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THOUGHTS ON TECHNOLOGY AND DEATH: AN APPRAISAL OF CALIFORNIA'S NATURAL DEATH ACT

William J. Winslade*

California's Natural Death Act became effective January 1, 1977. It was the first legislation to be passed in the United States that allows qualified patients to instruct their physician to withhold medical procedures which would prolong life but provide no therapeutic benefits. After describing the Natural Death Act, the author examines ambivalence toward death, limitations on the use of the Act, and the Act's value as a symbolic gesture and a social experiment.

I. INTRODUCTION

In the confusion . . . in which we are caught up, relying as we must on one-sided information, standing too close to the great changes that have already taken place or are beginning to, and without a glimmering of the future that is being shaped, we ourselves are at a loss as to the impressions which press in upon us and as to the value of the judgements which we form.¹

This passage was written by Freud about war in 1915. But it is no less true about technology in 1977. Uncertainties, conflicts and tensions generated by technological development pervade our social and psychic life. We have begun to doubt whether humans have the capacity to control and contain their technological creations. Seduced by false hopes that technology provides the key to human conquest of nature, we are not only in danger of losing control of technology, but also threatened with the prospect of becoming unwilling prisoners of devices originally created to liberate us. A prime example of this ironic consequence is that modern medical technology has provided us with unparalleled power to prolong life while combating disease. Yet, at the same time, it

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1. S. FREUD, *Thoughts for the Times on War and Death* in 14 THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 275 (1957).

threatens to make us passive and mute victims of life support systems which may postpone death indefinitely but not improve health or restore functional life. This mixed blessing inevitably gives rise to mixed feelings. It has begun to dawn on us that we may win only a pyrrhic victory in the war against death.

In response to the problems created by technology's "artificial prolongation of life beyond natural limits," the California legislature enacted the Natural Death Act.² This statute details related rights, responsibilities and legal procedures of patients and physicians³ in the context of terminal injury, illness or disease. This article describes the Natural Death Act and then critically examines it from legal, political, psychological and philosophical perspectives.

II. OVERVIEW OF THE NATURAL DEATH ACT

For many persons, the idea of natural death is associated with death with dignity, and the thought of dying in a hospital with one's body connected to machines and tubes is frightening and unnatural. It is difficult to forget the image of Karen Ann Quinlan weighing only 70 pounds, locked into a fetal position and attached to a respirator that kept her for months in a persistent vegetative state. The prospect of a "natural" death, therefore, may seem preferable to technological, artificial life. By calling this statute the "Natural Death Act,"⁴ the California legislature apparently sought to contrast natural death with mechanical, artificial prolonging of the dying process.⁵

2. The Natural Death Act, CAL. HEALTH & SAFETY CODE §7185-7195 (West Supp. 1977) [hereinafter cited as CAL. HEALTH & SAFETY CODE]. See Appendix for full text of the Act.

3. At certain places in the statute, reference is made to licensed health professionals other than physicians. See, e.g., CAL. HEALTH & SAFETY CODE §7190. For convenience, in this article, references to physicians should be construed, where appropriate, to include other licensed health professionals.

4. CAL. HEALTH & SAFETY CODE §7185.

5. The phrase "natural death" is often linked with dying with dignity and permitting persons to die naturally. But just as removal from the respirator did not bring death to Karen Ann Quinlan, so also the Natural Death Act does not guarantee death with dignity. The absence of so-called artificial life-sustaining procedures does not, for example, provide the loving, caring and companionship of other persons which can serve as an insulation against the fear of loss of self and of relationships caused by death. At most, one particular form of indignity—senseless bondage to technology—is prevented.

A more accurate name for the legislation would be the "Right to Refuse in Advance

The legislative findings emphasize the right of adult persons to control their own medical care decisions.⁶ This fundamental right is linked with the protection of individual human dignity as well as the prevention of unnecessary pain and suffering of a person in a terminal condition. The statute enables certain persons to instruct their physician to withhold or withdraw life-sustaining procedures when the use of such procedures would prolong life but provide no medical benefits.⁷

Contrary to some misleading reports,⁸ the Natural Death Act neither establishes a "right to die" nor gives legal effect to a "living will."⁹ In addition, the statute expressly denies that it authorizes mercy killing¹⁰ or suicide.¹¹ The legal rights granted by the Natural Death Act do not guarantee a "natural death." Yet, by expressly granting individual patients the right to refuse medical treatment,¹² the statute attempts to resolve uncertainty about the legal status of the desires of terminally ill patients.

A. *The Directive*

One prescribed way for a person to give legal effect to the right to refuse medical treatment in the event of a terminal condition is to sign a document called a "Directive to Physicians."¹³ Al-

Useless Medical 'Treatment' in Certain Limited Circumstances Act." Given this verbose alternative, the catchy but misleading "Natural Death Act" may have greater appeal. This is especially true if one wishes to add a tone of legitimacy to legislation that seems, in a sense, to favor death over life. In dealing with such a sensitive issue, it is not surprising that the legislature adopted a name designed to evoke a favorable response against inhuman, "unnatural" machinery.

6. CAL. HEALTH & SAFETY CODE §7186.

7. *Id.* §7188.

8. See, e.g., Holles, *Law Goes Into Effect in California Giving the Terminally Ill the Right to Die by Barring Medical Aid*, N.Y. Times, Jan. 2, 1977, at 32. In this article, Holles mistakenly calls the directive to physicians a "living will."

