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Comments

Medical Self-Determination: A Call for Uniformity

There is an appointed time for everything, and a time for every affair under the heaven. A time to be born and a *time to die*.

Ecclesiastes 3:12-2.

I. INTRODUCTION

What is death? Medical technology has clouded the answer to this once seemingly simple question.¹ Years ago there were no miracle drugs to promote healing and no ingenious devices to prolong life when the body's natural forces failed. Families did not have to make decisions whether to withdraw life support systems from a hopelessly ill relative. In modern times medical science has made it possible for a person to be held at the threshold of death for an indeterminate period of time.² Through the use of extraordinary mechanical devices and other artificial means it has become possible to sustain the body's vital functions.³ The procedures employed

1. Historically death has been defined as the cessation of the heart and respiratory functions. However, modern statutes define death "as an individual who has sustained either (1) irreversible cessation of the circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain including the brain stem." *Barber v State of California*, 195 Cal Rptr 484, 487, 147 Cal App 3d 1006, 1013 (1983); discussed in text page 94-5.

2. *John F Kennedy Memorial Hospital, Inc. v Bludworth*, 452 S2d 921, 923 (Fla 1984).

3. *Bludworth*, 452 S2d at 923. Francis Landy was admitted to the hospital in April and within two days had stopped breathing. Landy was placed on a mechanical ventilator, a tube was placed in his trachea, and an artificial support system breathed for him. Id at 922.

See also, Kelly C. Mulholland, *Protecting the Right to Die: The Patient Self-Determination Act of 1990*, 28 Harv J. on Legis 609 (1991) stating "Technological improvements in medical care increasingly blur the distinction between life and death. The dying process is

by the medical profession in cases of the terminally ill have at times been classified as techniques in prolonging the aging process, rather than a means of continuing life.⁴

Eighty percent of the estimated two million deaths that occur each year are in hospitals or long term care facilities.⁵ Seventy percent of these deaths occur after a decision has been made to forego life sustaining treatment.⁶ Further, it has been noted that the majority of people in this country will at some point during their lifetime be unable to participate in medical treatment decisions affecting their own health care.⁷ Unwanted medical procedures may make a patient and his family prisoners of medical technology, thereby subjecting them to tremendous financial and emotional suffering.⁸

Death has become a matter of choice. "Medical technology has created a twilight zone of suspended animation where death commences, while life, in some form, continues."⁹ Increasingly, patients are asserting their right to refuse medical treatment, especially once diagnosed with a terminal illness. Unfortunately, the law surrounding the making of such choices is confusing. This comment addresses: (1) the origin and case law surrounding the right to make personal medical decisions ("self-determination"); (2) the federal legislative response to the right of Self-Determination (The Patient Self-Determination Act of 1990); (3) existing state statutory law; and (4) a model statute aimed at lessening the conflicting and confusing law surrounding patient self-determination.

now extended through the use of artificial, extraordinary, extreme, or radical medical or surgical procedures." Mulholland, *Protecting the Right to Die*, 28 Harv J on Leg at 611.

4. *Bludworth*, 452 S2d at 923.

5. *Cruzan v Director, Missouri Department of Health*, 497 US 261, 110 SCt 2841, 2864 (1990) (Brennan dissenting), citing President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to forgo Life Sustaining Treatment* 15 M.1 and 17-18 (1983). *Cruzan*, 110 SCt at 2864 n 3.

6. *Cruzan*, 110 SCt at 2864.

7. Fred H. Cole and Barbara A. Gill, *The Patient Self-Determination Act: Implementation Issues and Opportunities*, 6 *The Health Lawyer* 1 (Spring 1992).

8. Mulholland, 28 Harv J on Leg at 609 (cited in note 3).

9. *Rasmussen v Fleming*, 154 Ariz 200, 741 P2d 667, 678. (1988). Here a patient in an incurable and irreversible condition was being sustained through a nasal gastric tube which had been in place for 2 ½ years. The court granted the guardian's petition to have life support withdrawn. *Fleming*, 741 P2d at 668.

II. ORIGIN AND CASE LAW OF SELF-DETERMINATION

A. *Foundation of the Right of Self-Determination*

Patients have a general right to refuse medical treatment. Historically the states have grounded this right on the common law doctrine of informed consent and/or the constitutional right of privacy.¹⁰ The doctrine of informed consent is recognized as being firmly rooted in American tort law.¹¹ This doctrine requires a physician to inform a patient of the risks involved with medical treatment.¹² The patient must understand these risks and freely consent prior to the administration of such treatment.¹³ The logical corollary of the doctrine of informed consent is that a patient generally possesses the right not to consent: the right to refuse medical treatment.¹⁴

The constitutional right of privacy has also been used by state courts to justify a patient's right to refuse medical treatment.¹⁵ The right of privacy guaranteed in the federal Constitution is said to arise from the penumbra of specific rights contained in the

10. See *Cruzan*, 110 SCt at 2847. See also *Fleming*, 741 P2d at 686.

11. Restatement (Second) of Torts § 892 A, 892 B (1977); See also *Cruzan*, 110 SCt at 2846 stating "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of Law." Id. citing *Union Pacific R Co v Botsford*, 141 US 250, 251, 11 SCt 1000, 1001, 35 LE 734 (1891).

12. Mulholland, 28 Harv J on Leg at 610-11 (cited in note 3).

See also *Schloendorff v Society of New York Hospital*, 211 NY 125, 129, 105 NE 92, 93 (1914) when Judge Cardozo stated: "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 for in damages." *Schloendorff*, 105 NE at 93, and *Cruzan*, 110 SCt at 2846-7.

13. Mulholland, 28 Harv J on Leg at 610-11 (cited in note 3).

14. *Cruzan*, 110 SCt at 2847.

See also *Delio v Westchester County Medical Center*, 516 NYS2d 677, 129 A2d 1 (1987) where the court held the right of self determination grounded in the common law right of informed consent forms the foundation for a competent adult the right to refuse life sustaining treatment even if the effect is to hasten death. *Delio*, 129 A2d at 14.

Also, *In re Gardner*, 534 A2d 947 holding Maine's common law of informed consent recognizes the personal right of any individual to refuse life sustaining treatment. *Gardner*, 534 A2d at 951.

15. See *In re Quinlan*, 70 NJ 10, 355 A2d 647 (1976), cert denied, 429 US 922 (1976).

See also *Fleming*, 741 P2d at 682 holding the right to refuse medical treatment is a personal right sufficiently fundamental or implicit in ordered liberty to fall within the constitutionally protected zone of privacy. Id.

Also, *Superintendent of Belchertown State School v Saikewicz*, 373 Mass 728, 370 NE2d 417 (1977) holding the right of privacy encompasses the right of a patient to preserve his or her right of privacy against unwanted infringements of bodily integrity. *Saikewicz* 370 NE 2d 424.

