

1976

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Recommended Citation

John G. Strand, *The Living Will: The Right to Death with Dignity?*, 26 Case W. Res. L. Rev. 485 (1976)

Available at: <https://scholarlycommons.law.case.edu/caselrev/vol26/iss2/7>

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Note

THE "LIVING WILL": THE RIGHT TO DEATH WITH DIGNITY?

An increasing demand for greater control over one's medical destiny has led to the desire for a death with dignity. The patient's desire in this regard puts the physician in an unbearable dilemma, for the law is unclear as to at what point his contractual duty to treat the patient is superseded by the patient's power to modify and discharge that duty. The author discusses the "Living Will," a document executed by the patient which, if recognized, would specify the physician's duty in situations of critical illness and thus present a possible solution to the problem. The author concludes that if problems such as revocation and physician diagnosis can be resolved, the Living Will, as one means to solve the current dilemma, should be legalized by legislative or judicial action.

I. INTRODUCTION

BECAUSE OF RECENT ADVANCES in medical science, individuals today are presented with the prospect of a significantly increased life expectancy.¹ This situation has been accompanied by an increasing tendency on the part of the public to demand more significant control over one's medical destiny and by an upsurge of interest in a "death with dignity."² Many persons, fearing a long and pro-

1. At the turn of the century, the average life expectancy in the United States was 49.3 years. By 1940, this figure was 62.9 years. For 1971, the average life expectancy was 67.4 years for males and 74.9 years for females, for an average life expectancy of 71.1 years. STATISTICAL POLICY DIVISION, OFFICE OF MANAGEMENT AND BUDGET, SOCIAL INDICATORS 26 (1973).

2. See Dempsey, *The Living Will—and The Will to Live*, N.Y. Times, June 23, 1974, § 6 (Magazine), at 12. See also S. ALSOP, STAY OF EXECUTION (1973); GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, THE RIGHT TO DIE: DECISION AND DECISION MAKERS (Symposium No. 12, 1973); E. KUBLER-ROSS, QUESTIONS AND ANSWERS ON DEATH AND DYING (1974); M. MANNES, LAST RIGHTS (1974); O.R. RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA (1975); A. WEISMAN, ON DYING AND DENYING (1972); *A Right To Die?* NEWSWEEK, Nov. 3, 1975, at 58; *Medical Ethics—Who Decides the Life-and-Death Issues*, U.S. NEWS & WORLD REPORT, June 16, 1975, at 63.

A significant area of controversy concerning "death with dignity" lies with the definition of death itself. While the law has traditionally considered a person to be alive unless such "vital signs" as heartbeat, pulse, and respiratory movements are absent, Capron & Kass, *A Statutory Definition of Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 89 (1972), a new standard has been proposed detailing three criteria of "irreversible coma": (1) "unreceptivity and unresponsivity" to "externally applied stimuli and inner need"; (2) absence of spontaneous muscular movements or spontaneous respiration; and (3) no elicitable reflexes. In addition, a flat electroencephalogram (EEG) is to be of "great con-

tracted death, have taken measures to assert their "right to die" by executing a document known as "The Living Will," which, in effect, instructs their physicians to allow them to die if there is no reasonable chance of recovery from a serious mental or physical disability.³

This interest in a dignified death has created agonizing legal, medical, and ethical problems for hospitals, physicians, and the courts. Already confronted by a malpractice crisis of massive proportions, health personnel and institutions may discover this crisis aggravated by the patient's demand for control over his medical destiny. This presents the physician caring for a critically ill patient with an uncomfortable dilemma. If the physician ignores the expressed desires of his patient and administers unwanted treatment, he may be civilly and criminally liable for assault and battery.⁴ If, however, he acquiesces in the patient's demands to withhold treatment and the patient dies because of the failure to provide such treatment, then he may be civilly and criminally liable for the patient's death, since the patient may not have been competent to refuse the treatment, rendering the physician liable for failing to fulfill his

firmatory value" in determining death. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J.A.M.A. 337-38 (1968). At the time of publication, at least six states have modified their laws to conform substantially to the Harvard criteria. See CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1975); KAN. STAT. ANN. § 77-202 (Supp. 1974); MD. ANN. CODE art. 43, § 54F (West Supp. 1975); MICH. STAT. ANN. § 14.228(2) (Current Material 1975, at 753); N.M. STAT. ANN. § 1-2-2.2 (Supp. 1973); VA. CODE ANN. § 32-364.3:1 (Supp. 1975).

Dr. Vincent Collins, professor of anesthesiology at Northwestern University Medical School, has proposed a modification of the Harvard criteria in order that a variety of factors be considered in determining a patient's death. His method, which would utilize the EEG reading as only one of thirteen factors to be considered, resembles a scorecard and is far more comprehensive than either the traditional legal approach or the Harvard criteria. See Collins, *Considerations in Prolonging Life—A Dying and Recovery Score*, 148 ILL. MED. J. 42 (1975).

3. Estimates indicate that at least 750,000 model Living Wills have been distributed by physicians, churches, and schools, although it is not known how many of these documents have actually been signed. This number does not include those persons who have written such documents on their own. The chief source for these documents is the Euthanasia Educational Council, Cleveland Plain Dealer, Nov. 11, 1975, at 22-A, Col. 6, although the Catholic Hospital Association has begun distributing similar documents entitled the "Christian Affirmation of Life" to terminally ill patients, in order that they might avoid unnecessary treatment and suffering at the time of imminent death. Kutner, *The Living Will: Coping with the Historical Event of Death*, 27 BAYLOR L. REV. 39, 43-44 (1975).

4. See, e.g., *Moos v. United States*, 118 F. Supp. 275 (D. Minn. 1954); *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905); *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914); *Darran v. Kite*, 32 App. Div. 2d 208, 301 N.Y.S.2d 286 (1969); *Rolater v. Strain*, 39 Okla. 572, 137 P. 96 (1913).

duty of care.⁵ The physician is thus caught between Scylla and Charybdis, finding himself in a position where either action or inaction imposes potential liability. As medical science discovers additional methods for prolonging life⁶ and the public becomes more concerned with having a death with dignity, this dilemma will become increasingly severe and dangerous.

This Note examines the legal implications of a patient's desire to die with dignity by refusing lifesaving treatment. Emphasis will be placed upon the legal response to refusing treatment rather than upon euthanasia and upon the legal effects that refusing treatment has upon the physician-patient relationship. The concept of the Living Will will be analyzed as a possible solution to the physician's problem of how to respond to the request for a dignified death. The legal effects of the Living Will, as well as the potential problems created by the document, will be examined.

II. THE RIGHT TO DEATH WITH DIGNITY

A. *The Concept of Antidysthanasia*

Antidysthanasia has been defined as the "failure to take positive action to prolong the life of an incurable patient with intractable pain."⁷ This is to be distinguished from euthanasia, which has been defined as the taking of positive action to end the life of an incurable patient.⁸ The distinction is thus the difference between an act and an omission and is a critical one, for it underlies the difference between legally permissible action and murder in the first degree.⁹

5. Gurney, *Is There a Right to Die?—A Study of the Law of Euthanasia*, 3 CUMBERLAND-SAMFORD L. REV. 235, 244 (1972); Note, *The Right to Die*, 7 HOUSTON L. REV. 654, 659 (1970) [hereinafter cited as *Right to Die*].

6. Mankind may not attain immortality, but that failure will not be for lack of effort:

Notwithstanding the scientific prognostications of geneticists and protagonists of the technology of creating a mechanical man, cryonics (or deep freeze), and the anguish and desperate struggle against the inevitability of death, it is not possible to extend effective human life indefinitely. Delaying the aging process by reversing cell blockage; by transplants; animal organ implementation; estrogen pills; diet; drugs; anti-oxydants; bio-feedback; anti-biosis; or freezing the body immediately after death, cyronic hibernation—all inspire research centers around the world.

Kutner, *supra* note 3, at 40.

7. S. SHINDELL, *THE LAW IN MEDICAL PRACTICE* 118 (1966).

8. *Id.*; cf. Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 351 (1954) ("mercy-motivated killing of a human being").

9. Euthanasia in the legal system constitutes murder in the first degree. *Right to Die* 657. For a discussion of treatment of euthanasia in other countries, see D. MEYERS, *THE HUMAN BODY AND THE LAW* 150 (1970); Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 970-

Both criminal and tort law recognize the distinction between an act and an omission.¹⁰ Early tort law distinguished between a "misfeasance," active misconduct working positive injury to others, and "nonfeasance," the passive inaction or a failure to take steps to protect others from harm.¹¹ Liability has traditionally attached to the former but not to the latter. The rationale for this distinction lies in the different effects each has on the plaintiff. Through misfeasance, the tortfeasor has created a new risk of harm to the plaintiff. Through nonfeasance, however, the actor has made the situation no worse, having merely failed to benefit the plaintiff.¹² The

71 n.9 (1958); Orth, *Legal Aspects Relating to Euthanasia*, 2 MD. MED. J. 120, 127 (1953); Silving, *supra* note 8, at 352-53 n.5. Despite this equation with murder, there have been very few convictions for euthanasia. Survey, *Euthanasia: Criminal, Tort, Constitutional, and Legislative Considerations*, 48 NOTRE DAME LAWYER 1202, 1203, 1213 (1973) [hereinafter cited as *Euthanasia: Considerations*]. Perhaps the reason for the lack of convictions is that motive has been utilized by judges and juries as a de facto mitigation of the offense, although the common law has not recognized motive as a defense. See Kalven, *A Special Corner of Civil Liberties: A Legal View I*, 31 N.Y.U.L. REV. 1223, 1235-36 (1956).

10. Holmes defined an act as a "muscular contraction resulting from an operation of the will." O.W. HOLMES, *THE COMMON LAW* 54 (1938). This definition is still widely used. See MODEL PENAL CODE § 1.13(2) (Tent. Draft No. 4, 1955) ("bodily movement whether voluntary or involuntary"); R. PERKINS, *CRIMINAL LAW* 551 (2d ed. 1969) ("exertions of the will manifested in the external world"); RESTATEMENT (SECOND) OF TORTS § 2 (1965) ("external manifestation of the actor's will").

11. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 56, at 338-39 (4th ed. 1971).

12. *Id.* at 339. As Chief Justice Carpenter of New Hampshire has noted:

Suppose A, standing close by a railroad, sees a two-year-old babe on the track and a car approaching. He can easily rescue the child with entire safety to himself, and the instincts of humanity require him to do so. If he does not, he may, perhaps, justly be styled a ruthless savage and a moral monster; but he is not liable in damages for the child's injury, or indictable under the statute for its death.

Buch v. Amory Mfg. Co., 69 N.H. 257, 260, 44 A. 809, 810 (1898). There are a number of cases that have held that an expert swimmer may passively watch a person drown a few feet away. See *Handiboe v. McCarthy*, 114 Ga. App. 541, 151 S.E. 2d 905 (1966) (failure of defendant's servant to rescue plaintiff's child, a licensee, in defendant's swimming pool afforded no cause of action since the duty owed to a licensee was only to refrain from willful or wanton acts); *Osterlind v. Hill*, 263 Mass. 73, 160 N.E. 301 (1928) (failure of defendant, engaged in business of letting pleasure boats for hire, to respond to deceased's outcries after rented canoe overturned, held to have infringed no legal rights of deceased); *Yania v. Bigan*, 397 Pa. 316, 155 A.2d 343 (1959) (where defendant was not legally responsible, in whole or in part, for placing decedent in perilous position, mere fact that he saw decedent in position of peril in water imposed upon him no legal obligation or duty to go to his rescue). Nor is a physician under a duty to respond to the pleas of a dying person who might be saved but is not a regular patient. See *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901) (physician is not liable for arbitrarily refusing to respond to patient's call, even though he is the only physician available); cf. *Findley v. Board of Supervisors*, 72 Ariz. 58, 230 P.2d 526 (1951) (resolution adopted by county board of supervisors providing that any physician who failed to give professional assistance at request of another physician should not be allowed to use facilities of county hospital was so unreasonable as to be unconstitutional).

only exception to the general rule of nonliability for nonfeasance is where a duty is owed to the person in peril by virtue of certain situations recognized by law.¹³ A breach of this duty could also render the party breaching the duty criminally liable.¹⁴

Unfortunately, the distinction between an act and an omission is nebulous. Attempts at drawing the distinction when confronted with facts meet with significant difficulty.¹⁵ As is all too often the case with legal formulations, the apparently simple verbal formulation can mold itself to a set of facts in such a way that diametrically opposite applications result. For example, the omission to repair a gas pipe could also be regarded as the act of negligent distribution of gas.¹⁶ The confusion inherent in the omission-commission distinction becomes even more obvious in the context of the physician rendering aid to a seriously ill patient. For instance, in the case of a patient being kept alive by a mechanical respirator though requesting death, it is unclear whether terminating the respirator treatment is an act or an omission. The distinction is crucial, for if unplugging the respirator is an act, the law would classify it as murder.