9. Although several versions of the so-called "living will" exist, none have been recognized as legally valid. Nevertheless, several hundred thousand such documents have been signed in recent years. The living will documents typically are cast in vague and expansive terms creating even more difficult problems of interpretation than the Natural Death Act. But the most important difference, for legal purposes, is that the Directive to Physicians is a document which enables a person to exercise a legal right to refuse medical treatment. A living will is, at best, only an expression of a person's desires.

10. CAL. HEALTH & SAFETY CODE §7195.

11. *Id.* §7192(a).

12. *Id.* §7188.

13. *Id.*

though any adult may sign a directive, it is valid only if such a person is of "sound mind," "understands the full import" of the directive and is "emotionally and mentally competent" at the time of the signing.¹⁴ The standard of competence required under the statute is not further specified.

Of those persons who sign a directive, an important distinction is made between qualified and nonqualified patients. To be "qualified," a patient must be "diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient."¹⁵ The physician is legally obligated to carry out or cause to be carried out the valid directive of a qualified patient in appropriate circumstances.¹⁶ A valid directive of a nonqualified patient, however, has relevance only as "evidence of a patient's directions regarding the withholding or withdrawing of life-sustaining procedures" to which a physician "may give weight" along with other relevant factors.¹⁷

A directive in the form prescribed by the statute must be dated, appropriately filled in, and signed by the person making a directive in the presence of two witnesses.¹⁸ A valid directive so executed remains in effect for five years.¹⁹ It serves as an instrument for refusing treatment only if a patient "becomes comatose or is rendered incapable of communicating with the attending physician."²⁰ If a patient subsequently regains the ability to communi-

14. *Id.*

15. *Id.* § 7187(e).

16. *Id.* § 7191(b).

17. *Id.* § 7191(c).

18. *Id.* § 7188. The statute sets forth precise requirements for witnessing the directive. The directive must be signed by the patient

in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive.

Id. In addition, special witness requirements apply to patients in nursing homes. *Id.* § 7188.5.

19. *Id.* § 7189.5.

20. *Id.*

cate, the directive is no longer deemed the "final expression" of the patient's "legal right to refuse medical or surgical procedures."²¹

Although it is difficult to satisfy the eligibility requirements and prescribed procedures for executing a valid directive, revocation at any time is easily accomplished. The patient may revoke by destroying the directive or by communicating to the attending physician a written or even a verbal revocation.²²

It should be noted that signing a directive is only one way in which persons may give legal effect to their desires concerning the withholding or withdrawing of life-sustaining procedures.²³ No one can be required to sign a directive as a condition of receiving health care or health insurance, and signing a directive shall not impair in any respect existing life insurance or one's right to obtain life insurance.²⁴

B. *The Obligations of Physicians*

The statute requires that two physicians diagnose a terminal condition and certify it in writing to the patients. The physicians must find:

an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.²⁵

However, the statute is silent as to whether a physician must disclose a diagnosis of a terminal condition if the patient expressly waives the right to know the diagnosis.

Prior to carrying out the instructions of a directive, the attending physician must determine if it is valid.²⁶ The physician must

21. *Id.* §7188.

22. *Id.* §7189.

23. *Id.* §7193. Although the legislature explicitly states that the Natural Death Act is cumulative and does not restrict relevant pre-existing rights to refuse treatment, it is unclear what those rights are. Presumably this legislation was needed also because of uncertainties about procedures for exercising such rights.

24. *Id.* §7192(b).

25. *Id.* §7187(f).

26. *Id.* §7191(a). See notes 65-66 and accompanying text *infra*.

determine if all formalities were satisfied, especially the requirement of qualified witnesses. In addition, the physician must assess the patient's competence at the time the directive is to be put into effect. If the patient is competent and able to communicate, the physician must again confirm that the patient still desires the withholding or withdrawal of life-sustaining procedures. The statute implies that a physician who withholds or withdraws life-sustaining procedures pursuant to an invalid directive could be liable criminally for homicide or civilly for wrongful death.²⁷

If a qualified patient has executed a valid directive, then the attending physician must determine if "death is imminent whether or not life-sustaining procedures are utilized."²⁸ This criterion is quite restrictive because life-sustaining procedures may not be withheld or withdrawn if they will postpone death beyond the period of imminence.²⁹ Life-sustaining procedures may be withheld or withdrawn when they would postpone the actual *moment* of death,³⁰ but they cannot be withheld or withdrawn if they would postpone death for a long time.

If an attending physician has a qualified patient who has executed and not revoked a valid directive, whose death is imminent whether or not life-sustaining procedures are utilized, and who either reaffirms the directive or is unable to communicate, then the attending physician has a duty to effectuate the directive. Although the duty is purportedly a legal obligation, a physician cannot be held liable either criminally or civilly for failure to carry out such a directive. It is, however, considered unprofessional conduct for a physician not to comply with the directive or transfer the qualified patient to a physician who will carry out the directive.³¹

If a person was not a qualified patient when a valid directive was executed and has not subsequently reexecuted a valid direc-

27. *Id.* §7190.

28. *Id.* §§7187(c), 7188.

29. To illustrate, assume that "imminence" is defined as a period of time less than X and that, without the use of life-sustaining procedures, a patient would die in a period of time less than X. If life-sustaining procedures would prolong life for a period of time greater than X, then they may not be withheld or withdrawn pursuant to the directive.

30. *Id.* §§7187(c), 7187(f), 7188.

31. *Id.* §7191(b).

tive at least 14 days after becoming a qualified patient, then such a directive is not legally binding on the physician. The physician may consider the directive as evidence of the patient's wishes;³² however, the statute does not indicate whether it is deemed unprofessional conduct not to effectuate the invalid directive even when circumstances justify it. The most plausible reading of this provision seems to be that in such a case a physician is permitted but not required to effectuate the directive.