First, Fourth, Fifth, Ninth, and Fourteenth Amendments.¹⁶ The scope of this implied right is said to be sufficiently broad to encompass a patient's decision to forego medical treatment. "The decision by the incurably ill to forego medical treatment . . . is so manifestly a 'fundamental' decision in their lives, that it is virtually inconceivable that the right of privacy would not apply to it."¹⁷

The most widely publicized case establishing the right of privacy as a basis to allow the termination of medical treatment was the New Jersey case of *In Re Quinlan*.¹⁸ In *Quinlan*, Karen Ann Quinlan, age 22, suffered severe brain damage leaving her in a "chronic persistent vegetative state."¹⁹ Although Ms. Quinlan was unaware of her surroundings and her breathing was assisted by a respirator without which doctors believed she would not survive, Ms. Quinlan did not exhibit the signs of "brain death."²⁰ The New Jersey Supreme Court, in a unanimous decision, held that her father as guardian could exercise Ms. Quinlan's privacy right and authorize removal of artificial life support systems.²¹ After *Quinlan*, however, most state courts have based the right of self-determination solely on the common law right of informed consent or on both the common law doctrine and the right of privacy.²²

Ordinarily, the right of self-determination is based upon the competency of a patient to assert the right to refuse medical treatment. Thus, traditionally only the person whose common law or constitutional rights are at issue may assert them.²³ As *Quinlan* illustrates, however, the rights of informed consent and privacy are not lost when a patient becomes incompetent. The states are all in agreement that an incompetent patient is entitled to the same rights and choices regarding medical self-determination that a competent patient is entitled. Recognizing that human dignity extends to both the competent and incompetent, the courts have extended the right of privacy and the common law right of self-de-

16. *Griswold v Connecticut*, 381 US 479, 484, 85 SCt 323, 13 LE2d 2d 339 (1965).

17. *Eichner v Dillion*, 426 NYS2d 517, 73 AD2d 431 (1980). Here the appeal concerned the right of a terminally ill patient in a comatose and vegetative state to have life sustaining measures discontinued. *Dillion*, 73 AD2d at 459.

18. 70 NJ 10, 355 A2d 647 (1976), cert denied 429 US 922 (1976).

19. *Quinlan*, 355 A2d at 654.

20. *Id* at 654-5. Experts testified that Ms Quinlan did have some brain stem function, although, not sufficient to sustain breathing. *Id*.

21. *Id* at 664.

22. *Cruzan*, 110 SCt at 2847 citing L. Tribe, *American Constitutional Law* § 15-11 p 1365 (2d ed 1988). *Id*.

23. *Fleming*, 741 P2d at 685.

termination to the incompetent patient.²⁴

B. *State Interests v The Individual's Right*

The right to refuse medical treatment, although extended to all persons, is not absolute. The right of the patient must be weighed against certain state interests. Generally the interests asserted are: (1) the preservation of life; (2) the protection of innocent third persons; (3) the prevention of suicide; and (4) the maintenance of the integrity of the medical profession.²⁵ These interests have at times been strong enough to outweigh the patient's right of self determination.²⁶ In a leading case, *In re President & Directors of Georgetown College, Inc.*,²⁷ a hospital sought permission to perform a blood transfusion to save a patient's life despite the patient's unwillingness based upon religious beliefs.²⁸ The court held that it had the power to allow the transfusion.²⁹ The court justified its decision based on the state's *parens patriae* interest in protecting the patient's minor child from abandonment by the parent.³⁰

The state's interests are strongest when the affliction is curable and dwindles as the prognosis grows dimmer.³¹ Often no states' in-

24. See *Brophy v New England Sima Hospital, Inc.*, 497 NE2d 626 (1986), where a once healthy robust male was left in a vegetative state following an aneurism rupturing in his brain. A petition was filed by his spouse to have the G-tube supplying nutrition either clamped or removed. *Brophy*, 497 NE2d at 628-34.

See also *John F Kennedy Memorial Hospital v Bludworth*, 452 S2d 921, (Fla 1984) holding "this right of the terminally ill patients should not be lost when they suffer irreversible brain damage, become comatose and are no longer able to express their wishes . . ." *Bludworth*, 452 So2d at 924.

25. *Cruzan*, 110 SCt at 2847-8; *Fleming*, 741 P2d at 683; *In re Colyer*, 99 Wash2d 114, 660 P2d 738, 743 (1983); *Saikewicz* 370 NE2d at 427.

26. See *In re Conroy*, 98 NJ 321, 486 A2d 1209 (1985) holding the states interest in preserving life is the most significant interest and embraces the life of a particular individual as well as preserving the sanctity of all life. *Conroy*, 486 A2d at 1223.

See also *In re Caulk*, 125 NH 226, 480 A2d 93 (1984) where the court held states could force feed a prisoner who was starving himself to death because he preferred death to life imprisonment.

Also, *Fleming*, 741 P2d at 684 where the court recognized the medical profession itself now recognizes that it is no longer obligated to provide medical treatment in all situations citing the American Medical Association's Council on Ethical and Judicial Affairs. *Id.*

27. 118 US App DC 80, 331 F2d 1000, Cert denied, 377 US 978, 84 Sct 1883 (1964).

28. *Georgetown*, 331 F2d at 1002.

29. *Id.* at 1008.

30. *Id.*

31. *Quinlan*, 335 A2d at 664.

See also *Brophy*, 497 NE2d at 635 stating states interest is very high when human life can be saved since affection is curable.

Also, *Saikewicz*, 370 NE2d 425-6.

terests will outweigh the individual's right of self determination, even at the risk of death. For example, in *Lane v Candura*³² a Massachusetts appellate court recognized a competent person's right to refuse amputation of a gangrenous leg.³³ Case law holding otherwise has either involved the interest of protecting innocent third persons or has concerned the competency of the patient to make a rational and considered choice.³⁴

C. Case Law—A State of Confusion

The case law surrounding the patient's right of self-determination has created a confusing array of judicial decisions. The publicized judicial decisions granting the patient the right to refuse life-saving treatment offers health care providers with little guidance as to whether they can legally withhold or discontinue treatment.³⁵ A physician fearing criminal or civil liability may refuse to carry out a patient's recognized right of self-determination. This interference with a patient's right may escalate as a patient becomes unable to personally assert his wishes.

The decision to forego medical treatment in the case of an incompetent patient does not often involve court intervention.³⁶ The frequently practiced procedure is for the physician and the incompetent patient's family to confer and make treatment decisions concerning the patient.³⁷ In some instances, however, the state or other interested parties assert an interest, thus forcing the court to make decisions that are laced with moral and ethical concerns involving the delicate matters of life saving or sustaining treatment

32. 6 Mass App Ct 377, 376 NE2d 1232 (1978).

