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TO DIE OR NOT TO DIE: THE NEW YORK LEGISLATURE PONDERES A NATURAL DEATH ACT

Like it or not, we are increasingly involved in life-and-death questions to which we have no consistent response. Science is leaving us in the dust.¹

[Governor Mario Cuomo, New York, 1984]

I. Introduction

In December, 1984, New York's Governor Mario Cuomo appointed a twenty-three member commission to recommend ways for the New York State Legislature to respond to a vast range of issues concerning medicine and morality.² One of the major issues the commission will examine is the medical and legal implications arising from doctors' withholding or withdrawing³ life-sustaining medical treatment from terminally ill patients.⁴ Hospitals and doctors recently have urged the adoption of a statute which would allow them to withhold or withdraw such life-saving treatment with full immunity from civil or criminal liability, "when [the] doctor agrees with the patient or the patient's family that so-called 'heroic' measures would only prolong needless suffering."⁵

1. Oreskes, *Cuomo Plans Unit on 'Right to Die,'* N.Y. Times, Oct. 4, 1984, at A1, col. 1 (quoting Address by Governor Cuomo, St. Francis College in Brooklyn, New York (Oct. 3, 1984)) [hereinafter cited as Oreskes]. At this address the Governor announced the establishment of a task force to respond to a series of questions involving medicine, morality and the law. *Id.*

2. Severo, *Cuomo Appoints 23 to Study Issues in Medical Technology,* N.Y. Times, Dec. 23, 1984, at A22, col. 1 [hereinafter cited as Severo]. The commission includes doctors, nurses, priests, rabbis, lawyers and professors. *Id.* The chairman of the commission is Dr. David Axelrod, the State Health Commissioner. *Id.*

3. An example of life-sustaining medical treatment which can be *withheld* is cardiopulmonary resuscitation. Examples of life-sustaining medical treatment that can be *withdrawn* are respiratory support and artificial feeding tubes.

4. Severo, *supra* note 2, at A22, col. 1; *see also* Sullivan, *State Officials Drafting a Bill on Withholding Life Support,* N.Y. Times, Sept. 17, 1984, at A1, col. 1 (discussing Health Commissioner's initial decision to draft legislation) [hereinafter cited as Sullivan]. The commission will also examine other issues such as abortion and the legal rights of embryos formed outside the womb. *See* Oreskes, *supra* note 1, at A1, col. 1.

5. Sullivan, *supra* note 4, at A1, col. 1. Doctors and hospitals in New York currently follow guidelines issued by the Medical Society of New York in 1982

Since the New Jersey Supreme Court settled the question of liability for doctors who withdraw life-support systems from terminally ill patients in *In re Quinlan*,⁶ six other state judiciaries have addressed the issue. There are vast differences, however, in these state courts' perceptions of the manner in which the decision to withdraw or withhold life-saving measures should be made.⁷ Thirty-five states and the District of Columbia have enacted "living will" statutes to settle this decision-making issue since California enacted the first such law in 1976.⁸ These statutes generally recognize a competent patient's directive, or living will, which authorizes a doctor to withdraw or withhold life-sustaining treatment if the patient becomes terminally ill and frees doctors and hospitals complying with a legally effective directive from all liability.⁹ Although the New York State Legislature has not acted on this matter, New York courts have addressed the issue of withholding or withdrawing life support treatment from a dying patient.¹⁰

The withholding or withdrawing of life-sustaining medical treatment from terminally ill patients requires a balancing of several competing and potentially conflicting interests. The state's interests in compelling lifesaving medical treatment¹¹ must be weighed against

which outline the circumstances under which they can withhold life-prolonging treatment. For a discussion of these guidelines, see *infra* notes 223-33 and accompanying text.

6. 70 N.J. 10, 54, 355 A.2d 647, 671, *cert. denied*, 429 U.S. 922 (1976) (respirator systems may be withdrawn without any liability on part of any participant when certain procedures are followed). For an in-depth discussion of *Quinlan*, see *infra* notes 20-37 and accompanying text.

7. The six other judiciaries are Delaware, Florida, Massachusetts, Minnesota, New York and Ohio. See *infra* notes 38-83, 179-219. Compare *In re Spring*, 380 Mass. 629, 636, 405 N.E.2d 115, 120 (1980) (ultimate decision-making responsibility should not be taken away from probate court as to continuance or termination of treatment) and *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 758-59, 370 N.E.2d 417, 434-35 (1977) (decision to withdraw treatment is not to be entrusted to patient's guardian, family, doctors, or hospital ethics committee) with *Quinlan*, *infra* notes 20-37 and accompanying text. See *infra* notes 45-49 and accompanying text for a discussion of these differences.

8. See, e.g., CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1984). See *infra* notes 84-112 and accompanying text for a discussion of the California statute, and *infra* notes 113-78 and accompanying text for a discussion of the other statutes.

9. See *infra* notes 84-178 and accompanying text for a discussion of these statutes.

10. See, e.g., *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (2d Dep't 1980), *modified sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). See *infra* notes 179-219 and accompanying text for a discussion of these cases.

11. These interests include: (1) preventing suicide; (2) protecting incompetents; (3) protecting the medical profession; (4) protecting minor children through the

the patient's or the incompetent patient's family's constitutional right to privacy in dying with dignity.¹² Further, the "doctors are asked to balance odds of survival, fears of malpractice lawsuits, family guilt and their own personal sense of ethics in determining the care of the dying."¹³

This Note first examines how states other than New York have settled the question of withholding or withdrawing life-support treatment from dying patients by judicial decision¹⁴ or by statute.¹⁵ The Note then discusses recent New York decisions addressing this issue.¹⁶ Following a discussion of recent developments and legislative proposals,¹⁷ this Note recommends that the New York State Legislature adopt a "living will" statute which enunciates the procedures to be followed in withdrawing or withholding life-saving treatment from terminally ill patients.¹⁸ In addressing this issue, the legislature should

state's role as *parens patriae*; and (5) protecting public health. See generally Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 *FORDHAM L. REV.* 1, 16-35 (1975) (listing and describing the state's interests) [hereinafter cited as Byrn].

12. The Supreme Court first recognized the right to privacy when it held that married couples have a constitutional right to use contraceptives. *Griswold v. Connecticut*, 381 U.S. 479 (1965). The Court extended its recognition of the right to privacy when it protected a woman's right to have an abortion. *Roe v. Wade*, 410 U.S. 113 (1973). The New Jersey Supreme Court has held that this right to privacy enunciated by the United States Supreme Court also included an individual's right to decline medical treatment under certain circumstances. *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663, *cert. denied*, 429 U.S. 922 (1976). See generally Cantor, Quinlan, *Privacy and the Handling of Incompetent Dying Patients*, 30 *RUTGERS L. REV.* 243 (1977) (discussing *Quinlan* and constitutional right to privacy) [hereinafter cited as Cantor]. This Note does not address the arguments for and against the right to die. This Note assumes that such a right exists and examines the various procedures that states have established for the exercise of that right.

13. Kleiman, *Hospital Care of the Dying: Each Day, Painful Choices*, N.Y. Times, Jan. 14, 1985, at A1, col. 1; see also Byrn, *supra* note 11, at 29-33 (discussing medical profession's interest in protecting itself); Kleiman, *Doctors Ask, Who Lives? When to Die?*, N.Y. Times, Jan. 16, 1985, at B1, col. 1 (discussing questions confronting doctors when terminating or prolonging life). See generally Greenbaum, *Current Standards of Practice in Medicine: The Medical, Judicial, and Legislative Roles*, 7 *W. ST. U.L. REV.* 3, 13-23 (1979) (discussing decisions to withhold and withdraw life-support systems) [hereinafter cited as Greenbaum].

14. See *infra* notes 20-83 and accompanying text.

15. See *infra* notes 84-178 and accompanying text. This Note will examine only those statutes enacted prior to 1985. In 1985, thirteen of the thirty-five states enacted statutes between the writing and publishing of this Note. See Otten, *New 'Wills' Allow People to Reject Prolonging of Life in Fatal Illness*, Wall St. J., July 2, 1985, at 35, col. 4 (states are Arizona, Colorado, Connecticut, Indiana, Iowa, Maine, Maryland, Missouri, Montana, New Hampshire, Oklahoma, Tennessee and Utah).