13. There are at least four situations in which the failure to act may constitute breach of a legal duty. One can be held criminally liable: first, where a statute imposes a duty to care for another; second, where one stands in a certain status relationship to another; third, where one has assumed a contractual duty to care for another; and fourth, where one has voluntarily assumed the care of another and so secluded the helpless person as to prevent others from rendering aid.

Jones v. United States, 308 F.2d 307, 310 (1st Cir. 1962).

Certain problems arise, however, concerning the second situation, the existence of a status relationship, and the third relationship, the contractual duty of care. The courts have been confronted with the problem of where to draw the line between a relationship and a nonrelationship. In *People v. Beardsley*, 150 Mich. 206, 113 N.W. 1128 (1907), in which a man and woman were engaged in a weekend adulterous enterprise, the man was held to have no duty to provide medical assistance after the woman had taken poison and become helpless. The duty did exist, however, in *Stehr v. State*, 92 Neb. 755, 139 N.W. 676 (1913), in which the parents of a bed-wetting child were found guilty of not acting where a duty to act existed when they permitted the child to sleep, wet and freezing, without blankets or heat and the child died from gangrenous complications from frostbite.

The physician-patient relationship has been held to confer a contractual duty upon the physician to render assistance to his patients. That duty continues, in the absence of an agreement to the contrary, for as long as the case requires. *Ricks v. Budge*, 91 Utah 307, 64 P.2d 208, 211 (1937).

14. *Jones v. United States*, 308 F.2d 307, 310 (1st Cir. 1962).

15. In *Rex v. Smith*, 2 Car. & P. 449, 172 Eng. Rep. 203 (Gloucester Assizes 1829), the potential criminality of the defendant for failure to care for an idiot brother depended on whether keeping his brother locked up was an act or an omission. Finding the latter, the court held that the defendant had no legal duty to aid his brother and directed an acquittal. See W. LAFAVE & A. SCOTT, *HANDBOOK ON CRIMINAL LAW* 182-91 (1972); R. PERKINS, *supra* note 10, at 547-51; W. PROSSER, *supra* note 11, § 56, at 338-51.

16. See *Consolidated Gas Co. v. Connor*, 114 Md. 140, 78 A. 725 (1911).

If it is an omission, there is no liability unless an underlying duty is breached. In the case of an omission, the law looks beyond the act to the doctor-patient relationship to determine whether there was a duty and whether the physician breached that duty.

The current state of the law does not provide a definite answer to the commission-omission inquiry. From the legal perspective, the unplugging of the respirator can be classified as either an act or an omission.¹⁷ Under traditional tests, there is support for the proposition that the unplugging of the respirator or the turning off of a cardiac machine would constitute an act.¹⁸ Certainly such a physical action would be an "external manifestation of the actor's will."¹⁹ However, as Professor George Fletcher has observed:

That turning off the respirator takes physical movement need not be controlling. There might be "acts" without physical movement, as, for example, if one should sit motionless in the driver's seat as one's car heads toward an intended victim. Surely that would be an act causing death; it would be first-degree murder regardless of the relationship between the victim and his assassin. Similarly, there might be cases of omissions involving physical exertion, perhaps even the effort required to turn off the respirator. The problem is not whether there is or there is not physical movement; there must be another test.²⁰

Considering the ultimate outcome, the niceties of a commission-omission distinction make little difference to the patient.²¹ What is needed is a practical distinction understandable to the doctor which will better enable him to serve the patient.

Professor George Fletcher has proposed a new test: an act would *cause* something to occur, while an omission would merely *permit* something to occur.²² It would appear from this test that the unplugging of the respirator would merely constitute an omission rather than an act since, by omitting supportive means from the treatment schedule rather than taking affirmative, legal action, the doctor is permitting the patient to expire but is not himself the cause of the death. While this test has not yet been utilized in a legal opinion, it is more practical than the current test in cases involving medical treatment. This proposal would equate the turning

17. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999, 1006 (1967); Gurney, *supra* note 5, at 247; *Right to Die* 659.

18. *Id.*

19. RESTATEMENT (SECOND) OF TORTS § 2 (1965); *see* note 10 *supra*.

20. Fletcher, *supra* note 17, at 1006-07.

21. *Cf.* Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATHOLIC U.L. REV. 723, 736-37 (1973).

22. Fletcher, *supra* note 17, at 1007-08.

off of a mechanical respirator with the situation where a passerby passively watches a child drown in a swimming pool.²³ Under this test, injecting air into a patient's veins would still constitute an act and would be euthanasia, as would withholding insulin shots, which do not merely prolong life but whose absence would *cause* death to occur.²⁴ However, turning off a life-support system would constitute an omission. The question of physician liability would then compel the law to turn to the physician-patient relationship in order to determine if a legal duty existed and if it was breached. Thus, unless such a special legal relationship creating a duty did exist, the physician could *permit* death but could not *cause* it to occur.

B. *The Physician's Contractual Duty*

Assuming under either current law or Fletcher's proposed test that an act such as unplugging of the respirator is an omission, the duty imposed by the contractual nature of the physician-patient relationship becomes the controlling factor in determining liability. "[T]he law imposes . . . liability for an omission to act only where there is a legal duty to do so; therefore, any discussion of a physician's liability for omission should begin with an examination of duty. If there is no duty, there is no liability."²⁵

Since the physician-patient relationship is contractual in nature, it may be analyzed through the traditional framework of offer and acceptance.²⁶ The patient, as the offeror, communicates the offer to the physician by seeking his services, usually by walking into the physician's office. The physician, as offeree, may accept the offer or refuse it categorically.²⁷ However, if he decides to treat the patient,

23. *Id.* at 1004. In *In re Quinlan*, Docket No. C-201-75, at 33 (N.J. Super. Ct., Nov. 10, 1975), Judge Muir specifically rejected the Fletcher test, noting: "An intricate discussion on semantics and form is not required since the substance of the sought-for authorization would result in the taking of the life of Karen Quinlan when the law of the state indicates that such an authorization would be a homicide." See note 54 *infra* and accompanying text.

24. *Id.* at 1013-14.

25. *Euthanasia: Considerations* 1207. As Chief Justice McAlvy noted in *People v. Beardsley*, 150 Mich. 206, 209, 113 N.W. 1128, 1129 (1907):

This rule of law is always based upon the proposition that the duty neglected must be a legal duty, and not a mere moral obligation. It must be a duty imposed by law or by contract, and the omission to perform the duty must be the immediate and direct cause of death.

26. S. SHINDELL, *supra* note 7, at 18-19; see A. HOLDER, *MEDICAL MALPRACTICE LAW* ch. 1 (1975); Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189 (1961).

27. See *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901); *Rice v. Rinaldo*, 119 N.E.2d 657, 659 (Ohio Ct. App. 1951) (dictum); *Limbaugh v. Watson*, 12 Ohio L. Abs. 150, 151 (Ct. App. 1932); R. MORRIS & A. MORITZ, *DOCTOR AND PATIENT AND THE LAW* 135 (5th ed. 1971); *Louisell, supra* note 21, at 730-31.

he has, in effect, accepted the patient's offer and a contract is formed. In order for the contract to be valid, all the elements of a traditional contract, including mutuality of understanding, must exist.²⁸ Furthermore, both the physician and the patient retain the power to terminate the contract at will, at least to the extent that it remains mutually executory,²⁹ although under certain circumstances the physician must give the patient reasonable notice of his withdrawal.³⁰ Perhaps the best way to describe the physician-patient relationship is that it is one of "mutual participation,"³¹ in which there is a "series of continuing offers on the part of the patient that ripen into contracts as the physician performs a series of services."³²

Absent some agreement to the contrary, once the physician accepts the patient's offer, whether by words or by action, the law imposes a duty on the physician to continue treatment as long as it is required.³³ Even if the patient has a flat electroencephalogram

28. A. HOLDER, *supra* note 26, at 1; S. SHINDELL, *supra* note 7, at 20.

29. C. CUSAMANO, MALPRACTICE LAW DISSECTED FOR QUICK GRASPING 31 (1962), *quoted in* EUTHANASIA: CONSIDERATIONS at 1226; R. MORRIS & A. MORITZ, *supra* note 27, at 135; S. SHINDELL, *supra* note 7, at 24.

30. Failure of the physician to provide reasonable notice of withdrawal has been held to be actionable in tort. *See* Norton v. Hamilton, 92 Ga. App. 727, 89 S.E.2d 809 (1955) (physician refused to come to pregnant patient's home prior to birth of her child); McGulpin v. Bessmer, 43 N.W.2d 121 (Iowa 1950) (physician abandoned patient even though the latter's foot needed amputation); Johnson v. Vaughn, 370 S.W.2d 591 (Ky. Ct. App. 1963) (physician abandoned patient who had just been shot); Ricks v. Budge, 91 Utah 307, 64 P.2d 208 (1937) (physician withdrew from case because of patient's old debt although patient's hand needed immediate attention); Vann v. Harden, 187 Va. 155, 47 S.E.2d 314 (1948) (physician suddenly left city for a week when patient's leg was in excruciating pain).

Morris and Moritz have suggested that the physician, in order to protect himself, should send a letter, preferably by certified or registered mail, to the patient explaining the situation. Factors that should be taken into consideration in determining whether the notice is adequate are the condition of the patient, the size of the community, and the availability of other physicians. R. MORRIS & A. MORITZ, *supra* note 27, at 135.

31. S. SHINDELL, *supra* note 7, at 17; Szasz & Hollender, *A Contribution to the Philosophy of Medicine—The Basic Models of the Doctor-Patient Relationship*, 97 ARCHIVES OF INTERNAL MEDICINE 585, 587 (1956).

32. S. SHINDELL, *supra* note 7, at 24. The fact that the patient can terminate the contract at any time may create difficulty for the physician, who is presumed to have "superior knowledge" and who may feel that the patient should therefore not be permitted, in a sense, to dictate treatment. If the patient chooses a different method of treatment than that preferred by the physician, "the physician has only two alternative courses of action: (1) persuade the patient to follow the physician's advice; or (2) withdraw from the case altogether (after a reasonable standby period for the patient to obtain another doctor to avoid the charge of abandonment)." R. MORRIS & A. MORITZ, *supra* note 27, at 136-37; *see* cases cited in Ricks v. Budge, 91 Utah 307, 314, 64 P.2d 208, 212 (1937).

33. *See* Johnson v. Vaughn, 370 S.W.2d 591 (Ky. Ct. App. 1963); Lee v. Dewbre,

(EEG) reading and no chance of recovery, the physician may be obligated to keep the respirator going indefinitely.³⁴ If the patient were injured by the physician's failure to perform in accordance with this agreement, the physician could be held criminally liable³⁵ and the injured patient could recover for breach of contract.³⁶

Notwithstanding this duty, the physician may be liable for assault and battery if he operates on the patient without the patient's consent,³⁷ even if the treatment benefited the patient³⁸ or was given with a high degree of skill.³⁹ Without contractual authorization for a specific operation, the physician would be liable for an unauthorized touching. Consequently, if the patient desired to end treatment, he could do so merely by terminating the contract, discharging the physician's duty.⁴⁰ The physician would then have neither the right nor the duty to treat the patient and would not be liable for abandoning the patient.

The physician must ensure that the patient's consent to treatment is an informed consent or there is no contract. The leading case on informed consent, *Natanson v. Kline*,⁴¹ held that a physician would be liable for an unauthorized treatment if he "affirmatively misrepresents the nature of the operation or has failed to point out the probable consequences of the course of treatment."⁴² The doc-

362 S.W.2d 900 (Tex. Civ. App. 1962); *Gray v. Davidson*, 15 Wash. 2d 257, 130 P.2d 341 (1942); *McManus v. Donlin*, 23 Wis. 2d 289, 127 N.W.2d 22 (1964). See also *Brandt v. Grubin*, 131 N.J. Super. 182, 329 A.2d 82 (Sup. Ct. 1974).

34. Fletcher, *supra* note 17, at 1015.

35. S. SHINDELL, *supra* note 7, at 26.

36. *Euthanasia: Considerations* 1208. In such a situation, the physician could not plead that his failure to act was "inaction" rather than an "affirmative action." See D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ch. VIII (rev. ed. 1973); D. MEYERS, *THE HUMAN BODY AND THE LAW* 147-48 (1970); Kamisar, *supra* note 9, at 982 n.41.

37. As Justice Cardozo has noted: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). See also *Moos v. United States*, 118 F. Supp. 275 (D. Minn. 1954); *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905); *Darran v. Kite*, 32 App. Div. 2d 208, 301 N.Y.S.2d 286 (1969); *Rolater v. Strain*, 39 Okla. 572, 137 P. 96 (1913).