33. *Candura*, 376 NE2d at 1235-6. See also *In re Osborne*, 294 A2d 372 (DC 1972) (upholding patient's right to refuse life-saving blood transfusion) and *In re Yetter*, 62 Pa D&C 2d 619 (1973) (upholding patient's right to refuse biopsy and removal of possible breast cancer.)

34. *Cruzan*, 110 SCt at 2848 citing *In re Conroy*, 98 NJ 321 at 54, 486 A2d 1209 at 1225 (1985).

35. Linda Flewellen Gould, *Right to Die Legislation: The Effect on Physicians' Liability*, 39 Mercer L Rev 517 (1988), stating "well publicized judicial decisions granting patients the right to refuse life sustaining treatment provide little guidance to physicians struggling with the issue of whether they can legally discontinue treatment in specific situations." Gould, 39 Mercer L Rev at 523.

36. Mulholland, 28 Harv J on Leg at 612 (cited in note 3).

See also *Conroy*, 486 A2d at 1220-1, stating many health care decisions occur each day without the use of legal help.

37. Mulholland, 28 Harv J on Legis at 612 (cited in note 3).

See also *Conroy*, 486 A2d at 1220-1.

for the patient.³⁸

Courts vary in their approach to ascertain the patient's intent, demonstrating both similarity and diversity in their methods.³⁹ Most courts search for evidence of the incompetent's clearly stated desires.⁴⁰ These desires may be evidenced by written advanced directives.⁴¹ Oral statements made by the party while competent may also be given great weight.⁴² In the absence of such evidence, the courts will use tests that utilize subjective and/or objective evidence.⁴³

The substitute judgment test, subjective in nature, places a burden on a surrogate decision maker. Under this approach the court normally allows family members to act as the surrogate decision maker. Experience indicates that the family, due to its special bonds and grasp of the incompetent patient's approach to life, is best qualified to express the desires of the patient.⁴⁴ The surrogate must convince the courts that his or her choice in medical treatment reflects the decision the incompetent patient would make if competent and making his or her own decision under the circumstances.⁴⁵ The focus is centered upon the individual. Accordingly, what the majority of people might consider to be a prudent and wise medical decision making is not controlling under the substitute judgment approach.⁴⁶

38. *Id.*

See for example: *Bludworth*, 452 S2d at 922-23 where upon request to terminate life support the hospital fearing liability filed for declaratory relief to continue or discontinue treatment.

See also: *Candura*, 376 NE2d 1232, where the patient's daughter petitioned to have her 77 year old mother declared incompetent and herself appointed guardian so consent could be given to have a gangrenous leg amputated. *Candura*, 376 NE2d at 1233).

39. *Cruzan*, 110 Sct at 2851.

See also *Mulholland*, 28 Harv J on Legis at 612 (cited in note 3).

40. *Mulholland*, 28 Harv J on Legis at 612 (cited in note 3).

See also *Conroy*, 486 A2d at 1229.

41. *Fleming*, 741 P2d at 689 n 21.

See also *Conroy*, 486 A2d at 1229.

42. *Fleming*, 741 P2d at 689.

See also *Mulholland*, 28 Harv J on Legis at 612 (cited in note 3), citing *In re Gardner*, 534 A2d 947 (1987). Also, *Conroy*, 486 A2d at 1229.

43. *Fleming*, 741 P2d at 688.

44. *Quinlan*, 355 A2d at 664.

See also, *In re Jobses*, 108 NJ 394, 529 A2d 434 (1987) holding family members are best qualified to make substituted judgements for incompetent patients. *Jobses*, 529 A2d at 451.

45. *Id.* at 688-9.

See also *Saikewicz*, 370 NE2d at 431, holding must ascertain the incompetent person's actual interest and preferences.

46. *Saikewicz*, 370 NE2d at 427.

A second test utilized by the courts is an objective test known as the best interest test. Under this approach the court will consider factors such as: (1) the degree, duration, and consistency of pain; (2) the maturity of the patient; (3) the patient's life expectancy; (4) the prognosis; (5) the patient's physical and cognitive functions; (6) the nature of the treatment and degree of humiliation associated with such treatment; and (7) the alternative treatments available.⁴⁷ After examining such evidence the court will then make a decision and base its conclusion on the best interest of the patient. This test seems most appropriate when the patient has never been competent, such as in the case of a minor or a mentally handicapped person.⁴⁸ In utilizing this test the court must be cautious not to base its decision on an assessment of the individual's personal worth or value to society.⁴⁹

One difficulty with such tests is that the results of these tests are often uncertain due to the complexities and ambiguities of the facts surrounding the individual circumstances of the case.⁵⁰ Further uncertainties are created since a court may use a single test or a combination of these tests to arrive at a decision.⁵¹ Courts have also been criticized in their application of a test that seems ill suited for the facts of a particular case.⁵² The unpredictable results create confusion for the patient and health care provider relying on the law.

In some jurisdictions the termination of life-sustaining devices may result in criminal liability. Although no convictions for participating in such decisions have been recorded, in *Barber v Califor-*

47. *Fleming*, 741 P2d at 689.

See also, Mulholland, 28 Harv J on Legis at 613 (cited in note 3). Also, *Barber*, 195 Cal Rptr at 493. And, *Conroy*, 486 A2d at 1232.

48. See *Fleming*, 741 P2d at 688 stating the substitute judgement test is best suited when the patient has manifested an intent while competent. *Id.* citing *Foody* 40 Conn Sup at 139-40, 482 A2d at 721.

See also *Conroy*, 486 A2d at 1231.

49. See *Cruzan*, 110 SCT at 2853 where the Court held a state may properly decline to make judgements about life. *Id.*

See also, *Brophy*, 497 NE2d at 635 holding the trial judge was correct by not pronouncing judgement that Brophy's life is not worth preserving. "We do not approve of an analysis . . . which focuses on the quality of Brophy's life." *Id.* Also, *Conroy*, 486 A2d at 1232-3.

50. Mulholland, 28 Harv J on Legis at 613.

51. *Id.* For example, see *Conroy*, 486 A2d at 1231-2 stating, this court recognizes that the right of self-determination can be exercised under either the substitute judgement or best interest tests.

52. See *Fleming*, 741 P2d at 689 pointing out the criticisms of using the substitute judgement test when patient was never competent. *Id.* at 689 n 22. See also, Mulholland, 28 Harv J on Leg at 613 (cited in note 3).

nia⁵³ two doctors were indicted for the removal of life-sustaining devices.⁵⁴ The doctors removed life support from Clarence Herbert at the request of his family.⁵⁵ Mr. Herbert was in a permanent coma and had informed his family of his desire not to be kept alive through the use of "heroic" measures.⁵⁶ The California appellate court found the doctors were not criminally negligent for withdrawing the devices using a subjective test to enforce Mr. Herbert's right of self determination.⁵⁷ Notwithstanding the results in *Barber*, the physicians' indictment creates apprehension in any doctor asked to discontinue medical treatment.