16. See *infra* notes 179-219 and accompanying text.

17. See *infra* notes 220-64 and accompanying text.

18. See *infra* notes 265-77 and accompanying text. This Note will not address the issue of what constitutes death. Thirty-six states and the District of Columbia

take special notice of and seek to remedy the inadequacies of existing "living will" statutes so that current questions pertaining to artificial feeding and decision-making for incompetent patients¹⁹ are answered. Only then will doctors and hospitals be fully protected from civil and criminal liability resulting from the withholding or withdrawing of life-sustaining medical treatment from terminally ill patients.

II. Judicial Development of the "Right to Die"

A. *In re Quinlan*

In 1976, the New Jersey Supreme Court unanimously ruled that Joseph Quinlan could withdraw the respiratory life-support system from his twenty-one-year-old comatose daughter, Karen Ann Quinlan, without fear of civil or criminal prosecution.²⁰ In deciding that the respiratory life-support system could be removed, the supreme court also held that the "said action shall be without any civil or criminal liability . . . on the part of any participant, whether guardian, physician, hospital, or others."²¹

have used a brain-based criteria to define death. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-1984, at 30 (1984) (states are Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming) [hereinafter cited as RIGHT TO DIE HANDBOOK]. Although New York has no statute, the New York State Court of Appeals recently recognized a brain-based criteria for determining death. *People v. Eulo*, 63 N.Y.2d 341, 346, 472 N.E.2d 286, 288-89, 482 N.Y.S.2d 436, 438-39 (1984). Recently, Governor Cuomo asked the commission to recommend legislation that would define brain death. Sullivan, *Cuomo Asks Panel for Brain Death Proposal*, N.Y. Times, Mar. 17, 1985, § 1, at 44, col. 1.

19. See *infra* notes 271-74 and accompanying text.

20. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). The superior court had refused to give Mr. Quinlan the authority to terminate the life-support treatment of his incompetent daughter. *In re Quinlan*, 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975).

21. *Quinlan*, 70 N.J. at 54, 355 A.2d at 671. For a discussion of the question of civil and criminal liability in withholding life-saving treatment from dying patients which *Quinlan* presented, see Collester, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304 (1977) (discussing issue of civil and criminal liability in treatment of dying patients); Hirsch and Donovan, *The Right to Die: Medico-Legal Implication of In re Quinlan*, 30 RUTGERS L. REV. 267, 270-73 (1977) (discussing removal of civil and criminal liability); Note, *The Right to Die a Natural Death: A Discussion of In re Quinlan and the California*

On April 15, 1975, for reasons that still remain uncertain,²² Quinlan stopped breathing and lapsed into a coma.²³ She was placed on a respirator at Newton Memorial Hospital and later was transferred to Saint Clare's Hospital.²⁴ Because her physicians refused to discontinue her life-support treatment for reasons of traditional medical practice and ethics,²⁵ Quinlan's father initiated a suit in a state court of equity for a decree permitting him, as appointed guardian of his daughter, to discontinue the treatment.²⁶ The superior court denied this relief, reasoning that the decision to remove the life-support treatment was a medical not a legal matter.²⁷ The court stated that the decision "may be concurred in by the parents but not governed by them."²⁸ The court also stated that its refusal to grant the authorization did not violate an incompetent's constitutional right to privacy.²⁹ The court declared that "[t]here is no constitutional

Natural Death Act, 46 U. CIN. L. REV. 192, 203-05 (1977) (discussing role of physicians and hospitals in withholding life-saving treatment fully immune from liability) [hereinafter cited as *California Natural Death Act*].

22. Urine and blood tests indicated the presence of quinine, aspirin, barbiturates and traces of valium and librium. The drugs were found to be in the "therapeutic range, and the quinine consistent with mixing in drinks like soda water." *In re Quinlan*, 137 N.J. Super. at 237, 348 A.2d at 806.

23. *Id.* at 237, 348 A.2d at 806-07. On the morning of April 16, 1975, Dr. Morse examined Ms. Quinlan and "found her in a state of coma, with evidence of decortication indicating altered level of consciousness." *Id.* at 237, 348 A.2d at 807.

24. *Id.* at 237-38, 348 A.2d at 807. Ms. Quinlan was:

[P]laced on a MA-1 respirator, which provides air to her lungs on a controlled volume basis. It also has a "sigh volume," which is a periodic increase in the volume of air to purge the lungs of any accumulation of fluids or excretions. The machine takes over completely the breathing function when the patient does not breathe spontaneously.

Id. at 239, 348 A.2d at 807; see also Bellegie, *Medical Technology As It Exists Today*, 27 BAYLOR L. REV. 31, 32 (1975) (description of functioning of respirator).

25. Dr. Morse had "concluded that to terminate the respirator would be a substantial deviation from medical tradition, that it involved ascertaining 'quality of life,' and that he would not do so." *Quinlan*, 137 N.J. Super. at 250, 348 A.2d at 814. Such refusals are usually based on the ethical standards stated by the Hippocratic Oath. Note, *In re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150, 153 n.14 (1976).

26. Mr. Quinlan asserted that his daughter and her family "have by virtue of the constitutional right of privacy a right of self-determination which extends to the decision to terminate 'futile use of extraordinary measures.'" *Id.* at 251, 348 A.2d at 814. In essence, Mr. Quinlan sought to relieve his daughter from any further suffering.

27. *Id.* at 260, 348 A.2d at 819.

28. *Id.*

29. *Id.* at 265, 348 A.2d at 822.

right to die that can be asserted by a parent for his incompetent adult child."³⁰

In reviewing the lower court's conclusion,³¹ the New Jersey Supreme Court overcame the threshold consideration of Quinlan's obvious inability to make a decision about her future medical care³² by deciding to allow her parents to make the choice for her.³³ However, Chief Justice Hughes stated that this judicial authorization of parental power would be allowed only when the hospital's "ethics committee" and the patient's attending physicians concluded that there was no hope of recovery.³⁴

In its analysis, the supreme court examined a patient's right to privacy in making decisions concerning medical treatment and concluded that it is "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."³⁵ The court also held that Quinlan's right to privacy outweighed the State's interest in protecting her life.³⁶ In reversing the lower court, the

30. *Id.* at 266, 348 A.2d at 822.

31. Mr Quinlan appealed to the Superior Court, Appellate Division, but prior to a hearing before the intermediate appellate court, the case was directly certified to the New Jersey Supreme Court. *In re Quinlan*, 70 N.J. 10, 18, 355 A.2d 647, 651 (1976).

32. *Id.* at 39, 355 A.2d at 663. For a discussion of the living will and its effect on treatment decisions for the incompetent patient, see *infra* notes 161-63 and accompanying text.

33. *Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664. The court concluded "that Karen's right of privacy may be asserted on her behalf by her guardian [her father]" *Id.* at 41, 355 A.2d at 664.

34. *Id.* at 54, 355 A.2d at 671. Chief Justice Hughes also noted that "such a system would be protective to the hospital as well as the doctor in screening out, so to speak, a case which might be contaminated by less than worthy motivations of family or physician." *Id.* at 50, 355 A.2d at 669. For a discussion of this concept of an "ethics committee," see Teel, *The Physician's Dilemma A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975) [hereinafter cited as Teel].

In her discussion of the "ethics committee" Dr. Teel states:

Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, . . . which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body.

Quinlan, 70 N.J. at 49, 355 A.2d at 668 (quoting Teel, *supra*, at 8-9).

35. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663. For a discussion of this issue, see Cantor, *supra* note 12, at 243.

36. *Quinlan*, 70 N.J. at 40-41, 355 A.2d at 663-64. Here the court paid special attention to Ms. Quinlan's prognosis, which was extremely poor. Ms. Quinlan

New Jersey Supreme Court recognized a need for reform in the law regarding the withholding of life-saving treatment from terminally ill patients.³⁷

B. Post-Quinlan Judicial Development

The New Jersey landmark decision in *In re Quinlan*³⁸ was the predecessor of other state court decisions concerning liability in support withdrawal cases.³⁹ One year after *Quinlan*, the Massachusetts Supreme Judicial Court, in *Superintendent of Belchertown State School v. Saikewicz*,⁴⁰ permitted the appointed guardian ad litem⁴¹ of Joseph Saikewicz, a sixty-seven-year-old retarded man suffering from leukemia,⁴² to discontinue his ward's chemotherapy treatments.⁴³ Like the *Quinlan* court, the unanimous *Saikewicz* court "recognize[d] a general right in all persons to refuse medical treatment in appro-

would never resume cognitive life and was described as "emaciated, having suffered a weight loss of at least 40 pounds, and undergoing a continuing deteriorative process." *Id.* at 26, 355 A.2d at 655. For a discussion of the State's interest in ordering life-saving treatment, see Byrn, *supra* note 11, at 16-35.

