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EUTHANASIA AND THE RIGHT TO DIE: NANCY CRUZAN AND NEW MEXICO

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I. NANCY CRUZAN COMES TO COURT

At about 1:00 a.m. on January 11, 1983 a recently married thirty-year-old employee of the State of Missouri, Nancy Cruzan, was involved in a one-car accident in Jasper County, Missouri.¹ The car was overturned and she was found about 35 feet from the car. Police arrived five or six minutes after being dispatched to the scene of the accident; paramedics arrived about nine minutes after the police. Nancy Cruzan was not conscious when she was taken to the hospital. The hospital did a series of tests which revealed lacerations of her liver but no significant brain abnormality. She was provided treatment for all of her physical ailments, although she remained unconscious. The only way she interacted with her environment was to react reflexively to sound and perhaps to painful stimuli.²

Although she was able to take nutrition orally, to "assist her recovery and to ease the feeding process," a gastrostomy tube, a feeding tube, was placed into her stomach.³ A gastrostomy tube is a flexible piece of tubing that goes through the abdomen into the stomach so that food can be poured through the tube into the stomach. There followed, over years, what the court described as "valiant efforts" at rehabilitation.⁴ Nancy's parents visited her regularly and tried various ways of communicating with her. Several rehabilitation experts worked with her and tried to communicate with her, hoping that they would see some kind of improvement, but she has not improved.

It is now seven years later and Nancy Cruzan is thirty-six years old. She now sits—or, rather, she sometimes rests on her back, sometimes on her stomach, depending on her placement by nurse's aides, in a nursing home in Missouri. The trial court made seven findings of fact, based on the consensus opinions of her doctors, about her and her prospects for life. First, she can breathe on her own, and she will continue to breathe on her own. Second, she is oblivious to her environment. Third, what used to be her brain, or at least the cerebral cortex, has

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1. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc). The following facts are taken from the *Cruzan* opinion at 410-11. This case was pending before the United States Supreme Court at the time this lecture was delivered. The United States Supreme Court ultimately reversed the Missouri Supreme Court. 110 S. Ct. 2841 (1990).

2. *Id.* at 411.

3. *Id.*

4. *Id.*

atrophied and that area within the skull is now filling with spinal fluid. Her brain deterioration is "irreversible, permanent, progressive, and on-going."⁵ Fourth, her highest cognitive brain function is exhibited by grimacing, perhaps in response to pain and sound. Fifth, she is a spastic quadriplegic. Sixth, her arms and legs are contracted as a consequence of the absence of brain activity. There is irreversible damage to the muscles and tendons in her arms and legs. Seventh, she lacks the cognitive and reflexive ability to chew and swallow all that she needs to sustain herself. She will never be able to recover these cognitive functions.⁶ In sum, she is in a persistent vegetative state. Her condition will not improve, and she may live like this for another thirty years.⁷ She was a state employee and is now in Mt. Vernon State Hospital, essentially a state nursing home. All of her expenses are being paid by the State of Missouri.⁸

While she was competent, before her accident, Nancy Cruzan told her friends that she didn't want to live unless she could live what she called a "halfway normal" life.⁹ Her parents, who have maintained decreasing hope for the past six years and who have visited her regularly, believe now that the gastrostomy tube should be removed. They believe that their daughter would want the tube removed.¹⁰ In any case, they believe that it is appropriate and consistent with the maintenance of her dignity for the tube to be removed. If the tube is removed, she will not be able to receive any food or fluids and she will die. Her death would be an absolute certainty, probably within a week. Nancy's parents, who are also her legal guardians, have now asked the Mt. Vernon State Hospital to remove the tube. Mt. Vernon State Hospital refused to do so without a court order.¹¹

The case went to trial in a trial court in Missouri, which heard arguments on behalf of the Cruzan family, who wanted the tube removed from their daughter's stomach.¹² They also heard arguments from the state, which intervened and argued that the tube should not be removed. The trial court gave permission to remove the tube, but it stayed its order so that there could be an appeal. The regular members of the Missouri Supreme Court appear to have been equally divided on the issue. There were three who thought the tube could be removed and three who thought the tube could not be removed.¹³ Under these circumstances the Chief Justice can appoint another judge to sit with the court—in this case,

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.* at 411 n.2. *See also id.* at 432 (Higgins, J., dissenting) (citing the judgment of the trial court, Justice Higgins notes that Nancy Cruzan has no financial resources other than Social Security and that her medical insurance ran out in January 1986).

9. *Id.* at 432 (Higgins, J., dissenting).

10. *Id.* at 422.

11. *Id.* at 410.

12. *Id.*

13. *Id.* at 442 (Welliver, J., dissenting).

effectively giving the Chief Justice two votes¹⁴—and the Missouri Supreme Court ultimately voted four to three that the tube could not be removed and that in Missouri a feeding tube—nutrition and hydration—could never be withheld from an incompetent patient in a persistent vegetative state.¹⁵

Is Nancy Cruzan's the only story like this? No, there are hundreds of people like Nancy Cruzan—although most, fortunately, do not have their cases go before the Missouri Supreme Court. This case was heard by the United States Supreme Court on December 6, 1989. This is the first right-to-die case to be heard by the United States Supreme Court; many believe it will be the only right-to-die case the Supreme Court will ever hear. The United States Supreme Court will address one issue: whether the United States Constitution includes a right that extends to permitting incompetent patients to terminate nutrition and hydration. That is the whole of the question. On one side is the Cruzan family. On the other side is Attorney General Webster, whose name appears in *Webster v. Reproductive Services of Missouri*,¹⁶ the abortion case last term. The right-to-die organizations and virtually all of the medical organizations in the country, as well as most civil rights organizations, have filed briefs supporting the Cruzan family in their attempts to have the tube removed. The right-to-life organizations and organizations dedicated to protecting disabled people have filed briefs on the other side, supporting the state in its effort to block removal of the tube. Church-related groups have filed briefs on both sides of the issue.

II. ANALYZING THE ISSUES

A. Brain Death

The first fact that strikes many people is that most of Nancy Cruzan's brain has disappeared. Most of her brain is now fluid. Is she still a person? What are the basic attributes of personhood that define a human being, and does Nancy have them? Is she dead? While we may wish to define her as dead, there is no question that under the current law she is not dead.

Let me give you a very brief history of the development of the "brain death" definition of death and explain why we have to go on to answer much harder questions to deal with the Cruzan case. Historically, death was seen to have occurred with the irreversible cessation of the heart and the lungs. It was pretty easy to tell when the heart and lungs had irreversibly ceased—certainly after several minutes it was quite clear. With the development of the heart/lung machine and more sophisticated tech-

14. MO. REV. STAT. §477.020 (1987), Rule 84.15. See *Cruzan*, 760 S.W.2d at 444-45 (Welliver, J., dissenting).

15. *Cruzan*, 760 S.W.2d at 410.

