸ The substituted judgment standard, whereby courts determine what an incompetent's decision would have been under the circumstances, lends support for the right to die. Living will legislation avoids the need to rely on the substituted judgment standard. The standard, however, acts not only as a default measure (where legislation is lacking) but also illustrates the judicial trend towards allowing a patient to request that life-sustaining treatment be withheld or withdrawn.

So, *Quinlan* was a step towards the acceptance of living wills. Four years later, the New York Court of Appeals adopted the informed consent doctrine while declining to employ the privacy right basis.¹⁴⁹ In *In*

¹³⁸ *Quinlan*, 355 A.2d at 671-72.

¹³⁹ *Id.* at 662-64.

¹⁴⁰ *Quinlan*, 355 A.2d at 663-64.

¹⁴¹ *Id.* at 671-72.

¹⁴² *Cruzan*, 110 S. Ct. at 2847.

¹⁴³ See LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15-11, at 1365 (2d ed. 1988).

¹⁴⁴ 370 N.E.2d 417 (Mass. 1977).

¹⁴⁵ *Id.* at 424.

¹⁴⁶ Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 376 (1988).

¹⁴⁷ *Id.*

¹⁴⁸ *Cruzan*, 110 S.Ct. at 2847. Cf. *In re Spring*, 405 N.E.2d 115 (1980).

¹⁴⁹ *In re Storar*, 420 N.E.2d 64 (N.Y. 1981), cert. denied, 454 U.S. 858 (1981).

re *Storar*, informed consent was the preferred theory because the patient (a 52-year-old man suffering from bladder cancer) had been severely retarded for most of his life; thus an attempt to determine what he would decide concerning his life prolonging treatment if competent was "unrealistic."¹⁵⁰ A companion case, *In re Eichner*,¹⁵¹ moves further towards a support of advance declarations. The patient, an 83-year-old priest, suffered a cardiac arrest during surgery and was thereafter in a vegetative state. His statements, made when competent, to his close friend for twenty-six years, Father Philip Eichner, were found by the court to be sufficient evidence that "he did not want to be maintained in a vegetative coma by use of a respirator."¹⁵² This is significant because the patient was allowed to die even in the absence of a written declaration.

6. A More Subjective Standard

Later cases have relied heavily on the approach taken in *Quinlan*, *Saikewicz*, and *Storar/Eichner*. *In re Conroy*, employed an even more subjective standard.¹⁵³ In deciding whether a nasogastric feeding tube could be removed from an 84-year-old incompetent nursing home resident with irreversible mental and physical symptoms, the court first held that self-determination and informed consent were decisive.¹⁵⁴ The court went on to state that the right of self-determination should not be ignored simply because an incompetent cannot sense its violation.¹⁵⁵ Life-sustaining procedures may be withheld or withdrawn, said the court, when it is clear that the particular patient would have refused the treatment under the circumstances,¹⁵⁶ thus, a subjective standard was imposed.¹⁵⁷ Where such evidence is lacking, the court held that an individual's right could still be invoked under the more objective "best interests" standard.¹⁵⁸

¹⁵⁰ *Id.* at 72.

¹⁵¹ 420 N.E.2d 64 (N.Y. 1981), *cert. denied*, 454 U.S. 858 (1981).

¹⁵² *Id.* at 72.

¹⁵³ *In re Conroy*, 486 A.2d 1209 (N.J. 1985). The subjective standard involved seeking to determine what that particular patient would have wanted under the circumstances not what the reasonable person would have done. *Id.*

¹⁵⁴ *Id.* at 1225-1226.

¹⁵⁵ *Id.* at 1237.

¹⁵⁶ *Id.* at 1229.

¹⁵⁷ *Id.* Although *Conroy* held that the evidence in the instant case did not meet all the tests for termination of life-sustaining treatment, the case's significance lies in the fact that it recognized a subjective standard, as opposed to the more objective, reasonable person standard.

¹⁵⁸ *Id.* at 1229-1233. The court mentions the possibility of the patient's having expressed "in one or more ways" an intent not to have life-sustaining medical intervention. *Id.* at 1229. A "living will," one vehicle for expressing such intent, was not legally binding in New Jersey at the time of the decision (the New Jersey legislature has not enacted a statute). The court cited *John F. Kennedy Memorial Hosp., Inc. v. Blutworth*, 452 So.2d 921, 926 (Fla. 1984), for the proposition that "[w]hether or not they are legally binding, however, such advance directives are relevant evidence of

7. The "Best Interests" Test

The best interests test is illustrated in the case of *In re Dinnerstein*,¹⁵⁹ The family and physician of Shirley Dinnerstein, a 67-year-old woman hospitalized with severe Alzheimer's disease, petitioned the court for a ruling on the legality of entering a "no-code" (do-not-resuscitate or "DNR") order on her medical chart.¹⁶⁰ Using the straight best interests test, the Court held the DNR order permissible in light of her hopeless condition.¹⁶¹ Thus, in *Dinnerstein* and *Conroy*, even though no evidence of the patient's desires was available, the courts held that life-sustaining measures could be terminated.¹⁶² In analyzing the judicial treatment of living wills, this point is significant. If courts are willing to accept an even lower evidentiary standard, they may be quick to accept written proof of intent, as contained in a living will.