37. *Quinlan*, 70 N.J. at 42-51, 355 A.2d at 664-69. Medical standards and practices of the attending physician are not binding on the court in responding to the decision to withdraw life-sustaining medical treatment from terminally ill patients. *Id.* at 51, 355 A.2d at 669.

38. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). See *supra* notes 20-37 and accompanying text for a discussion of this case.

39. For a discussion of these cases, see *infra* notes 40-83 and accompanying text. See also Note, *The Right to Die a Natural Death and the Living Will*, 13 TEX. TECH L. REV. 99, 104-10 (1982) [hereinafter cited as *Right to Die a Natural Death*]. See *infra* notes 179-219 and accompanying text for a discussion of the New York cases.

40. 373 Mass. 728, 370 N.E.2d 417 (1977). After appointing a *guardian ad litem*, the probate judge agreed that discontinuing the resident patient's treatment would be in the patient's best interest. Questions concerning the decision were reported to the appellate court. The case reached the Supreme Judicial Court when it granted a request for direct review. *Id.* at 729-30, 370 N.E.2d at 419. See *infra* note 41 for a definition of *guardian ad litem*.

41. A *guardian ad litem* is a "special guardian appointed by the court to prosecute or defend, in behalf of an infant or incompetent, a suit to which he is a party, and such guardian is considered an officer of the court to represent the interests of the infant or incompetent in the litigation." BLACK'S LAW DICTIONARY 635 (5th ed. 1979).

42. *Id.* at 731-32, 370 N.E.2d 420. Leukemia is a disease of the blood which results when the body produces an excessive amount of white blood cells and other abnormal cellular structures. See STEDMAN'S MEDICAL DICTIONARY 777 (24th ed. 1982) [hereinafter MEDICAL DICTIONARY]. The disease causes "internal bleeding and weakness, and, in the acute form, severe anemia and high susceptibility to infection." *Saikewicz*, 373 Mass. at 732, 370 N.E.2d at 420.

43. *Saikewicz*, 373 Mass. at 759, 370 N.E.2d at 435.

appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both."⁴⁴

The *Saikewicz* court, in applying a different analysis than *Quinlan*, further ruled that the decision to terminate the life-sustaining treatment of an incompetent individual was one for the courts alone to make.⁴⁵ Thus, the court would make a "substituted judgment" based on all available evidence as to the treatment the incompetent patient would have chosen.⁴⁶ Here, the court determined that this patient, if competent, would have terminated treatment based on evidence of the probable side effects of the treatment, the slight chance of remission, the patient's suffering, and the patient's inability to cooperate with the treatment.⁴⁷ The New Jersey Supreme Court, in *Quinlan*, had entrusted this decision to the patient's guardian, family, attending doctors, and hospital "ethics committee."⁴⁸ In *Saikewicz*, Justice Liacos, writing for the unanimous court, rejected this approach, stating:

[S]uch 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 the 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

44. *Id.* at 745, 370 N.E.2d at 427; *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663; see also *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980) (prognosis and magnitude of proposed invasion of bodily integrity are to be taken into account when determining appropriate circumstances for discontinuing treatment); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 474-75, 380 N.E.2d 134, 138-39 (1978) (appropriate circumstances for treatment refusal include fact that elderly hospital patient was in vegetative state and was irreversibly and terminally ill).

45. *Saikewicz*, 373 Mass. at 755-59, 370 N.E.2d at 432-35.

46. *Id.* at 750-52, 370 N.E.2d at 430-31. The court stated:

[T]he decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.

Id. at 752-53, 370 N.E.2d at 431.

47. *Id.* at 753-55, 370 N.E.2d at 432.

48. *Quinlan*, 70 N.J. 10, 54, 355 A.2d 647, 671; see *supra* notes 31-34 and accompanying text. In its conclusion, the *Quinlan* court also stated that "we do not intend to be understood as implying that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice." *Quinlan*, 70 N.J. at 55, 355 A.2d at 672.

purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.⁴⁹

The *Saikewicz* judicial determination rationale for the withholding or withdrawing of life-saving treatment from an incompetent patient has been adopted by other jurisdictions.⁵⁰ For example, the Delaware Supreme Court, in *Severns v. Wilmington Medical Center, Inc.*,⁵¹ found that the husband-guardian of a comatose patient with irreversible brain damage⁵² could seek court relief to discontinue her life-sustaining medical treatment.⁵³ Unlike the court in *Quinlan*, however, the *Severns* court concluded that a full evidentiary hearing must be held by the lower court to decide whether the relief requested was appropriate.⁵⁴ Moreover, in contrast to the *Saikewicz* court, the *Severns* court explicitly recognized the need for a "living will" statute,⁵⁵ which the Delaware General Assembly has since enacted.⁵⁶ State courts in Florida,⁵⁷ Minnesota,⁵⁸ New York⁵⁹ and Ohio⁶⁰ have

49. *Saikewicz*, 373 Mass. at 759, 370 N.E.2d at 435; see also *In re Spring*, 380 Mass. 629, 636, 405 N.E.2d 115, 120 (court affirmed *Saikewicz* and held that decision-making responsibility properly belongs to courts). This approach, however, does not give any guidelines as to future cases. A comprehensive "living will" statute, on the other hand, would remedy this situation. See *infra* notes 265-77 and accompanying text.

50. See, e.g., *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1349-50 (Del. 1980) (evidentiary hearing required in request to remove life-sustaining treatment); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 11, 426 N.E.2d 809, 815 (C.P. 1980) (judicial standard of "clear and convincing" proof of patient's desire to refuse treatment required before treatment can be withheld).

51. 421 A.2d 1334 (Del. 1980)

52. *Id.* at 1336-37. Mrs. Severns suffered her injury in a one-car accident. The severe damage to her brain had significantly impaired its functioning. *Id.*

53. *Id.* at 1347.

54. *Id.* at 1349-50. The high court answered the lower court's certified question responding that "the Court of Chancery shall make specific findings of fact before determining what relief is appropriate based on such findings." *Id.* at 1350.

55. *Id.* at 1346. For a discussion of *Saikewicz*, see *supra* notes 40-49 and accompanying text.

56. DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983). For a discussion of this and other "living will" statutes, see *infra* notes 84-178 and accompanying text.

57. See, e.g., *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980). For a discussion of *Satz*, see *infra* notes 61-67 and accompanying text.

58. See, e.g., *In re Torres*, 357 N.W.2d 332 (Minn. 1984). For a discussion of *Torres*, see *infra* notes 68-73 and accompanying text.

59. See, e.g., *In re Storar*, 52 N.Y.2d 363, 378-80, 420 N.E.2d 64, 71-72, 438 N.Y.S.2d 266, 274 (1981). For a discussion of *Storar* and other New York cases, see *infra* notes 179-219 and accompanying text.

60. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 12-13, 426 N.E.2d 809, 815-16 (C.P. 1980).

authorized the withdrawal of life-support systems from terminally ill patients. In *Satz v. Perlmutter*,⁶¹ the Florida Court of Appeals affirmed the trial court's ruling that a seventy-three-year-old *competent*, terminally ill patient⁶² could authorize a doctor to discontinue his extraordinary medical treatment.⁶³ The Florida Supreme Court, unanimously affirming⁶⁴ one year after the patient's death, refused to establish guidelines for future cases.⁶⁵ However, it recognized the need for legislative intervention⁶⁶ just as the Delaware Supreme Court had in *Severns*.⁶⁷

In November, 1984, the Minnesota Supreme Court allowed the conservator of a comatose patient with irreversible brain damage to order removal of the patient's respirator in *In re Torres*.⁶⁸ As in *Quinlan*, the court recognized the individual's right to "order the disconnection of extraordinary life support systems."⁶⁹ Like the Delaware and Florida high courts, Justice Todd, author of the majority decision, recognizing a court's inability to handle this entire issue, stated: "[t]his case has presented the court with an opportunity to consider a number of issues of great societal concern. We have declined to do so at this time, however, since we believe the legislative process would be a superior method of insuring public input into such vital questions."⁷⁰ The court held that, under the facts, a court

61. 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

62. *Satz*, 362 So. 2d at 161. Abe Perlmutter suffered from amyotrophic lateral sclerosis, commonly known as Lou Gehrig's disease, of which there is no known cure. See MEDICAL DICTIONARY, *supra* note 42, at 1264. Life expectancy for inflicted patients is about two years. *Satz*, 362 So. 2d at 161.