III. APPRAISAL OF THE NATURAL DEATH ACT

A. *Ambivalence Toward Death and Technology*

Because others have reviewed some of the "politics of natural death,"³³ this Article will call attention to only one aspect of its social psychology. The emotions provoked by public discussion of the Natural Death Act in 1976³⁴ ranged on a spectrum from hostile accusations that the proposed law opened the door to genocide and involuntary euthanasia to uncritical praise that it would guarantee death with dignity and the right to die. Such extreme reactions are not surprising in view of the powerful and deep conflicting feelings aroused by the technological war against death.

In view of the discomfort and perplexity expressed in judicial opinions pertaining to death and dying, as well as mounting public pressure, legislative action is understandable. But legislatures are notoriously impatient; passing *something* at least appears to remove uncertainty and indecision.³⁵ The Natural Death Act rep-

32. *Id.* §7191(c).

33. See, e.g., Garland, *Politics, Legislation and Natural Death*, 1976 HASTINGS CENTER REPORT 5.

34. Earlier, in 1974, Assemblyman Barry Keene introduced a one-sentence bill which read as follows: "Every person has the right to die without the prolongation of life by medical means." Although hearings were held on this bill, it did not survive preliminary legislative review.

35. The notoriety created by the Karen Ann Quinlan case and other issues related to life and death in medicine, such as the definition of death, organ transplantation and abortion, gave impetus to a bill called the "Natural Death Act," introduced by Assemblyman Keene on February 13, 1976. By the end of the summer of 1976, after much political and public debate, the Natural Death Act had been amended nine times. Nevertheless, it was passed by the California legislature by a substantial majority. During the month of September, Governor Brown, while deliberating about whether to sign the bill, refused

resents a sincere effort to solve what appears to many to be an intractable problem. And for some persons the new law might, at least initially, provide psychological relief and eliminate the uneasiness associated with the fear of dying enslaved to medical machinery.

Going beyond legislative impatience and judicial discomfort,³⁶ perhaps the Natural Death Act engendered so much controversy and confusion because it touches a deeply rooted but volatile ambivalence³⁷ towards death itself. Death, and preoccupation if not obsession with it, is complicated in our age by our anxiety about technology. One explanation for this obsession, in the words of the late Ernest Becker, is that

the idea of death, the fear of it, haunts the human animal like nothing else; it is a mainspring of human activity — activity designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny for man.³⁸

to discuss it publicly. On September 30, 1976, three hours before the bill would have become law without the Governor's signature, he signed the bill.

36. L. Rothenberg, *Demands for Life and Requests for Death: The Judicial Dilemma* (Feb. 25, 1977) (unpublished paper presented at the National Meeting of the American Association for the Advancement of Science).

37. Although ambivalence is deeply rooted in human experience, the word "ambivalence" was not coined until early in the twentieth century. This is not wholly surprising, for often the most fundamental and pervasive features of the human condition are taken for granted rather than identified and analyzed. Over sixty years after Eugen Bleuler first labeled the phenomenon of ambivalence and after Freud and others further analyzed it, the word "ambivalence" has, in some ways, become all too familiar. It has become what Fowler in *Modern English Usage* calls a "popularized technicality," a word which has been used so widely and loosely that its descriptive value has been all but lost. This, too, is not surprising, for often words which capture a very important feature of experience are soon corrupted. There is a natural tendency to generalize an insight extensively beyond the point of illumination, to make too much of a good thing. Because "ambivalence" has been overused and stretched beyond proper limits, the concept of ambivalence often is combined with concepts such as ambiguity, indecision, and, in general, mixed feelings. The close connections among these concepts often degenerates into conceptual confusion.

Nevertheless, for present purposes it is possible to concentrate on what is characteristic of the phenomenon of ambivalence without attempting to analyze the concept fully. "Ambivalence" etymologically comes from "ambi" which means both and "valens" (the present participle of "valere") which means, literally, to be strong. Note also the link to "valence" which means, broadly, the capacity of something to unite, react, or interact with something else. This suggests the connection with mixed feelings. In this article "ambivalence" can be characterized roughly as the coexistence in a person of unresolved conflicting feelings which are strong and long lasting, concern matters of importance and have a significant impact on a person.

38. E. BECKER, *THE DENIAL OF DEATH* ix (1974).

The idea of death is ubiquitous—at the beginning and throughout life, not only at its end.

The topic of death both frightens and fascinates us. Most people would rather turn away from and try to ignore the terminally ill; yet the fate of Karen Ann Quinlan became, for a time, an addicting drama. We deplore murder, but we romanticize and publicize institutionalized killing called the death penalty.³⁹ In debates about abortion or the tragic newborn,⁴⁰ some passionately plead for the right to life while others argue fervently against it. Uncertainty and disagreement are rampant even about such fundamental issues as the definition of death.

Freud believed that a “conflict due to ambivalence” about death arises when “two opposing attitudes toward death, the one which acknowledges it as the annihilation of life and the other which denies it as unreal, collide and come into conflict.”⁴¹ We consciously and intellectually acknowledge that our own death is inevitable, but unconsciously and emotionally find it difficult to accept. Even if, as the research of Elisabeth Kubler-Ross suggests, persons often pass through various emotional stages in their attitudes toward their own impending death—denial, rage, bargaining, depression and acceptance—there is also the underlying presence of hope.⁴² The fact of death, one’s own or that of others, can be mastered in many ways: confronted realistically, experi-

39. The newspaper publicity of Gary Gilmore’s execution is one example. See *New York Times*, Jan. 17, 1977, at 1, col. 1.