An additional obstacle an individual may encounter in asserting the right of self-determination results from the diversity of procedural requirements among the various jurisdictions. The two leading cases often cited to demonstrate this diversion are *In re Quinlan* and *Superintendent of Belchertown State School v Saikewicz*. The decision rendered in *Saikewicz* is illustrative of a jurisdiction that requires a court order before life-sustaining procedures may be withheld or withdrawn from an incompetent patient. The *Saikewicz* court stated:

We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent . . . We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.⁵⁸

Along these lines, the Massachusetts Supreme Judicial Court indicated that a court must consider a variety of circumstances in determining whether a court order is necessary prior to withholding medical treatment from a patient.⁵⁹ The court further provided

53. 147 Cal App 3d 1006, 195 Cal Rptr 484 (1983).

54. *Barber*, 195 Cal Rptr 484.

55. *Id* at 486.

56. *Id* at 493.

57. *Id* at 490-1.

58. *Saikewicz*, 470 NE2d at 434-5.

59. *In re Spring*, 380 Mass 629, 405 NE2d 115, 120 (1980), stating the extent of impairment, whether the patient is in the custody of a state institution, the prognosis with and

that once a court order is sought, the probate court has the ultimate responsibility to determine whether the physician can withhold or withdraw life-sustaining devices from an incompetent patient.⁶⁰ Under such circumstances a physician threatened with criminal or civil liability will ultimately seek a court order before acting to carry out the desires of a patient seeking to have life sustaining devices withdrawn.

The *Quinlan* case demonstrates the other end of the spectrum where the court's role is limited. In *Quinlan* the court attempted to establish a procedure for determining whether a physician should disconnect life-sustaining devices. The *Quinlan* court maintained that as a general practice such decisions "should be controlled within the patient-doctor-family relationship."⁶¹ In so holding, the court reasoned that a need to apply to a court to confirm such decisions would not only be time consuming, but an encroachment upon the medical profession's field of competence.⁶² Further, the *Quinlan* court advocated the establishment of a hospital ethics committee to assist in the decision making to protect against less than trustworthy motives by the surrogate decision maker.⁶³

Ethical concerns of health care providers present another obstacle in the execution of the right of self-determination. The professional training of a physician focuses on the preservation of life and the curing of disease; therefore, many health care providers strongly oppose the termination of life-sustaining treatment.⁶⁴ Early cases recognized and supported such a medical position. One such case was *In re President & Directors of Georgetown College*⁶⁵ where a mother could not refuse a blood transfusion to prevent her own death.⁶⁶ The court based its decision, inter alia, on the duty of the medical profession to effectively treat any patient committed to its care.⁶⁷ Therefore, some providers may resist efforts to with-

without treatment, possible side effects . . . all must be considered to determine if a court order is necessary. *Spring*, 405 NE2d at 120-21.

60. *Id.* at 122. See also Gould, 39 Mercer L Rev at 525-26 (cited in note 35).

61. *Quinlan*, 355 A2d at 669.

62. *Id.*

63. *Id.*

64. Mulholland, 28 Harv J on Legis at 614-15 (cited in note 3).

65. 118 US App DC 80, 331 F2d 1060 cert denied, 377 US 978, 84 Sct 1883 (1964).

66. *Georgetown College, Inc.*, 331 F2d at 1001-2.

67. *Id.* at 1009. See also, *John F Kennedy Memorial Hospital v Heston*, 58 NJ 576, 279 A2d 670 (1971), where a 22 year old unmarried female was severely injured in an auto accident, the court allowed a blood transfusion to prevent death. *Heston*, 279 A2d at 670-1. The court stated hospitals exist to aid the sick, the providers are consecrated to preserve life. The hospital and staff should be permitted to preserve their function. *Id.* at 673.

hold or withdraw life-sustaining treatment and may require a court order before they respond.

III. THE SUPREME COURT AND SELF-DETERMINATION

The United States Supreme Court first addressed the issue of an incompetent patient's "right-to-die" in the landmark case of *Cruzan v Director, Missouri Department of Health*.⁶⁸ According to one commentator, the fifty one page decision with three majority and two dissenting opinions should be "the basis for the legal profession, health care providers and legislators focusing upon a variety of legal and ethical issues concerning the use or nonuse of living wills or advanced health care directives."⁶⁹ The facts of the *Cruzan* case are not atypical of thousands of persons involved in accidents each year.⁷⁰ Nancy Cruzan had suffered multiple trauma, anoxia (lack of oxygen), and irreparable and irreversible brain damage as a result of an automobile accident.⁷¹ She lingered in a "persistent vegetative state" for six years with her existence being sustained by nutrients and fluids mechanically pumped through a gastrostomy tube surgically implanted in her stomach.⁷² After it became apparent that Ms. Cruzan's condition would not improve, her parents and co-guardians requested the removal of life sustaining devices.⁷³ When hospital employees refused to honor their request, the parents sought a court order to implement their request.⁷⁴ The trial court found Ms. Cruzan had a fundamental right under both the federal and state constitutions to the withdrawal of "death prolonging procedures" and authorized the termination of treatment.⁷⁵

The Missouri Supreme Court reversed the trial court and ordered the hospital to continue treatment.⁷⁶ The Missouri court found that a patient in Ms. Cruzan's condition had a common law right of self-determination, but under the facts of this particular

68. 497 US 261, 110 SCt 2841, (1990).

69. Jerome Apfel, *Your Pennsylvania Living Will: Don't Leave Home Without it in 1991*, 62 Jan Pa B A Q 19 (Jan 1991).

70. Experts estimate that approximately 10,000 Americans currently exist in a persistent vegetative state. Cole and Gill, 6 Health Lawyer 1 (Spring 1992) (cited in note 7).

71. *Cruzan*, 110 SCt at 2845.

72. *Id* at 2846.

73. *Id*.

74. *Id*.

75. *Id*.

76. *Id*.

case the evidence was not sufficient to terminate the treatment.⁷⁷ The court held that the testimony of Ms. Cruzan's parents and of Ms. Cruzan's roommate did not amount to the clear and convincing evidence necessary to indicate the desires of the incompetent patient.⁷⁸

The United States Supreme Court, in an opinion written by Justice Rehnquist, affirmed the Missouri Supreme Court's decision.⁷⁹ Justice Rehnquist wrote that the Fourteenth Amendment provides that no state shall deprive any person of life, liberty, or property without due process of the law and the right to refuse medical treatment is best analyzed under this Amendment.⁸⁰ According to the *Cruzan* Court, the administering of medical treatment without a patient's consent would be a substantial interference with one's liberty interest.⁸¹ However, in cases involving an incompetent patient, the state has a substantial interest in the sustaining of life and may protect this interest by the imposition of heightened evidentiary requirements.⁸² In addition, the state may properly decline to make judgments about the quality of life and simply assert an unqualified interest in the preservation of life.⁸³

In affirming the Missouri court's decision, the Supreme Court recognized that there would be situations where family members might not be acting to protect the patient and explained that a state is entitled to guard against these potential abuses.⁸⁴ Specifically, Justice Rehnquist wrote that the due process clause does not require a state to accept the "substitute judgment" of close family members in the absence of substantial proof that their views reflect the views of the patient.⁸⁵ The due process clause does not require the state to rest judgment on these matters with anyone but the patient.⁸⁶ The Supreme Court thus concluded it was not erroneous for the Missouri Supreme Court to find that the testimony adduced at trial did not meet the allowable clear and con-

77. *Id.*

78. *Id.* at 2845. Ms. Cruzan's parents and her roommate testified that their conversations with Ms. Cruzan revealed she did not wish to be sustained by mechanical devices. *Id.*

79. *Id.* at 2841.