63. *Id.* at 164. The court decided that the patient's respirator device could be removed stating that Mr. Perlmutter "should be allowed to make his choice to die with dignity." *Id.*

64. *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980).

65. *Id.* at 360-61.

66. *Id.* The Florida Legislature has recently enacted the Life Prolonging Procedure Act which became effective on October 1, 1984. FLA. STAT. ANN. §§ 765.01-.15 (Supp. 1985). See *infra* notes 84-178 and accompanying text for a general discussion of "living will" statutes. See also John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926-27 (Fla. 1984) (life-support system of terminally ill, comatose patient who executed "living" will can be withdrawn without fear of civil or criminal liability without court approval).

67. See *supra* notes 55-56 and accompanying text.

68. *In re Torres*, 357 N.W.2d 332 (Minn. 1984). Mr. Torres had been comatose and dependent on the respirator for about eight months. Mr. Torres suffered irreversible brain damage as the result of an accident in his hospital room. *Id.* at 333-34.

69. *Id.* at 339. For a discussion of the *Quinlan* case, see *supra* notes 20-37 and accompanying text.

70. *Id.* at 341. See *supra* notes 51-56 for a discussion of the *Severns* case and notes 61-67 for a discussion of the *Satz* case.

order was necessary⁷¹ since the patient had no immediate family that could be consulted.⁷² Where a comatose patient did have an immediate family, however, the majority, in dictum, stated that a court order would not be necessary.⁷³

Although these state courts have decided to adjudicate the question of withdrawing or withholding life-sustaining treatment from terminally ill patients,⁷⁴ they have declined to issue guidelines as to future cases. For example, the question of whether artificial or tube-feeding is extraordinary medical treatment within the meaning of the *Quinlan* decision⁷⁵ has not been answered in most of these jurisdictions.

The New Jersey Supreme Court, however, recently decided that artificial feeding could be withdrawn from a terminally ill patient pursuant to the *Quinlan* decision.⁷⁶ *In re Conroy* involved an eighty-four-year-old nursing home patient who was mentally incompetent and terminally ill.⁷⁷ The appellate division refused to grant the director

71. *Torres*, 357 N.W.2d at 341.

72. The court noted that “[u]nlike Karen Quinlan, Rudolfo Torres has no immediate family.” *Id.* at 337.

73. Justice Todd stated that a court order would not be necessary in situations where there is “consultation between the attending doctor and the family with the approval of the hospital ethics committee.” *Id.* at 341 n.4. Three justices concurred in the majority opinion but felt “that in all cases when the decision of continued life or likely death is involved there should be a court procedure” *Id.* at 341 (Kelly, J., concurring specially); see also *id.* (Peterson, J., concurring specially) (“[a] requirement of judicial oversight is a basic recognition of the state’s undoubted interest in the safety of its citizens”). See *supra* notes 40-49 and accompanying text for a discussion of the *Saikewicz* case.

74. See *supra* notes 20-73 and accompanying text.

75. In *Quinlan*, Ms. Quinlan’s father sought to have only her respirator removed. Ms. Quinlan has continued to live in a vegetative state after the respirator was disconnected. See Norman, *Our Towns: The Quinlans and the Latest Right-to-Die Ruling*, N.Y. Times, Jan. 24, 1985, at B4, col. 4 [hereinafter cited as Norman]. See *supra* notes 20-37 and accompanying text for a discussion of *In re Quinlan*.

76. *In re Conroy*, 98 N.J. 321, 374, 486 A.2d 1209, 1236-37 (1985); see also *Barber v. Superior Court of California*, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (1983) (withdrawal of feeding tubes is no different from withdrawal of respirator).

77. *Conroy*, 98 N.J. at 335, 486 A.2d at 1216. The trial court found that Ms. Conroy had become incompetent, that her life had become “impossibly and permanently burdensome,” and that the removal of the feeding tube should therefore be allowed. 188 N.J. Super. 523, 529, 457 A.2d 1232, 1236 (Ch. Div. 1983). Although Ms. Conroy died with the nasogastric tube still intact, the appellate division reversed and concluded that the withdrawal of the feeding tube was the kind of active euthanasia that ethically was impermissible and would therefore set a dangerous precedent. 190 N.J. Super. 453, 475-76, 464 A.2d 303, 315 (App. Div. 1983).

of the nursing home authority to withdraw this equipment.⁷⁸ The supreme court reversed and refused to draw a distinction between an artificial feeding tube and a respirator in decisions involving the withdrawal of life-sustaining medical treatment.⁷⁹ The court also established special guidelines to be followed before withdrawing medical treatment from nursing home patients. First, the nursing home would have to notify an ombudsman to protect the patient's interests.⁸⁰ Second, at least two outside physicians would have to concur in a decision to withhold or withdraw treatment.⁸¹ The complexities of the problems presented in *In re Conroy* led Justice Schreiber, writing for the majority,⁸² to comment that:

Perhaps it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to formulate general guidelines that may be applicable to a broad range of situations.⁸³

III. Natural Death and Living Will Legislation

A. The California Natural Death Act

In 1976, several months after the New Jersey Supreme Court's

78. 190 N.J. Super. at 476, 464 A.2d at 315.

79. 98 N.J. at 372-74, 486 A.2d at 1235-37; see also Sullivan, 'Right to Die' Rule in Terminal Cases Widened in Jersey, N.Y. Times, Jan. 18, 1985, at A1, col. 1. It is interesting to note that the Quinlans have decided not to remove their daughter's feeding tubes. See Norman, *supra* note 75, at B4, col. 4. It might be argued that by allowing the removal of feeding tubes a court might next permit the withholding of oral feeding. However, a nasogastric tube is quite different from feeding a patient with a spoon. See *Conroy*, 98 N.J. at 373, 486 A.2d at 1236 ("[n]asogastric tubes may lead to pneumonia, cause irritation and discomfort, and require arm restraints for an incompetent patient").

80. *Conroy*, 98 N.J. at 383-84, 486 A.2d at 1241-42. For a discussion of how the California Natural Death Act's provides for the protection of terminally ill nursing home patients, see *infra* note 102 and accompanying text.

81. *Conroy*, 98 N.J. at 384-85, 486 A.2d at 1242-43.

82. In dissent, Justice Handler noted that other life-and-death issues beyond pain and suffering should be considered. *Id.* at 388-99, 486 A.2d at 1244-50 (these issues include "all concerns and values that have a legitimate bearing on the decision whether to provide particular treatment at the very end of an individual's life").

83. *Id.* at 344, 486 A.2d at 1220-21 (footnote omitted).

*In re Quinlan*⁸⁴ decision, California became the first state to legislate rules and procedures governing the withholding or withdrawal of life-saving medical treatment.⁸⁵ The Natural Death Act created a procedure whereby a competent patient could direct his doctors, under certain conditions, to withhold life-saving treatment without resort to the courts.⁸⁶ The California Legislature was motivated primarily by its recognition of the "uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn."⁸⁷

Of six definitions, which apply throughout the California statute⁸⁸ the three most important defined terms are "life-sustaining procedure,"⁸⁹ "qualified patient,"⁹⁰ and "terminal condition."⁹¹ The terms, as defined, determine the scope of the statute's application. Thus, the statute focuses on the competent "qualified patient's" right to execute a directive⁹² which orders the withholding or withdrawing of "life-sustaining procedures" when the patient is in a "terminal condition."⁹³

84. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). For a discussion of this case, see *supra* notes 20-37 and accompanying text.