40. Recently the popular media has evidenced a strong interest in the issue of whether the country’s medical resources should be employed to prolong the life of grossly retarded infants or those with severe multiple birth defects. Many doctors are refusing to save such infants, emphasizing the inferior quality of the life they could expect to lead even if they were saved. These doctors have chosen not to preserve life at any cost and under any condition. A study conducted in the early seventies at Yale-New Haven Hospital, recently cited by *Time Magazine* and the *Washington Post*, reveals that of the 299 deaths analyzed, 43 of the deformed infants died because doctors and parents decided to discontinue medical treatment. Few cases concerning these issues have been the subject of legal action and, at present, there is no indication how the courts will rule on the question of withholding medical treatment from the malformed infants. See *The Hardest Choice*, *TIME*, March 25, 1974, at 84; *Chicago Tribune*, Dec. 11, 1976, at 1, col. 1; *Washington Post*, Nov. 7, 1976, at 26, col. 2.

41. S. FREUD, *Thoughts for the Times on War and Death* in 14 *THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD* 298 (1957). Although Freud was speaking here of a person’s response to the death of a loved one, an analogous point may be made about one’s own death.

42. E. KUBLER-ROSS, *ON DEATH AND DYING passim* (1969).

enced emotionally or analyzed exhaustively. No matter how an individual prepares for death, however, one is inescapably ambivalent toward it.⁴³

Perhaps this helps to explain why the procedures for executing a valid directive are so demanding and yet the directive is so easily revoked. Ambivalence tends to produce a fluctuation of feelings. At one moment a person might long for death and in the next moment cling to life. The Natural Death Act mirrors the underlying theme of ambivalence toward death.

B. Limitations on Use of the Natural Death Act

1. Inadequate information and education are limiting

No provision is made in the Natural Death Act to make copies of the directive readily available or to provide for dissemination of information about the new law. The office of Assemblyman Keene, the bill's original sponsor, has responded to well over 1,000 personal requests for directives. This is clearly not the most efficient method to meet the needs of persons who might wish to sign one. It is reported that the failure to include provisions in the statute for dissemination of information was a mere oversight by the legislators.⁴⁴ But one might also wonder whether the apparent oversight reveals an unconscious desire to make it difficult to exercise the statutorily-created rights of terminally ill patients.

Likewise, it is not clear who, if anyone, has the responsibility to educate the adult population about their rights pursuant to the Natural Death Act. Physicians and hospitals cannot advise patients adequately about their rights until the doctors have been educated themselves. But most busy physicians and other health professionals are not going to be enthusiastic about studying the fine details of the statute. Even if they do learn the specifics of the new law, they will be cautious about appearing to promote

43. This is not to deny that many other attitudes, beliefs and behaviors are associated with death. Individuals, institutions and cultures may cope with their ambivalence in a variety of ways. For example, awareness of the fact of death may be repressed and the fear of it unrecognized; until the last minute this was the response of Ivan Ilyich in Tolstoy's famous story. Death, or the threat of death, may be confronted as a limit that gives greater meaning to life. My point is simply that ambivalence about death, regardless of how one responds to it, is pervasive and persistent.

44. Scarr, *New 'Right-to-Die' Bill Lacks an Elemental Part*, L.A. Daily J., Feb. 1, 1977.

and encourage persons to sign a directive. And they will still be faced with difficult decisions about how to advise their patients.

Perhaps lawyers should educate the public about its rights under the Natural Death Act. But lawyers, like physicians, need to be educated about the relevant medical considerations, the psychological aspects of terminal illness and dying, and technical problems with the statute and the directive. A cautious lawyer very well might increase the uncertainty of a client seeking advice about whether to sign a directive or of a physician about his responsibilities and liabilities.

Many physicians, especially those who identify strongly with the ideal of preserving life, might feel uncomfortable about encouraging the use of directives. Medical insurance companies might not. Indeed, it is clearly in the economic interest of health insurance companies to avoid payment for useless life-sustaining procedures which only prolong the dying process. One can imagine cynically that insurance companies might give a discount to persons who execute a valid directive to physicians. Nothing in the statute precludes such an enticement.

Hospitals, on the other hand, might have mixed reactions. Prolonging the dying process of terminally ill patients increases revenues and requires only caretaking activities. Yet, an image of hospitals as technological depositories for unconscious, semi-human organisms is depressing to staff who desire to perform medical work that has a beneficial outcome.

If terminally ill patients do not sign or freely revoke directives, and if physicians are reluctant to withhold or withdraw useless life-sustaining procedures in the absence of a valid directive, then it is possible that more rather than fewer persons will suffer the indignity of a technological prolongation of the dying process. This possibility magnifies the need for adequate information and education about the Natural Death Act.

2. *Unclear terminology is limiting*

The major problem with the name of the law is that it rests upon and promotes a conceptual confusion contained in the artificial/natural distinction. The mistake is to suppose that the term "natural" death clarifies anything. The important issue is not the artificial prolonging of life by medical intervention, but the fact that our capacity to prolong life exceeds our capacity to cure. It

is not prolonging life beyond natural limits but prolonging life "while providing nothing medically necessary or beneficial to the patient"⁴⁵ that is objectionable. Useless procedures disguised as medical "treatment" are the true target of dissatisfaction. To talk about the "natural limits" of life only obscures the central problem of maintaining human control over the use of often inadequate medical technology. The artificial/natural distinction creates further difficulties in connection with definitions of other key terms.