16. *Webster v. Reproductive Serv. of Missouri*, 109 S. Ct. 3040 (1989). Now a candidate for Governor, Mr. Webster has apparently reconsidered his position.

nology over the course of the last forty years, we now can take bodies whose heart and lungs would otherwise cease and we can keep those organs working—we can keep the heart beating, we can keep the lungs breathing. Applying only the traditional definition of heart-lung death, now we can keep people alive forever. It may not be the kind of “life” anyone would want to live, but with only the heart-lung definition of death, it would be possible to take virtually any otherwise dead body and keep it “alive” until it decomposed.

Historically, when the heart and the lungs stopped, the brain ceased functioning shortly thereafter; it could not operate for more than a few minutes after the heart and the lungs stopped. There was no need or ability to distinguish between brain death and heart-lung death: if the heart and lungs stopped, the brain stopped.

That is no longer true. Now we keep the heart and lungs going even after the brain has ceased functioning irreversibly. As a consequence, most states now recognize that where there is the permanent and irreversible death or the cessation of functioning of all parts of the brain, the patient is dead.¹⁷ Because, traditionally, that would have happened only when the heart and lungs had stopped, the brain-death definition of death really encompasses the same cases as were encompassed by the traditional heart-lung definition; it simply overcomes the recently developed inability to apply the heart-lung definition when the heart and lungs are maintained by machinery.

Why doesn't Cruzan fit within this definition of brain death? She isn't brain dead because her brain stem is still operating. The portion of her brain that controls neither cognitive abilities nor emotions, but that controls her lungs and her heart (and non-cognitive functions), is still operating. She has suffered what some people have called “higher brain death,” or “cognitive brain death.” Despite this, though, there is some living portion of her brain, and so she is not brain dead under the laws of any state.

Should we move to a “higher brain death” definition?¹⁸ If there is no thinking or feeling ability left—if there is nothing except the ability for the heart and the lungs and the pineal gland to operate—should that

17. See, e.g., N.M. STAT. ANN. §12-2-4 (Repl. Pamp. 1988). See also *Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 205 J. A.M.A. 85 (1968). This report may well have facilitated the adoption of the brain death definition by state legislatures. The first state legislature to enact a brain death statute was Kansas. KAN. STAT. ANN. §77-202 (1970) (repealed 1984). See also UNIFORM DETERMINATION OF DEATH ACT (1980). This Act was created out of the consensus of the American Bar Association, the American Medical Association, and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The issue is discussed extensively in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *DEFINING DEATH: A REPORT ON THE MEDICAL, LEGAL AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH* (1981).

18. For arguments in support of and opposed to the use of a higher brain death definition, see Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850 (1986) (includes a proposed neocortical death statute). See also Veatch, *The Definition of Death: Ethical, Philosophical and Policy Confusion*, 315 ANNALS OF N.Y. ACAD. OF SCI. 307 (1978); Dworkin, *Death in Context*, 48 IND. L.J. 623 (1973).

be enough for us to declare someone to be dead? Is there any personhood left in a piece of decaying flesh with an operating heart and working lungs? We would feel very uncomfortable burying somebody who is breathing. Because we feel uncomfortable treating breathing people as dead bodies, no jurisdiction has adopted the higher brain death definition of death. Thus, the question is not whether Nancy Cruzan is dead; the question is whether Nancy Cruzan should be allowed to die (or be forced to die, depending on how you look at it) by the removal of her gastrostomy feeding tube.

B. The Right to Die - Fundamental Principles of Bioethics

There are three principles that philosophers and courts have applied in analyzing how health care decisions ought to be made in individual cases where there is potentially valuable but potentially harmful treatment available. The three principles are autonomy, beneficence and social justice. Let me define them and investigate how we can apply them, at least generally, and then return to see how we might apply them in the Cruzan case.

The principle of autonomy says that each person is in control of his or her own body, soul, spirit, and life. It means we each control our own lives, and that includes controlling our own bodies. Autonomy is an important principle and one that has been recognized by philosophers for centuries and by courts for a century. It is certainly a fundamental principle in this country, where self-determination and independence are extremely highly valued.

The principle of beneficence, an equally fundamental principle, says that we ought to do what is best for people; we should act to help other people.

The principle of social justice says that we should treat like cases in like ways and thus, by extension, that we should fairly distribute the resources of society. When we limit ourselves to reviewing the case of one person who is facing a life or death decision, the distributive questions are virtually impossible to apply.

The resolution of these individual cases often arises from an analysis of the conflict between the principles of autonomy and beneficence. The principle of autonomy says we should let people do what they want to do. The principle of beneficence says we should do what is best for people. When these two principles are not consistent—for example, when we believe that somebody would want to die, but we do not think that it is best for that person to die—there is a real dilemma, a real conflict between basic principles.

Let me divert for just a moment to suggest that autonomy, as you would guess, is very important to lawyers. It has its greatest social manifestation in this culture in the law. For lawyers, autonomy virtually always prevails. In contrast, doctors tend to be beneficence-oriented. Doctors are trained to do what is good for people. Doctors are trained to help people. As a consequence, where there is a conflict between autonomy and beneficence you may also see a conflict between lawyers

and doctors. Lawyers and the law are much more likely to support what the principle of autonomy would require, and doctors are much more likely to support what the principle of beneficence would require.

C. *The Right to Die - Principles of Law*

How have these dilemmas been resolved? Ultimately, many of these cases have found their way into the courts.¹⁹ And which do you think prevails - autonomy or beneficence? Of course, it is autonomy that usually will prevail under these circumstances. In some areas the law is now fairly well established. The simplest case is the case of a competent adult faced with a choice about life-sustaining treatment. The law now recognizes the competent adult's right to forego that treatment, and that right has been virtually unquestioned since the *Bouvia*²⁰ case was decided in California. For competent adults, autonomy trumps beneficence. The *Bouvia* case and its wide acceptance mark a dramatic change in the way we view these problems. As long as these issues were resolved by doctors without recourse outside the hospital, beneficence trumped. If there was any real doubt, treatment was provided. Since these cases have now become legal cases, autonomy prevails. Now these decisions are by and large left to individual patients—at least so long as they are competent adults able to give informed consent.