8. States Which Lack a Common Law Response

There remain, however, a few states which have yet to see litigation concerning living wills. As of August 31, 1991, the right to die issue had not been litigated in only two states.¹⁶³ As we have seen, the dicta statements in *In re Conroy* provide insight into the court's probable treatment of the issue.¹⁶⁴ *In re Severns*,¹⁶⁵ provides further insight. Not only was evidence introduced that the patient had often expressed the ardent hope that she would never be kept alive in a vegetative state, but it was supported by proof that she had proposed to her husband that they execute living wills.¹⁶⁶ In light of this obvious intent, the court ruled that the

the patient's intent." *Id.* at 1229 n.5. After listing other vehicles (i.e. durable power of attorney, appointed proxy, evidence of oral directive, or deduction based on religious beliefs) the court stated, "[o]f course, dealing with the matter in advance in some sort of thoughtful and explicit way is best for all concerned." *Id.* at 1229-1230.

¹⁵⁹ 380 N.E.2d 134 (Mass. App. Ct. 1978).

¹⁶⁰ *Id.* at 135. The court refers to "no code" as meaning order not to resuscitate or "ONTR." *Id.* at 136.

¹⁶¹ *Id.* at 139.

¹⁶² *Conroy*, 486 A.2d at 1241-44 (outlining a procedure to be followed in determining whether to withhold or withdraw life-sustaining treatment from an elderly nursing home resident who is incompetent); *In re Dinnerstein*, 380 N.E.2d at 139 (concluding that in certain situations, a DNR order will be acceptable).

¹⁶³ See MEISEL, *supra* note 21, at 1-11. The States are Kentucky and South Dakota. Note that six jurisdictions have not enacted living will legislation. These states include: Massachusetts, Michigan, Nebraska, Pennsylvania, Puerto Rico, and Rhode Island. See *supra* note 18 and accompanying text.

¹⁶⁴ See *supra* notes 153-158 and accompanying text. See also Lobe, *supra* note 7, at 76. The court's reference to living wills occurs in the context of substitute decision-making. Thus it remains unclear whether New Jersey would enforce such a directive if the incompetent's guardian or next of kin were not making the treatment decision. *Id.*

¹⁶⁵ 425 A.2d 156 (Del. 1980).

¹⁶⁶ *Id.* at 158.

patient's husband could exercise her right to refuse artificial life support.¹⁶⁷

Courts in Massachusetts,¹⁶⁸ Ohio,¹⁶⁹ and Minnesota¹⁷⁰ have authorized a substituted decision-maker to withdraw life-sustaining procedures from an incompetent patient in certain circumstances. Pennsylvania has no case law addressing an incompetent patient's right to refuse treatment, but an analogous case was decided in the district court in 1973.¹⁷¹ Mrs. Yetter, a schizophrenic, was committed to a mental hospital after having refused to consent to cancer surgery. Her brother petitioned for a court-appointed guardian to impose consent to the surgery. In refusing to appoint a guardian, the court held that she was competent at the time of refusal. It held that a competent person has the right to refuse to accept medical treatment that may prolong life.¹⁷²

In New York, the issue of the enforceability of living wills was addressed before the state had passed applicable legislation. A 70-year-old woman suffering from emphysema and cancer petitioned the court to determine whether her living will would be valid. The document had been prepared with the help of her attorney.¹⁷³ Although the court refused to declare living wills legally binding, it found the document analogous to an "informed consent medical statement."¹⁷⁴ Thus, the document provides clear and convincing evidence of the patient's intent, and should be given great weight by physicians and hospital authorities in decision-making.¹⁷⁵ Going further, the court stated that the physicians and hospitals acting in good faith would be immune from both civil and criminal

¹⁶⁷ *Id.* at 160.

¹⁶⁸ *Brophy v. New England Sinai Hospital*, 497 N.E.2d 626 (Mass. 1986) (relying on testimony of several informal declarations made by the patient prior to his incompetency in allowing substitute decision maker to withdraw treatment if she determines that this is what the patient would have wanted). See also *In re Spring*, 405 N.E. 2nd 116 and *Saikewicz*, 370 N.E. 2d 417.

¹⁶⁹ *Leach v. Akron Medical Ctr.*, 426 N.E.2d 809 (1985). Mrs. Leach expressed a desire to avoid life-sustaining treatment, even so close as two days before she was admitted. She said, "That's the one thing that terrifies me. I don't want to be put on life support systems. I don't want to live if I have to be a vegetable." *Id.* at 811. See also *Lobe*, *supra* note 7, at 78 (noting that Ohio's acceptance of this oral expression is good evidence that it would most likely accept a formal, written declaration).

¹⁷⁰ *In re Torres*, 357 N.W. 2d 332, 335 (Minn. 1984) (upholding appointment of conservator to remove life-sustaining treatment based on (1) evidence of conversation with cousin regarding respirators and (2) best friend's testimony concerning patient's unwillingness to wear a pacemaker).

¹⁷¹ *In re Maida Yetter*, 67 Pa. D. & C.2d 619 (1973).

¹⁷² *Id.* at 623. Although the case discusses refusal of surgery, it establishes a patient's right to choose a course of action which may result in death.

¹⁷³ *Saunders v. State*, 492 N.Y.S.2d 510 (N.Y.Sup.Ct. 1985). Note that no state requires that a living will be prepared by, or with the help of, an attorney.

¹⁷⁴ *Id.* at 516.