The definitions of certain essential terms in Section 7187 have two primary purposes: to clarify key concepts and to restrict the scope of the Natural Death Act. The former goal is not achieved fully because one important definition remains unclear. The statute defines "life-sustaining procedure" as follows:

any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.⁴⁶

An initial problem is that the scope of the term "mechanical or other artificial means" is not clear. Although one naturally thinks of a respirator,⁴⁷ does the definition also include, for example, chemicals used to maintain the functioning of certain organs or intravenously administered fluids, such as glucose or vitamins, which provide nourishment? Such interventions arguably employ mechanical or other artificial means to sustain, restore or supplant a vital function. Yet they are neither medication nor methods of alleviating pain. While most physicians might agree that

45. CAL. HEALTH & SAFETY CODE §7186.

46. *Id.* §7187(c).

47. The legislature considered primarily, if not exclusively, respirators as the artificial means of prolonging life. In an early version of the bill introduced on February 13, 1976, respirators were mentioned specifically as an illustration of an artificial life-sustaining procedure. However, the reference to respirators was deleted from the final version of the bill.

the legislative definition includes both respirators and intravenous feeding devices, few currently think of them in the same terms. For example, the doctors in the Karen Ann Quinlan case disagreed about whether the respirator was a useless procedure which should be discontinued. But no one proposed to remove the intravenous nourishment, even though it was useless as a therapeutic measure. Perhaps the reasons for this difference of attitude towards such procedures are psychological rather than logical.⁴⁸ In this respect the open legislative definition may provide needed flexibility.⁴⁹

Unfortunately, another phrase in the definition raises additional problems of interpretation. The Natural Death Act provides that life-sustaining procedures may be withheld or withdrawn only when "death is imminent whether or not such procedures are utilized."⁵⁰ This qualifying phrase not only drastically limits the general scope of the Natural Death Act, but it also raises particular problems about the use of respirators. If death can be postponed beyond the period of imminence, then the Natural Death Act is inapplicable. Even on a broad reading of "imminence," the use of respirators often can prolong breathing and other vital functions for a long period of time. As a result, the imminence criterion excludes from the scope of the act some of the most problematic cases. For example, an automobile accident victim who has severe brain damage and is in a coma with no hope of recovery might be maintained indefinitely by artificial life-sustaining procedures. Thus, the Natural Death Act may increase rather than decrease the use of respirators even when they provide no medical benefits.

In addition, medical opinions concerning the imminence of death vary widely and are not always reliable.⁵¹ Because physi-

48. Ramsey, *Prolonged Dying: Not Medically Indicated*, 6 HASTINGS CENTER REPORT 1, 16 (1976).

49. The lack of specificity of the legislation accommodates future possible changes, but it is likely that current medical practices will not be affected immediately by the new statutory language.

50. CAL. HEALTH & SAFETY CODE §7187(c).

51. We need only recall the testimony of physicians in *In re Quinlan* that if Karen Ann Quinlan were to be removed from the respirator, her death would be imminent. *In re Quinlan*, 70 N.J. 10, 25, 355 A.2d 647, 655 (1976). This was in early June, 1976. She was removed from the respirator and, as of this writing, she, or at least her body, is still alive.

cians are often mistaken, they are likely to be cautious about withholding or withdrawing life-sustaining procedures. Although caution is normally commendable in medical care, in this context it will restrict further the practical application of the Natural Death Act.

3. *Eligibility requirements are limiting*

The requirements for executing a valid directive also severely restrict the applicability of the Natural Death Act. Each of the main eligibility requirements for becoming a qualified patient—adulthood, competence, terminal condition—narrows the class of persons who may execute a valid and legally binding directive. The pregnancy clause adds still another limiting condition.⁵²

Adulthood does not appear at first to be a particularly objectionable eligibility condition. This provision does, however, raise some technical as well as practical questions. Does the statute exclude children simply because they are presumed to be incompetent? If the right to refuse useless medical treatment is a fundamental personal right, should a competency presumption be conclusive or rebuttable? The Natural Death Act adopts the policy of a conclusive presumption for it does not permit children to *sign* a directive much less count as qualified patients. Perhaps a more realistic and sensitive response to children, especially older and mature children, might be to permit them to sign a directive to express their desires; however, its status might be similar to that of a nonqualified patient, only relevant evidence to be considered by a physician but not a legally binding document.⁵³

52. The pregnancy clause precludes women diagnosed as pregnant from executing a valid directive during the course of their pregnancy. CAL. HEALTH & SAFETY CODE §7188(3). It is obvious that due process, equal protection and privacy rights flowing from the recent plethora of cases concerning women's rights, and especially the abortion cases, raise considerable doubts about the constitutionality of this clause. Moreover, since a nonviable fetus is not recognized as a person under California law, *People v. Smith*, 59 Cal. App.3d 896, 129 Cal. Rptr. 498 (1976), it is not clear whose rights are being protected by this clause, at least with respect to a woman in the early stages of pregnancy.