80. *Id.* at 2852 n 7.

81. *Id.*

82. *Id.* at 2852-3.

83. *Id.* at 2853.

84. *Id.*

85. *Id.* at 2855.

86. *Id.*

vincing evidence standard set by the state court.⁸⁷

After the *Cruzan* decision it would appear that a state court or legislature may enact laws or procedural rules less burdensome than did Missouri.⁸⁸ The *Cruzan* Court acknowledged that the Missouri standard was a most restrictive law, but right to die issues (subject to due process) should be decided pursuant to state law.⁸⁹ In light of the *Cruzan* holdings one is hard pressed to imagine what evidence would have to be produced to satisfy a court in a state such as Missouri requiring clear and convincing evidence.⁹⁰ What is more convincing than conversations with family members and friends expressing one's desire not to have one's life sustained by mechanical means?

The *Cruzan* court made it clear that its decision did not decide the issue of whether a state must give effect to advanced directives expressly made by the patient while competent.⁹¹ However, a forceful concurring opinion by Justice O'Connor may indicate that such advanced directives are constitutionally protected. O'Connor stated "[t]oday's decision . . . does not preclude a future determination that the Constitution requires the states to implement the decisions of a patient's duly appointed surrogate."⁹²

IV. STATUTORY LAW AND THE RIGHT OF SELF-DETERMINATION

A. *Types of State Statutory Law*

During the last ten years states have enacted three different types of legislation to deal with the health care of the incompetent patient. The first of these statutes is best known as the "Living Will" or "Health Care Directive" acts. Currently the District of Columbia and all but a few states have such legislation in place.⁹³ This legislation provides adults, while competent, the opportunity to make and execute a writing expressing the patient's desires to

87. Id at 2855-6.

88. Apfel, 62 Jan Pa B A Q at 20 (cited in note 69).

89. Id at 20.

90. Id.

91. *Cruzan*, 110 SCt at 2856 n 12.

92. *Cruzan*, 110 SCt at 2858 (O'Connor concurring).

93. Cole and Gill, *The Patient Self-Determination Act: Implementation, Issues, and Opportunities*, 6 *The Health Lawyer* at 3 (Spring 1992). Courts in states such as New York have authorized the use of the living will. Only Massachusetts, Michigan, and Nebraska have apparently made no such provision for living wills. Id at 3.

See also, Apfel, 62 PA B A Q 19, 21 (Jan 1991) however since such writing Pa has enacted a living will statute (cited in note 70). Also, George Alexander, *Time For a New Law on Health Care Advance Directives*, 42 *Hasting L J* 755 (1991).

receive or decline and/or continue or discontinue medical treatment.⁹⁴ The directives are triggered when the patient becomes incompetent and terminally ill.⁹⁵ The statutes usually contain quite specific definitions with regard to who is a qualified patient and under what situations a patient is considered terminally ill.

The second type of legislation regarding the medical care of a patient who has become incompetent is known as the medical or health care durable power of attorney.⁹⁶ Under this type of legislation a patient, while competent, may appoint an agent to make appropriate decisions for the patient in the event the patient becomes incompetent.⁹⁷ The power of the attorney-in-fact is limited to the power expressly granted in the properly executed document as well as the limits set by the enabling statute.⁹⁸ Currently the District of Columbia and all but seven states provide power of attorney statutes specific for health care decisions.⁹⁹

The final type of legislation applicable to this area is known generally as the "family consent" laws.¹⁰⁰ Under these provisions a surrogate, proxy, or guardian is authorized to make "right-to-die" decisions in the absence of a living will, health care directive or a valid durable medical power of attorney.¹⁰¹ Typically these statutes establish a priority list of decision makers which usually includes the spouse, parents, adult child, etc.¹⁰² The statutes differ by state as to whether court approval is necessary to carry out the decisions made by such surrogates.¹⁰³

94. Gill, 6 *The Health Lawyer* at 3.

95. *Id.*

96. Cole and Gill, 6 *The Health Lawyer* at 4 (Spring 1992) (cited in note 7).

See also, Apfel, 62 PA B A Q at 21 (cited in note 70). Also, George Alexander, 42 *Hasting L J* 755 (1991) (cited in note 94).

97. Cole and Gill, 6 *The Health Lawyer* at 4, All states and DC provide for general powers of attorney, also DC and all but 7 states (Alabama, Alaska, Arizona, Hawaii, Maryland, Nebraska, and Oklahoma) provide specifically for health care decisions. *Id.* (cited in note 7).

98. *Id.*

99. *Id.*

100. Cole and Gill, 6 *The Health Lawyer* at 4 (Spring 1992) (cited in note 7).

See also, Apfel, 62 PA B A Q at 21 (cited in note 70). Also, Alexander, 42 *Hasting L J* 755 (1991) (cited in note 94).

101. Gill, 6 *The Health Lawyer* at 4 (cited in note 7).

102. *Id.*

103. Apfel, 62 Pa B A Q at 21 (cited in note 70).

B. Federal Legislation: *The Patient Self-Determination Act*

The Federal Omnibus Budget Reconciliation Act of 1990¹⁰⁴ (hereinafter "Self-Determination Act"), when it became effective on November 5, 1991, gave new importance to states' statutory law regarding advanced medical directives. Participation by health care providers in federal Medicare and Medicaid programs is conditioned upon compliance with this Act. The effects, therefore, will be felt by most hospitals, nursing facilities, home health agencies, hospice programs, and health maintenance organizations.¹⁰⁵ The Act requires that the provider both comply with state law in regard to advance directives and disseminate information on patients' rights to make advanced directives under such state law.¹⁰⁶ "Advanced directive" is defined as "a written document, such as a living will or a durable power of attorney for health care, recognized under state law when an individual is incapacitated."¹⁰⁷

Under the Act every adult patient must be provided with written information regarding:

- (1) the individual's rights under state law (whether statutory or as recognized by the state court) to make decisions concerning health care. These rights include the right to accept or refuse treatment and the right to formulate advanced directives; and
- (2) the written policies of the provider regarding the implementation of such rights.¹⁰⁸

Documentation of the execution or failure to execute an advanced directive must be maintained in the patient's medical record.¹⁰⁹ Discrimination of any type for the execution or the failure to execute a directive is prohibited by the terms of the Act.¹¹⁰

In addition to the distribution of information required by the Self-Determination Act, the most significant aspect of the Act is the requirement that education be provided to the medical staff and community on issues regarding the right to die.¹¹¹ A 1988 AMA survey showed that 56% of those surveyed told family mem-

104. Pub L No 101-508 § 4206, 1990 U.S. Code Cong. & Admin. News (104 Stat. 1388), 291.

105. Id § 4206 (f) (2) (A-E).

106. Id § 4206 (f) (1) (D) requires the provider comply with state law respecting advanced directives. § 4206 (f) (1) (A) requires the provider to supply written information to individuals.