¹⁷⁵ *Id.*, at 517.

liability in "honoring the patient's desires."¹⁷⁶

9. Significance of Evidence of Intent

Obviously, the case for living wills can be based upon the notion that *more* evidence of intent is better than *less*. Courts find it easier to approve removal or withholding of life-sustaining procedures when tangible expression of the patient's desires, prior to incompetency, is available. Perhaps the decisions seem more justified. Perhaps the courts feel that the margin for error is reduced proportionately to the amount of evidence available. Patients who have clearly expressed their desires concerning removal of life-sustaining measures are less likely, in general, to seek to hold a complying physician liable; and physicians with more evidence of the patient's request can more easily rebut a claim for liability. Although oral evidence is sometimes held to be sufficient, error in interpretation or failure to recall the conversation exactly may make courts hesitant to rely on such evidence. A written directive, on the other hand, reduces the possibility of ambiguity or misinterpretation. The Supreme Court, in dicta in the recent *Cruzan* decision, highlighted this issue.¹⁷⁷ The New York Court of Appeals, in *In re Westchester County Medical Center on Behalf of O'Connor*,¹⁷⁸ refused to accept less than the clearly expressed wishes of a patient before permitting the exercise of the right to refuse treatment by a surrogate decision maker.¹⁷⁹ Living wills, in this author's view, constitute clearly expressed documentation of the patient's desires.

IV. STATUS IN CANADA

A. Contrast to the United States

In sharp contrast to the United States, which has both a statutory and common law framework on point, the treatment of living wills in

¹⁷⁶ *Id.* See Lobe, *supra* note 7, at 77:

"[t]he court in Saunders, without expressly declaring the enforceability if living wills, went far in ensuring their effectiveness beyond the substituted judgment context by directing that they be given great weight, by not requiring judicial proceedings prior to their implementation, and by providing immunity for those who comply with their instructions."

¹⁷⁷ Justice O'Connor, in her concurrence, notes, for example, that "these procedures for surrogate decision-making, which appear to be rapidly gaining in acceptance, may be a valuable additional safeguard of the patient's interest in directing his medical care." *Cruzan*, 110 S.Ct. at 2858.

¹⁷⁸ 531 N.E.2d 607 (N.Y. 1988).

¹⁷⁹ The court granted an order to insert a feeding tube into a 77-year-old woman who was incompetent as a result of several strokes. The court rejected the notion that any person or court should substitute its judgment as to what would be an acceptable quality of life for another. "[W]e adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort to minimize the opportunity for error." *Id.* at 613.

Canada is scarce. The question of validity of living wills simply has not arisen in the courts. Thus, there is no present statutory framework and little, if any, common law response. One author, noting this lack of precedent, states, "neither civil nor criminal law has imposed a duty upon the physician to furnish treatment that offers no reasonable hope of benefit to the mentally incompetent patient. The law's silence is thus interpreted by the medical profession as the law's acquiescence in the practice of passive nonvoluntary euthanasia."¹⁸⁰ In its Report 20: "Euthanasia, Aiding Suicide and Cessation of Treatment" (a discussion of Working Paper 28), the Law Reform Commission of Canada (hereinafter "LRCC") acknowledged that Canadian physicians daily "pull the plug" on incompetent patients.¹⁸¹ The LRCC went on to comment:

Many people believe there is no longer any problem: the practice is legal because it exists, because it occurs every day, and because the law has never seen fit to intervene. The law's silence is thus interpreted as an endorsement or tacit consent on its part.¹⁸²

Sneiderman's assertion that Canada, in effect, follows U.S. precedent in an unspoken law of acceptance of living wills is quite valid. He points out that a Canadian court faced with a petition by an incompetent patient's family demanding life-prolonging treatment be terminated would most likely grant the petition on two grounds: 1) the common law right, or 2) a constitutional right.¹⁸³ Under the common law right, the court would rule under *Eichner* that an incompetent patient, in the same manner as a competent patient, has a common law right to cessation of non-beneficial life support measures.¹⁸⁴ This reliance on a common law right is significant in light of the absolute lack of judicial precedent available across the provinces. The issues of a right to die and the right to rely on an advance directive simply have not been addressed in Canadian courts.

The constitutional right has more support. To support the constitutional right, Sneiderman notes, the court could trace the right to protection outlined in § 7 of the Canadian Charter of Rights and Freedoms.¹⁸⁵ This section deals explicitly with the "security of the person."¹⁸⁶ This decision would parallel the *Quinlan* decision's holding of a constitutional privacy right. In discussing the Canadian response to advance directives, then, both common law and statutory response is minimal.

¹⁸⁰ SNEIDERMAN, *supra* note 17, at 321.

¹⁸¹ *Id.* at 324.

¹⁸² *Id.* at 324-325.

¹⁸³ *Id.* at 330. Sneiderman assumes that there is sufficient evidence to satisfy either the substituted judgment or best interests standard. *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ CAN. CONST. (Constitutional Act, 1982) sched. B, pt. I, § 7 [hereinafter CANADIAN CHARTER].

¹⁸⁶ See *supra* notes 151-54 and accompanying text.