38. *Church v. Adler*, 350 Ill. App. 471, 113 N.E.2d 327 (1953) (physician was engaged to remove patient's diseased ovaries but removed the appendix instead).

39. *Perry v. Hodgson*, 168 Ga. 678, 148 S.E. 659 (1929); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

40. See *Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 1, at 25 (1972); *Euthanasia: Considerations* 1208.

41. 186 Kan. 393, 350 P.2d 1093 (1960).

42. *Id.* at 406, 350 P.2d at 1103. For a discussion of the doctrine of informed

trine of informed consent thus imposes additional responsibility upon the physician. In addition to his contractual duty, the physician has the duty of ensuring that the patient is sufficiently informed to make an intelligent decision. If the physician is remiss in this additional duty, the patient has an action for either battery or negligence.⁴³

The strict requirements of contract law are somewhat relaxed in certain circumstances. One such circumstance is where an emergency situation exists,⁴⁴ as, for example, where the patient is bleeding to death and an operation is necessary to save his life. In such a case the common law dispenses with the requirement that the patient and physician have a contractual relationship before the physician can act and, under the doctrine of "implied consent," sanctions the operation.⁴⁵ It must be recognized, however, that this doctrine is a legal fiction based on an assumption that if the patient were a reasonable person, he would consent to the treatment.⁴⁶ The policy considerations that give rise to the fiction are, of course, quite compelling. Without the doctrine the physician would be required to act at his peril in emergency situations, deterring such action and depriving many emergency patients of their lives, even though if given the choice, they would have consented to

consent, see W. PROSSER, *supra* note 11, § 32, at 161-66; Fraser & Chadsey, *Informed Consent in Malpractice Cases*, 6 WILLAMETTE L.J. 183 (1970); Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A.L. REV. 758 (1970); Plante, *An Analysis of "Informed Consent,"* 36 FORDHAM L. REV. 639 (1968); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974); Note, *Restructuring Informed Consent: Legal Therapy For the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970).

43. Some courts have held that failure to inform the patient before treatment constitutes a battery. See *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966). The prevailing view, however, is that, in the absence of willful intent by the physician, the failure to inform is negligence. See *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972). For an analysis of the distinction between the theories of battery and negligence, and a collection of the cases, see *id.* at 620-21, 295 A.2d at 685-86.

44. See generally Annot., 25 A.L.R.3d 1439, 1440 n.3 (1969); Annot., 9 A.L.R.3d 1391, 1392 (1966); Note, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 CALIF. L. REV. 860, 863 (1965) [hereinafter cited as *Unauthorized Treatment*].

45. *Jackovach v. Yokom*, 212 Iowa 914, 237 N.W. 444 (1931); *Wells v. McGehee*, 39 So. 2d 196 (La. App. 1949); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912); *King v. Carney*, 85 Okla. 62, 204 P. 270 (1922); *Gravis v. Physicians & Surgeons Hosp.*, 415 S.W.2d 674 (Tex. Civ. App. 1967).

46. W. PROSSER, *supra* note 11, § 18, at 103; *Unauthorized Treatment* 863 n.21; see RESTATEMENT (SECOND) OF TORTS § 62 (1965).

treatment.⁴⁷ Therefore, in the interest of those who would choose to live, the balance is tipped at the expense of those who would prefer to remain untreated. Such balancing is but a reflection of the traditional value placed on life in our legal system.

In addition to the emergency situation, the contractual nature of the physician-patient relationship is modified in the case of a patient who is critically ill. Certain conditions inherent in the medical treatment of critically ill patients alter the physician-patient relationship. Here, where continued treatment may be extremely costly or experimental or perhaps futile, the physician may not be under a duty to provide every conceivable treatment. Rather, only such treatment as may be feasible under the circumstances is required.

The issue of to what extent the contractual duty to treat a critically ill patient is modified requires an inquiry into what means of treatment are ordinary and what means are extraordinary. Ordinary means are "all medicines, treatments and operations which offer a reasonable hope of benefit, and which can be obtained and used without excessive expense, pain or other inconvenience," while extraordinary means are "those which do involve these factors, or which, if used, would not offer a reasonable hope of benefit."⁴⁸ Although this distinction has received only limited judicial recognition,⁴⁹ it has been accepted by the medical profession,⁵⁰ as well as by Catholic and Protestant theologians.⁵¹

Those who recognize the distinction are in substantial agreement that extraordinary means need not be employed to maintain the life of a critically ill or terminal patient.⁵² The current state of

47. *Right to Die* 668-69.

48. N. ST. JOHN-STEVAS, *LIFE, DEATH AND THE LAW* 275-76 (1961); cf. S. SHINDELL, *supra* note 7, at 117-18. See also, Kelly, *The Duty to Preserve Life*, 12 *THEOLOGICAL STUDIES* 550 (1951).

49. In *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971), the Supreme Court of New Jersey noted the distinction:

If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other. It is arguably different when an individual, overtaken by illness, decides to let it run a fatal course. But unless the medical option itself is laden with the risk of death or of serious infirmity, the State's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide.

Id. at 581-82, 279 A.2d at 673.

50. The American Medical Association has adopted a policy statement in favor of withdrawing extraordinary means of treatment from those patients requesting such a withdrawal. *N.Y. Times*, Dec. 5, 1973, at 22, cols. 3-5.

51. Gurney, *supra* note 5, at 248.

52. In 1957, Pope Pius XII told an assembly of physicians that "in order to permit the patient, already virtually dead, to pass on in peace," when death becomes inevitable, the physician need not make further efforts to stave off death. *N.Y.*

the law, which is not bound by the opinions of physicians and theologians, is unclear. No prosecutions have been brought, however, for the failure to use extraordinary means of treatment.⁵³ The recent controversy in New Jersey involving the unplugging of a respirator of a comatose patient reveals the uncertainty that exists.⁵⁴ Yet even though the opinions of doctors and theologians are not legally conclusive, it is logical to expect their opinions to play a significant role in shaping the development of the future legal definition of a physician's duty to a dying patient.⁵⁵ In view of current medical and religious views and of the anticipated development of the law to conform to these views, the problem confronting the physician becomes not so much whether he must use extraordinary means of treatment, but rather how to distinguish between ordinary and extraordinary means. As Professor David Meyers has noted:

Unfortunately, advances in medical science have blurred this distinction by making obsolete traditional definitions of death and leaving a wide area of uncertainty as to where

Times, Nov. 25, 1957, at 1, col. 3. As Rev. Richard A. McCormick of Georgetown's Kennedy Center for Bioethics noted: "There is a moral difference between killing and allowing to die. When you cease extraordinary effort, it is the disease that kills, not the withdrawal." *A Right To Die?* NEWSWEEK, Nov. 3, 1975, at 59. This conclusion is shared by several other religions. S. SHINDELL, *supra* note 7, at 120. It is also considered sound medical practice by some in the profession. Williamson, *Prolongation of Life or Prolonging the Act of Dying?*, 202 J.A.M.A. 162, 163 (1967). *Contra*, *Hearings on "Death with Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 1, at 23 (1972).

53. Gurney, *supra* note 5, at 248.

54. The controversy involved 21-year-old Karen Ann Quinlan, who had been in a coma since April 1975 and had suffered permanent brain damage with no realistic hope of recovery. The adoptive parents of Miss Quinlan, who had the support of their religious advisor, a Roman Catholic priest, petitioned Judge Robert Muir of the New Jersey Superior Court to authorize the disconnection of the respirator that had kept her alive.

Judge Muir did not grant the sought-after relief, refusing to "consider the 'extraordinary' versus 'ordinary' discussions viable legal distinctions." *In re Quinlan*, Docket No. C-201-75, at 39 (N.J. Super. Ct., Nov. 10, 1975). Perhaps the reason for Judge Muir's refusal even to consider the distinction was the medical testimony of the expert witnesses, all but one characterizing the use of the respirator as an "ordinary" means of treatment. Moreover, the only witness to classify the respirator's use as "extraordinary" admitted that the term "extraordinary" lacks "precision." *Id.* at 16.

Judge Muir did indicate, however, that his decision might have been different if the patient, rather than her parents, had been the petitioning party: "Karen Quinlan while she was in complete control of her mental faculties to reason out the staggering magnitude of the decision not to be 'kept alive' did *not* make a decision. This is *not* the situation of a Living Will which is based upon a concept of informed consent." *Id.* at 30-31 (emphasis added).

55. As Lord Justice Coleridge noted: "It is not correct to say that every moral obligation is a legal duty, but every legal duty is founded upon a moral obligation." *Regina v. Instan*, 17 Cox Crim. Cas. 602, 603 (Q.B. 1893).

life-preserving activities become no more than a palliative means of prolonging imminent death. Many of the scientific devices by which people are kept 'alive' today must be classified as 'extraordinary' means: haemodialysis units, 'iron-lung' respirators, heart circulation pumps, intravenous feeding, and the like. The line between ordinary and extraordinary therapy to preserve life is not an objective or straight one. It can only be discerned in individual cases, based on the presented circumstances, which will always be somewhat dissimilar.⁵⁶

At present, then, the physician may be free not to give extraordinary treatment to a critically ill patient. In practical application, such freedom could be quite significant. Unplugging a respirator, for example, would be terminating the use of complex equipment—*i.e.*, the failure to use extraordinary means of treatment. As an omission, this would impose no liability on the physician as long as there were no underlying duty to render extraordinary treatment. Acceptance of the concept that extraordinary means may be waived in critical illnesses would mean that a patient's discharge of the physician's duty would be effective, allowing the physician to terminate the treatment without liability.

As medical knowledge expands, however, the ability on the part of the physician to distinguish between ordinary and extraordinary means may decrease. As the extraordinary becomes ordinary, at least to the extent that the line between the two cannot be surely and clearly drawn,⁵⁷ the physician's decision will become increasingly difficult. This will leave the physician with the continuing problem of second-guessing the law in cases where the

56. D. MEYERS, *supra* note 36, at 148.

57. Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 *FORDHAM L. REV.* 695, 700 (1968). "It has also been pointed out that the extraordinary measures of today are the routine procedures of tomorrow." *Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 1, at 23 (1972).

Both moral considerations and professional standards may shape the routine-extraordinary distinction. For example, Professor David Louisell has suggested that a surgical removal of a tumor that would save the life of a three-year-old child, but condemn that child to a life of total blindness, would constitute extraordinary means, at least from the moral perspective. Louisell, *supra* note 21, at 735. The American Medical Association recently adopted a resolution in favor of withdrawing life-support equipment when there is irrefutable evidence that death is imminent and when the patient and/or his immediate family requests such a withdrawal. *N.Y. Times*, Dec. 5, 1973, at 22, cols. 3-5.

The resolution was adopted about one year after the Board of Trustees of the American Hospital Association approved for its 7,000 member hospitals a "Patients' Bill of Rights," which included as point four: "The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action." *N.Y. Times*, Jan. 9, 1973, at 30, col. 4.

patient requests that futile or expensive treatment be discontinued. As science advances, this problem may become more significant.

Even if extraordinary means need not be undertaken, there may be very few cases in which the physician can exercise this freedom to refuse treatment. This is because the number of patients requiring such means are most likely to be a small minority of the "problem deaths."⁵⁸ Most patients seeking death with dignity could be treated by ordinary means. This situation creates problems because the law, in dealing with treatment by ordinary means, remains somewhat nebulous.

Present case law does not appear to sustain an individual's right to refuse ordinary means of treatment.⁵⁹ In recent years, this has been manifested in several cases concerning the refusal of blood transfusions for religious reasons by members of the Jehovah's Witnesses. The leading case on this issue is *Application of President and Directors of Georgetown College*,⁶⁰ in which Judge J. Skelly Wright, sitting alone on an emergency appeal, granted a court order to a hospital to permit it to administer a blood transfusion over the patient's objections. The patient, the mother of a three-month-old child, was suffering from massive internal bleeding caused by a ruptured ulcer. Judge Wright's reasoning rested on two considerations: the hospital's responsibility and an analogy to suicide.

The holding in this case is indicative of the judicial reluctance to allow patients to refuse ordinary means of treatment and has been followed by several other courts.⁶¹ Despite these decisions, however, the case law is far from uniform. Two years prior to the

58. Dempsey, *The Living Will—and the Will to Live*, N.Y. Times, June 23, 1974, § 6 (Magazine), at 12.

59. *Euthanasia: Considerations* 1220.

60. 331 F.2d 1000 (D.C. Cir.), *reh. en banc denied*, 331 F.2d 1010 (D.C. Cir.) *cert. denied*, 377 U.S. 978 (1964).