85. Natural Death Act, ch. 1439, 1976 Cal. Stat. 6478 (codified at CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1984)). See generally *The Right to Die a Natural Death*, *supra* note 39, at 111-14 (describing California Natural Death Act); *California Natural Death Act*, *supra* note 21 (discussing *Quinlan* and California Natural Death Act).

86. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984) ("[a]ny adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition").

87. CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1984). The statute applies both to the withholding and the withdrawal of life-sustaining treatment. *Id.* See *supra* note 3 for examples of the types of medical treatments that might be withheld or withdrawn.

88. CAL. HEALTH & SAFETY CODE § 7187 (West Supp. 1984).

89. *Id.* § 7187(c) (West Supp. 1984) ("[l]ife-sustaining procedure' means any medical procedur [sic] or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which . . . would serve only to artificially prolong the moment of death . . .").

90. *Id.* § 7187(e) (West Supp. 1984) ("[q]ualified patient' means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians . . .").

91. *Id.* § 7187(f) (West Supp. 1984) ("[t]erminal condition' means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death . . .").

92. These directives are known as "living wills." See *supra* note 9 and accompanying text.

93. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984).

Under the California statute, the written directive stays effective for five years from the date of execution⁹⁴ and may be revoked at any time by the declarant.⁹⁵ The directive must be made in the presence of two witnesses who may not be: (1) a relative of the declarant; (2) the attending physician or an employee of the health facility in which the declarant is a patient; or (3) any person with a claim in the declarant's estate.⁹⁶ The attending physician will act pursuant to the directive only if "the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive"⁹⁷

The statute also addresses the vital question of doctor-hospital liability in withdrawing life-sustaining treatment pursuant to such a directive. It grants immunity from civil and criminal liability for those health professionals who properly observe the terms of an executed directive.⁹⁸ One section of the statute also provides a standard form, entitled "Directive to Physicians,"⁹⁹ which includes provisions that: (1) invalidate the directive during pregnancy; (2) create the effective period of five years; and (3) require the patient to be competent at the time of its execution.¹⁰⁰ The statute also insures that a patient who dies after the withholding of life-saving treatment in compliance with the statute not be considered a suicide.¹⁰¹ If the individual making the directive is a patient in a skilled nursing home, additional formalities are required.¹⁰² The statute also provides crim-

94. *Id.* § 7189.5 (West Supp. 1984). Nothing in this section should "be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 7188" *Id.* The directive must in writing and signed by the declarant. *Id.* § 7188 (West Supp. 1984).

95. *Id.* § 7189 (West Supp. 1984). The living will can be revoked in writing, verbally, or by destroying the patient's directive at his direction and in his presence. *Id.*

96. *Id.* § 7188 (West Supp. 1984).

97. *Id.* § 7191(b) (West Supp. 1984). The California statute specifically provides that it will not hold liable any physician or health facility for failing to effectuate the directive of a "qualified patient." Such action will, however, constitute unprofessional conduct. *Id.*

98. *Id.* § 7190 (West Supp. 1984).

99. *Id.* § 7188 (West Supp. 1984).

100. *Id.*

101. *Id.* § 7192(a) (West Supp. 1984). The statute provides that "[t]he withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide." *Id.*

102. One of the two witnesses to the directive of a nursing home resident must be a patient advocate or an ombudsman as designated by the State Department of Aging. *Id.* § 7188.5 (West Supp. 1984). The legislature commented:

inal sanctions for the wrongful tampering with the formation or revocation of a directive.¹⁰³ Finally, the statute concludes by stating that it does not approve of "mercy killings" under any circumstances.¹⁰⁴

The California Natural Death Act, the first of its kind, recognized the validity of a competent, terminally ill individual's right to terminate life-sustaining medical treatment.¹⁰⁵ The Act also gives full immunity to all doctors and hospitals complying with this statute in the termination of life-support treatment.¹⁰⁶ However, the statute does not provide a procedure for terminating treatment in the case of incompetent terminally ill patients.¹⁰⁷ In fact, a California court recently decided that if the patient is incompetent and has not executed an advance declaration the statute has no application.¹⁰⁸

In addition, the fourteen day waiting period¹⁰⁹ and the five year effective period¹¹⁰ are too restrictive since the patient could become incompetent after being diagnosed as terminally ill and before executing or reexecuting the directive and since it is more sensible to allow an executed directive to remain valid unless and until a person chooses to revoke it.¹¹¹ Additionally, the California statute does not

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

Id. See *supra* notes 80-81 and accompanying text for a discussion of this special problem in the *Conroy* decision.

103. CAL. HEALTH & SAFETY CODE § 7194 (West Supp. 1984). Tampering with a directive will result in a misdemeanor. Tampering with a directive or a revocation which results in the withholding or withdrawal of life-sustaining procedures contrary to the declarant's wishes will be subject to prosecution for unlawful homicide. *Id.*

104. *Id.* § 7195 (West Supp. 1984) ("[n]othing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter").

105. See *supra* notes 85-104 and accompanying text.

106. See *supra* note 98 and accompanying text.

107. See CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1984).

108. See, e.g., *Barber v. Superior Court of California*, 147 Cal. App. 3d 1006, 1018, 195 Cal. Rptr. 484, 491 (1983) (Natural Death Act does not provide procedure for withholding of treatment from incompetent patients). See *infra* notes 161-63 and accompanying text for discussion of a procedure for withholding treatment from incompetent patients.

109. See *supra* note 97 and accompanying text.

110. See *supra* note 94 and accompanying text.

111. See *infra* notes 275-77 and accompanying text. One reason in favor of the fourteen day waiting period might be to allow the patient time to "cool off" after

specify whether artificial or tube-feeding comes under its definition of "life-sustaining procedure."¹¹²

B. Post-1976 Statutory Development

Although California was the first state to address the question of withholding or withdrawing life-sustaining medical treatment from terminally ill, competent patients legislatively, its Natural Death Act is not as comprehensive as some of the subsequent "living will" statutes of other states.¹¹³ Thirty-five states, including California and the District of Columbia, have enacted "living will" statutes to settle the legal controversy over potential civil and criminal liability for withholding life-saving treatment from terminally ill patients.¹¹⁴ Although no two are alike in every respect,¹¹⁵ several basic provisions are found in most of the statutes. For example, all of these statutes

diagnosis of a terminal illness. The legislature might have desired to prevent patients from making hasty directives after the initial shock of a terminal illness diagnosis. One reason in favor of the five-year effective period might be to provide for an automatic revocation for those patients who might forget about the directive, i.e. elderly patients.

112. The California Court of Appeals for the second district recently decided that for the purpose of enforcing the Natural Death Act, there is no legal difference between the withdrawal of feeding tubes from a patient and the withdrawal of a respirator. *See Barber*, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (1983). For a discussion of the New Jersey case, *In re Conroy*, and its decision concerning removal of artificial feeding tubes, see *supra* notes 76-83 and accompanying text.

113. For a discussion of these other statutes, see *infra* notes 114-78 and accompanying text.

114. ALA. CODE §§ 22-8A-1 to -10 (1984); ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1983); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1984); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1984); FLA. STAT. ANN. §§ 765.01-.15 (Supp. 1985); GA. CODE ANN. §§ 31-32-1 to -12 (Supp. 1984); IDAHO CODE §§ 39-4501 to -4508 (Supp. 1984); ILL. ANN. STAT. ch. 110 1/2, §§ 701-710 (Smith-Hurd Supp. 1984-1985); KAN. STAT. ANN. §§ 65-28, 101 to 109 (1980); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1984); NEV. REV. STAT. §§ 449.540-.690 (1983); N.M. STAT. ANN. §§ 24-7-1 to -11 (1981 & Supp. 1984); N.C. GEN. STAT. §§ 90-320 to 322 (1981 & Supp. 1983); OR. REV. STAT. §§ 97.050-.090 (1983); TEX. REV. CIV. STAT. ANN. art. 4590(h) (Vernon Supp. 1984); VT. STAT. ANN. tit. 18, §§ 5251-5262, tit. 13, § 1801 (Supp. 1984-1985); VA. CODE §§ 54-325.8:1 to :13 (Supp. 1984); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (West Supp. 1984-1985); W. VA. CODE §§ 16-30-1 to -10 (Supp. 1984); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1984-1985); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1984). In 1985, thirteen of the thirty-five states enacted living will legislation after the writing of this Note. *See Otten, supra* note 15.