107. Id § 4206 (f) (3).

108. Id § 4206 (f) (1) (A) (i-ii).

109. Id § 4206 (f) (1) (B).

110. Id § 4206 (f) (1) (C).

111. Id § 4206 (f) (1) (E).

bers of their wishes concerning the use of life sustaining treatment if they entered an irreversible coma; only 15% completed a living will specifying those wishes.¹¹² Research also indicates 85% of California physicians knew little about advanced directives.¹¹³ Similarly, a Colorado study found that 23% of the physicians in that state were unfamiliar with living wills and 74% were unfamiliar with durable power of attorney in health care.¹¹⁴ In Arkansas, only 38% of physicians were aware of the state's advanced directive laws.¹¹⁵ These findings illustrate the need for information and education in the area of medical self-determination.

Although the effects of the Self-Determination Act will not be immediately known, its expected benefit will be to help close the gap between patients' desires and the implementation of these desires by medical providers. A patient will have easier access to information concerning advanced directives which should increase the execution of such directives.¹¹⁶ The resistance of physicians to implement a patient's advanced directive due to a fear of malpractice litigation should be alleviated. Educational programs mandated by the Act should provide physicians with sufficient knowledge of state law in the area of advanced directives to execute valid advanced directives without fear of civil or criminal liability.

Additionally, research in this area indicates that only 4% of patients surveyed inquired about the health care provider's policy on implementing advanced directives.¹¹⁷ An individual, therefore, could easily find himself in a facility unwilling to implement his advanced directives. The required publication and distribution of the provider's policies concerning the execution of advanced directives should enable a patient to select a health care provider willing to carry out the expressed directive.

C. *Ineffectiveness of Present Statutory Law*

The federal Self-Determination Act creates no new rights; in-

112. American Medical Association Surveys of Physicians and Public Opinion on Health Care Issues 29-30 (1985), cited in *Cruzan* 110 SCt at 2858 n 1.

113. Zinberg, *Decisions for the Dying: An Empirical Study of Physician's Responses to Advance Directives*, 13 Vt L Rev 445, 472 (1989), cited in Alexander, *Time For A New Law on Health Care Advanced Directives*, 42 Hastings L J at 771 n 88.

114. Mulholland, 28 Harv J on Legis at 622 n 61 (cited in note 3).

115. *Id.*

116. See also, Cole & Gill, 6 *The Health Lawyer* 1 (Spring 1992) stating as of 1987 only 9% of Americans have completed living wills; however, more recent studies suggest as many as 15% may have some form of advanced directive. *Id.* at 4. (cited in note 7).

117. Mulholland, 28 Harv J on Legis at 622 n 59 (cited in note 3).

stead it defers these issues to the individual states. Unfortunately, the state statutory law on self-determination, like that of the case law previously discussed, is ineffective to equitably institute such rights. The states' statutory laws have been criticized as being ambiguous and inconsistent.¹¹⁸ One commentator has gone so far as to state that "in states with poorly drafted living will statutes . . . these statutes actually increase a physician's potential liability relating to a decision to terminate life-sustaining procedures."¹¹⁹

The definition of "terminal illness" is one area where these ambiguities and inconsistencies is evidenced. All living will statutes provide that the document becomes effective once a patient is diagnosed as being terminally ill. Unfortunately, the answer to the question, "What is meant by terminally ill?" is unclear.

Several states statutes define a "terminal condition" as:

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.¹²⁰

States such as Pennsylvania and Florida require a more stringent standard.¹²¹ Rather than the mere medical judgment standard, health care providers in these states must be satisfied within a reasonable degree of medical certainty that without the application of life-sustaining procedures death will result.¹²² On the other hand, some states will define terminal condition based upon the opinion of the health care provider.¹²³

Such an array of statutory definitions may cause physicians to

118. Gould, 39 Mercer L Rev at 526, 533 (cited in note 35).

See also, Cole and Gill, 6 The Health Lawyer at 4 (Spring 1992) stating 3 factors significantly limit the effectiveness: (1) the use of ambiguous language, (2) lack of knowledge as to the directives existence, and (3) confusion as to the scope of living wills. Id at 4 (cited in note 7).

119. Gould, 39 Mercer L Rev at 519-20 (cited in note 35).

120. DC Code § 6-2421 (6) (1991).

See also, Utah Code Ann § 75-2-1103(7) (1985); NH Rev Stat Ann § 137-H:2(VI) (1991); Or Rev Stat § 127.605(6) (1989). and Cal Health and Safety Code § 7186(j) (1991).

121. Fla Stat Ann § 765.03(6) (West 1992; General Assembly of Pennsylvania, Senate Bill No 3 Session 1991; Printer's No 1326. This bill has recently been signed into law to take effect immediately.

122. Id.

123. See Conn Gen Stat Ann § 19a-570(3) (West 1992) and Ariz Rev Stat Ann § 36-3201(6) (West 1991). Under this standard, unlike the medical judgment standard, a physician's diagnosis will not be evaluated against the traditional norms of the medical community.

resist the termination of life-sustaining treatment based solely on their own judgment. Courts are familiar with giving effect to such terms as reasonable judgment or reasonable certainty, but it is foreseeable that a physician untrained in such terminology will turn to the courts before implementing a patient's advanced directive.¹²⁴ More perplexing are those instances of rare disease or experimental treatments where the medical field itself cannot agree on what constitutes reasonable treatment under the circumstances.

A second area of criticism of statutory law surrounding the right of self-determination are those provisions exempting a physician from civil or criminal liability. Again ambiguities and inconsistencies surround what will qualify a physician for protection. Some statutes protect the physician if his decision comports with "reasonable medical standards."¹²⁵ Such an ambiguous standard again invites litigation and thus resistance by the provider to terminate life-sustaining treatment. Other statutes grant immunity if the provider acts in accordance with the requirements of the act.¹²⁶ Here, a provider may act in accordance with the expressed provisions of the act, but may face liability due to a technical flaw.¹²⁷ In such jurisdictions a provider would be wise to consult an attorney before executing the terms of an advanced directive. The problem with all this, of course, is that it takes time.