53. One might also wonder whether the automatic exclusion of children from the purview of the Natural Death Act will exacerbate an existing dilemma about the treatment of children with terminal conditions. It is psychologically more difficult for parents and physicians to give up hope for the cure of children in contrast to adults. It is tempting,

The competence requirement is another troublesome issue because different standards of competence govern informed consent to medical treatment. A lesser degree of competence is required to consent to medical treatment than to refuse treatment.⁵⁴ Typically, if a person consents to a medical treatment which is generally accepted as useful for the patient's condition, competence to give consent is not questioned. It is only when a person wishes to refuse useful medical treatment that competence is likely to be questioned and a higher standard employed. However, the question of competence in the context of the Natural Death Act is interesting because, on the one hand, it concerns refusal of treatment; on the other hand, it is a refusal of *useless* treatment. Should the standard of competence be the higher standard normally associated with refusal of treatment, or a lower standard because useless rather than useful treatment is being refused? To the limited extent that the competence requirement is articulated in the statute, it seems to favor the higher standard of competence required for refusal of treatment.

A second aspect of the competency requirement is that a person must "understand the full import"⁵⁵ of a directive. One might wonder whether anyone has the capacity to meet this high standard. It is particularly problematic whether a qualified patient—who has been notified in writing of his or her impending death—has the capacity to grasp fully the technical concepts and legal jargon contained in the directive. It is more likely that a person who signs a directive in good health, a nonqualified patient, will understand the full import of a directive.⁵⁶ The compe-

therefore, to employ more radical therapies as well as technological life-sustaining procedures in treating children.

Although parents are permitted to consent to treatment for their children, the parents' right to refuse treatment on their children's behalf is much less clear. As a practical matter, informal agreements to discontinue useless and painful treatment are sometimes made between parents and physicians. But the restrictions implied by the Natural Death Act might discourage such agreements, however humane they might be. For the Natural Death Act might be taken to imply that parents are not permitted to refuse even useless medical treatment for their children. Contrary to the objectives of this legislation, this may very well cause unnecessary pain and suffering to children as well as to parents and physicians.

54. Roth, Maisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 *AM. J. PSYCHIATRY* 279 (1977).

55. CAL. HEALTH & SAFETY CODE §7188(6).

56. It is particularly ironic that a directive executed by a nonqualified patient is not

tence requirement further constricts the utilization of the Natural Death Act by requiring determinations of the patient's comprehension and competence to refuse treatment at a time when the patient is especially vulnerable to emotional instability.

The third eligibility requirement, the diagnosis and written certification of a terminal condition, is neither a pleasant prospect for a patient nor an attractive task for a physician. Although the definition of "terminal condition"⁵⁷ at first glance appears to be very broad, it is not clear whether or *when* the physician may or must inform the patient. Does the physician inform the patient of the terminal condition as soon as it is diagnosed or when the application of life-sustaining procedures would serve only to postpone the moment of death? If physicians are hesitant in making their diagnoses, then patients may not be informed soon enough to fulfill the fourteen-day waiting period required before executing a valid directive. But if physicians are precipitous in making diagnoses of terminal conditions, patients may become alarmed needlessly and may suffer unnecessary anxiety.

Physicians are cautious about diagnosing terminal conditions; they are likely to be especially circumspect about certifying a diagnosis of a terminal condition in writing. Although some conditions warrant a terminal diagnosis, most medical diagnoses are inherently fallible because physicians can err, and patients can experience spontaneous remissions. Also, some physicians believe that a written diagnosis of a terminal condition might be psychologically damaging⁵⁸ and anti-therapeutic. In the face of a diagno-

legally binding. For the individual autonomy of this large class of healthy and presumably competent adults is given less legal backing than the class of terminally ill qualified patients. To give maximum legal effect to a directive for nonqualified patients would decrease the need for the fourteen-day waiting period, decrease the administrative and judgmental responsibilities of physicians, and truly uphold the ideal of individual autonomy in more than a token way.

57. The Natural Death Act defines "terminal condition" as follows:

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

CAL. HEALTH & SAFETY CODE §7187(f).

58. In response to this line of reasoning, it could be argued that the requirements of the Natural Death Act allow persons to confront directly the harsh reality of death. Instead of denying death and encouraging self-deception, perhaps we should "give death the place

sis of a terminal condition, patients and physicians alike may give up hope. Moreover, terminally ill patients may often be the least well-treated by physicians and other hospital staff. Despite the valuable pioneering work of Elisabeth Kübler-Ross and of the Hospice movement,⁵⁹ most medical personnel are unsure about how to respond to dying patients. Determination of "terminal condition," required by the Natural Death Act, very well may increase both the alienation of the dying patient and the neglect by hospital personnel and the patient's family.

4. *Procedural requirements are limiting*

Bureaucratic burdens placed upon patients and physicians by the Natural Death Act tend to further restrict the right to refuse medical treatment. The expression of this right becomes an empty gesture and hollow rhetoric⁶⁰ because procedures do not facilitate the exercise of the right. Instead, undue restrictions curtail the patient's right to control medical decisions.

The directive states that fourteen days must have elapsed between the notification of the terminal condition and the signing of the directive.⁶¹ Presumably, this is to prevent impulsive reactions to a notification of a terminal condition. However, the fourteen-day clause is both an inconvenient and unnecessary procedural burden. It is inconvenient because it adds another administrative formality to the directive. It is unnecessary because the directive can be revoked easily in a variety of ways.

The witness clause presents yet another procedural obstacle.⁶²

in reality and in our thoughts which is its due." S. FREUD, *Thoughts for the Times on War and Death* in 14 THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 299 (1957).

However, even if one agrees with Freud that we must prepare ourselves for death, *id.* at 300, it does not necessarily follow that we need or wish to be informed in writing by our physician that we have a terminal condition. A person might be willing to sign a Directive to Physicians but not wish to be informed that he or she is afflicted with a terminal condition. The Natural Death Act may in effect force a person to be informed of something he or she does not want to know in order to exercise a fundamental right.