115. For a comparison of the statutes, see *infra* notes 116-78 and accompanying text. *See also* RIGHT TO DIE HANDBOOK, *supra* note 18, at 31-34.

recognize the validity of the "living will,"¹¹⁶ or directive, and grant civil and criminal immunity to health professionals who properly comply with the statute.¹¹⁷ The laws also define terms used throughout the statute,¹¹⁸ and twenty of them contain a standard form for the declaration which must be followed exactly¹¹⁹ or substantially.¹²⁰

116. ALA. CODE § 22-8A-4 (1984); ARK. STAT. ANN. § 82-3802 (Supp. 1983); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984); DEL. CODE ANN. tit. 16, § 2503 (1983); D.C. CODE ANN. § 6-2422 (Supp. 1984); FLA. STAT. ANN. § 765.04 (Supp. 1985); GA. CODE ANN. § 31-32-3 (Supp. 1984); IDAHO CODE § 39-4504 (Supp. 1984); ILL. ANN. STAT. ch. 110 1/2, § 703 (Smith-Hurd Supp. 1984-1985); KAN. STAT. ANN. § 65-28, 103(a) (1980); LA. REV. STAT. ANN. § 40:1299.58.3(A) (West Supp. 1985); MISS. CODE ANN. § 41-41-107 (Supp. 1984); NEV. REV. STAT. § 449.600 (1983); N.M. STAT. ANN. § 24-7-3 (1981 & Supp. 1984); N.C. GEN. STAT. § 90-321(c) (1981 & Supp. 1983); OR. REV. STAT. § 97.055 (1983); TEX. REV. CIV. STAT. ANN. art. 4590(h), § 3 (Vernon Supp. 1984); VT. STAT. ANN. tit. 18, § 5253 (Supp. 1984-1985); VA. CODE § 54-325.8:3 (Supp. 1984); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1984-1985); W. VA. CODE § 16-30-3 (Supp. 1984); WIS. STAT. ANN. § 154.03 (West Supp. 1984-1985); WYO. STAT. § 33-26-145 (Supp. 1984).

117. ALA. CODE § 22-8A-7 (1984); ARK. STAT. ANN. § 82-3804 (Supp. 1983); CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1984); DEL. CODE ANN. tit. 16, § 2505 (1983); D.C. CODE ANN. § 6-2427(a) (Supp. 1984); FLA. STAT. ANN. § 765.10 (Supp. 1985); GA. CODE ANN. § 31-32-7 (Supp. 1984); IDAHO CODE § 39-4507 (Supp. 1984); ILL. ANN. STAT. ch. 110 1/2, § 707 (Smith-Hurd Supp. 1984-1985); KAN. STAT. ANN. § 65-28, 106 (1980); LA. REV. STAT. ANN. § 40:1299.58.8 (West Supp. 1985); MISS. CODE ANN. § 41-41-117 (Supp. 1984); NEV. REV. STAT. § 449.630 (1983); N.M. STAT. ANN. § 24-7-7 (1981 & Supp. 1984); N.C. GEN. STAT. § 90-321(h) (1981 & Supp. 1983); OR. REV. STAT. § 97.065(3) (1983); TEX. REV. CIV. STAT. ANN. art. 4590(h), § 6 (Vernon Supp. 1984); VT. STAT. ANN. tit. 18, § 5259 (Supp. 1984-1985); VA. CODE § 54-325.8:8 (Supp. 1984); WASH. REV. CODE ANN. § 70.122.050 (West Supp. 1984-1985); W. VA. CODE § 16-30-7(a) (Supp. 1984); WIS. STAT. ANN. § 154.07 (West Supp. 1984-1985); WYO. STAT. § 33-26-149 (Supp. 1984).

118. ALA. CODE § 22-8A-3 (1984); CAL. HEALTH & SAFETY CODE § 7187 (West Supp. 1984); DEL. CODE ANN. tit. 16, § 2501 (1983); D.C. CODE ANN. § 6-2421 (Supp. 1984); FLA. STAT. ANN. § 765.03 (Supp. 1985); GA. CODE ANN. § 31-32-2 (Supp. 1984); IDAHO CODE § 39-4503 (Supp. 1984); ILL. ANN. STAT. ch. 110 1/2, § 702 (Smith-Hurd Supp. 1984-1985); KAN. STAT. ANN. § 65-28, 102 (1980); LA. REV. STAT. ANN. § 40:1299.58.2 (West Supp. 1985); MISS. CODE ANN. § 41-41-103 (Supp. 1984); NEV. REV. STAT. §§ 449.540-.590 (1983); N.M. STAT. ANN. § 24-7-2 (1981 & Supp. 1984); N.C. GEN. STAT. § 90-321(a) (1981 & Supp. 1983); OR. REV. STAT. § 97.050 (1983); TEX. REV. CIV. STAT. ANN. art. 4590(h), § 2 (Vernon Supp. 1984); VT. STAT. ANN. tit. 18, § 5252 (Supp. 1984-1985); VA. CODE § 54-325.8:2 (Supp. 1984); WASH. REV. CODE ANN. § 70.122.020 (West Supp. 1984-1985); W. VA. CODE § 16-30-2 (Supp. 1984); WIS. STAT. ANN. § 154.01 (West Supp. 1984-1985); WYO. STAT. § 33-26-144 (Supp. 1984). The Arkansas statute does not have a definition provision.

119. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984); GA. CODE ANN. § 31-32-3 (Supp. 1984); IDAHO CODE § 39-4504 (Supp. 1984); OR. REV. STAT. § 97.055 (1983); TEX. REV. CIV. STAT. ANN. art. 4590(h), § 3 (Vernon Supp. 1984).

120. ALA. CODE § 22-8A-4(c) (1984); D.C. CODE ANN. § 6-2422(c) (Supp. 1984); FLA. STAT. ANN. § 765.05 (Supp. 1985); ILL. ANN. STAT. ch. 110 1/2, § 703(e)

1. *The Early Statutes*

From 1977 to 1980, nine states followed California's example and enacted "living will" laws.¹²¹ One of these laws, which closely resembles the California statute in structure and format, is the Texas Natural Death Act.¹²² Like the California law, the Texas statute: (1) recognizes the individual's right to refuse medical treatment with an executed directive if he is in a terminal condition;¹²³ (2) invalidates the directive during pregnancy;¹²⁴ (3) grants immunity from civil and criminal liability to all health professionals who act without negligence in accordance with the statute;¹²⁵ (4) provides a standard form directive entitled "Directive to Physicians" which must be followed exactly;¹²⁶ and (5) requires that the patient be diagnosed as terminally ill before a living will will be enforced.¹²⁷ There are two major differences between the statutes, however. First, Texas rejected California's five year limitation on the duration of a directive in favor of an amendment which states that the patient's directive will remain

(Smith-Hurd Supp. 1984-1985); KAN. STAT. ANN. § 65-28, 103(c) (1980); LA. REV. STAT. ANN. § 40:1299.58.3(C)(1) (West Supp. 1985); MISS. CODE ANN. § 41-41-107(1) (Supp. 1984); NEV. REV. STAT. § 449.610 (1983); N.C. GEN. STAT. § 90-321(d) (1981 & Supp. 1983); VT. STAT. ANN. tit. 18, § 5253 (Supp. 1984-1985); VA. CODE § 54-325.8:4 (Supp. 1984); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1984-1985); W. VA. CODE § 16-30-3(d) (Supp. 1984); WIS. STAT. ANN. § 154.01(2) (West Supp. 1984-1985); WYO. STAT. § 33-26-145(d) (Supp. 1984). For an extensive list of these basic provisions, see RIGHT TO DIE HANDBOOK, *supra* note 18, at 12-13.

121. Arkansas, Idaho, Nevada, New Mexico, North Carolina, Oregon, and Texas enacted their statutes in 1977. Death with Dignity Act, ch. 879, 1977 Ark. Acts 2236; Natural Death Act, ch. 106, 1977 Idaho Sess. Laws 228; Withholding or Withdrawal of Life-Sustaining Procedures Act, ch. 393, 1977 Nev. Stat. 759; Right to Die Act, ch. 287, 1977 N.M. Laws 2236; Right to Natural Death Act, ch. 815, 1977 N.C. Sess. Laws 1101; Rights with Respect to Terminal Illness Act, ch. 183, 1977 Or. Laws 113; Natural Death Act, ch. 398, 1977 Tex. Gen. Laws 1085. Kansas and Washington enacted their statutes in 1979. Natural Death Act, ch. 199, 1979 Kan. Sess. Laws 970; Natural Death Act, ch. 112, 1979 Wash. Laws 433. See *supra* note 114 for citations to these statutes.