1. The Common Law

Let me suggest some of the legal bases for this triumph of autonomy. Courts have looked to a variety of legal sources to find support for this right of competent patients to make decisions. Most of the courts that have considered it find it in the common law. The common law is judge-made law; it is the residual law. It is the law that judges apply when the courts must apply some legal principle, but they have not been provided any by the federal or state constitutions or by any statute from Congress or the state legislatures. Most courts have found the principle of autonomy in the common law of the state. The basic common law principle, based in a notion of privacy, provides that unless there is a countervailing interest, each person can do whatever he wants with his body, with his mind and with his soul and spirit. Common law is developed on a state by state basis. So we look to the law of each state to see if the courts in that state have found a right of privacy manifested in the

19. The majority in *Cruzan* cites 53 state cases decided between 1976 and 1988 which involved either the initiation or removal of life-sustaining treatment. 760 S.W.2d at 412-13 n.4. There have been a few more since *Cruzan* was decided by the Missouri Supreme Court in 1988.

20. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (court ordered writ of mandamus to compel lower court to grant request of petitioner Elizabeth Bouvia, a competent adult diagnosed with severe cerebral palsy, quadriplegia, and arthritis, for a preliminary injunction requiring the public hospital where she lived to remove her nasogastric tube).

state's common law, and to determine whether that common law right of privacy allows patients to make their own health care decisions.²¹

2. State Constitutional Law

There are other legal sources for these same principles. Some states have found a vigorous right of privacy in their own state constitution.²² It is clearest, I suppose, in Alaska, California, Florida and those other states that have explicit rights of privacy in their constitutions. New Mexico does not. In some states—New Jersey is one example—the state constitution has been read to guarantee the right to make health care decisions, although it is hard to pinpoint exactly which part of the constitution yields up that right.

3. State Statutory Law

There is very little state statutory law (and whether we should be thankful about that is something you can answer for yourself) that affects this common law right to make health care decisions. The rare statutory law has been construed in a variety of ways. One state where statutory law has had an effect on the way the common law has been interpreted is Missouri, where, as you recall, Nancy Cruzan remains alive. In Missouri, there are two kinds of statute that the court considered important. One is the same anti-abortion statute that the Supreme Court considered last year in the *Webster* case.²³ The Missouri Supreme Court said that statute shows a clear preference for maintaining life at every stage and under all conditions in Missouri.²⁴ The Missouri Supreme Court found that statute affected whatever the common law otherwise would have been.

That same court also looked to the Missouri living will statute, a revision of the Uniform Rights of the Terminally Ill Act.²⁵ That statute provides that under certain circumstances one can sign a living will and, if one meets a very constraining and unusual set of requirements, treatment can be discontinued. That statute explicitly provides that the treatment

21. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 738-40, 370 N.E.2d 417, 427-29 (1977) (common law right to privacy is one source of patient's right to refuse medical treatment). See also *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 424, 497 N.E.2d 626, 633 (1986) and *In re Conroy*, 98 N.J. 321, 334-35, 486 A.2d 1209, 1222-23 (1985) (noting the existence of a common law right to "self-determination"). Finally, see *In re Storar*, 52 N.Y.2d 363, 369-70, 438 N.Y.S.2d 266, 272-73, 420 N.E.2d 64, 70-71 (1981) (a competent adult has a common-law right to accept or decline medical treatment).

22. State court cases cited by the majority in *Cruzan* as having authorized the refusal of life-sustaining treatment after finding a right of privacy expressly provided for in their state constitutions include *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Ct. App. 1986); *In re Guardianship of Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); and *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987). See *Cruzan*, 760 S.W.2d at 417 n.12.

23. 109 S. Ct. 3040 (1989). See Mo. REV. STAT. §188.010 (1986) (The legislature intends to grant the "right to life to all humans, born and unborn. . ."). See also *Cruzan*, 760 S.W.2d at 419; Mo. REV. STAT. §§188.015(7), 188.130 (1986).

24. See Mo. REV. STAT. §188.010 (1986).

25. *Id.* §459.010 et seq. (1986).

that may be discontinued—which it defines as a “death prolonging procedure”—does not include the performance of any procedure to provide nutrition or hydration.²⁶ There are many reasons that such language might have been written into statute law in Missouri. Anyone who has watched a bill travel through a state legislature knows that there are hundreds of different reasons that different legislators vote for or against it. There was a battle in the Missouri legislature over whether or not nutrition and hydration should be included among those procedures that could be discontinued. Some observers of the Missouri legislature claim that this language was a compromise that simply took the whole issue out of the statute and left the undetermined common law on the removal of nutrition and hydration intact. These observers believe that the Missouri legislature did not decide that one could never discontinue nutrition and hydration, and they did not decide that one could discontinue it—they just did not decide the issue at all. The Missouri Supreme Court apparently concluded that because “death prolonging procedures” do not include any procedure to provide nutrition or hydration, it is Missouri policy to forbid the removal of nutrition and hydration in all circumstances. This statute, interpreted this way, modified the common law.²⁷

4. Federal Constitutional Law

Another source of the law to which many courts look for guidance in this area is United States constitutional law. One argument that was made on behalf of the Cruzan family is that the liberty interest protected by the due process clause of the fourteenth amendment to the United States Constitution includes the right to discontinue medical treatment.²⁸ This argument says that that liberty interest includes the right to choose one's own medical care, and that right extends even to incompetent people. Several states have found this right in the United States Constitution.²⁹ The Missouri court, as you can guess, found that there was no common law right, no state constitutional right, and no federal constitutional right to discontinue treatment, at least in the case of Nancy Cruzan, who is not terminally ill, and where the burdens upon her do not outweigh the state's interest in preserving life.³⁰

Because the state supreme court is the highest arbiter of state law, all questions except the federal constitutional question will be answered state by state, and there is no reason to believe that the answer in New Mexico will be the same as the answer in Missouri or Arizona or California or

26. *Id.* §459.010(3).

27. *Cruzan*, 760 S.W.2d at 420.

28. This argument was accepted by the lower court. *Id.* at 434 n.3 (Higgins, J., dissenting) (citing trial court opinion). Of course, this was the basis of the argument to the United States Supreme Court.

29. See, e.g., *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626; *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 738, 370 N.E.2d at 424; *In re Quinlan*, 70 N.J. at 40, 355 A.2d at 663; *In re Quackenbush*, 156 N.J. Super. 282, 289-90, 383 A.2d 785, 789 (1978).

30. *Cruzan*, 760 S.W.2d at 424.

Wyoming. The United States constitutional issue will be finally determined by the United States Supreme Court, and we should know the answer to that question this summer. If the United States Supreme Court decides that there is a United States constitutional right which allows patients to discontinue treatment, that decision will protect patients throughout the country. If the Cruzan family wins, it will be a tremendous victory for those people who support the right to die. If the Cruzan family loses, it will be a loss for that movement, but the issue will ultimately be decided state by state, because each state will have to evaluate its common law, its statutory law and its own constitutional law. The United States Supreme Court can require the right be extended to all people in all states; it probably cannot forbid the right from being extended by states otherwise disposed to do so.