B. *Rights Paralleling U.S. Constitutional Rights*

As noted above, the Canadian Charter of Rights and Freedoms provision dealing with the security of the person closely parallels provisions found in the American Bill of Rights. The Canadian Charter reads:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.¹⁸⁷

This Charter exists as a part of the Canadian Constitution, which was originally enacted in 1867 under the popular name of *The British North American Act, 1867*.¹⁸⁸ In addition to this Charter, Canada also has a bill of rights which was adopted in 1960.¹⁸⁹ The Canadian Bill of Rights, in language almost identical to that contained in the Fourteenth Amendment to the United States Constitution, outlines the human rights and fundamental freedoms relating to "the right of the individual to life, liberty, security of the person and enjoyment of property, and the rights not to be deprived thereof except by due process of law."¹⁹⁰

The language in both the Charter and the Bill of Rights mentions "security of the person." This phrase can be interpreted to mean the right to live a life free of restraint or interference by others, which would offer a great deal of support for living will justifications. In addition the phrase could literally be taken to mean security to control one's body. Taken a step further, security would include the decision to undergo or to abstain from certain medical procedures. Case law in the United States has incorporated these ideas into the theories of informed consent. Under cases such as *In re Quinlan*, *Superintendent of Belchertown State School*, and *Storar/Eichner*, American courts have illustrated that the notions of privacy right and bodily integrity, as extracted from the Fourteenth Amendment, are still vital and, some argue, should be protected vehemently.¹⁹¹

In the alternative, the phrase "right to life" might encompass the right to decide when that life shall be terminated. The right to death theory encounters political problems in the United States — as illus-

¹⁸⁷ CANADIAN CHARTER, *supra* note 185.

¹⁸⁸ See generally R.S.C. 1985, appendices No. 44.

¹⁸⁹ THE CANADIAN BILL OF RIGHTS (1960).

¹⁹⁰ *Id.* pt. I, § 1(a) (1960). The Fourteenth Amendment of the United States Constitution states, "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law." U.S. CONST. amend. XIV, § 1. Note the similarity of the language. The Fourteenth Amendment was adopted in 1868.

¹⁹¹ *In re Quinlan*, 355 A.2d 647 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (1977); *In re Storar*, 420 N.E.2d 64 (1981); *In re Eichner*, 420 N.E.2d 64 (1981).

trated by the hotly contested abortion cases.¹⁹² Those cases involve the balancing between an individual's right to make determinations concerning one's own body and the state's interest in preserving human life. The abortion issue, however, is not so controversial in Canada. Because the Canadian Charter and the Canadian Bill of Rights each contain right to death justifications, they support the notion of living wills.

C. Common Law Rights

Because judicial authority in the area of living wills is nearly non-existent in Canada, those with vested interests — physicians, health care practitioners, patients, and families — rely primarily on American case law. There are, however, a few Canadian cases which merit discussion.

1. Two Leading Cases

Two frequently quoted Canadian cases in right to refuse medical treatment discussions are *Mulloy v. Hop Sang*,¹⁹³ and *Marshall v. Curry*,¹⁹⁴ Both of these cases, which continue to be cited as controlling authority, were decided in the 1930's. Today, sixty years later, the Canadian provinces continue to rely on these decisions. The fact that, in this vast time period, neither case has been overruled or that more recent precedent has not been set is significant. The case law in Canada concerning right to die issues generally and living wills specifically is minimal.

2. Medical Necessity Versus Patient's Rights

Mulloy illustrates that a doctor's ethical and legal duties may conflict. The patient in that case sought a physician's care in tending to a post-car accident hand injury. Although the patient repeatedly expressed his desire that the hand not be amputated, the physician found it was "necessary" and performed the amputation.¹⁹⁵ The court found that the operation was necessary and performed in a highly satisfactory manner and consequently, reduced the patient's claim for damages to fifty dollars.¹⁹⁶ Strikingly, a discussion of the patient's rights was absent from the opinion. At first glance, this opinion does not appear to support the theoretical underpinnings of advance directives. Clearly, the physician's view was accepted as superior in this particular emergency situation.¹⁹⁷

¹⁹² See *Roe v. Wade* 410 U.S. 113 (1973); *Webster v. Reproductive Health Serv.*, 492 U.S. 490 (1989).

¹⁹³ 1 W.W.R. 714 (Alta. C.A. 1935).

¹⁹⁴ 3 D.L.R. 260, 274 (Can. 1933).

¹⁹⁵ *Mulloy*, 1 W.W.R. at 716.

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

Does the lack of emphasis placed on the patient's wishes preclude applying this case in support of living wills? No, it does not. In this situation, the patient would continue to live with or without his hand. So this was not a controversy concerning the final disposition of his body upon a life-threatening occurrence. Further, the patient seemingly had not had the opportunity to comment on or to request what should be done if such a car accident occurred. Because of these distinguishing points, *Mulloy* does not directly destroy support for living wills.

3. Recognition of the Patient's Right to Refuse Treatment

The court in *Marshall*, however, recognized the patient's right to refuse medical treatment.¹⁹⁸ The patient brought suit against his physician who, upon surgery to cure a hernia, removed the patient's left testicle.¹⁹⁹ The court held, "[a] person's body must be held inviolate and immune from invasion by the surgeon's knife, if an operation is not consented to."²⁰⁰ Consent, or lack thereof, thus becomes a pivotal issue in this case, much the same as it did in the substituted judgment cases discussed above. *Marshall*, a Canadian Supreme Court case, adds significant weight to the argument because it was decided by the highest court and is thus controlling authority in all provinces. So, Canadian patients, despite a lack of appropriate case law, should be allowed to maintain bodily integrity.

D. *The Criminal Code Trap*

Alongside this lack of judicial authority concerning living wills or the right to die is the Canadian Criminal Code's threatening venire of sanctions for physicians aiding in the process of suicide or omitting the performance of reasonable medical procedures. In the United States, individual states maintain authority to legislate in the criminal area.²⁰¹ In Canada, however, the "residuary powers" rest with the national government.²⁰²

The Criminal Code provisions could present a threat to physicians. Hypothetically, the Crown prosecutor could bring claims against a physician participating in the withholding of life-prolonging treatment under a number of Criminal Code provisions.²⁰³ In reality, however, the number

¹⁹⁸ *Marshall*, 3 D.L.R. at 274.