122. TEX. REV. CIV. STAT. ANN. art. 4590(h) (Vernon Supp. 1984).

123. *Id.* § 3 (Vernon Supp. 1984).

124. *Id.*

125. *Id.* § 6 (Vernon Supp. 1984). The Texas statute is slightly different from the California statute concerning doctor-hospital liability. The doctors and hospitals are granted full immunity "unless negligent." *Id.* However, the statute does not define what it means by being negligent. See *id.* The California statute makes no mention of negligence. See CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1984).

126. TEX. REV. CIV. STAT. ANN. art. 4590(h), § 3 (Vernon Supp. 1984).

127. *Id.* § 7(b) (Vernon Supp. 1984).

effective until revocation.¹²⁸ The Texas statute also eliminated the requirement of a fourteen day waiting period after diagnosis of a terminal illness before an executed directive is considered valid and operative.¹²⁹

The New Mexico Right to Die Act, which was enacted in 1977,¹³⁰ differs greatly from the California statute. Though notable for its conciseness, the New Mexico statute is more comprehensive than the California and Texas laws because it permits the withholding or withdrawing of life-sustaining treatment from a patient who has lapsed into an irreversible coma and who has not executed an advance declaration¹³¹ as well as from a patient in a terminal condition who has executed a directive.¹³²

The statute also provides short definitions for such terms as "maintenance medical treatment"¹³³ and "terminal illness."¹³⁴ Unlike the California law, however, the New Mexico Right to Die Act does not provide a standard form directive and does not invalidate a directive executed during pregnancy.¹³⁵ The New Mexico statute does

128. *Id.* § 5 (Vernon Supp. 1984). The statute provides that "[a] directive shall be effective until it is revoked in a manner prescribed in Section 4 of this Act." *Id.* In contrast, California's statute requires re-execution every five years. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1984).

129. TEX. REV. CIV. STAT. ANN. art. 4590(h), § 7(b) (Vernon Supp. 1984); *cf.* CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1984) (requiring fourteen-day waiting period). For further comparison, see RIGHT TO DIE HANDBOOK, *supra* note 18, at 31-34.

130. N.M. STAT. ANN. §§ 24-7-1 to -11 (1981 & Supp. 1984); *see supra* note 121.

131. *Id.* § 24-7-8.1 (Supp. 1984). If this situation exists, "a physician may remove maintenance medical treatment from that person when all family members who can be contacted through reasonable diligence agree in good faith that the patient, if competent, would choose to forego that treatment." *Id.* Six other states also have a provision to deal with incompetent patients who have no directive: Arkansas, Florida, Louisiana, North Carolina, Oregon, and Virginia. *See* ARK. STAT. ANN. § 82-3803 (Supp. 1983); FLA. STAT. ANN. § 765.07 (Supp. 1985); LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1985); N.C. GEN. STAT. § 90-322 (1981 & Supp. 1983); OR. REV. STAT. § 97.083(1)-(3) (1983); VA. CODE § 54-325.8:6 (Supp. 1984).

132. N.M. STAT. ANN. § 24-7-3 (Supp. 1984).

133. The statute provides: "'maintenance medical treatment' means medical treatment designed solely to sustain the life processes" *Id.* § 24-7-2(C) (Supp. 1984). For the California statute's definition of "life-sustaining procedure," *see supra* note 89.

134. The statute provides: "'terminal illness' means an illness that will result in death . . . , regardless of the use or discontinuance of maintenance medical treatment." N.M. STAT. ANN. § 24-7-2(F) (Supp. 1984). For the California statute's definition of "terminal condition," *see supra* note 91.

135. *See id.* § 24-7-3 (Supp. 1984). The California statute does provide a standard form directive which also invalidates the directive during pregnancy. *See supra* notes 99-100 and accompanying text.

contain a provision that establishes health professionals' immunity from civil and criminal liability where they act on a directive executed under this statute.¹³⁶ Like the Texas statute, there is an exception from immunity because of the doctor's or hospital's negligence.¹³⁷ However, the statute also states that doctors and hospitals acting pursuant to the law are "presumed to be acting in good faith."¹³⁸

The seven other states which enacted "living will" statutes before 1980 are Arkansas, Idaho, Kansas, Nevada, North Carolina, Oregon and Washington.¹³⁹ Like the California and Texas statutes, the Idaho Natural Death Act requires a terminal illness determination before execution of a directive.¹⁴⁰ Like the New Mexico statute, the Arkansas, North Carolina and Oregon laws contain provisions that permit the termination of life-sustaining treatment under certain circumstances for incompetent patients who have no advance directive.¹⁴¹ The Washington Natural Death Act, however, does not contain such a provision.¹⁴² Noting this omission, the Washington Supreme Court recently provided guidelines for the withdrawing of medical treatment from incompetent patients who have not executed a directive under the "living will" law.¹⁴³ The court also wisely observed that:

136. N.M. STAT. ANN. § 24-7-7 (Supp. 1984).

137. *Id.* For a discussion of the Texas statute's provision on doctor-hospital immunity from liability, see *supra* note 125 and accompanying text.

138. N.M. STAT. ANN. § 24-7-7(A) (Supp. 1984).

139. ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1983); IDAHO CODE §§ 39-4501 to -4508 (Supp. 1984); KAN. STAT. ANN. §§ 65-28, 101 to 109 (1980); NEV. REV. STAT. §§ 449.540-.690 (1983); N.C. GEN. STAT. §§ 90-320 to 322 (1981 & Supp. 1983); OR. REV. STAT. §§ 97.050-.090 (1983); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (West Supp. 1984-1985). For dates of enactment, see *supra* note 121.

140. The statute does not address a declaration executed before diagnosis of a terminal condition. See IDAHO CODE § 39-4504 (Supp. 1984).

141. See ARK. STAT. ANN. § 82-3803 (Supp. 1983); N.C. GEN. STAT. § 90-322 (1981 & Supp. 1983); OR. REV. STAT. § 97.084 (1983).

142. See WASH. REV. CODE ANN. §§ 70.122.010 to .905 (West Supp. 1984-1985).

143. *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983). These guidelines include: (1) a unanimous concurrence of at least three physicians, including the attending physician, that the patient's condition is incurable; (2) court appointment of a guardian, including appointment of a *guardian ad litem* to represent the interests of the incompetent patient; (3) withdrawal of the life-sustaining medical treatment if in the guardian's best judgment the incompetent would have done so if competent; and (4) if required, "a court determination of the rights and wishes of the incompetent, with a guardian ad litem appointed to represent the incompetent patient and to present all relevant facts to court." *Id.* at 137, 660 P.2d at 751.

While the judiciary has the power and authority to decide such issues, our decisions are limited by the facts before us. As these issues necessarily involve society's moral standards as well as legal and medical issues, the Legislature is the body most capable of assessing the views of the people of this state.¹⁴⁴

2. Recent Statutes

Since 1980, twenty-five additional states and the District of Columbia have enacted "living will" laws.¹⁴⁵ Most of the recent legislation has focused on some of the ambiguities of the earlier statutes and their failure to make statutory provisions for the situation in which a terminally ill incompetent patient does not have a living will.¹⁴⁶ Five of these recent statutes include provisions which allow patients to choose a proxy appointment.¹⁴⁷ Three other recent statutes provide procedures for decision-making on behalf of comatose patients who have not executed advance written declarations.¹⁴⁸ It is also significant

144. *Id.* at 139, 660 P.2d at 752.