61. See *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) (father of four minor children could not refuse a blood transfusion because of his religious beliefs, since the state has an interest in upholding respect for the doctor's conscience and professional oath); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (state can appoint a guardian to consent to blood transfusions since the refusal of such transfusions is equivalent to suicide and there is no constitutional right to choose to die); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964) (woman in her 32nd week of pregnancy could not refuse a blood transfusion on religious grounds since the state had a duty to protect the life of the quickened fetus); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965) (court did not believe patient's refusal on religious grounds to authorize a blood transfusion and held that she had actually wanted the transfusion that she had refused to authorize).

Georgetown College decision, a New York court held that a competent patient had the right to refuse a life-saving transfusion.⁶² In the case of *In re Estate of Brooks*,⁶³ decided one year after *Georgetown College*, the Illinois Supreme Court ruled that giving a blood transfusion to a competent Jehovah's Witness with no minor children who objected to such treatment violated her first amendment right of freedom of religion. The *Brooks* decision has been followed in other jurisdictions, establishing, to some extent, the right of a patient to refuse ordinary treatment on the grounds of religious freedom.⁶⁴

Some consistency may be found in these opposing lines of cases. Those courts rejecting the patient's right to refuse ordinary treatment have presented three factors to justify their holdings even where freedom of religion is claimed. These factors are: (1) the patient is so weakened by his illness as to be mentally incompetent;⁶⁵ (2) the patient has minor children or an unborn child;⁶⁶ and (3) there is a possibility of civil or criminal liability of the hospital and attending physicians.⁶⁷ Furthermore, those courts taking the opposite position and allowing the patient to refuse ordinary treatment have not been faced with circumstances which give rise to

62. *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

63. 32 Ill. 2d 361, 205 N.E.2d 435 (1965). The patient had signed a release absolving the hospital and her physician from liability.

64. In *Winters v. Miller*, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971), the Second Circuit held that a hospital must respect the right of a 59-year-old Christian Scientist to refuse medication. The court noted that first amendment rights could not be infringed on such "slender grounds" as could other rights emanating from the fourteenth amendment.

In *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (E.D. Ill. 1972), an Illinois district court held that the state's appointing a conservator for the purpose of ordering medical treatment was a violation of the patient's first amendment right to freedom of religion.

In *In re Osborne*, 294 A.2d 372 (D.C. App. 1972), the District of Columbia Court of Appeals held that there was no compelling interest to justify overriding the patient's decision and appointing a guardian to give consent for the administration of the blood transfusion. The patient, a 34-year-old with full understanding who had made provisions for the support of his two children, executed a statement releasing the hospital from liability and "viewed himself as deprived of life everlasting" even if he had involuntarily received the transfusion.

65. *Application of President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), reh. en banc denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

66. *Id.*; *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964).

67. *Application of President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), reh. en banc denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

these factors. It can thus be concluded that if all of those factors are absent or if the concerns raised by the factors are not compelling, a qualified right to refuse ordinary treatment might exist.⁶⁸

A large factor in the early cases upholding the right to refuse ordinary treatment was the religious convictions of the patient. Until 1972, there had been no reported case in which the refusal of medical care was based on nonreligious convictions.⁶⁹ In 1971 an unreported Florida county court decision⁷⁰ and in 1972 a concurring opinion in the District of Columbia Court of Appeals⁷¹ both found that a patient without such religious convictions also has the right to refuse ordinary treatment. In 1972, a Wisconsin county court ruled that a 77-year-old woman could refuse the amputation of a gangrenous leg as a matter of choice without requiring that the decision be based on religious beliefs.⁷² Even though these recent opinions cannot as yet be considered a definite trend, their presence and the potential conflict in the earlier cases compel the conclusion that the issue of whether ordinary treatment can be refused on grounds of religious freedom is still unresolved.

These conflicting decisions have led to significant legal con-

68. See Note, *Legal Aspects of Euthanasia*, 36 ALBANY L. REV. 674, 680-81 (1972).

69. *In re Osborne*, 294 A.2d 372, 374 n.2 (D.C. App. 1972).

70. See *Palm Springs Gen. Hosp., Inc. v. Martinez*, No. 71-12678 (Fla. Cir. Ct., July 2, 1971), quoted in Gurney, *supra* note 5, at 244. Mrs. Martinez, a 72-year-old woman, was critically ill from anemia and suffering from collapsed veins, requiring an operation in order to make blood transfusions possible. After she refused to undergo the surgery, the hospital petitioned the court for emergency declaratory relief. Judge Pepper declined such relief, holding: "A conscious adult patient who is mentally competent has the right to refuse medical treatment, even when the best medical opinion deems it essential to save her life." *Id.*

However, the *Martinez* case may not be that useful in asserting nonreligious refusal of ordinary treatment. The treatment given to Mrs. Martinez was extremely painful—surgical incisions were made into the skin in order that blood could be forced into her veins. Dempsey, *supra* note 58, at 13. Thus, her treatment may have constituted extraordinary means because of the significant amount of pain involved. For this reason the *Martinez* case is an excellent example of the blurred line between ordinary and extraordinary means of treatment.

71. As Associate Judge Yeagley concurred in *In re Osborne*, 294 A.2d 372, 376 (D.C. App. 1972), the right to refuse treatment "while based on the first amendment, is not . . . based solely on religious freedom, but also on the broader based freedom of choice whether founded on religious beliefs or otherwise."

72. See *In re Raasch*, No. 455-996 (Milwaukee County Ct., Probate Div., Jan. 25, 1972), quoted in Sullivan, *The Dying Person—His Plight, and His Right*, 8 NEW ENG. L. REV. 197 (1973). The court held that competent adults have the right to make life-and-death medical decisions over their own bodies. As Judge Sullivan noted: "I believe we should leave [the patient] depart in God's own peace." *In re Raasch*, *supra*, at 2, quoted in Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 235 (1973).

fusion,⁷³ placing hospitals and physicians in the absurd and dangerous position of being potentially liable for a battery action if they give unwanted care or potentially liable for wrongful death if they do not. This situation has caused hospitals to turn to the courts for resolution of problem cases in an effort to avoid liability.⁷⁴ It would not, however, appear to be compatible with the practice of good medicine that the hospital or physician seek judicial relief on a case-by-case basis, especially when there is a lack of unanimity in the treatment of the issues.⁷⁵ Compounding these difficulties is the Supreme Court's refusal to confront the matter. The Court has denied certiorari to every case potentially dealing with this issue.⁷⁶

Thus, although there is a contractual relationship between the physician and the patient, because of the nature of that relation-

73. As Professor Alexander Capron lamented before the Senate Special Committee on Aging:

So far as I know there are no clear and certain answers to such questions as:

1. When can a dying patient choose to cease being treated?
2. Who else can exercise that authority on the patient's behalf?
3. What interests do physicians and the State have in prolonging treatment and what weight do these interests carry compared with others?
4. What action could be taken against a physician who—on his own initiative or at the request of a patient or his relatives—ceased treatment?

Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging, 92d Cong., 2d Sess., pt. 2, at 81 (1972).

74. Frequently, hospitals are the moving parties in such judicial proceedings, either as business organizations, *Application of President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir.), reh. en banc denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); Palm Springs Gen. Hosp., Inc. v. Martinez, No. 71-12678 (Fla. Cir. Ct., July 2, 1971); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); by their administrators, Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962); or by another on behalf of the hospital, United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (United States Attorney on behalf of a Veterans Administration hospital). Potentially, the problem is more significant than indicated by the relatively small number of cases. Perhaps many people avoid a confrontation on the matter or do not seek appeal after treatment has been ordered. Cantor, *supra* note 72, at 230 n.9.*

75. It has been suggested that the seeking of a prior judicial order from a judge may create abuse. Perhaps physicians ought to justify their actions before a jury on a suit for battery rather than obtain prior approval from a judge. *Unauthorized Treatment 875-77*. Yet emergency situations do not always permit ample time for reflection. Certain jurists, such as Judge Wright in *Georgetown College* and Judge Bacon in *Osborne*, have demonstrated that the judicial system is capable of both speed and compassion.

76. Certiorari has been denied in *Winters v. Miller, 404 U.S. 985 (1971); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 377 U.S. 985 (1964); Application of President & Directors of Georgetown College, 377 U.S. 978 (1964); State v. Perricone, 371 U.S. 890 (1962); People ex rel. Wallace v. Labrenz, 344 U.S. 824 (1952).*

ship, some of the general tenets of contract law must be altered to accommodate the circumstances. In addition to the variations of the right of the physician to terminate the relationship⁷⁷ and the legal fiction of implied consent for emergency situations,⁷⁸ the contractual nature of the relationship is further altered when the patient is in critical condition. Most commentators agree that if extraordinary means of medical care are necessary to keep the patient alive, those means may be rejected by the patient and his wishes respected without exposing the physician to liability. Unfortunately, there is a dearth of case law in this area. Moreover, if only ordinary means are necessary, the law remains uncertain. It is in the best interests of both the medical profession and the patient that this confusion be replaced with law that is both uniform in its application and predictable in its result.

C. *The Constitutional Right to Privacy*

Judicial opinions which refuse to allow patients the right to reject ordinary means of medical care may be contested on the basis of the right to privacy, which has been employed recently in other cases involving the rights of individuals to control their lives. The basic philosophy behind the right of privacy appears to have been inspired by Justice Brandeis in his dissent in *Olmstead v. United States*,⁷⁹ in which he noted: "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the *right to be let alone—the most comprehensive of rights and the right most valued by civilized men.*"⁸⁰

The right to privacy was initially recognized as a constitutional right created by several fundamental constitutional guarantees in *Griswold v. Connecticut*,⁸¹ where the Supreme Court invalidated a Connecticut statute prohibiting the use of contraceptives by married couples and the distribution of birth control information and devices to them. Mr. Justice Douglas, writing for the Court, viewed several amendments of the Bill of Rights as creating "zones of privacy."⁸² Mr. Justice Goldberg, concurring, found the right to privacy in the

77. See notes 29-36 *supra* and accompanying text.

78. See notes 44-47 *supra* and accompanying text.

79. 277 U.S. 438 (1928).

80. *Id.* at 478 (emphasis added). Brandeis' dissent was relied upon by both then-Judge Burger in his dissent in the *Georgetown College* case and by Justice Underwood of Illinois in the majority opinion in *Brooks*.

81. 381 U.S. 479 (1965).

82. *Id.* at 484.

ninth amendment and therefore required the states to demonstrate a compelling interest for restriction of the right.⁸³ Justices White and Harlan, while not referring to "privacy" as such in their concurring opinions, considered the statute unconstitutional under the fourteenth amendment.⁸⁴ In recognizing the right to privacy, then, the Court did not articulate a definition, but rather left it to be developed on a case-by-case method.⁸⁵

The Court further extended the zone of privacy in the abortion cases. In *Roe v. Wade*⁸⁶ the Court held that, within certain limits, a woman has the right to determine whether or not to have an abortion. Justice Blackmun, writing for the majority, found that only compelling state interests can justify governmental interference with this choice. This decision rested on fourteenth amendment grounds, but the Court subsequently underscored its "right of privacy" underpinnings. In *Doe v. Bolton*⁸⁷ the Court relied on the right of privacy, without commenting on its origin, to invalidate a Georgia anti-abortion statute. This opinion served not only to reaffirm that the right of privacy was a constitutional guarantee,⁸⁸ but clearly brought the right to choose competent medical treatment within its parameters.

A logical extension of the right of a pregnant woman to decide whether or not to obtain an abortion would appear to be an acknowledgment of a patient's right to choose to refuse medical treatment. The right to refuse treatment has already been upheld by some courts on the first amendment grounds of religious freedom.⁸⁹ A further expansion of the right of privacy to include the right to choose to obtain medical treatment appears imminent.

While the right to privacy has been significantly expanded by

83. *Id.* at 497.

84. *Id.* at 499, 502.

85. See *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (recognition of "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child"); *Stanley v. Georgia*, 394 U.S. 557, 565 (1969) (an individual has "the right to read or observe what he pleases" within the home).

86. 410 U.S. 113 (1973). For commentary on *Roe*, see Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 *FORDHAM L. REV.* 807 (1973); Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 *YALE L.J.* 920 (1973); Heymann & Barzelay, *The Forest and the Trees: Roe v. Wade and Its Critics*, 53 *BOSTON U.L. REV.* 765 (1973); Loewy, *Abortive Reasons and Obscene Standards: A Comment on the Abortion and Obscenity Cases*, 52 *N.C.L. REV.* 223 (1973); Tribe, *The Supreme Court, 1972 Term—Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 *HARV. L. REV.* 1 (1973).

87. 410 U.S. 179 (1973).

88. *Euthanasia: Considerations* 1240.