¹⁹⁹ *Id.* at 260.

²⁰⁰ *Id.*

²⁰¹ U.S. CONST. amend. VI; U.S. CONST. amend. X.

²⁰² John Stephens, *The Right to Die*, 1 LEGAL MED. Q. 111 (1977).

²⁰³ These include: R.S.C. 1985, c.C-46, § 217 (stating that every one who undertakes to do an act is under a legal duty to do it if the omission is or may be dangerous to life); *id.*, c.C-46, § 216 (one undertaking to administer surgical medical procedure must use reasonable care and knowledge — except in the case of a necessity); *id.*, c.C-46, § 229 (culpable homicide is murder when a person

of cases prosecuted under the Criminal Code is negligible.²⁰⁴

E. LRCC Recommendations

As in the United States, there have been significant changes in Canadian medical technology and related medical treatment in the past few decades. These changes have occurred since the relevant Code provisions were first enacted.²⁰⁵ The Criminal Code, however, has not been amended to reflect these medical and societal changes. According to the LRCC, "sophisticated and scientific palliative care was either unknown or at best in its infancy,"²⁰⁶ at the time of drafting. The Commission notes that not only are some of these provisions obsolete, but they are also plagued with ambiguity.²⁰⁷ The LRCC thus recommends revision.²⁰⁸

Report 20 analyzed the proposed reform contained in three basic areas: (1) voluntary euthanasia and mercy killing, (2) aiding suicide, and (3) cessation and refusal of treatment.²⁰⁹ First, the Commission concluded that active euthanasia should not be legalized.²¹⁰ This is in accordance with the United State's inherent ban on active euthanasia.²¹¹

Second, it pointed out that aiding suicide should not be decriminalized.²¹² This is reflected in several of the state criminal statutes in the United States.²¹³ Third, the Commission held that the Criminal Code should clearly express that a physician cannot be held criminally liable

who causes the death of a human being means to cause his death); or *id.*, c.C-46 § 241 (everyone who counsels or procures a person to commit suicide or aids and abets a person is guilty of an indictable offence.)

²⁰⁴ See SNEIDERMAN, *supra* note 17, at 324-325. Suicide is not a crime, but under R.S.C. 1985, c. C-46 § 14, "No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given."

²⁰⁵ This change in circumstances, however, is meant to reflect the original draft of these code provisions which was in 1970

²⁰⁶ LAW REFORM COMMISSION OF CANADA, REPORT 20: EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT 9 (1983) [hereinafter REPORT 20]. See also *supra* notes 2-6 and accompanying text. Palliative care is defined as care which "makes less severe, without curing; [which] reduce[s] the pain or intensity of; [which] mitigates." THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 945 (New College ed. 1980).

²⁰⁷ REPORT 20, *supra* note 205, at 9.

²⁰⁸ *Id.*

²⁰⁹ *Id.* at 17-28.

²¹⁰ *Id.* at 17. The reasoning behind this recommendation is focused on the potential for abuse, the thought that it would indirectly condone murder, and the fact that the Commission believed it would be morally unacceptable to the majority of Canadian people to legalize active euthanasia. *Id.* at 18.

²¹¹ See *supra* notes 108-112 and accompanying text.

²¹² REPORT 20, *supra* note 205, at 21. The Commission noted that R.S.C. 1985 c. C-46 § 241 should be retained in its present form. See *supra* note 203 and accompanying text.

²¹³ For example, the New York Statute states "A person is guilty of promoting a suicide at-

“merely” for undertaking or continuing palliative care.²¹⁴ Note that one of the aims of most state living wills statutes in the United States is the protection of physicians from liability.²¹⁵ This measure of protection encourages physicians to comply with advance directives.²¹⁶ The Commission also opined that treatment “should never be imposed against a person’s will.”²¹⁷ In its most supportive conjecture of living wills, the Commission recommends that physicians not incur criminal liability in the event they discontinue or fail to commence treatment for an incompetent when the treatment is no longer “therapeutically useful and in the patient’s best interests.”²¹⁸ The distinction between treatment which is therapeutically useful and that which is not is sometimes blurry. Therapeutically useful treatment offers some benefit to the patient, be it comfort or some level of healing.²¹⁹ If treatment is not therapeutically useful, the patient will not benefit from the treatment in any way.²²⁰ In allowing this distinction to be made, the recommendations of the LRCC run contrary to the Canadian Criminal Code. The Criminal Code strictly prohibits termination of treatment under various provisions.²²¹ As the Commission suggests, change is badly needed. LRCC in Working Paper 28, while maintaining a presumption in favor of life,²²² held that the patient’s autonomy and right to “self-determination” are crucial.²²³

F. Evidence of Trend Toward Acceptance of Living Wills

One Canadian commentator is convinced that the LRCC, supporting the substituted judgment and best interests tests, is leaning toward acceptance of advance declarations.²²⁴ The 1983 Commission stated that

tempt when he intentionally causes or aids another person to attempt suicide. Promoting suicide is a class E felony.” N.Y.PENAL LAW § 120.30 (McKinney 1987).

²¹⁴ REPORT 20, *supra* note 206, at 23.

²¹⁵ See *supra* notes 8 & 98 and accompanying text.

²¹⁶ See *supra* sections A5 and A6.