State laws may also pose obstacles for the patient trying to have advanced directives honored, due to restrictions on the type of treatment decisions the statute permits to be withdrawn. Several states, when defining the life-sustaining procedures that may be withdrawn or withheld from a qualified patient, exclude the administration of medication or medical procedure deemed necessary

124. See *Havasy v Resnick*, A2d , 1992 WL 93085 (Pa Super) (1992), the court stated a physician is not liable for an error of judgment . . . if a physician employs the skill, knowledge, and care customarily exercised in his profession he is not liable. *Resnick* 1992 WL at 10.

See also, Gould, 39 Mercer L Rev at 527-28 n 70-1 (cited in note 35) stating the common law requires a physician to meet a standard of care determined by the degree of skill, knowledge, and care ordinarily exercised by other members of their profession under similar circumstances; expert testimony is necessary to establish such a standard (citation omitted).

125. See Ill Ann Stat ch 110 ½ p 707 § 7 (Smith-Hurd 1991); Kan Stat Ann § 65-28, 106 (1990); DC Code § 6-2427(a) (1991); Ala Code § 22-8a-7 (1991).

126. See Ariz Rev Stat Ann § 36-3205(C) West 1991); Or Rev Stat Ann § 127.620 (1-3) (1991); Fla Stat Ann § 765.10(1) (West 1992).

127. All living will legislation provides specific requirements for an advanced directive to be valid. Such requirements include such elements as the party be over 10 and the document be properly witnessed.

to provide comfort care or to alleviate pain.¹²⁸ This exclusion may make it impossible for a patient to terminate life-prolonging measures.¹²⁹ An advanced directive may not be enforced if a physician deems undesired treatment necessary for the alleviation of pain. Of greater concern for a physician fearful of liability is the discontinuation of treatment that an interested party alleges should have been continued as a means of providing comfort care. Under such circumstances either the physician, patient, or patient's representative may be forced to apply to the courts for resolution of such uncertainties.

V. A CALL FOR UNIFORMITY: A MODEL STATUTE ON ADVANCED DIRECTIVES

Recognizing the diversity and confusion surrounding the laws regarding patient self-determination rights, uniform legislation has been prepared. The Medical Treatment Decision Act is a model statute which adequately alleviates the current ambiguities in existing statutory law and offers consistency throughout the United States.¹³⁰ The model Medical Treatment Decisions Act provides:

Section 1. Definitions

A. **Attending Physician.** The physician selected by, or assigned to, a patient who has primary responsibility for the treatment and care of that patient.

B. **Declaration.** A document in writing, voluntarily executed by a patient in accordance with Section 3.

C. **Health Care Provider.** Any physician, nurse, hospital or other health care institution, including all employees of any of these.

D. **Life-Sustaining Procedure.** Any medical procedure which, in the judgment of the attending physician, would achieve no goal other than prolonging the dying process of a patient in a terminal condition. The term "Life-Sustaining Procedure" does not include administration of food or fluids or the performance of any procedure necessary for the comfort of the patient or to alleviate pain.

E. **Qualified Patient.** A patient who has executed a Declaration and who is physically unable to communicate his desires concerning medical treatment or is INCOMPETENT or unconscious.

F. **Terminal Condition.** Incurable or irreversible medical condition that in the opinion of the attending physician and one other physician who has personally examined the patient: (i) results in there being no reasonable expectation that the patient's condition will improve and (ii) will imminently re-

128. See Kan Stat Ann § 65-28, 102(c) (1990); Or Rev Stat § 127.605(3) (1989); Ariz Rev Stat Ann § 36-3201(4) (West 1991); DC Code § 6-2421(3) (1991).

129. Gould, 39 Mercer L Rev at 532 (cited in note 35).

130. Gould, 39 Mercer L Rev at 533 (cited in note 35).

sult in the patient's death.

Section 2. Right to Determine Medical Treatment

A. Every adult person has the right to direct what medical treatment or procedures are utilized for his own medical care, so long as the exercise of this right does not result in death of a patient or fetus not in a Terminal Condition. No patient may utilize this right to force any Health Care Provider to utilize any medical treatment or procedure which that Health Care Provider does not condone.

B. Every adult person has the right to execute a Declaration concerning decisions to be made with respect to his own medical treatment, which Declaration will be effective at any time such patient is a Qualified Patient as defined in Section 1.

Section 3. Execution of Declaration

A. Every adult person has the right to execute a Declaration concerning what medical treatment or procedures are to be utilized or withheld for his medical care in the event that person becomes a Qualified Patient as defined in Section 1. To be effective, a Declaration must be in writing, and signed by the declarant or by another person in the declarant's presence and by the declarant's expressed direction if the declarant is unable to sign his name. The declaration must also be signed by two witnesses eighteen (18) years of age or older. Such witnesses cannot be (i) the person who signed the declaration on behalf of the declarant, (ii) entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant, or (iii) directly financially responsible for the declarant's medical care.

B. A physician who has been given a copy of a Declaration shall have the right to presume the validity of that Declaration, and act in accordance with the Declaration, unless he has knowledge of facts indicating that the Declaration is not valid or effective.

C. A Declaration in the following form, whether or not it contains both of the paragraphs numbered 1 and 2 below, shall be deemed valid, if signed and witnessed in accordance with this Section.

DECLARATION CONCERNING MEDICAL TREATMENT

This Declaration is made this day of , I, , willfully and voluntarily appoint , my , as my agent and attorney-in-fact, without right of substitution, with lawful authority to make any decisions concerning my medical treatment that I would have the right to determine, at any time that I am physically unable to communicate such decisions or am INCOMPETENT or unconscious.

If I am diagnosed as having a terminal condition, so that my attending physician and one other physician who has personally examined me determine that there is no reasonable expectation that my condition will improve and that such condition will imminently result in my death, I direct that all medical procedures which my attending physician deems would achieve no goal other than prolonging the dying process, be withheld or withdrawn. This paragraph shall supersede any directions made by an attorney-in-fact for me, if there is a conflict between this paragraph and such directions.

I understand the full import of this Declaration, and I am mentally competent to make the decisions contained herein.

Name of Declarant

This declarant is known to me, and I believe him or her to be of sound mind.

Name of Witness

Name of Witness

D. Notwithstanding anything herein to the contrary, no patient may require by means of a Declaration, and no attorney-in-fact appointed by a Declaration may require on behalf of a patient, any medical treatment, care, or inaction which endangers the life of a patient not in a terminal condition or endangers the life of a fetus.

Section 4. Revocation of Declaration

A. A Declaration may be revoked at any time by the declarant:

1. By means of a signed dated writing expressly superseding or revoking the Declaration;

2. By physical cancellation or destruction of the Declaration by the declarant or by another in the declarant's presence and at the declarant's direction; or

3. By means of an oral expression of intent to revoke.

B. Any such revocation is immediately effective. Nevertheless, no person shall be held liable for any action taken based on a good faith belief that a Declaration was still in effect, unless that person has actual knowledge of such revocation.