89. See notes 62-64 *supra*.

the Supreme Court in recent years, it must be noted that if the state shows compelling interests, it can overcome or at least limit the exercise of a fundamental right.⁹⁰ Presumably, the right to privacy which attaches to fundamental rights⁹¹ could also only be overcome by state interests sufficiently compelling to justify striking down that right. This is the teaching of *Roe v. Wade*, in which the Court indulged in a compelling-interest type analysis⁹² and stated that it was not until the end of the first trimester of pregnancy that the state interests in protecting the mother's health and until the end of the second trimester that the fetus' potential life became sufficiently compelling to overcome the mother's right to privacy.⁹³ Similarly, there are various compelling state interests that conceivably could be balanced against and even outweigh a patient's right to refuse medical treatment, even if that right is deemed to be included within the constitutional right to privacy. The question then becomes what interests these might be, and whether they will in every instance justify denying the patient the right to refuse medical treatment.

One of these interests is the life of the patient. The right to life is recognized in the fourteenth amendment, is regarded as a fundamental freedom, and enjoys a "preeminent position among the hierarchy of constitutional values."⁹⁴ In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,⁹⁵ the New Jersey Supreme Court held that a woman in her eighth month of pregnancy could

90. The denial of fundamental rights will be held to deny equal protection unless justified by a compelling state interest. See *Shapiro v. Thompson*, 394 U.S. 618, 658-62 (1969) (Harlan, J., dissenting); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963). See also Gunther, *The Supreme Court, 1971 Term—Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1 (1972).

91. "[It is] clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' . . . are included in this guarantee of personal privacy." *Roe v. Wade*, 410 U.S. 113, 152 (1972).

92. Where certain "fundamental rights" are involved, the Court has held that regulation limiting these rights may be justified only by a "compelling state interest" . . . and that legislative enactments must be narrowly drawn to express only legitimate state interests at stake. . . . In the recent abortion cases . . . the courts have recognized these principles.

Id. at 158-59.

93. *Id.* at 162-65.

94. *Euthanasia: Considerations* at 1247. Society has a fundamental interest in the preservation of human life. See Cantor, *supra* note 72, at 243-44; *cf.* *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan, J., concurring).

In *In re Quinlan*, Docket no. C-201-75, at 38-39 (N.J. Super. Ct., Nov. 10, 1975), Judge Muir held that the right to life of the patient was pre-eminent over the patient's right to privacy when asserted by a parent. See note 54 *supra* and accompanying text.

95. 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

be required to have a blood transfusion against her religious objections; first amendment free exercise rights were thus not a justification for endangering the life of the quickened fetus. The United States Supreme Court recognized the importance of the right to life in the abortion cases, in which it held that the right to life of the quickened fetus, in the latter states of pregnancy, is preeminent over the mother's right of privacy.⁹⁶ The right to life has thus been given preeminence over other constitutional rights, including the free exercise of religion and the right to privacy.

The state's interest in preserving life has also been safeguarded even where no other person is directly affected. A state court has upheld the conviction of a group of pacifists who purposely failed to take shelter during air raid drills.⁹⁷ Several state courts have held in the snake-handling cases⁹⁸ that such ceremonies by religious sects could be forbidden by law, since it is constitutional to enact a "law prohibiting the practice of a religious rite which endangers the lives, health, or safety of the participants"⁹⁹ Duelling has been made illegal by statute, despite the consent of both parties.¹⁰⁰ Suicide still remains a felony or a misdemeanor in a few states,¹⁰¹ although legal attitudes toward suicide have relaxed in recent years. As the New Jersey Supreme Court stated in *John F. Kennedy Memorial Hospital v. Heston*:¹⁰² "[T]here is no constitutional right to choose to die," even though the patient claims that his religious faith ordains his death.¹⁰³

There is, however, some doubt concerning the continued viability of these arguments. The Supreme Court in *Roe*, for example, held that it need not determine the complex question of when life begins¹⁰⁴ and found the mother's clear right to privacy paramount over a debatable or potential right of the fetus to life. Thus, the court appears to favor the right to privacy, which has implications

96. *Roe v. Wade*, 410 U.S. at 154-63; *Doe v. Bolton*, 410 U.S. at 189.

97. *State v. Congdon*, 76 N.J. Super. 493, 185 A.2d 21 (App. Div. 1962).

98. See, e.g., *Lawson v. Commonwealth*, 291 Ky. 437, 164 S.W.2d 972 (1942); *State v. Massey*, 229 N.C. 734, 51 S.E.2d 179, *appeal dismissed sub nom.*, *Bunn v. North Carolina*, 336 U.S. 942 (1949); *Harden v. State*, 188 Tenn. 17, 216 S.W.2d 708 (1948).

99. *Lawson v. Commonwealth*, 291 Ky. at 441-42, 164 S.W.2d at 974.

100. See, e.g., CAL. PENAL CODE § 225 *et seq.* (West 1970); N.Y. PENAL LAW § 35.15(1)(c) (McKinney 1967).

101. *State v. Willis*, 255 N.C. 473, 121 S.E.2d 854 (1961); *State v. Lavelle*, 34 S.C. 120, 13 S.E. 319 (1891).

102. 58 N.J. 576, 279 A.2d 670 (1971).

103. *Id.* at 580, 279 A.2d at 672.

104. 410 U.S. at 159.

as to the right to accept or refuse medical treatment, over the right of another to live.¹⁰⁵

Another state interest that has been deemed sufficiently compelling by various courts to overcome the right to refuse treatment is the guardianship of minor children. If an adult patient refuses ordinary treatment and is allowed to die, children of that patient might become wards of the state. This concern existed in both *United States v. George*¹⁰⁶ and in *Georgetown College*.¹⁰⁷ In none of the cases in which the court upheld the patient's right to refuse treatment did that patient have minor children who, without the patient, would have no adequate provision for their care.¹⁰⁸ Since the

105. It could be argued that by compelling persons to receive expensive and scarce medical care that they do not desire the state is denying this care, and thereby the right to life, to others, since the state does not have sufficient funds for basic health services for those persons who need, but cannot afford, such basic services. The effect of highly technological health care on the general health of the population can be observed by examining the effects of proposed catastrophic illness health insurance programs. HEW has estimated that the costs of such a program could be \$87 billion by 1995, compared with total personal health expenditures of \$230 billion and the aggregate personal income of \$3.8 trillion in that year. OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, CATASTROPHIC ILLNESSES AND COSTS 34-35 (1971). But for the same money and manpower that would operate kidney centers serving 8,000-22,000 seriously ill people, 100 comprehensive community health centers serving approximately 2,500,000 people could be operated. *Id.* at 24-25. As the Brookings Institution has observed:

Nationwide adoption of a catastrophic insurance program of this kind could dramatically encourage the already growing emphasis of the health care industry on highly publicized and expensive technology—open heart surgery, cobalt machines, organ transplants, intensive care units, and the like. This emphasis, many observers believe, absorbs enormous resources at the expense of more prosaic treatment oriented toward early diagnosis and prevention, which does more in the long run to save lives and improve health.

C. SCHULTZE, E. FRIED, A. RIVLIN & N. TEETERS, SETTING NATIONAL PRIORITIES, THE 1973 BUDGET 238 (1972). Query whether this disturbing and possibly dangerous trend should be further stimulated by requiring by law that people use this technology even when they do not want it.

The argument is even more convincing when it is considered that the life of the patient forced to receive care may be merely lengthened for a period of months, while those denied care may have years of useful life remaining. Thus, forcing patients to receive medical care may in fact merely prolong the life of one rather than saving the life of another.

While this argument is somewhat compelling on the issue of whether the patient should be allowed to refuse *extraordinary* care, its significance may be insubstantial where the issue is only the refusal of *ordinary* care. Blood transfusions and the like are not considered to be extraordinary means of treatment. In fact, extraordinary treatment, by definition, is that which does involve "excessive expense." See N. ST. JOHN-STEVAS, LIFE, DEATH AND THE LAW 275-76 (1964).

106. 239 F. Supp. 752 (D. Conn. 1965).

107. 331 F.2d 1000 (D.C. Cir.), *reh. en banc denied*, 331 F.2d 1010 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

108. See cases cited notes 62-64, 70-72 *supra*. In *In re Osborne*, 294 A.2d 372

state, admittedly, has a compelling interest in ensuring that children are properly cared for, it would seem that only where provisions have been made for the welfare of the patient's children are the courts likely to recognize the patient's right of privacy to the extent of allowing him to refuse treatment.

The courts have also recognized that the protection of the physician and the hospital is a potentially compelling state interest. If a patient refuses ordinary treatment, there is a possibility of liability on the part of the physician and the hospital based on their duties toward the patient.¹⁰⁹ Furthermore, the state may have an interest in preserving respect for the physician's conscience and medical oath.¹¹⁰

These state interests, however, may not outweigh a fundamental right nor a constitutional guarantee arising from fundamental rights. In *Roe v. Wade*, for example, the Supreme Court rejected the view that a physician's oath creates a compelling state interest sufficient to restrict the performance of abortions.¹¹¹

The state's interest in reducing the liability of physicians and hospitals can arguably be served in ways that do not require limiting the rights of patients. Specifically, the patient could sign a waiver or exculpatory agreement with the physician and the hospital. The legal effectiveness of such waivers of liability, however, is not clear at the present time. In both *In re Estate of Brooks*¹¹² and *In re Osborne*¹¹³ the patients whose decisions to refuse treatment were upheld by the courts had executed such waivers. Yet, in both *United States v. George*¹¹⁴ and in *Georgetown College*,¹¹⁵ waivers were ignored by the respective courts in refusing to allow a patient to reject treatment. The significance of waivers is made even more uncertain by the fact that none of these cases dealt specifically with the legal adequacy of waivers in restricting the physician's or hospital's liability. Thus, whether the state's interest in protecting physicians and hospitals from liability can be effectively served by a patient's waiver is an open question.

(D.C. App. 1972), the court did allow a patient with two minor children the right to refuse ordinary treatment, but noted that the patient had made provisions for the support of his children. *Id.* at 374.

109. See note 67 *supra* and accompanying text.

110. See *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 582, 279 A.2d 670, 673 (1971).

111. 410 U.S. at 130-32.

112. 32 Ill. 2d at 372, 205 N.E.2d at 442.

113. 294 A.2d at 373.

114. 239 F. Supp. at 753.

115. 331 F.2d at 1015-16.

Absent legislation, the courts must balance these various interests of the state, the physician, and the patient as presented in the specific fact situations before them. In one recent case, *In re Yetter*, a lower court in Pennsylvania has already utilized the right of privacy to strike the balance in favor of the right of a schizophrenic to refuse cancer therapy.¹¹⁶ Based on recent decisions, it would appear that if and when the Supreme Court does finally decide the issue, it is very likely to rule in favor of a patient's right to refuse ordinary medical treatment, limited perhaps by the patient's duty to provide for his children. The Court's decisive 7-2 margin in *Roe v. Wade* is the clearest indicator that the right of privacy may be expanded to include the right of a patient to refuse treatment. The dissent of then Judge Burger in the *Georgetown College* case lends further support to this view of the present Court's probable position. Referring to Justice Brandeis' famous dissent in *Olmstead v. United States*,¹¹⁷ in which Brandeis championed the "right to be let alone," Burger added:

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.¹¹⁸

If the past is indeed a preface, it would seem that the Supreme Court will strike the balance in favor of the patient's right to refuse ordinary care, even if the result is death.

Prognostications notwithstanding, the current state of the law is dangerously confused. Until a decisive course is charted, physicians and hospitals will continue to overtreat some patients and undertreat others while standing in constant fear of increasingly

116. In our opinion the constitutional right of privacy includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests; in short, that the right of privacy includes a right to die with which the State should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or morals. If the person was competent while being presented with the decision and in making the decision which she did, the Court should not interfere even though her decision might be considered unwise, foolish or ridiculous.

62 Pa.D. & C. 2d 619, 623 (C.P. Northampton County Ct. 1973). For a critical analysis of *Yetter*, as well as a balancing of the various state interests involved in a patient's decision to reject lifesaving medical treatment, see Byrn, *Compulsory Life-saving Treatment for the Competent Adult*, 44 *FORDHAM L. REV.* 1 (1975).

117. 277 U.S. 438 (1928).

118. 331 F.2d at 1017.

costly, if not crippling, liability. The consequence of continuing under this confused state may be an increasing number of operations by court order. This course is both unfortunate and unsatisfactory from the point of view of the patient, the physician, and the court.

III. THE CONCEPT OF THE LIVING WILL

Various suggestions, legislative and nonlegislative, have been proposed to alleviate the confusion in this area. As one such proposal, the Living Will has been signed by perhaps 750,000 Americans in the hope that it will make possible a death with dignity.¹¹⁹ While having no specific legal effect at this time,¹²⁰ the document could have far-reaching importance, especially if a judicial or legislative recognition is accorded it. The Living Will could not only change the concept of liability for both physicians and hospitals, but could also alter the entire physician-patient relationship, thereby relieving the difficulties impinging upon compliance with the patient's desires.