²¹⁷ REPORT 20, *supra* note 206, at 22. The physician, further, is under a duty to inform the patient of his options and their various consequences. *Id.* These suggestions closely parallel the suggested need to ensure that American patients keep intact their constitutional rights of privacy and bodily integrity. See *supra* section A5. Relatedly, the Canadian Bill of Rights provides in part I:

It is hereby recognized and declared that in Canada there have existed and shall continue to exist . . . the following human rights . . . (a) the right to life, liberty, security of the person . . . and the right not to be deprived thereof except by due process of law.

Cynthia A. Baker, *The Living Will: The Final Expression*, 4 LEGAL MED. Q. 2, 11 (1980). (quoting from the Canadian Bill of Rights).

²¹⁸ REPORT 20, *supra* note 206, at 27-28.

²¹⁹ See *supra* notes 83-84 and accompanying text.

²²⁰ *Id.*

²²¹ See *supra* notes 203-04.

²²² REPORT 20, *supra* note 206, at 11.

²²³ *Id.* at 11-12.

²²⁴ See SNEIDERMAN, *supra* note 17, at 322-323 & 328-330.

decisions concerning life-sustaining treatment should be “*based upon the wishes of the person prior to becoming incompetent*, or upon his best interests determined by others.”²²⁵ Sneiderman further points out that “the purpose of the law is to grant authority to the patient, through the *mechanism of the living will*.”²²⁶ The mere fact that the LRCC identified and has begun to discuss the pros and cons of living will legislation in light of Canada’s previous trend to ignore the subject entirely is promising.

Further evidence of this trend can be seen in a 1977 Private Members Bill, the Natural Death Act, concerning the living will. This bill, upon introduction in the Ontario legislature, never progressed beyond its first reading.²²⁷ A local election intervened.²²⁸ A similar bill was introduced in the Alberta legislature in the same year, which too was defeated after first reading. Between 1977 and 1990, it appears that no additional legislation concerning living wills was introduced in any of the provincial legislatures. In April, 1990, however, two new proposals were introduced in the Ontario legislature. The first, entitled, The Natural Death Act, 1990 declared its purpose to be the recognition of an adult person’s right to “make a written declaration (living will) that instructs a physician or other health-care provider to withhold or withdraw life-sustaining procedures in the event of a terminal condition.”²²⁹ The Bill, presented by Mr. Norman Sterling on April 3, 1990, has not yet been definitively voted upon, and research yields no evidence of proceedings or related debates on the bill. The second bill, also presented by Mr. Sterling, entitled The Powers of Attorney Amendment Act, 1990²³⁰ is purported to “provide for a durable power of attorney with respect to consent and withdrawal of consent to medical treatment.”²³¹

Both bills are succinct and straightforward. The Powers of Attorney Amendment Act is a proposed amendment to § 5 of chapter 386 of the Revised Statutes of Ontario (1980). It seeks the addition of the following language:

(2) A provision in a power of attorney may authorize another person to give consent or directions respecting, (a) the medical treatment of the person giving the authorization; or (b) *the withdrawal of medical treatment for the person giving the authorization.*²³²

Section (b), because it focuses on *withdrawal* of medical treatment, is of

²²⁵ *Id.* at 323 (emphasis added).

²²⁶ *Id.* at 329 (emphasis added).

²²⁷ Tom Campbell, *Euthanasia and the Law*, 17 ALBERTA L. REV. 188, 200 (1979). The Bill was modeled after the California statute. *Id.*

²²⁸ The minority Progressive Conservative government was defeated in April, 1977. *Id.*

²²⁹ NATURAL DEATH ACT, 1990, explanatory note.

²³⁰ POWERS OF ATTORNEY AMENDMENT ACT, 1990.

²³¹ *Id.* explanatory note.

²³² *Id.* (emphasis added).

great interest. Not only does the bill state that the appointed person has authority to make decisions regarding medical treatment in general, but it specifically addresses the issue of treatment termination. This portion of the bill closely reflects the durable power of attorney provision found in the California state statute.²³³ Both allow an appointed individual to make decisions concerning termination of treatment.²³⁴ Both provisions, however, leave open the question of who has decision-making authority in the event that no proxy is appointed.

The Natural Death Act, on the other hand, sets forth two important goals. First, it seeks to protect physicians who withhold or withdraw life-sustaining procedures in accordance with a patient's wishes (under a living will) from civil liability and disciplinary action.²³⁵ Second, the bill attempts to impose penalties on physicians and health-care providers who refuse to follow the living will and, relatedly, refuses to make "reasonable efforts to transfer the patient to another physician or health care provider" willing to do so.²³⁶ In general, this bill appears identical in substance and form to the majority of state living will statutes. It contains a definition section.²³⁷ Further, it requires certain formalities in execution.²³⁸ Parallel to the United States' statutes, witnesses cannot be related to the declarant, or be a potential beneficiary to the declarant's estate.²³⁹ Like most U.S. statutes, the proposal negates a living will's validity while the declarant is pregnant.²⁴⁰ Lastly, the proposal contains specific requirements for revocation.²⁴¹ In the final analysis, these two very recently proposed bills provide evidence of concrete support among

²³³ See generally SOCIETY HANDBOOK, *supra* note 13. See also *supra* note 12 and accompanying text.

²³⁴ See *supra* note 17; POWERS OF ATTORNEY AMENDMENT ACT, 1990, explanatory note.

²³⁵ Again, this proposal, like that in Working Paper 20, and the "immunity from liability" provisions in most state statutes, seeks to protect physicians and encourage compliance. See *supra* section A6 (Immunity from Liability).