5. Limitations on the Right—Countervailing State Interests

Even states that have found that autonomy is an important part of the common law or the constitutional law of the state, and thus say patients have a right to make health care decisions on their own, have put some limitations on that right. Courts generally find four countervailing interests. While they very rarely have found that a countervailing interest outweighs the autonomy of a patient, on occasion they have.

The first countervailing interest is the interest in the preservation of life. Sometimes the interest in the preservation of life can overcome the interest in the patient to make a decision. Of course, this is a very weak countervailing interest. Why should we force someone to stay alive because the state has some generalized and disembodied interest in the preservation of life? In this country the state exists to serve its citizens, the citizens do not exist to serve the state. That is the difference between this form of government and other forms of government for which we have less respect.

A second countervailing interest is the state's interest in the prevention of suicide. This interest has subsided as suicide has disappeared as a crime in virtually all states, and even in those few that name suicide as a crime, the laws against suicide are not enforced. It is true that criminal laws against suicide were never enforced against anyone who was successful. No one was ever convicted of the completed crime of suicide, but people were convicted of attempted suicide.

The third potential countervailing interest is the interest in the protection of innocent third parties. The rare cases in which this principle has been applied include those cases involving pregnant women who want to refuse blood transfusions³¹ or women who have very small children and who

31. See, e.g., *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964) (pregnant Jehovah's Witness not permitted to refuse a necessary blood transfusion).

can be returned to full health by non-risky treatment they wish to refuse for religious or other reasons.³²

Finally, there is the state interest in the protection of the ethical integrity of the medical profession. Many courts have cited this as a reason to limit the right to die.³³ However, we have a health care system to serve patients' interests, not doctors' interests. Patients are not there to serve doctors; doctors ought to be there to serve patients. It does not make any sense to say that a patient cannot do what would otherwise be appropriate because doing so offends the ethical sense of the some physicians.

6. Special Issues—Vitalism, Extraordinary and Ordinary Treatment and Nutrition and Hydration

There are several questions that are less significant than they may seem at first. First, can we ever decide that life should be terminated? There are those who suggest that it is simply beyond the scope of human authority because life in any form, under any circumstances, is precious and thus must be preserved. This is called the vitalist position and it is attractive only in its symbolism; it leads to untold grief in the real world. It has also led to a debate between those who hold life as sacred under all circumstances—the "sanctity of life" position—and those who view quality of life as a relevant consideration—the "quality of life" position. Unfortunately, the "sanctity of life" people and the "quality of life" people have great difficulty even talking to one another primarily because of the absurd results that flow from the "sanctity of life" position.

Second, should the nature of the treatment that is to be discontinued make a difference? Maybe it should be acceptable to discontinue extraordinary treatment, but not ordinary treatment. That distinction may have made sense a couple of decades ago, but it is an anachronism now. What is ordinary and what is extraordinary? Some treatment might be extraordinary (or at least very unusual) in one case, and perfectly ordinary in another case. While the use of a ventilator may be extraordinary under some circumstances, it is very ordinary when used to help people im-

32. See, e.g., *In re President and Directors of Georgetown College*, 331 F.2d 1000, 9 A.L.R.3d 1367 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (in ordering a blood transfusion for the Jehovah's Witness mother of a seven-month-old child, the court based its decision in part on the rationale that the competing interests of the dependent child can overcome the interests of the patient herself). See also *Public Health Trust v. Wons*, 541 So. 2d 96, 99 (Fla. 1989) ("Absent evidence that a minor child will be abandoned, the state has no compelling interest sufficient to override the . . . patient's right to refuse treatment.").

33. See *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). This interest was first articulated in *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 735-37, 370 N.E.2d at 425-27, where the court identified the existence of this interest but found it to be modified significantly by prevailing medical ethical standards which recognized the right to refuse necessary treatment in certain circumstances.

For an articulation of the American Medical Association's position that doctors may ethically withdraw life-prolonging treatment from patients who are in a persistent vegetative state, see CURRENT OPINIONS, THE COUNSEL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION - 1989: WITHHOLDING OR WITHDRAWING LIFE-PROLONGING TREATMENT (1989).

mediately following serious accidents; it keeps them alive until they can be properly treated. There is no way to draw a line between ordinary treatment and extraordinary treatment. The law now recognizes that, just as most philosophers have for some time.

Despite that, might there be something special about nutrition and hydration? Perhaps we should never allow the discontinuation of nutrition and hydration. I am not really sure why people make this argument. Some might believe that nutrition and hydration is "ordinary" and other kinds of treatment are "extraordinary." But, as we have seen, that distinction is meaningless. Others may believe that nutrition and hydration are not medical treatment at all. Nutrition and hydration are just food and water, they are just comfort care, not medical care. But if nutrition and hydration are just eating and drinking, a ventilator is merely breathing and dialysis is merely kidney function. Each one is equally mechanical, each one is equally electronic, and each one is equally artificial. There is no reasonable way of distinguishing between the use of mechanically or electronically provided nutrition and hydration, the use of a ventilator, and the use of kidney dialysis. All of them are equally medical or equally "natural." The way you resolve this issue may depend on the way you state it. It is easy to say that electronically provided nutrition and hydration is a medical treatment. It is hard to say that food and water constitute medical treatment. When you talk about someone starving to death or thirsting to death, you tend to think of that as an inhumane way to die. When you talk about removing the gastrostomy tube from Nancy Cruzan, you may find that to be a very humane, perhaps the only humane, way for her to die.

D. Applying the Principles

Let's go back to the Cruzan case now and apply this framework for analysis to somebody who has been in a coma for six years. If autonomy trumps beneficence and competent adults have the right to make decisions for themselves, how do we treat an incompetent adult in a persistent vegetative state? Does autonomy still prevail? Does it make any sense to talk about what, in fact, she wants? She does not know what she wants and she certainly cannot express what she wants. Indeed, she lacks the cognitive ability to possess a desire or an interest or a value.

In this society, though, we value the integrity of the patient even if that patient is incompetent. We still put importance on the values that were important to the patient throughout life. Thus, we can still serve the interests of autonomy by looking at the values once possessed by that patient and doing our best to act consistently with those values. We can do this by asking what she would want if she were competent for a moment and could see herself in her current condition. It may well be that it is valuable to do that—not because Nancy Cruzan actually cares any longer—but because the rest of us care about what is going to happen to us when we are in that position. Many of the rest of us want to be able to decide now how we are going to be treated if we become incompetent. We want the security now or knowing that our

wishes will be followed later. This control of our future is fundamental to our autonomy now.