A. Description of the Document

The Living Will is drafted to resemble a testamentary document.¹²¹ It is notarized and attested to by at least two witnesses affirming that the maker was of sound mind and acted of his own free

119. Cleveland Plain Dealer, Nov. 11, 1975, at 22-A, col. 6; see Dempsey, *The Living Will—and the Will to Live*, N.Y. Times, June 23, 1974, § 6 (Magazine), at 12.

120. *Id.* at 13; Note, *The Right to Die*, 10 CALIF. W. L. REV. 613, 625 (1974).

121. The model Living Will, distributed by the Euthanasia Educational Council, is as follows:

TO MY FAMILY, MY PHYSICIAN, MY LAWYER, MY CLERGYMAN
TO ANY MEDICAL FACILITY IN WHOSE CARE I HAPPEN TO BE
TO ANY INDIVIDUAL WHO MAY BECOME RESPONSIBLE FOR MY HEALTH,
WELFARE OR AFFAIRS

Death is as much a reality as birth, growth, maturity and old age—it is the one certainty of life. If the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures." I do not fear death itself as much as the indignities of deterioration, dependence and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Signed

will.¹²² While this process is somewhat cumbersome, it does provide safeguards meant to avoid a later allegation that such factors as pain or the prospect of the family's financial ruin have unduly influenced the patient's decision at the time of the execution of the document.¹²³

Both the name of the document and the formalities of its execution suggest an analogy to the testamentary disposition of property. The Living Will could even be viewed as an advance disposition of a person's life. Furthermore, just as the Statute of Wills created an exception to the rule that a person could not dispose of his property by a testamentary instrument,¹²⁴ so the Living Will is an attempt to create an exception to the general rule that a person cannot take his own life. Because of these similarities, the law governing the testamentary disposition of property can serve as a useful source of legal principles as well as an indication of problems that may arise with the Living Will. Analogies can be drawn, for example, in analyzing the issues involving revocation and capacity.'

Date
Witness
Witness
Copies of this request have been given to

.
.
.
.

Dempsey, *supra* note 119, at 26. While there are other types of Living Wills, this model is the type believed to be most widely used.

It should be emphasized that while the model Living Will of the Euthanasia Educational Council is the most widely distributed document of its kind, it is only a model. Various writers have criticized that model for being either vague or for not having any present legal significance. See, e.g., *id.* at 13 (Living Will cannot solve problems of "death with dignity" since it has no legal effect); Note, *The Right to Die*, 10 CALIF. W.L. REV. 613, 625 (1974) (hospitals ignore the document since it has no legal effect); Note, *Antidysthanasia Contracts: A Proposal for Legalizing Death with Dignity*, 5 PAC. L.J. 738, 739-40 (the document provides no assurance that its provisions will be carried out); Note *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1663-64 (1974) (most Living Wills are so vague that their intent will not be followed). While these criticisms are applicable to the specific model Living Will distributed by the Euthanasia Educational Council, they are inapplicable to the concept of the Living Will, especially if the document were to be looked upon with favor by a court or legislature. Even without such legislative or judicial approval, the document would serve to reveal the competent choice of the patient, were he later to become incompetent or unconscious. There would appear to be no reason why the maker could not include an appendix to the model Living Will in order to satisfy his individual desires. In this appendix the maker could specifically designate the types of treatment to which he would or would not give consent. See Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 550-51 (1969).

122. *Id.* at 551.

123. *Euthanasia: Considerations* 1254-55.

124. See T. ATKINSON, *HANDBOOK OF THE LAW OF WILLS* 14-18 (2d ed. 1953).

There are also significant dissimilarities between the Living Will and a will disposing of property. First, testamentary documents are authorized by statute; in fact, the freedom to make testamentary dispositions can be wholly or sharply curtailed by statute.¹²⁵ The Living Will, at least at present, has no such statutory authority.¹²⁶ Furthermore, courts have not always recognized the legal effect of documents purporting to release the hospital from liability for not administering refused treatment.¹²⁷ It must be noted, however, that in those decisions the patient's competency could not be so well established as in cases involving an advance declaration, such as the Living Will.

The concept of advance declaration, which is central to the viability of the Living Will, has met with varying reactions. One court has maintained that the patient cannot waive in advance the liability of a hospital and its attending physicians, since such a release would be unenforceable as contrary to public policy.¹²⁸ Commentators have agreed that, while possibly unenforceable as a waiver of liability, an advance statement could be evidence of the lack of consent to the proposed treatment, and be considered a contract not to sue in consideration for the promise not to administer treatment.¹²⁹ Finally, adding to the uncertainty of its legal status, at least two courts have used the advance waiver as part of the balancing process in granting the patient the right to refuse ordinary treatment.¹³⁰ These distinctions may necessitate the use of contract law as the basis for the legal effect of the Living Will.

While the Living Will is not statutorily recognized by any state, it does at least indicate that at the time it was executed, the patient made a competent decision to reject medical care in the future, should certain circumstances occur. Since the document requests that the patient "not be kept alive by artificial means or 'heroic measures,'"¹³¹ the patient by signing the document has at least refused extraordinary means of treatment. Since the right to refuse extraordinary means is recognized by commentators and

125. *See id.* at 23-30.

126. *See note 119 supra.*

127. *See text accompanying notes 112-15 supra.*

128. *See Tunkl v. Regents of the Univ. of Calif.*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

129. Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 *FORDHAM L. REV.* 695, 702 (1968).

130. *See notes 112-13 supra.*

131. *See note 121 supra.*

theologians,¹³² the utility of the document begins with its affirmation of the patient's exercise of this right of refusal.¹³³

The legal effect of the Living Will need not, however, be so limited. As it is now being drafted, it also makes the specific request that drugs be given to alleviate suffering even though the drugs might hasten death.¹³⁴ Furthermore, if courts come to recognize a qualified right of patients to refuse even ordinary medical treatment,¹³⁵ the Living Will could be modified to exclude those ordinary means of treatment which the patient wishes to avoid. A person could, for example, attach a detailed appendix to the model Living Will to indicate the treatments to which he does not consent.¹³⁶

Finally, it must be emphasized that the Living Will need not be considered a document merely designed to end life. Rather, it enables a patient to control his own medical destiny. It could allow the patient, upon consideration of his religious convictions, personal desires, and financial circumstances, to expand as well as limit the treatment to which he consents. Not only would the Living Will then be a means of limiting expensive treatment, it would also be a means for a patient to express his desire for all the treatment that is available.¹³⁷

B. *The Living Will and Patient Capacity*

The possibilities inherent in the Living Will for limiting or expanding the patient's future treatment also raise questions very similar to those involved in the testamentary disposition of property. One analogy to the law of wills can be drawn in the inquiry

132. See notes 48-55 *supra* and accompanying text.

133. It has been suggested that to propose legislation that permits the refusal of extraordinary treatment is redundant, although such legislation would provide security to the physician and the hospital. *Euthanasia: Considerations* 1255. The recent controversy in New Jersey concerning the case of Karen Ann Quinlan underscores the need to provide security to health care personnel.

The Euthanasia Educational Council's model for the Living Will also requests that the physician administer pain-relieving drugs, even if they may hasten death. The legal status of that request will be considered later in this Note, but with the exception of that sentence, the document might possibly be a mere notification of the current state of the law.

134. See note 121 *supra*.

135. See notes 63-65 *supra* and accompanying text.

136. See Kutner, *supra* note 121, at 550-51.

137. There is a suspicion that persons with modest means are given less intensive care than are the wealthy. In Britain a few years ago a government-supported hospital, as a regular practice, denied a resuscitator to aged patients, until public pressure forced a change in policy. The Living Will could be a means to assure that patients are not arbitrarily deprived of medical care. See *id.* at 548-50.

of capacity. The Living Will can only be executed by a person who has the capacity to give consent to treatment.¹³⁸ Just as with a testamentary disposition,¹³⁹ the maker must be competent if the Living Will is to have effect.¹⁴⁰ A minor or a person adjudged incompetent could not sign such a document or make such a declaration.¹⁴¹ The signatures of witnesses would attest to the competency of the maker.¹⁴²

Through the device of advance declaration, the Living Will eliminates the necessity of determining the competency of the patient-declairee when the patient is critically ill and refusing treatment. This fact is significant because of the several factors that can affect the competency of the patient in critical condition. First, the patient's wishes may be affected by "what he thinks his relatives want, by the emotional stress caused by the illness, by the doctor's attitude, by the relatives' attitudes, and even by financial considerations."¹⁴³ Second, psychological studies have indicated that all persons have a suppressed longing for death—the death wish, or "thanos."¹⁴⁴ Since that desire can manifest itself on a conscious level when a person is seriously ill, the patient must be protected from this temporary manifestation. Third, the patient may not know his true condition.¹⁴⁵ Of course, while some or all of these factors could be at play when the Living Will is executed, their presence is far less likely to occur if the Living Will is executed prior to any illness.

In addition, if execution occurs early, the maker has time to reflect on his decision before and after execution. This is important, for although the law presumes sanity rather than insanity and competency rather than incompetency,¹⁴⁶ the very act of refusing treatment may evidence incompetency, since the doctrine of implied consent assumes that the sane or competent person will accept rather than reject treatment.¹⁴⁷ The Living Will, with its

138. See *id.* at 552.

139. See T. ATKINSON, *supra* note 124, at 228-52. Generally, the competency requirements of age and mental capacity in a Living Will are similar to those requirements in a testamentary disposition. *Id.*

140. See Kutner, *supra* note 121, at 552.

141. See *id.* at 552.

142. *Id.* at 551.

143. Gurney, *Is There a Right to Die—A Study of the Law of Euthanasia*, 3 CUMBERLAND-SAMFORD L. REV. 235, 260 (1972).

144. Kutner, *supra* note 121, at 545.

145. Dempsey, *supra* note 119, at 13.

146. *Rose v. Rose*, 298 Ky. 404, 407-08, 182 S.W.2d 977, 978 (1944); *Nyka v. State*, 268 Wis. 644, 646-47, 68 N.W.2d 458, 460 (1955); Annot., 25 A.L.R.2d 1439, 1440 (1969).

147. See notes 44-47 *supra* and accompanying text.

advance declaration, provides the patient with a means to refuse treatment at a time when competency is less open to doubt and at a time when he is not making a choice between life and immediate death.

Advance declaration also enables a person to make a competent determination before being incapacitated by a debilitating ailment. For example, a stroke, sudden accident, or coronary deprives a person of the opportunity to determine the extent to which he wishes treatment. In the Living Will, the patient is able to detail in a clear and competent fashion the extent to which he consents to treatment. He need only add these instructions to the body of the model Living Will.

The Living Will also has the advantage of allowing an advance declaration in the face of impending insanity, provided that the maker knows of his mental illness and is not already insane. Although a person's Living Will would ordinarily be considered revoked if that person is subsequently adjudged incompetent, the revocation would not be implied where the "state of incompetency resulted from the medical condition which was contemplated in making the declaration."¹⁴⁸ A person would, therefore, while sane, be able to choose through advance declaration between death and a life of insanity, provided that the death could not be the result of positive action taken by another person.

Yet even if the Living Will allows the maker to escape an assault upon his competency by making his medical decision early, the benefit is an empty one if the document is not easily accessible when the time for determining treatment arrives. This raises the crucial problem of where the Living Will should be kept. In an emergency in which the patient is in critical condition, the physician or the hospital may have to act quickly. If the physician must telephone the patient's home in search of a Living Will before administering treatment, the patient could die before the treatment can be rendered. Yet, if the physician were to save the patient's life, he would run the risk of later discovering that the patient had earlier declared his opposition to the treatment used. Although requiring the physician to make such inquiry might serve to safeguard the rights of those who would refuse treatment, it would create a grave risk to a presumably far greater number who would prefer treatment. It therefore seems that, if a person desires to avoid treatment through the use of a Living Will, he must be charged with the responsibility of bringing his refusals to the

148. Kutner, *supra* note 121, at 552.

attention of the physician rather than requiring the physician to waste valuable time in determining whether each patient has executed a Living Will. At the very least a patient should carry a copy of the document in his wallet and give another copy to his family doctor.¹⁴⁹ Alternatively, a person might carry identification advising that he has a Living Will and providing the phone number of a person who has a copy.

The increasing use of computer technology and data retrieval systems in the medical field may minimize the significance of this problem at some time in the future. Eventually, the entire medical history of a person may be available to medical personnel in a matter of seconds.¹⁵⁰ It may be feasible to include in such medical data a brief summary of the patient's Living Will, noting the types of treatment to which the patient consents and those which he refuses. For the present, however, the responsibility must be left with the individual to provide actual notice to a physician. It would be unfair to add to the physician's concerns the obligation to choose between delaying treatment at the risk of a malpractice suit and administering treatment at the risk of liability for assault because of the existence of a document of which he had no knowledge. If a person desires to exercise the right to refuse treatment, it is not unfair that he be required to inform those affected that he has exercised that right.