²³⁶ The addition of this proposed provision is significant. Prior to this proposal, Canadian reform has lacked a provision for imposition of penalties for physician non-compliance. A great number of U.S. state statutes, however, contain non-compliance provisions. See *supra* Section A5 (Noncompliance). Thus the addition of this provision further bridges the gap between the U.S. system of living wills laws and the developing Canadian response.

²³⁷ See *supra* Section A3 (Definition Section).

²³⁸ See *supra* Section A2 (Execution Formalities). The formalities state that the living will must: be in writing; signed by the declarant in the presence of two or more witnesses present at the same time; signed by these witnesses in the presence of the declarant; and properly dated.

²³⁹ See *supra* Section A2 (Execution Formalities).

²⁴⁰ See *supra* notes 53-58 and accompanying text.

²⁴¹ See *supra* Section A4 (Revocation Procedures). The proposal's revocation procedures, like most U.S. statutes, appear testamentary in nature. Thus a declarant must: destroy, deface or direct another to destroy or deface the document; prepare a written revocation; or orally revoke with conveyed intent to do so.

Canadian law-makers that living will acceptance is becoming more of a reality in Canada.

The discussion is incomplete, however, without some mention of the hesitation felt by those opposing statutory acceptance of living wills in Canada. The LRCC, in its 1984 report, cautioned against the enactment of living will legislation. It said: "We believe that it would risk the reversal of the already — established rule that there should be no duty to initiate or maintain treatment when it is useless to do so."²⁴² This statement, however, can be easily refuted. As we have seen, Canada generally follows U.S. precedent in an unspoken manner. Living will legislation, in creating clear-cut guidelines, would help to remedy existing ambiguities among health care practitioners and potential declarant alike.

G. Health Care/Insurance in Canada

In advising Canadian provinces as to which legislative provisions they should adopt concerning living wills, major differences between the two countries must be considered. One major systematic difference is that of health care coverage. The United States, for the most part, has a system of non-socialized health insurance coverage.²⁴³ Aside from Medicaid and Medicare, the majority of Americans are responsible for funding their own routine and emergency medical needs. By setting aside a portion of their earnings, or by taking into consideration contributions made by their employers, U.S. citizens are able to fund necessary health insurance.²⁴⁴ With some limitations, Americans are free to chose their physicians and health care facilities.²⁴⁵ Because Americans are, for the most part, financially responsible for their medical treatment and related insurance costs, they demand to play a significant role in deciding to terminate treatment.²⁴⁶ Should a physician fail to comply with his contractual obligation to carry out an advance directive, Americans have available to them the remedy of civil suit.²⁴⁷

Canadian patients, similarly, are able to chose the doctor and the hospital they desire for their health care treatment.²⁴⁸ Unlike other "so-

²⁴² SNEIDERMAN, *supra* note 17, at 328.

²⁴³ See generally GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 1-40 (1990) (providing an introduction to health care delivery in the United States).

²⁴⁴ *Id.*

²⁴⁵ These include financial constraints, emergency situations (where medical necessity requires an individual to be taken to the nearest hospital and to have the attending physician render emergency procedures), or choice restrictions set by individual health insurance plans. An H.M.O., for example, while providing inexpensive health care coverage, may require the patient to chose from a limited pool of physicians.

²⁴⁶ ANNAS, *supra* note 243.

²⁴⁷ See *supra* note 101 and accompanying text.

²⁴⁸ ROZOVSKY, *supra* note 9, at 13.

cialized" systems of health care, Canada's is based on the "free-enterprise system."²⁴⁹ Budget restrictions are the most significant limitation placed upon hospitals by the federal government in Canada.²⁵⁰ Thus, as Rozovsky notes, "the effect of this system on patient's rights is that the rights against a doctor or hospital concerning treatment and care do not effect the patient's rights to insurance for those services, and vice versa."²⁵¹ Withholding payment for medical bills is therefore not an effective threat to physicians who refuse to comply with living wills, as the government pays the bills.²⁵² Criminal liability (for aiding suicide under the Criminal Code, for example), however, becomes a more threatening potential under a system such as this because the government has a stronger hand in the day-to-day interaction between doctor and patient.

Health care coverage in Canada is based on residence.²⁵³ This concept is misleading, however, because if a Canadian citizen is considered a resident of a province for coverage purposes, he is eligible for world-wide coverage.²⁵⁴ The province where the patient created the living will is thus a significant factor. As with the United States, however, controversies will certainly arise concerning what the statute in the jurisdiction where the medical care is rendered will allow — that statute potentially conflicting with the statute enacted in the patient's "residential" province. Suggestions that Canada seek to enact uniform statutes, under this analysis, carry a great deal of weight.

H. U.S. State Living Will Statutes as Models

Encouraging Canadian legislators to enact living wills laws is a bold move. The trend towards acceptance of living wills has gained increased momentum in the past few years. Simply suggesting the Canadians would benefit if living wills laws were enacted does not solve the problem. Canadian legislators need more guidance. They need concrete examples of which provisions will be effective in the unique social and political arena found in Canadian provinces. Unfortunately, no true consensus has been established in the United States regarding which are *the* most effective provisions, or which provisions *absolutely should not be* employed in setting up new statutes.²⁵⁵

²⁴⁹ *Id.* at 10.

²⁵⁰ *Id.*

²⁵¹ *Id.* at 11.

²⁵² *Id.* at 21

²⁵³ *Id.* at 12.