59. Hospices, which originated in England, were established as centers to care for and alleviate the pain of the terminally ill. Patients at such centers receive no therapeutic treatment aimed at "cure." Currently, there are approximately forty such centers in the United States.

60. For an elaboration of this general theme, see Winslade, *The Juvenile Courts: From Idealism to Hypocrisy*, 3 SOCIAL THEORY & PRACTICE 181 (1975).

61. CAL. HEALTH & SAFETY CODE §7188.

62. *Id.*

A variety of persons who might ordinarily serve as witnesses to the directive are excluded on the grounds that they are potentially interested parties, many with possible economic interests in a patient's estate. By extending this exclusion even to hospital staff and other patients, the statute makes it difficult for the terminally ill patient to obtain witnesses. While it is understandable that interested parties should not serve as witnesses to the directive, other costs of this restriction should be noted. A patient will be required to disclose his terminal condition to at least two persons. This requirement may offend the patient's sensibilities, constitute an undesired exposure of personal matters, or increase psychological suffering to an extent that some patients might choose not to sign a directive.

While the bureaucratic responsibilities placed on patients are minimal, the administrative tasks imposed on physicians are substantial.⁶³ The statute provides that:

the attending physician shall determine that the directive complies with Section 7188 requirements for executing a valid Directive and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient.⁶⁴

Physicians must, in effect, act as lawyers in order to ascertain whether a directive complies with the law in all respects—a complicated determination for someone without legal training. Even if patients are not discouraged from signing directives, physicians may be reluctant to accept them. The administrative burdens as well as the potential legal liability for mistakes that might be made in determining the validity of a directive is an unwelcome burden to place on physicians or other hospital administrative

63. Prior to the passage of the Natural Death Act, as the legislative findings point out, CAL. HEALTH & SAFETY CODE §7186, physicians were in doubt as to whether it was legally permissible to withdraw or withhold non-beneficial medical procedures in accordance with a patient's wishes. Of course, that uncertainty will remain for all those persons who, for whatever reason, do not execute a Directive to Physicians. In fact, it might become more risky for physicians to withhold or withdraw useless medical procedures for terminal patients who have not executed a directive. With the formalization of this aspect of the physician-patient relationship, which may subject it to greater legal scrutiny, many physicians might be reluctant to make *medical* decisions to discontinue worthless treatment for fear of legal liability.

64. CAL. HEALTH & SAFETY CODE §7191(a).

staff.

In addition, the attending physician must determine when a directive should be implemented. This requires the physician to interpret certain technical language of the statute which lacks clear legal or medical meaning, or at best is difficult to apply. The vagueness of the terms "life-sustaining procedure," "moment of death," "mechanical or other artificial means," "death is imminent," "nothing medically necessary or beneficial to the patient," "sound mind," and "emotionally and mentally competent" are the most obvious examples. It is difficult enough for responsible physicians to make sound medical decisions; they are now being required to make both legal judgments as well as subtle linguistic analyses.

Another serious problem which imposes new decisionmaking responsibilities upon physicians concerns directives executed by nonqualified patients. If such a person later becomes a qualified patient and has not formally reexecuted a directive in accordance with all technical requirements, the original directive is not legally binding. It need be given only "some weight" by the physician who must apply a vague totality of the circumstances test.⁶⁵ This provides little guidance for the attending physician. In an era of defensive medicine, the cautious physician threatened by medical malpractice charges is not likely to give much weight to a non-binding directive.

The bureaucratic burdens created by the Natural Death Act can be understood by analogy to familiar debates about voluntary euthanasia laws. Many who do not object to voluntary euthanasia on moral or religious grounds typically oppose proposed legislation because of the difficulty of administering it without error or overreaching.⁶⁶ A similar concern arises about the restrictions and qualifications of the Natural Death Act. Unregulated individual freedom may leap into irrationality; but excessive regulations produce a quagmire of bureaucratic paternalism. The restriction of individual freedom is derived from a belief that humans are prone not only to error and bad judgment but also to evil. To protect against serious and irreversible though improbable risks,

65. *Id.* §7191(c).

66. See, Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

undue restrictions have been imposed. The legislature emphasized that the procedures established by the Natural Death Act do not facilitate suicide or condone euthanasia or mercy killing.⁶⁷ It is also stressed that the physicians who carry out a valid directive are not killing or murdering their patients. But the very fact that such disclaimers are included attests to the sensitivity of the legislators to possible appearances of impropriety.

C. *Value of the Natural Death Act*

Notwithstanding the numerous problems of interpretation and application of the Natural Death Act, it is important to realize that its primary significance at the present time may lie in its symbolic value. For patients, it pays tribute to self-determination and the right to control medical decisions. For physicians, it attempts to remove uncertainties about legal liability for carrying out the desires of patients. The immediate practical effect of the Natural Death Act may be limited; it provides only minimal operative force to individual rights and confronts physicians with new uncertainties. Once the principles are firmly established, however, the practical task of making them effective can be accomplished through public and scholarly discussion, judicial clarification and legislative amendment. An eloquent statement of this point of view was formulated by Alfred North Whitehead:

It is the first step in sociological wisdom, to recognize that the major advances in civilization are processes which all but wreck the societies in which they occur:—like unto an arrow in the hand of a child. The art of free society consists first in the maintenance of the symbolic code; and secondly in fearlessness of revision, to secure that the code serves those purposes which satisfy an enlightened reason. Those societies which cannot combine reverence to their symbols with freedom of revision, must ultimately decay either from anarchy, or from the slow atrophy of a life stifled by useless shadows.⁶⁸

67. CAL. HEALTH & SAFETY CODE §§7192(a), 7195.

68. A. WHITEHEAD, *SYMBOLISM* 88 (1927). Although the foregoing argument is powerful and tempting, perhaps a distinction should be made between symbolic value for patients and physicians and a broader notion of the symbolic value of the Natural Death Act. If the arguments presented in preceding sections of the Article are sound, then the Natural Death Act as it now stands provides little comfort for troubled patients or concerned

Thus, the Natural Death Act may be viewed as a symbolic gesture of human desires to control medical technology and to confront death.