Despite the advantages of the Living Will, doubts remain as to whether it could actually be considered competently made at the time the document is signed and ratified. It has been contended that an ordinary person could not understand the type of treatment he would want when dying.¹⁵¹ As Dr. Austin Kutscher has noted: "An individual signs it under circumstances when he is not concerned with his own death. It becomes operative at a time when he is 100 per cent involved."¹⁵²

Such concerns, however, ignore the fact that competency requires that a person have the mental capacity to understand, not

149. *Id.* at 551.

150. Even at the present time, with the recent advances in multiphasic screening and automated medical record systems, various health care facilities have almost instantaneous access to a person's individual medical history. See Haessler, Holland & Elshain, *Evolution of an Automated Database History*, 134 ARCHIVES OF INTERNAL MED. 586 (1974); Kennedy, Cleary, Roy & Kay, "Switch": A System Producing a Full Hospital Case-History on Computer, 2 THE LANCET 1230 (1968); Slack, Hicks, Reed & Van Cura, *A Computer-Base of Medical History System*, 274 N. ENG. J. MED. 194 (1966).

151. *Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 2, at 83 (1972).

152. Dempsey, *supra* note 119, at 12.

that he in fact actually understands what is before him.¹⁵³ If the analogy with the disposition of property is pressed further, competency may require no more than that the individual have the mental ability to know that he is choosing death by refusing treatment. It could be argued, though, that competency for purposes of a Living Will should be analogized to the doctrine of informed consent, thereby imposing a requirement that he not only have the ability to understand but that he in fact understand.¹⁵⁴ It is precisely the person's inability to give informed consent under certain circumstances, however, that in part necessitates a device like the Living Will.¹⁵⁵ Where a patient is unconscious or mentally incompetent, his only chance to give or refuse consent is through a prior act. It would be anomalous to use the doctrine of informed consent to defeat a person's chance of giving any consent at all.

The analogy to competency in the testamentary disposition of property suggests that a person executing a Living Will should not be barred from making this advance declaration even though his competency might be suspect if he made the same decision when critically ill. Furthermore, any problems posed by a possible failure to appreciate fully the significance of a Living Will at the time of execution are minimized by the opportunity to revoke.¹⁵⁶ While there are some indications that some signers of the Living Will change their minds when death becomes imminent,¹⁵⁷ those who are concerned about this possible change in attitudes could provide in the document that such a change would operate as a revocation. In any event, it is questionable that those Americans who may desire to refuse treatment when they are physically unable to do so should be denied a means to refuse in advance because of those whose attitudes are less fixed.¹⁵⁸ The laws governing testamentary disposi-

153. T. ATKINSON, *supra* note 124, at 237.

154. "To be legally binding, the consent given must be an informed consent with an understanding of what is to be done and of the risks involved, why it should be done, and alternative methods of treatment available and their attendant risks." A. MORITZ & R. MORRIS, *HANDBOOK OF LEGAL MEDICINE* 139 (4th ed. 1975).

155. See notes 143-45 *supra* and accompanying text.

156. See notes 159-65 *infra* and accompanying text.

157. Dempsey, *supra* note 119, at 22. According to a recent Gallup Poll, while those questioned who were under 30 years of age agreed by 56%-40% that a person should have the right to die "when this person is suffering great pain and has no hope of improvement," those questioned over 50 years of age disagreed by a significant margin of 61%-30%. The Gallup Opinion Index, Report No. 122, August 1975, at 23. Two possible explanations account for this result: (1) Persons who originally support the "right to die" change their opinions as they get older, and (2) younger people are more receptive to new ideas than are older people. More likely than not, the results can be explained by a combination of these two factors.

158. As Dr. Joseph Fletcher has noted:

tion of property enforce a disposition unless the testator has followed the law in revoking his will prior to his death. The same should be true of the Living Will. The advance declaration should be considered a competent decision by the maker, invalidated only upon revocation.

C. *Revocation of the Living Will*

A person may change his mind at least as readily about the type of medical treatment he might desire in the face of death as he might change his mind about the disposition of his property after death. It would certainly be as undesirable to lock a person into certain previously restricted methods of treatment as it would be to refuse to allow him to change the disposition of his property. Thus, it is crucial that methods be provided for the revocation of Living Wills, especially since there is no such provision now in the model Living Will.¹⁵⁹

To remedy this matter, the Euthanasia Educational Council has suggested that signers update the document once a year.¹⁶⁰ The legal effect of this updating is unknown, although it probably would be evidence of the maker's continued intention to limit treatment in this way. A testamentary document can be revoked by at least one of three methods: "(a) Certain well-defined changes in the circumstances of the testator from which a revocation will be implied by law. (b) Physical acts done to the will, as prescribed by statute. (c) A subsequent writing, in the form fixed by statute, either expressly or impliedly revoking the will."¹⁶¹ Perhaps similar methods could be applied to the Living Will. Certainly, the same safeguards that apply to a testamentary document should apply to a document of such potential importance as the Living Will.

Assuming there are recognized methods of revocation available, there remains the problem of determining whether or not the patient has the capacity to make a revocation. As in the execution of the document, the maker must be competent to revoke the Living Will.¹⁶²

The ugly truth is that sometimes patients *in extremis* try to outwit the doctors and escape from medicine's ministrations. They swallow Kleenex to suffocate themselves, or jerk tubes out of their noses or veins, in a cat-and-mouse game of life and death which is neither merciful nor meaningful. . . . Who is actually alive in these contrivances and contraptions? In such a puppet-like state most patients are, of course, too weakened and drugged to take any truly human initiative.

Fletcher, *The Patient's Right to Die*, in *EUTHANASIA AND THE RIGHT TO DEATH* 61, 65 (Downing, ed. 1970).

159. Dempsey, *supra* note 119, at 12.

160. *Id.*

161. T. ATKINSON, *supra* note 124, at 419.

162. The analogy to testamentary dispositions argues for such a policy. "In

As previously noted, several factors exist for the patient in critical condition or in an emergency situation that tend to reduce his overall competency.¹⁶³ If a patient who has previously signed and even has on his person a Living Will suddenly states from his hospital bed that he is revoking the document, the physician and hospital may discover themselves in the same dilemma that the Living Will is designed to avoid. If the physician honors the document, he conceivably could be liable for a wrongful death action, but if he treats the patient and honors the revocation, he could be liable for an assault and battery.

The question thus becomes whether a potentially irrational revocation should be allowed to undermine a previous rational consent to the document. If such a revocation were valid, the true intention of the patient to refuse such treatment could be neutralized and the purpose of the Living Will defeated. Yet, to ignore the revocation would be to deny the patient the opportunity to change his mind, whether or not he is rational, simply because the physician considers him irrational.

What is necessary to avoid this dilemma is a definite procedure whereby the physician and the hospital know when and how to respond to a purported revocation. Perhaps the physician and hospital should follow the simple rule that if there is doubt concerning the competency of a revocation, the physician should assume that the revocation is competent and proceed to treat the patient. That is not to contend that the Living Will should be ignored altogether; rather, if the physician and hospital, after serious consideration of the matter, conclude that there is serious uncertainty concerning the validity of the document because of a potentially competent revocation, then the physician should resolve the doubt in favor of treating the patient.¹⁶⁴ If doubt exists, the case could be submitted to the hospital board, which is designed to consider such matters.¹⁶⁵

On balance, it seems that if the physician is in doubt concerning

general, the same degree of mental capacity is required for revocation of a will as for its execution. Even by express provision in the will testator cannot effectively set up a method of revocation not permitted by law." *Id.* at 420-21.

163. See notes 142-44 *supra* and accompanying text.

164. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 251 n.117 (1973).

165. Such committees already exist in a number of hospitals. See Kutner, *supra* note 121, at 551. One commentator has noted, however, that the use of hospital boards is reminiscent of the issuance of a blank cartridge to one member of a firing squad or of providing to three executioners three switches, only one of which was a connector between the electric power and the electric chair. Weigel, *The Dying Patient's Rights—Do They Exist?*, 16 S. TEX. L.J. 153, 171 n.81 (1975).

the competency of a revocation, he should proceed with care and consider the revocation to be effective. Yet, without adequate standards, the result will be substituting one dilemma for another. The original problem of whether to refuse treatment, solved by the Living Will, would be unearthed as the problem of whether to give effect to a purported revocation. Proper standards for the effective revocation of a Living Will can and should be set to avoid undermining the utility of the document.

D. *The Living Will and the Administration of
Pain-Relieving Drugs*

The model Living Will contains a clause instructing the physician to administer pain-relieving drugs to the patient even though such an action might hasten the moment of death.¹⁶⁶ The problem is whether or not the clause authorizes an affirmative action intending death. If so, the clause directs euthanasia, an illegal act. The issue is crucial to the concept of a dignified death for if the clause is ineffective, not only would the patient not be treated by the physician, but he would receive no medication. The result could be extreme physical pain, hardly a death with dignity. While pain-relieving drugs would not save the patient from psychological pain,¹⁶⁷ they can be effective in eliminating much of the physical pain.¹⁶⁸ The legality of the clause thus becomes important to the concept of the Living Will.

The administering of pain-relieving drugs is unquestionably an act rather than an omission, for it falls within the commonly accepted definitions of an act.¹⁶⁹ The administration of such drugs even arguably qualifies as an act under Professor Fletcher's "cause-permit" test,¹⁷⁰ for the drugs might *cause* rather than merely *permit* death. Moreover, the administration of such drugs could also establish whether the physician intended to kill the patient or only alleviate pain, since action with the belief that certain consequences

166. The document specifically requests that "medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death." See note 121 *supra*.

167. See Hinton, *The Physical and Mental Distress of Dying*, 32 Q.J. MED. 1 (1963); Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239, 262-64 (1970); Williams, *Euthanasia and Abortion*, 38 COLO. L. REV. 178, 179 (1966); Williams, "Mercy-Killing" Legislation—A Rejoinder, 43 MINN. L. REV. 1, 8-9 (1958).

168. *Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 1, at 24 (1972) (testimony of Dr. Laurence Foye, Veterans Administration); Dempsey, *supra* note 119, at 20.

169. See note 10 *supra*.

170. See text accompanying notes 22-23 *supra*.

will follow is viewed by the law as the intention that those consequences occur.¹⁷¹ It is also often necessary to increase continually the dosage of the drugs "until it eventually becomes certain that the drugs will bring about the patient's death, either directly or indirectly."¹⁷² The physician who follows the language of the Living Will and administers such drugs could potentially be liable for both criminal and tort actions. Nor is the physical status of the patient a defense, for "[i]f any life at all is left in a human body, even the least spark, the extinguishment of it is as much homicide as the killing of the most vital being."¹⁷³ There is thus significant authority indicating that the administration of pain-relieving drugs is considered illegal if they hasten death.

Yet, it can be contended that by administering such drugs the physician is primarily concerned with relieving the patient's physical suffering and that the hastening of the patient's death is, at most, an indirect effect. As Professor Louisell has noted: "There is no serious practical question of the present legality of such use of drugs nor any genuine problem with its ethicality."¹⁷⁴ Even the Roman Catholic Church, probably the most ardent opponent of euthanasia, has approved the use of such drugs, provided that the primary reason for the administration of the drugs is to reduce pain, not to cause death.¹⁷⁵ As Norman St. John-Stevas has concluded, "Provided the patient consents, and the intention of the doctor is to relieve pain, not to kill the patient, their use is morally unobjectionable."¹⁷⁶

Thus, there appears to be agreement that as long as the physi-

171. RESTATEMENT (SECOND) OF TORTS § 8A (1965).

172. Gurney, *supra* note 143, at 241.

173. *State v. Francis*, 152 S.C. 17, 60, 149 S.E. 348, 364 (1929) (court's emphasis deleted). See also *State v. Mally*, 139 Mont. 599, 609-10, 366 P.2d 868, 873-74 (1961); *State v. Bebee*, 113 Utah 398, 400-01, 195 P.2d 746, 747 (1948).

174. Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATHOLIC U.L. REV. 723, 731 (1973).

175. As a statement of Pope Pius XII in 1957 reveals:

If there exists no direct causal link either through the will of interested parties or by the nature of things, between the induced unconsciousness and the shortening of life—as would be the case if the suppression of the pain could be obtained only by the shortening of life; and if, on the other hand, the actual administration of drugs brings about two distinct effects, the one the relief of pain, the other the shortening of life, the action is lawful. It is necessary, however, to observe whether there is, between these two effects, a reasonable proportion, and if the advantages of one compensate the disadvantages of the other. It is important also to ask oneself if the present state of science does not allow the same result to be obtained by other means. Finally, in the use of the drug, one should not go beyond the limits which are actually necessary.