²⁵⁴ *Id.* at 13.

²⁵⁵ One example of a provision which Canadian provinces should not employ is that of automatic revocation. Requiring that a living will be re-executed every five years will potentially mean that people intending to have enforceable living wills will inadvertently allow them to lapse. See *supra*, note 92.

1. Standard Form of Statute

One suggestion, however, is immediately apparent from a study of the U.S. state statutory scheme. Canada should attempt to make the statutory enactments throughout the provinces nearly identical in form and language. This would alleviate much of the ongoing confusion which stems from the great variety of individual state statutes in the United States. Physicians (or others asked to carry out the directives) and patients (or those wishing to make or enforce a living will) would more easily be able to interpret or enforce advance directives if all jurisdictions had the same requirements for creation, enforceability, and revocation of living wills. Ensuring, too, that the *language* of the statutes is similar would alleviate much of the interpretive controversies which presently plague the medical arena in the U.S.

Initially patients would not hesitate to create living wills if the requirements and limitations of such devices were spelled out in an understandable and consistent manner. Physicians would more easily feel justified in following advance directives if the statutes treated their required role and their potential liability for noncompliance in a direct and uniform manner. Squabbles over which state (or Provincial) statute applies in a particular instance would be virtually nonexistent because all provincial statutes would contain the same provisions.

2. Requirement of *Standard* Form of Living Will

Even if the provincially oriented political climate in Canada precludes the enactment of identical statutes across the provinces, ensuring that all statutes, regardless of their wording, require a standard living will form to be used by those making advance directives will put an end to many of the problems noted above. Health-care providers could make decisions concerning whether or not to follow a directive with ease. The origin of the directive, or whether or not the patient resided in a particular province would no longer be significant issues since a living will could be deemed valid or invalid immediately simply by ascertaining whether or not it complies with the standard form. Requiring any patient wishing to create a living will to follow a standard form would not only help to eliminate problems of interpretation at the enforcement level, but it would also wipe away some of the veil of mystery and intimidation that those patients might encounter if various forms were allowed.

3. Allowing Flexibility?

Aside from the possibilities of enacting a uniform statute or requiring that a standard form be used in creating living wills, should the provinces allow flexibility for those following the statutes? The U.S. state statutes vary greatly on this issue — some require that the form laid out

in the statute be followed exactly,²⁵⁶ while others have a rather vague form and allow for individual patients to add provisions as they see fit.²⁵⁷ There are advantages and disadvantages to both approaches. Those potentially interested in creating a living will may shy away from doing so if the statute they are guided by contains inflexible instructions regarding the provisions to be contained in their advance directive. Others may feel comfort in having all provisions spelled out for them, leaving them with fewer ambiguous questions to mull over as they contemplate making a living will. Certainly, at the enforcement level, statutes such as the Oregon example provide added comfort health care providers making the decision whether or not to comply with a directive. This is because the potential for miscommunication is greater under statutes, such as the Connecticut statute, which "permit personalized additions and directions as to treatment."²⁵⁸

V. CONCLUSION

A great deal of ambiguity exists in Canada surrounding the issue of living wills. Patients and physicians have no static authority to which they can refer regarding the validity of advance directives. This ambiguity must be eliminated.

Although Canadian physicians may rely on American norms as illustrated through our case law and statutory standards, this is a shaky and potentially disastrous practice. Canadian physicians are not *guaranteed* that they will be deemed to be acting lawfully under Canadian standards. There remains the potential for criminal liability under the Criminal Code, as well as unlimited civil liability. Medical practitioners need some standard by which they can competently continue to follow advance directives without being fearful of this potential liability or the omnipresent threat of conviction. What exists today in Canada is only a system of accepted norms. But who is to say that these norms will not be contradicted by a particularly zealous judge? Although passive euthanasia cases are rarely prosecuted, the possibility of a conviction is not yet extinct.

The Canadian health care system poses an additional dilemma for physicians. Under its socialized style of health care insurance, based primarily on residence for qualification, not all hospitals and medical services are insured.²⁵⁹ Thus a physician faces the prospect that his services

²⁵⁶ See e.g., OR. REV. STAT. § 127.610(1) (1991), which states that "The directive shall be in the following form. . . ."

²⁵⁷ See e.g., CONN. GEN. STAT. ANN. §§ 19a-575 (West 1991) (stating that "any adult person may execute a document in substantially the following form"). See also UNIFORM RIGHTS ACT, *supra* note 18, § 2.

²⁵⁸ SOCIETY HANDBOOK, *supra* note 13, at 19.

²⁵⁹ ROZOVSKY, *supra* note 9, at 10-21.

will be rejected for reimbursement under the provincial plans should he comply with a living will that is not (under case law or statute) legally binding. Canadian physicians, then, may be frightened into non-compliance. This possibility must be precluded.

There remain several unresolved issues regarding which specific provisions the provinces should adopt. These issues, however, are peripheral. Although they must be addressed, the important matter at this point is putting some sort of statutory framework into place. In order to maintain its comforting status quo, Canada must enact a statutory solution to the puzzle involving living wills. It cannot continue to look over the border and silently imitate the U.S. solution. For, as we have seen the United States still faces some inconsistencies and limitations.

What we must remember amidst all the confusion is that the notion behind the living will is a noble one: that each person should have the choice to accept or to refuse medical treatment. This notion is rooted in ethical, moral, constitutional, and now legal concepts and it is undeniably a right which should be protected for Americans and Canadians alike.

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