In this area, our interest is identical to our interest in the application of the law of wills. The decedent, the one who wrote the will, does not care how the property is distributed when the will is probated; indeed, he will never know how the property is distributed because he will be dead. Nonetheless, the rest of us want to know that we can decide now how our property will be distributed upon our death, and thus we think that it is important to carry into effect the desires that are evidenced in a will.

So it is with the wishes of Nancy Cruzan. The principle of autonomy requires that we figure out how to fulfill the values, interests and desires she possessed before her accident. But how do we know what she would have wanted? How can we figure that out?

1. The Living Will

There are several ways that a hospital or a physician, or family members or, if necessary, a court could determine what kind of treatment an incompetent person would want. The most well known is the living will. There is a right-to-die statute in New Mexico that authorizes the living will;³⁴ indeed, living wills are now authorized in most states.³⁵ The New Mexico Right to Die Act permits one to sign a document which provides that if the declarant is ever "terminally ill" or in "irreversible coma" certified by two doctors, then "maintenance medical care" may be withheld or withdrawn.³⁶ That is all the living will does. The real importance of the statute authorizing the living will is not that it relieves the doctor of liability, although it has that effect.³⁷ Its real importance is that it is the declarant's written indication of how he feels about certain kinds of treatment. That kind of information surely will be valuable to a patient's family and doctors and, if necessary, to the courts, if that patient is in a condition covered by the document.³⁸

2. The Durable Power of Attorney

The second kind of advance directive is the durable power of attorney. A durable power of attorney is a document authorizing someone else to make decisions on a person's behalf. Traditionally you could only authorize people to make decisions on your behalf as long as you were competent; any power of attorney expired as soon as you became incapacitated. Obviously, such a document could not help in making medical decisions, because only when you are incapacitated do you need someone

34. New Mexico Right to Die Act, N.M. STAT. ANN. §§24-7-1 to -10 (1978 and Supp. 1988).

35. Forty-one states now provide for living wills of some sort.

36. See N.M. STAT. ANN. §24-7-3 (1978).

37. See *id.* §24-7-7 (1978).

38. A form right-to-die document designed to be consistent with the New Mexico statute is attached as Appendix A.

else to make medical decisions for you. The Uniform Probate Code was amended in 1975 to provide that if you write in the body of a durable power of attorney that it will become effective or remain effective after you become incapacitated, then in fact it does remain effective.³⁹ A durable power of attorney thus can now allow you to appoint somebody to make health care decisions for you, and it can provide a process for having those decisions made. You can put virtually any limitation you want on any person you appoint in a durable power of attorney. You can appoint someone to make health care decisions for you and provide that these decisions are to be made only after consultation with the family, or with a priest, or with named philosophers, or with three named physicians, or after seeing a particular movie, or whatever you want. Because you can put virtually any limitation you want in a durable power of attorney, they turn out to be very powerful documents. First, they identify someone who actually can make health care decisions for you, and, second, they can provide a list of the values that are most important to you, or at least the people who are most important to you, who will review the relevant considerations when those decisions are made. We are fortunate indeed that the New Mexico Legislature has provided a form for a durable power of attorney that is presumptively valid, and that this form includes sections that deal directly with health care decisions and, even more precisely, with decisions about terminating life support treatment.⁴⁰

3. The Values History

How do we know what the wishes of the patient might be if there is no prior directive? Normally the common law looks to family members to help make that determination. We look to family members because family members are usually the ones closest to the patient and thus are the ones who were most likely to know the values of the patient. At least for terminally ill patients, or patients in irreversible coma, the New Mexico statute now directs physicians to look to family members—to close family members. That is one source for the values of the patient.⁴¹

Where else could you possibly look? Well, you could look to statements and comments that have been made by the patient. It is hard to know how to use that kind of information, though, and so Dr. Joan Gibson of the Institute of Public Law has now developed a new document that you might want to use to help people know what your values and interests are so that health care decisions can be made on your behalf if you become incompetent.⁴² The living will was the first development in this

39. UNIFORM PROBATE CODE §§5-501, 5-502 (1975). See also UNIFORM DURABLE POWER OF ATTORNEY ACT, promulgated by the National Conference of Commissioners on Uniform State Laws. 8 U.L.A. 70 (1981 Supp.). This act is identical to the provisions of the Uniform Probate Code.

40. N.M. STAT. ANN. §§45-5-501 (Repl. Pamp. 1989). A copy of this form durable power of attorney is attached as Appendix B.

41. *Id.* §24-7-8.1 (1978).

42. A copy of the values history form is attached as Appendix C.

area, and that was a decade ago. The use of the durable power of attorney for health care decisions was the second. The third, newest, and possibly most valuable document is the "values history."

The values history is a document that you might want to fill out sometime while you're still competent, as you all were at the beginning of this presentation. It includes questions like how do you feel about doctors? How do you feel about medicine? How do you feel about your family members? How important is religion to you? What else is important to you? This kind of document provides at least some framework that other people may be able to apply to serve your autonomy interest, to serve your values and to serve your integrity, if health care decisions have to be made on your behalf after you become incapacitated.

E. The Right to Die - Conclusion

Well, if you don't want to be a Nancy Cruzan, or for that matter, if you do want to be a Nancy Cruzan—if you do want to be kept alive under any circumstances—what can you do? Nothing will guarantee that your wishes will be respected. Your chances are improved if you have a living will. Your chances are improved even more if you have a durable power of attorney. Your chances are improved again if you have filled out a values history. Your chances are certainly improved if you've discussed these issues with the people close to you—with your family and your friends—and with your doctor.⁴³ I also wear a medical alert bracelet that requests that if I become comatose in Missouri, I be moved to Illinois.

F. Euthanasia

Is all of this enough? Is the legal development that allows patients, in consultation with families and physicians, to discontinue life sustaining treatment, enough? Is it sufficient for those patients who are either in excruciating pain, or humiliating indignity? What about those who want some kind of active intervention to hasten or to cause their death? Should the medical profession be involved in helping those people overcome that excruciating pain or that humiliating indignity through euthanasia? Is euthanasia—an act by a physician, at the request of a patient, designed to hasten the patient's death—any different from letting someone die? Is it any different from removing life-sustaining treatment from a terminally ill or an irreversibly comatose patient?

The law says that it is different. The law defines euthanasia as murder. It is, after all, an act by a physician that causes death and is intended to cause the death. Not only is it murder, but it is usually premeditated murder, the highest degree of murder. Logically, though, is euthanasia

43. Living wills and related documents will do you no good whatsoever in your safe deposit boxes. No one will look in your safe deposit box until long after it's too late. Your will you may keep in your safe deposit box; your living will should be in the hands of your doctor and your family.

different from allowing someone to die? That is a matter of great national debate. Indeed, an initiative that would have allowed euthanasia was almost on the ballot in California,⁴⁴ and the polls showed that if it had been on the ballot, it would have passed by a large margin.⁴⁵ It did not make it to the ballot because the signature collection drive was inadequate.⁴⁶ If it is a matter of real political debate in California now, we know that soon it will be a matter of debate in New Mexico.