Address of Feb. 24, 1957, 49 A.A.S. 129-47, at 146, *quoted in* N. ST. JOHN-STEVAS, *LIFE, DEATH AND THE LAW* 276-77 (1961).

176. N. ST. JOHN-STEVAS, *LIFE, DEATH AND THE LAW* 276 (1961).

cian's purpose in administering such drugs is to reduce pain, his action is morally correct. Applying Lord Coleridge's adage that "every legal duty is founded upon a moral obligation,"¹⁷⁷ it is submitted that the physician can follow the provision of the Living Will that instructs him to administer such drugs to reduce pain even if the patient's life might be shortened as a result. It should be stressed, however, that the purpose of the administration of such drugs must be the reduction of pain, a legally sanctioned act, rather than the hastening of death.

E. *The Living Will and Problems of Guardianship*

As already noted, the model Living Will could be amended by the inclusion of an appendix specifically consenting to certain types of treatment and detailing a limitation of various methods of treatment.¹⁷⁸ The maker of a Living Will could therefore conceivably anticipate mental illness and include a provision to limit treatment.¹⁷⁹

Such a provision for the limitation of treatment for mental illness, however, creates a dilemma for the potential patient. When a patient becomes mentally ill, a court might frustrate the document by appointing a guardian specifically to revoke the document. Since various courts have appointed guardians for the very purpose of consenting to blood transfusions in the Jehovah's Witnesses cases,¹⁸⁰ this possibility is not remote. Moreover, even if a court does not purposely frustrate the document, the appointed guardian could decide that the Living Will should be revoked, even though the patient would not revoke the document if he were competent.¹⁸¹

There are several possible solutions to this problem. For example, the Living Will could be drafted specifically to limit the power of revocation to the maker or to disallow the appointment of any guardian. The latter action would permit the Living Will to become

177. See note 55 *supra*.

178. See note 136 *supra* and accompanying text.

179. See Kutner, *supra* note 121, at 552-53. If the patient is confined in the hospital against his will, as determined by the Living Will, the document "could be used as a basis for invoking a writ of habeas corpus to effectuate his release." *Id.* at 553.

180. The appointment of a guardian for the very purpose of consenting to treatment resulted in the legal actions in *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (E.D. Ill. 1972); *In re Osborne*, 294 A.2d 372 (D.C. Ct. App. 1972); *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

181. Even spouses sometimes disagree on these matters. See *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965) (judge granted relief to a husband who sued his wife and her hospital for the purpose of forcing a blood transfusion).

effective, but would also cause the patient to forfeit his right of revocation, since if he becomes incompetent and guardianship is disallowed, there is no one to revoke.

Another solution would be to allow the appointment of a guardian but to limit his power to revocations made only for good cause. Such a solution, however, has its disadvantages. Giving the guardian such a power of revocation could force psychologically traumatic decisions on the guardian, who might be confronted with life-death decisions.¹⁸² Nor would it guarantee that the true interests of the patient would be followed if the guardian acted in the family's interest, which might differ from that of the patient.

A possible solution would also be the establishment of a trust relationship, with the patient as the res as well as the beneficiary and the physician as the trustee.¹⁸³ This solution would avoid the problem of the guardian's acting for the interests of the family when those interests differ from those of the patient. The maker of the Living Will would stipulate that the guardian must revoke the document if the physician-trustee informs the guardian of a competent revocation. The appointed physician would be the physician familiar with the patient's condition and most likely to be at the patient's bedside. Under the trust relationship the physician would merely be required to utilize "ordinary care, skill, and prudence" in the performance of his duties as trustee.¹⁸⁴ The physician-

182. Louisell, *supra* note 174, at 728-29. See also *Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 2, at 89 (1972).

183. Kutner, *supra* note 121, at 552-53.

The *Living Will* is analogous to a revocable or conditional trust with the patient's body as the res, the patient as the beneficiary and grantor, and the doctor and hospital as the trustees. The doctor is given authority to act as the trustee of the patient's body by virtue of the patient's consent to treatment. He is obliged to exercise due care and is subject to liability for negligence. The patient is free at any time to revoke the trust. From another perspective, the patient, in giving consent to treatment, is limiting the authority the doctor and other persons may exercise over his body. The patient has the ultimate right to decide what is to be done with him and may not irrevocably confer authority on somebody else. The patient may not be compelled to undergo treatment contrary to his will. He should not be compelled to take certain drugs, receive inoculations or therapy, or undergo surgery without his express assent. At any point he may stop treatment or he may change physicians.

Kutner, *The Living Will: Coping With the Historical Event of Death*, 27 BAYLOR L. REV. 39, 49 (1975) (emphasis original).

184. G. G. BOGERT & G. T. BOGERT, HANDBOOK OF THE LAW OF TRUSTS 337 (1973).

Reasonable care and skill is usually defined as the care and skill that a man of ordinary prudence would exercise in dealing with his own property. The standard is the objective one of the hypothetical man of ordinary prudence; the trustee fails in his duty if he does the best he can but his performance is below that of the hypothesized man.

trustee would not have the power of revocation, but by being present at the bedside of the patient, he would be present at such time as the patient's mind became lucid. If the patient were to communicate to the physician a reasonable revocation of the document, the physician would so inform the guardian, who would have the document revoked.¹⁸⁵ While the duty of trustee in this situation would entail new responsibilities and decisions for the physician, such a duty might be less onerous than the physician's status quo dilemma of whether or not to treat a patient.¹⁸⁶

These problems of guardianship and of providing for limitation of treatment in the event of mental illness highlight the necessity for resolving the conditions for revocation in the drafting process. The lawyer must anticipate the various factors that could frustrate the maker's intentions, especially the performance of potential guardians in a life-death situation, and seek to remedy the problem while formulating the document. The draftsman will need to strike a fine balance of conflicting influences, since in all likelihood the maker will desire to retain some power to revoke.

F. *The Living Will and Physician Judgment*

The Living Will requests the physician not to keep the patient alive by "artificial means or 'heroic measures'" if there is no "reasonable expectation of the patient's recovery from a physical or mental disability."¹⁸⁷ Physician judgment is thus required, highlighting the most critical problem with the document: it assumes that the physician can accurately determine the hopelessness of each case. Unfortunately, a uniform standard will be elusive, since there could be wide disagreement among physicians concerning the relative hopelessness of each case.¹⁸⁸ Moreover, even reasonable judgment may be incorrect, raising the possibility that the patient need not die at all, since there is always a slight percentage of terminal cases in which recovery occurs.¹⁸⁹ Considerations such as these may

P. HASKELL, PREFACE TO THE LAW OF TRUSTS 106 (1975). Perhaps physicians ought to be held to a higher standard, that of "the reasonable physician." Banks, for example, hold themselves out as having superior skills in investment and should be held to a higher standard than the person of ordinary prudence, although the traditional law holds banks to the normal standard. *Id.* at 106-07. Thus, it should be with physicians and the Living Will.

185. Kutner, *supra* note 121, at 552-53.

186. See notes 33-43 *supra* and accompanying text.

187. See note 121 *supra*.

188. *Hearings on "Death With Dignity" Before the Senate Special Comm. on Aging*, 92d Cong., 2d Sess., pt. 1, at 37 (1972).

189. As Dr. Laurence Foye has observed:

Typically, in incurable diseases, the future course of the disease in a

understandably make physicians reluctant to undertake such a decision. As Dr. Sidney Shindell has observed: "[W]e do not normally practice medicine on the basis of probabilities."¹⁹⁰ It is altogether likely that, before deciding that the case is "hopeless," the physician would seek extensive consultation with other physicians. Hospital committees to determine and to verify the hopelessness of a case would be useful in this situation.¹⁹¹ Ultimately, even after consultation and consideration, a physician may be reluctant to declare a case hopeless. If the physician is confronted with the choice of administering treatment and there is a question regarding the diagnosis, the physician will probably "err on the side of prolonging life."¹⁹²

In assessing the seriousness of the illness in terms of the judgment required under the Living Will, the physician need not concern himself with the possibility of new technological discoveries assisting the patient as long as such a discovery is not available or known to a physician of average competence. Admittedly, a scientific breakthrough can occur, changing an extraordinary means of treatment into an ordinary one.¹⁹³ Yet the implementation of a new medical discovery might take a significant time; in fact, the physician should be aware of such technology long before it is usable. Since the Living Will curtails treatment in the most certain and most advanced cases, such technological discoveries would probably not help the patient.¹⁹⁴ As a matter of practicalities, then, the prospect of new technological breakthroughs would not be a major consideration for the physician.

specific patient is not predictable except in a statistical sense. Thus, if, of 100 patients with similar disease, 20 die in 5 years, a specific patient may be said to have a 20 percent chance of dying in 5 years.

Therefore, while our prediction or "prognosis" in the individual case is based upon experiences with many different patients, usually treated differently by different doctors, the decision regarding euthanasia or "hopelessness" always relates to a specific patient whose course is not specifically and accurately predictable.

Every physician can, as a result, describe a number of patients for whom he predicted a rapidly fatal outcome—saying, "I knew they were going to die"—and was wrong. The patient who was told by his doctor that he had 6 months to live but is alive years later is legendary.

Id. at 23 see S. SHINDELL, *THE LAW IN MEDICAL PRACTICE* 121 (1966); Dempsey, *supra* note 119, at 12.

190. S. SHINDELL, *supra* note 189, at 121.

191. See note 165 *supra*.

192. Morris, *supra* note 167, at 260.

193. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 998-1005 (1968). For an analysis of the current difficulty in drawing the line between extraordinary and ordinary means of care, see notes 56-57 *supra* and accompanying text.

194. Morris, *supra* note 167, at 261.

The problem the physician would face would be the margin of error regarding his judgment on the hopelessness of the patient's condition. The obvious result is that the physician will move cautiously, thereby attempting to serve the best interests of the patient, the hospital, and himself. If the medical profession can arrive at uniform standards to aid in the determination of the hopelessness of a case, or if the patient's physician is willing to make that determination himself, the Living Will may be a means through which patient and physician both can be assured that the patient will have a death with dignity.

IV. CONCLUSION

The physician and hospital are frequently confronted with the dilemma of providing quality medical care and yet ensuring that the patient retains the right to control medical treatment. This problem has become more complicated as technology prolongs life, while the legal status of the physician's duty to the patient in certain situations remains murky at best. The result makes neither good medicine nor good law.

The Living Will is a possible alternative to the present system. While some physicians may be assisted by the mere presence of the document, the physician and the hospital still need protection. The Living Will can provide this protection but it must be legitimized in order to be effective. The process of legitimization could be accomplished by state legislation or even by court decision. The true effectiveness of the document will be determined by how many patients can control their own medical destinies and whether that control would entail the right to reject all treatment or the right to demand that even all extraordinary measures be used if necessary.¹⁹⁵

195. There is a distinct possibility that physicians may favor greater patient control over the patient's own medical destiny, especially concerning the matter of death, than does the general public. A 1974 random survey of physicians revealed that 20 percent agreed totally, 38 percent agreed in most circumstances, and 21 percent agreed in some circumstances with the statement that "[p]eople have a right to choose how they die by making their wishes known to their physician before a serious illness strikes." Only 7 percent completely disagreed with the statement. Kutner, *supra* note 183, at 43.

Support for the right of a patient in a hopeless situation to die had risen, according to the Gallup Poll, from 36% in 1950 to 53% in 1973. The Gallup Opinion Index, Report No. 98, August 1973, at 35. However, in a 1975 survey, the Gallup organization discovered that the public rejected such a right by a 51%-41% margin. The Gallup Opinion Index, Report No. 122, August 1975, at 23. The 1973 survey asked whether a physician should be allowed by the law to end a life of an incurable patient if that patient and his family requested it, while the 1975 survey merely asked whether a person had a moral right to end his or her life if that person had an incurable disease. Unfortunately, because of the changing in the wording of

Yet, for the document to have even some potential, the cooperation of doctors, hospitals, patients, and the courts is necessary. Even universal adoption and acceptance of the Living Will will not constitute a panacea unless physicians and hospitals successfully confront the delicate problems of revocation and the accuracy of diagnosis, each presently entailing a painful dilemma. In the final analysis, the potential success or failure of the Living Will will be determined by whether the document can enable physicians to substitute medical decisions for legal decisions. The necessity for the Living Will and the problems it faces are clearly delineated. What is now required are answers and solutions to those problems.

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the question from 1973 to 1975, the 12% decline in support for the question could be accounted for by (1) a changing of opinion about the right to die, (2) a recognition that the action may not be morally correct but should be legally permissible, (3) a willingness to permit physicians to make such life-and-death decisions that people would prefer not to make.

While the questions asked the physicians and the general public are not altogether similar, the responses obtained indicate that the physician support for such a proposal is at least equal to, if not greater than, that of the general public.