Section 5. Responsibility of Physicians and Health Care Providers

A. Each Health Care Provider shall honor all medical treatment decisions made by a patient to the extent permitted by Section 2 above. If a patient is a Qualified Patient, the Health Care Provider shall honor the patient's Declaration, including honoring the treatment decisions of one appointed as attorney-in-fact for the patient pursuant to a Declaration.

B. Notwithstanding anything herein to the contrary, no Health Care Provider shall be required to:

1. If the Health Provider is an individual, do any act or refrain from doing any act which is contrary to the dictates of that person's conscience; and

2. If the Health Care Provider is an institution, permit any action or any inaction for any patient being treated by the Health Care Provider which is contrary to the written by-laws or regulations of that Health Care Provider.

C. If any Health Care Provider is aware that a patient has executed a Declaration, and that the dictates of that Declaration may be contrary to the Health Care Provider's conscience, by-laws or regulations as set forth in Section 5B, that Health Care Provider shall immediately notify the patient, if possible, and the patient's immediate family that the Health Care Provider may be unwilling to comply with the Declaration. The Health Provider shall then utilize its best efforts to effectuate the transfer of the patient to another Health Provider chosen by:

1. The patient, if the patient is able to communicate the name of the Health Care Provider to which he wants to be transferred;

2. The attorney-in-fact for the patient, if the patient is unable to communicate and the patient's Declaration appoints an attorney-in-fact; or

3. The immediate family of the patient, if the patient is unable to communicate and no attorney-in-fact has been appointed. The Health Care Provider shall, in addition to using its best efforts to so transfer the patient, transfer all medical records in its possession concerning the patient to the

new Health Care Provider.

D. As soon as any attending physician determines that a patient is in a terminal condition, that physician shall request that another physician personally examine the patient. If that second physician concurs with the determination of a terminal condition, both physicians shall immediately record in the patient's medical records their determination that the patient is in a terminal condition.

E. Failure of any Health Care Provider to comply with the requirements of this statute shall constitute unprofessional conduct.

Section 6. Liability of Health Providers

A. Any Health Care Provider who in good faith participates (sic) in the withholding or withdrawing of Life-Sustaining Procedures or administers medical care or treatment:

1. In conformity with a Declaration;
2. In conformity with the express desires of a patient exercising his rights as set forth in Section 2, hereof; or
3. In conformity with the express desires of the patient's attorney-in-fact appointed pursuant to a Declaration, shall not be subject to any criminal or civil liability or penalty as a result thereof and shall not be deemed to have committed an act of unprofessional conduct thereby.

Section 7. General Provisions

A. This statute shall create no presumption concerning the intent of an individual who has not executed a Declaration.

B. Nothing in this statute shall be construed to condone, authorize, approve or permit any affirmative or deliberate act or omission to end a human life other than to permit the natural process of dying as provided in this statute.

C. The withholding or withdrawal of Life-Sustaining Procedures from a patient in a terminal condition pursuant to that patient's desires as expressed directly or through a Declaration shall not, for any purpose, constitute suicide, manslaughter, or homicide. [and shall not constitute the crime of assisting suicide].

D. The making of a Declaration shall not affect 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 life insurance policy. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of Life-Sustaining Procedures from a patient in a terminal condition, notwithstanding any term of the policy to the contrary.

E. No Health Care Provider or insurer may require any person to execute a Declaration as a condition for receiving health care services or health insurance.¹³¹

VI. CONCLUSION

In light of the United States Supreme Court's decision in *Cruzan* and the federal Self-Determination Act, state statutory law

131. *Id.* at 539-43.

and case law has assumed a controlling role in a patient's right of self-determination.¹³² However, as the foregoing discussion demonstrates, both the case and statutory law are riddled with confusion. In addition, the law varies from jurisdiction to jurisdiction. Thus, patients situated similarly and expressing the same medical desires may be treated differently depending upon where they ultimately become hospitalized. Ambiguous definitions and vague statements granting a health care provider immunity from liability thwart the very purposes of living will legislation.¹³³ Clearly uniformity is desirable.

The model Medical Treatment Decisions Act is an attempt to alleviate the deficiencies mentioned in this article. The model act strives to establish unambiguous definitions.¹³⁴ Terminal illness and life-sustaining procedures are defined in terms of the physician's opinion avoiding the problems associated with terms such as reasonable judgment.¹³⁵ Further, the act codifies the informed consent doctrine so that qualified persons without living wills are still able to assert the "right-to-die."¹³⁶ The model act indicates that the living will is to become effective only if the patient is unable to communicate his desires concerning medical treatment.¹³⁷ Therefore under the act, a patient while competent should be able to assert his rights of medical decision-making under the informed consent doctrine without relying on state case law.

Like some existing legislation the model act specifically provides for a medical power of attorney.¹³⁸ Physicians will be aided by a power of attorney designating a person to make decisions for the patient. This is particularly desirable when multiple family members disagree on medical procedures for a terminal illness or unconscious patient. Finally, the model act, like existing statutory law, releases a health care provider from civil or criminal liability. The language of the model act uses carefully worded definitions which are consistently applied throughout. Therefore, the model act provides a clear statement exempting a provider from liability

132. See text pages 18-21 accompanying notes and pages 24-28 and accompanying notes.

133. See text page 28-31 and accompanying notes.

134. See Model Act § 1.

135. Compare Model Act § 1 (D & F) with text page 28-29 and accompanying notes.

136. See Model Act § 2.

137. Model Act § 2(B).

138. See Model Act § 5.

See also, Utah Code and § 75-2-1106 (Supp 1987) permitting a patient to authorize by a power of attorney to have a third person make treatment decisions for a patient.

if he acts in good faith on reliance of an advanced directive.¹³⁹

Consequently, the model act should be enacted but with one additional provision. The Medical Treatment Decisions Act does not provide for those situations when an individual, unable to communicate his desires, has not made an advanced directive pursuant to the act. The act should include a provision such as the Utah's Personal Choice and Living Will Act¹⁴⁰ which provides for this occurrence. The act should establish a priority list of persons to be consulted along with the attending physician to make decisions regarding life-sustaining treatment. No legislation can provide all the answers. No one can predict where new medical advances will lead. The model act with the recommended addition should provide the maximum protection to such a highly personal choice—to live or to die.

Thomas Rivosecchi

139. See Model Act § 6.

140. Utah Code Ann § 75-2-1107(1-3) (Supp 1987) here the attending physician shall consult with another physician to confirm a patient is in a terminal condition and then obtain the consent of persons in the following order:

- (i) a legal guardian, or the person's spouse;
- (ii) a parent; or
- (iii) the person's children 18 years of age or older.