There is one country, the Netherlands, where euthanasia is permitted under limited circumstances.⁴⁷ While it is still technically illegal in the Netherlands, the prosecuting attorneys have announced that they will not prosecute doctors who perform euthanasia under the following five defined circumstances. First, there must be an explicit and repeated request by the patient that leaves no reason for doubt about the desire to die. Second, the patient must be in mental or physical suffering which is very severe and have no prospect of relief. Third, the patient's decision must be well-informed, free and enduring. Fourth, all other treatment options must have been exhausted or refused by the patient. Finally, the doctor must consult with another physician to ensure that all the previous conditions are met. When those five conditions are met, then euthanasia can be performed in the Netherlands without fear of prosecution or civil liability.⁴⁸ Does it happen? Yes, it happens in perhaps several thousand cases a year. Some say that the average family practitioner is called upon to perform euthanasia on a patient about once every three years.⁴⁹ It almost always takes place at home,⁵⁰ and the availability of euthanasia is politically very popular in the Netherlands. The vast majority of the population views it as being appropriate and helpful.

So, you might ask, why don't we do it here, at least under those narrow circumstances? First, it is murder and the prospect of life imprisonment is a disincentive for the physician who might otherwise be interested in participating. Are there other risks of euthanasia that aren't

44. The California initiative was publicized as "a logical extension of existing state living will legislation." See Parachini, *The California Humane and Dignified Death Initiative in Mercy, Murder & Morality: Perspectives on Euthanasia*, HASTINGS CENTER REPORT SPECIAL SUPPLEMENT 10 (Jan./Feb. 1989).

45. Three polls taken in 1986 and 1988 all revealed that between 58-70% of Californians would have supported passage of the bill. All that would have been required for the bill's passage would have been a bare majority of the votes cast. After the defeat in 1988, supporters of the bill promised to try again. Parachini, *supra* note 44, at 11.

46. Supporters of the initiative were only able to obtain 130,000 signatures, less than one-third of the 450,000 verified signatures required to present the issue to the voters. Both direct supporters of the initiative and other political observers attributed the lack of signatures to a failure in the political organization of the signature drive rather than a lack of popular support for the issue. Parachini, *supra* note 44, at 11.

47. Fenigsen, *A Case Against Dutch Euthanasia*, in *Mercy, Murder & Morality: Perspectives on Euthanasia*, HASTINGS CENTER REPORT SPECIAL SUPPLEMENT 22 (Jan./Feb. 1989); Rigter, *Euthanasia in the Netherlands: Distinguishing Facts From Fiction*, in *Mercy, Murder & Morality: Perspectives on Euthanasia*, HASTINGS CENTER REPORT SPECIAL SUPPLEMENT 31 (Jan./Feb. 1989).

48. Rigter, *supra* note 47, at 31.

49. Rigter, *supra* note 47, at 32 (citing Oliemans and Nijhuis, *Euthanasia in Family Practice*, 41 *MEDISCH CONTACT* 691 (1986) (in Dutch)).

50. Rigter, *supra* note 47, at 32.

present in just terminating life support systems? Is there some other argument against allowing euthanasia? There are five arguments against it. None of them, I think, is ultimately compelling, but let me list them.⁵¹ The first argument is that there might be a misdiagnosis and thus an inappropriate death. What happens if we perform euthanasia on somebody who otherwise would have miraculously recovered? Of course, the same argument can be made against discontinuing any kind of life-sustaining medical treatment. It could be used against the use of a "brain death" definition of death. Quite simply, it proves too much. The second argument is that euthanasia, even though we call it voluntary, is not really voluntary because we coerce people into saying that they want to die against their will. This has not been a problem under the Dutch system. There is no financial incentive for euthanasia in that country, which has a very good health care system. In fact, there is a disincentive because Dutch doctors are reimbursed on a per capita basis.⁵² Those who say that when euthanasia is available grandpa will be forced to die have a remarkably cynical view of families and other social institutions. I think that, by itself, ought not be an argument for prohibiting euthanasia when it is carefully limited and controlled, as it is in the Netherlands.

The third argument is that euthanasia puts us on the slippery slope. Now we are only permitting voluntary euthanasia, but next week it will be forced euthanasia of the socially undesirable and soon we'll be getting everyone who is under 5'8". This argument suffers from the same fallacy that affects all slippery slope arguments. We are always on the slope, but it need not be slippery. If we adopt the restrictions that the Dutch have imposed, there is no real danger of slipping down any slope. Indeed, there is no reliable evidence that the Dutch have slipped into inappropriate behavior.

The fourth argument against euthanasia is that it evidences a disrespect for the severely disabled, who may be the ones most likely to choose euthanasia. But it does not show any disrespect for someone to tell him that he may die if he chooses to die. The disrespectful position is the other one, the one that tells a disabled (or other) person, "You may have thought this through, you may be entirely mentally competent even though you are physically disabled, you may have decided that you would prefer to die, but we are not going to respect your decision."

The fifth argument, and, I think, the one that has been most significant, is that euthanasia changes the role of doctors substantially. Historically doctors preserved life, they did not take life. Some believe that it would be a terrible mistake to change the role of doctors to include taking life.

51. These arguments are taken from the excellent HASTINGS CENTER REPORT SPECIAL SUPPLEMENT entitled *Mercy, Murder & Morality: Perspectives on Euthanasia*. This supplement includes Koop, *The Challenge of Definition*; Callahan, *Can We Return Death to Disease*; Engelhardt, *Fashioning an Ethic for Life and Death in a Post-Modern Society*; Wolf, *Holding the Lone on Euthanasia*; Doerflinger, *Assisted Suicide: Pro-Choice or Anti-Life*; and Vaux, *The Theologic Ethics of Euthanasia*, in addition to the articles by Parachini, Fenigsen and Rigter, *supra* notes 44 and 47.

52. Rigter, *supra* note 47, at 32.

But, in fact, that change may be one that these times require. What we might be doing is changing the role of the doctor from that of one who will do anything under any circumstances to preserve a living organism, whatever the quality of life of that organism, to that of one who will cure when cure is possible, will comfort when comfort is necessary, and will help maintain honor and dignity when that is requested by the patient. That would be a change in the role of the physician from the role that requires doctors to keep people alive under all circumstances, but it would be a change that would be substantially for the better.