One final way to assess whether the Natural Death Act is merely an empty gesture or a useful legal instrument is to view it also as a political, psychological and legal experiment. It is a political experiment because it was the first legislation of its kind to be passed in the United States, thus breaking a stalemate that has existed in numerous state legislatures. Other states have already turned to California for guidance.⁶⁹

The Natural Death Act also invites some innovative psychological research. Analysis of the Act's implementation may reveal whether it encourages persons to be more willing to confront the fact of death or whether it facilitates their denial of death. Research will show also whether the Natural Death Act affects the physician-patient relationship⁷⁰ or whether it has an impact on family relationships, hospital care or the manner in which persons will choose to die.

The Natural Death Act is also a legal experiment which tests the limits of legal effectiveness. Because we live in a legalistic society which operates as if there is a practical legal solution to most human problems, many perplexing human problems are brought eventually into a legal forum. The problems of life pro-

physicians. It remains to be seen whether "fearlessness of revision," which is clearly needed to expand patients' rights or clarify physicians' responsibilities will be forthcoming.

69. By late 1977, over forty states had considered similar legislation, and in at least six states (Arkansas, Idaho, Nevada, New Mexico, Oregon and Texas) such legislation has been signed into law. Whether anyone will exploit the opportunity to study seriously and systematically the social and psychological impact of these novel political experiments in a timely manner is uncertain.

70. One could argue that the felt need for such legislation is so widespread because the physician-patient relationship has already changed dramatically, if not deteriorated. Many patients feel that it is very difficult to communicate with their physicians, especially with regard to life-threatening illnesses; others do not trust physicians to carry out their desires. The problems are compounded because in an age of assembly-line and specialized medical care, many patients do not have personal physicians. Many physicians are troubled by the spectre of malpractice litigation; others are uncomfortable with patients' desires, if not demands, for more information about their bodily condition. Physicians are uncertain whether to respond to their patients as potential plaintiffs, adults in a state of regression to childlike dependence, informed consumers, contractees, partners, or autonomous moral agents. The roles and responsibilities of patient and physician are no longer reducible to simple pictures. It is necessary to view them as complex collages which are an unstable mixture of shifting attitudes, changing beliefs, and revised values.

longed without benefit by artificial means may require subtle, sensitive and complex responses which cannot always be forced into a Procrustean legal bed.

Legal effectiveness ultimately depends upon the strength and clarity of the interests which law instrumentally serves. Our ambivalence toward technology and death as well as the perpetual tension between individual freedom and paternalism undermines a satisfactory legal solution to the problems the Natural Death Act addresses. Because such forces are uncertain and unstable, legal doctrines founded upon them will be controversial and impermanent. In the words of Ernest Becker,

In times such as ours there is a great pressure to come up with concepts that help men understand their dilemma; there is an urge toward vital ideas, toward a simplification of needless intellectual complexity. Sometimes this makes for big lies that resolve tensions and make it easy for action to move forward with just the rationalizations that people need. But it also makes for the slow disengagement of truths that help men get a grip on what is happening to them, that tell them where the problems really are.⁷¹

The Natural Death Act is but a pale reflection of emotional and philosophical conflicts which are inevitable results of attempts to control technology and to overcome death. It reiterates but does not resolve our ambivalence.

71. E. BECKER, *THE DENIAL OF DEATH* 1 (1974).

APPENDIX

THE NATURAL DEATH ACT

CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1977).

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

7186. The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

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

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

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

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

7187. The following definitions shall govern the construction of this chapter:

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

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

(c) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

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

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

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

7188. Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive

shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

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

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

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

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

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by ____, M.D., whose address is ____, and whose telephone number is ____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

5. This directive shall have no force or effect five years from the date filled in above.

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

Signed _____

City, County and State of Residence _____

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

Witness _____

Witness _____

7188.5. A directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section 1250 at the time the directive is executed unless one of the two witnesses to the directive is a patient advocate or ombudsman as may be designated by the State Department of Aging for this purpose pursuant to any other applicable provision of law. The patient advocate or ombudsman shall have the same qualifications as a witness under Section 7188.

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

7189. (a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

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

(2) By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. Such revocation shall become effective only upon communication

to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he received notification of the written revocation.

(3) By a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation.

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

7189.5. A directive shall be effective for five years from the date of execution thereof unless sooner revoked in a manner prescribed in Section 7189. Nothing in this chapter shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 7188, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

7190. No physician or health facility which, acting in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

7191. (a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with Section 7188, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient.

(b) If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision. A failure by a physician to effectuate the directive of a qualified patient pursuant to this division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.

(c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician

justify effectuating the directive. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision.

7192. (a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide.

(b) The making of a directive pursuant to Section 7188 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

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

7193. Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

7194. Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a misdemeanor. Any person who, except where justified or excused by law, falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 7189, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide as provided in Chapter 1 (commencing with Section 187) of Title 8 of Part 1 of the Penal Code.

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

SEC. 2. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

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