Let me make one final comment on the battle over euthanasia. Some argue that those people who support the right to die, those people who believe that Nancy Cruzan should not be forced to be kept alive, should not enter the public debate on euthanasia because of the political consequences. They say that the vitalists will use political support for euthanasia to show the terrible consequences of the right to die: "One moment you get right to die, the next day it's euthanasia, and, just like we told you, tomorrow it's forced euthanasia of anyone under 5'8''." Forty years ago some argued that we should just integrate colleges and universities because it would be politically too dangerous and too troublesome to integrate the public schools too. There may be greater social disagreement over euthanasia than there is over the right to die, but I do think we should face the question head on. Again, I don't mean to suggest that the right to die and euthanasia are the same, or that it is impossible to accept one without accepting the other. However, both the right to die and euthanasia require a new look at the role of the physician in providing palliative health care. Both require that the physician's job include helping us to live and helping us to die. Both require that the physician's job include helping us to live *well* and die *well*. Both are based on the same principles of human dignity and respect for persons, and both should be given our thoughtful and sensitive attention.

APPENDIX A

LIVING WILL AND DIRECTIVE TO PHYSICIANS

Directive made this ____ day of _____, 19__.

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

1. If at any time I should be certified in writing by two physicians, one of whom is my attending physician, to have a terminal condition or be in an irreversible coma, I direct that maintenance medical treatment be withheld or withdrawn, and that I be permitted to die naturally.

2. By maintenance medical treatment I mean any medical treatment that is designed solely to sustain the life process without effecting a real improvement in my condition. I mean to include within medical maintenance treatment the administration of antibiotics and the provision of nourishment, but I do not mean to include medication administered for the purpose of easing pain and discomfort.

3. In the absence of my ability to give directions regarding the use of such medical maintenance treatment, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical and surgical treatment and accept the consequences from such refusal.

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

5. I understand that I may revoke this directive at any time.

6. This document was executed in accordance with N.M. Stat. Ann. § 24-7-1 et. seq. (1978 and 1984 Supp.).

7. The original of this document is to be retained _____, and copies are to be held _____.

8. If there are any uncertainties or ambiguities about this directive, or the treatment that I should be given if I become incompetent, I request my physician to discuss the matter with _____, who knows my interests and values, and with whom I have discussed my wishes.

Declarant Address

We believe the Declarant to be of sound mind. We are not related to the Declarant by blood or marriage, nor would we be entitled to any portion of the Declarant's estate on declarant's decease, nor are we the attending physicians of Declarant or any employee of the attending physician or a health facility in which Declarant is a patient. We are not patients in the health care facility in which the Declarant is a patient, and we have no claim against any portion of the estate of the Declarant upon his or her decease.

On this ____ day of _____, 19__, the Declarant, _____, of _____, _____, New Mexico, signed the foregoing document, consisting of one typewritten page, in our sight and presence and declared the same to be the Declarant's document under the Right To Die Act, and at the Declarant's request and in the Declarant's sight and presence and in the sight and presence of each other, we have hereunto set our names as subscribing witnesses.

Witness Address

Witness Address

APPENDIX B
POWERS OF ATTORNEY

THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THIS FORM, THE NEW MEXICO STATUTORY SHORT FORM UNDER SECTION 45-5-502 NMSA 1978, DOES NOT PROHIBIT THE USE OF ANY OTHER FORM.

POWER OF ATTORNEY

New Mexico Statutory Short Form

I, _____ reside in _____, County, New Mexico. I appoint _____ to serve as my attorney(s)-in-fact.

If any attorney-in-fact appointed above is unable to serve, then I appoint _____ to serve as successor attorney-in-fact in place of the person who is unable to serve.

CHECK AND INITIAL THE FOLLOWING PARAGRAPH ONLY IF MORE THAN ONE PERSON IS APPOINTED TO ACT ON YOUR BEHALF AND YOU WANT ANY ONE OF THEM TO HAVE THE POWER TO ACT ALONE WITHOUT THE SIGNATURE OF THE OTHER(S). IF YOU DO NOT CHECK AND INITIAL THE FOLLOWING PARAGRAPH AND MORE THAN ONE PERSON IS NAMED TO ACT ON YOUR BEHALF THEN THEY MUST ACT JOINTLY.

() If more than one person is appointed to serve as my attorneys-in-fact then they may act severally, alone initials and independently of each other.

My attorney(s)-in-fact shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

INITIAL IN THE OPPOSITE BOX EACH AUTHORIZATION WHICH YOU DESIRE TO GIVE TO YOUR ATTORNEY(S)-IN-FACT. YOUR ATTORNEYS(S)-IN-FACT SHALL BE AUTHORIZED TO ENGAGE ONLY IN THOSE ACTIVITIES WHICH ARE INITIALED.

- 1. real estate transactions; ()*
2. bond, share and commodity transactions; ()*
3. chattel and goods transactions; ()
4. banking transactions; ()
5. business operating transactions; ()
6. insurance transactions; ()
7. estate transactions; ()
8. claims and litigation; ()
9. government benefits ()
10. records, reports and statements; ()
11. decisions regarding lifesaving and life prolonging medical treatment; ()
12. decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, institutionalization in a nursing home or other facility and home health care; ()
13. transfer of property or income as a gift to the principal's spouse for the purpose of qualifying the principal for governmental medical assistance; ()
14. list other; ()

15. list all other powers;..... ()
 _____ ()
 _____ ()
 _____ ()

*Specifically identified real estate or stocks and bonds for which my attorney-in-fact is authorized to act follow. If nothing is listed, then the attorney-in-fact is authorized to act with respect to any real estate or stocks and bonds and other securities that I own. A copy of this power of attorney must be recorded in the office of the county clerk where the real estate is located.

This power of attorney shall not be affected by my incapacity, but will terminate upon my death unless I have revoked it prior to my death.

CHECK AND INITIAL THE FOLLOWING PARAGRAPH IF YOU INTEND FOR THIS POWER OF ATTORNEY TO BECOME EFFECTIVE ONLY IF YOU BECOME INCAPACITATED. YOUR FAILURE TO DO SO WILL MEAN THAT YOUR ATTORNEY(S)-IN-FACT ARE EMPOWERED TO ACT ON YOUR BEHALF FROM THE TIME YOU SIGN THIS DOCUMENT UNTIL YOUR DEATH UNLESS YOU REVOKE THE POWER BEFORE YOUR DEATH.

() This power of attorney shall become effective only if I become incapacitated. My attorney(s)-in-fact shall be entitled to rely on notarized statements from two qualified health care professionals as to my incapacity. By incapacity I mean that among other things, I am unable to effectively manage my personal care, property or financial affairs.

initials _____

 (Signature)
 Dated: _____, 19__

ACKNOWLEDGEMENT

STATE OF NEW MEXICO)
)ss.
 COUNTY OF _____)
 The foregoing instrument was acknowledged before me this ____ day of _____, 19__, by _____

 Notary Public
 My Commission Expires:

APPENDIX C
VALUES HISTORY FORM*

Name: _____ Date: _____

If someone assisted you in completing this form, please fill in their name, address, and relationship to you:

The purpose of this form is to assist you in thinking about and writing down what is important to you about your health. If you should at some time become unable to make health care decisions for yourself, your thoughts as expressed on this form may help others make a decision for you in accordance with what you would have chosen.

The first section of this form asks whether you have already expressed your wishes concerning medical treatment through either written or oral communications and if not, whether you would like to do so now. The second section of this form provides an opportunity for you to discuss your values, wishes, and preferences in a number of different areas, such as your personal relationships, your overall attitude toward life, and your thoughts about illness.

SECTION I

A. Written Legal Documents

Have you written any of the following legal documents? If so, please complete the requested information.

Living Will

Date written: _____ Document location: _____

Comments: _____

(e.g., any limitations, special requests, etc.)

Durable Power of Attorney

Date written: _____ Document location: _____

Comments: _____

(e.g., who have you named to be your decision maker?)

Durable Power of Attorney for Health Care Decisions

Date written: _____ Document location: _____

Comments: _____

(e.g., who have you named to be your decision maker?)

Organ Donations

Date written: _____ Document location: _____

Comments: _____

(e.g., any limitations on which organs you would like to donate?)

B. Wishes Concerning Specific Medical Procedures

If you have ever expressed your wishes, either written or orally, concerning any of the following medical procedures please complete the requested information. If you have not previously indicated your wishes on these procedures and would like to do so now, please complete this information.

* If you use or adapt this Values History form for your own research, which you are free to do, we ask that you simply acknowledge as follows: "The original Values History form was developed at the Institute of Public Law, University of New Mexico, through a grant from the Ittleson Foundation.

The form, released in June, 1989, is being piloted in New Mexico and in selected sites throughout the country as part of a National Values History Project made possible through a grant from the Ittleson Foundation. The form is undergoing constant editing and refining.

Organ Donation

To whom expressed: _____ If oral, when? _____
If written, when? _____ Document location: _____
Comments: _____

Kidney Dialysis

To whom expressed: _____ If oral, when? _____
If written, when? _____ Document location: _____
Comments: _____

Cardiopulmonary Resuscitation (CPA)

To whom expressed: _____ If oral, when? _____
If written, when? _____ Document location: _____
Comments: _____

Respirators

To whom expressed: _____ If oral, when? _____
If written, when? _____ Document location: _____
Comments: _____

Artificial Nutrition

To whom expressed: _____ If oral, when? _____
If written, when? _____ Document location: _____
Comments: _____

Artificial Hydration

To whom expressed: _____ If oral, when? _____
If written, when? _____ Document location: _____
Comments: _____

C. General Comments

SECTION II

A. Your overall attitude toward your health

1. How would you describe your current health status? If you currently have any medical problems, how would you describe them?

2. If you have current medical problems, in what ways, if any, do they affect your ability to function?

3. How do you feel about your current health status?

4. How well are you able to meet the basic necessities of life — eating, food preparation, sleep, personal hygiene, etc.?

5. Do you wish to make any general comments about your overall health?

B. Your perception of the role of your doctor and other health caregivers

1. Do you like your doctors?

2. Do you trust your doctors?

3. Do you think your doctor should make the final decision concerning any treatment you might need?

4. How do you relate to your caregivers, including nurses, therapists, chaplains, social workers, etc.?

5. Do you wish to make any general comments about your doctor and other health caregivers?

C. Your thoughts about independence and control

1. How important is independence and self-sufficiency in your life?

2. If you were to experience decreased physical and mental abilities, how would that affect your attitude toward independence and self-sufficiency?

3. Do you wish to make any general comments about the value of independence and control in your life?

D. Your personal relationships

1. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment you may need now or in the future?

2. Have you made any arrangements for your family or friends to make medical treatment decisions on your behalf? If so, who has agreed to make decisions for you and in what circumstances?

3. What, if any, unfinished business from the past are you concerned about (e.g., personal and family relationships, business and legal matters)?

4. What role do your friends and family play in your life?

5. Do you wish to make any general comments about the personal relationships in your life?

E. Your overall attitude toward life

1. What activities do you enjoy (e.g., hobbies, watching T.V., etc.)?

2. Are you happy to be alive?

3. Do you feel that your life is worth living?

4. How satisfied are you with what you have achieved in your life?

5. What makes you laugh/cry?

6. What do you fear most? What frightens or upsets you?_____

7. What goals do you have for the future?_____

8. Do you wish to make any general comments about your attitude toward life?_____

F. Your attitude toward illness, dying, and death

1. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

2. Where would you prefer to die?

3. What is your attitude toward death?

4. How do you feel about the use of life-sustaining measures in the face of: terminal illness? _____

permanent coma? _____

irreversible chronic illness (e.g., Alzheimer's disease)? _____

5. Do you wish to make any general comments about your attitude toward illness, dying, and death?

G. Your religious background and beliefs

1. What is your religious background?

2. How do your religious beliefs affect your attitude toward serious or terminal illness?

3. Does your attitude toward death find support in your religion?

4. How does your faith community, church or synagogue view the role of prayer or religious sacraments in an illness?

5. Do you wish to make any general comments about your religious background and beliefs?

H. Your living environment

1. What has been your living situation over the last 10 years (e.g., lived alone, lived with others, etc.)?

2. How difficult is it for you to maintain the kind of environment for yourself that you find comfortable? Does any illness or medical problem you have now mean that it will be harder in the future?

3. Do you wish to make any general comments about your living environment?

I. Your attitude concerning finances

1. How much do you worry about having enough money to provide for your care?

2. Would you prefer to spend less money on your care so that more money can be saved for the benefit of your relatives and/or friends?

3. Do you wish to make any general comments concerning your finances and the cost of health care?

J. Your wishes concerning your funeral

1. What are your wishes concerning your funeral and burial or cremation?

2. Have you made your funeral arrangements? If so, with whom?

3. Do you wish to make any general comments about how you would like your funeral and burial or cremation to be arranged or conducted?

OPTIONAL QUESTIONS

1. How would you like your obituary (announcement of your death) to read?

2. Write yourself a brief eulogy (a statement about yourself to be read at your funeral).

* * * * *

Suggestions for Use

After you have completed this form, you may wish to provide copies to your doctors and other health caregivers, your family, your friends, and your attorney. If you have a Living Will or Durable Power of Attorney for Health Care Decisions, you may wish to attach a copy of this form to those documents.