145. Alabama enacted its statute in 1981. ALA. CODE §§ 22-8A-1 to -10 (1984). Delaware, Vermont and the District of Columbia enacted their statutes in 1982. DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1984); VT. STAT. ANN. tit. 18, §§ 5251-5262, tit. 13, § 1801 (Supp. 1984-1985). Illinois and Virginia enacted their statutes in 1983. ILL. ANN. STAT. ch. 110 1/2, §§ 701-710 (Smith-Hurd Supp. 1984-1985); VA. CODE §§ 54-325.8:1 to :13 (Supp. 1984). Florida, Georgia, Louisiana, Mississippi, West Virginia, Wisconsin and Wyoming enacted their statutes in 1984. FLA. STAT. ANN. §§ 765.01-.15 (Supp. 1985); GA. CODE ANN. §§ 31-32-1 to -12 (Supp. 1984); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1984); W. VA. CODE §§ 16-30-1 to -10 (Supp. 1984); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1984-1985); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1984). Thirteen of the twenty-five states recently enacted their statutes in 1985. See Otten, *supra* note 15.

146. For a discussion of these statutes and their differences, see *supra* notes 84-144 and accompanying text. For an analysis of these new laws, see *infra* notes 147-78 and accompanying text. See also RIGHT TO DIE HANDBOOK, *supra* note 18, at 12-28 (discussing all new laws from 1981-1984).

147. DEL. CODE ANN. tit. 16, §§ 2502(b)-(c) (1983); FLA. STAT. ANN. § 765.05(2) (Supp. 1985); LA. REV. STAT. ANN. § 40:1299.58.3(c)(1) (West Supp. 1985); VA. CODE § 54-325.8:4 (Supp. 1984); WYO. STAT. § 33-26-145(d) (Supp. 1984). These provisions allow an adult person to appoint by written declaration an agent who will make medical decisions for the patient if he becomes incapable of doing so. For a further discussion of the Delaware statute, see *infra* notes 151-55 and accompanying text.

148. FLA. STAT. ANN. § 765.07 (Supp. 1985); LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1985); VA. CODE § 54-325.8:6 (Supp. 1984). For a further discussion of the Virginia statute, see *infra* notes 156-67 and accompanying text. For a discussion of statutes enacted prior to 1980 which have a provision dealing with incompetent patients who have no directive, see *supra* note 131 and accompanying text.

that none of the new laws enacted contain the California, Texas, and Idaho natural death acts' major restriction that a directive is legally effective only if executed after the diagnosis of a terminal illness.¹⁴⁹ Five of the new laws also contain a provision that excludes the administration of nourishment/sustenance (artificial or tube-feeding) along with other procedures from the statute's definition of life-sustaining procedures that can be terminated.¹⁵⁰

In July, 1982, the Delaware Death with Dignity Act¹⁵¹ advanced a new approach to address the liability of medical professionals who withhold or withdraw life-saving treatment from dying patients. The Delaware statute provides for the prior appointment by the patient of an agent to act on his behalf in the event that, in the attending physician's judgment, he becomes incompetent.¹⁵² The agent is authorized to accept or reject life-sustaining medical treatment on behalf of the patient if the patient is subsequently declared incapable of making that decision.¹⁵³ Thus, the Delaware statute offers two kinds of decision-making procedures for the withholding or withdrawal of life-sustaining treatment from terminally ill patients: (1) a binding directive from a competent patient;¹⁵⁴ and (2) the appointment of

149. See *supra* notes 109-11 and accompanying text for a discussion of this restriction.

150. FLA. STAT. ANN. § 765.03(3) (Supp. 1985); GA. CODE ANN. § 31-32-2(5) (Supp. 1984); ILL. ANN. STAT. ch. 110 1/2, § 702(c) (Smith-Hurd Supp. 1984-1985); WIS. STAT. ANN. § 154.01(5) (West Supp. 1984-1985); WYO. STAT. § 33-26-144(a)(iii) (Supp. 1984).

151. DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983).

152. *Id.* § 2502(b) (1983). The statute provides:

An adult person by written declaration may appoint an agent who will act on behalf of such appointor if, due to a condition resulting from illness or injury and, in the judgment of the attending physician, the appointor becomes incapable of making a decision in the exercise of the right to accept or refuse medical treatment.

Id.

153. *Id.* § 2502(c) (1983). The statute provides in relevant part:

An agent appointed in accordance with this section may accept or refuse medical treatment proposed for the appointor if, in the judgment of the attending physician, the appointor is incapable of making that decision. This authority shall include the right to refuse medical treatment which would extend the appointor's life.

Id.

154. *Id.* § 2502(a) (1983). Like the other statutes, the declaration must be in writing, signed by the declarant, and witnessed by two or more adults. *Id.* § 2503 (1983). However, the Delaware statute, unlike most of the "living will" laws, does not contain a standard form directive. See *id.* §§ 2501-2508 (1983).

a proxy to make treatment decisions for a patient who becomes incompetent.¹⁵⁵

The Virginia Natural Death Act¹⁵⁶ has been referred to as "one of the best living will laws to be enacted"¹⁵⁷ primarily because it makes available three possible decision-making procedures in the withholding or withdrawing of life-sustaining medical treatment from a terminally ill adult.¹⁵⁸ The Virginia statute permits the termination of such treatment in situations: (1) where a competent adult makes a written or oral declaration instructing his physician to withhold or withdraw life-prolonging procedures in the event of a terminal condition;¹⁵⁹ (2) where a competent adult makes an advance designation appointing a proxy to accept or refuse life-sustaining medical treatment if he becomes unable to make such a decision and is diagnosed as suffering from a terminal condition;¹⁶⁰ and (3) where individuals designated by the statute, in a strict order of priority, decide to refuse life-sustaining medical treatment for an incompetent terminally ill patient who has not executed an advance directive.¹⁶¹ The individuals involved, in order of priority, include: (1) a judicially appointed guardian or committee of the patient if one exists; (2) the patient's designated proxy; (3) the patient's spouse; (4) the patient's adult child or children; (5) the parents of the patient; or (6) the patient's nearest living relative.¹⁶² If the decision to withdraw or withhold treatment is to be made by a person in category three, four, five or six, the consent of at least two such individuals is necessary, provided that they are reasonably available.¹⁶³

155. *Id.* § 2502(b)-(c) (1983). Four other states provide for a similar proxy appointment. See *supra* note 147 for the citations to these provisions.

156. VA. CODE §§ 54-325.8:1 to :13 (Supp. 1984).

157. RIGHT TO DIE HANDBOOK, *supra* note 18, at 23.

158. *Id.*; see VA. CODE § 54-325.8:1 to :13 (Supp. 1984).

159. VA. CODE § 54-325.8:3 (Supp. 1984). The statute provides in relevant part:
A written declaration shall be signed by the declarant in the presence of two subscribing witnesses. An oral declaration may be made by a competent adult in the presence of a physician and two witnesses by any nonwritten means of communication at any time subsequent to the diagnosis of a terminal condition.

Id.

160. *Id.* § 54-325.8:4 (Supp. 1984). A competent adult has the right to "designate another to make the treatment decision for him, in the event such person is diagnosed as suffering from a terminal condition." *Id.* § 54-325.8:1 (Supp. 1984).

161. *Id.* § 54-325.8:6 (Supp. 1984).

162. *Id.*

163. *Id.*

The Virginia statute does not contain any of the major restrictions found in the California statute. First, the declaration remains effective until revoked.¹⁶⁴ Second, the Virginia statute does not make the written directive binding only if executed after a terminal illness diagnosis.¹⁶⁵ As the "product of an extensive study of the rights of the terminally ill by a joint subcommittee composed of senators, delegates, physicians, attorneys, and clergy,"¹⁶⁶ the Virginia statute is clearly the most comprehensive "living will" statute enacted thus far.¹⁶⁷

Like the Virginia Natural Death Act, the Florida Life-Prolonging Procedure Act¹⁶⁸ and the Louisiana Life-Sustaining Procedures Act,¹⁶⁹ both enacted in 1984, provide for proxy appointments¹⁷⁰ and priority systems for decisions involving an incompetent patient¹⁷¹ in addition to a written or oral declaration by a competent adult.¹⁷² The Wyoming Act, like the Delaware law,¹⁷³ provides only for a proxy appointment¹⁷⁴ and a written declaration by a competent adult.¹⁷⁵ Only two of the recent statutes, the Georgia Living Wills Act and the Wisconsin Natural Death Act, restrict the effectiveness of the declaration to a specific number of years.¹⁷⁶ Each of the other new statutes provides for the directive to remain in effect until revoked.¹⁷⁷ Finally, the

164. *See id.* § 54-325.8:5 (Supp. 1984). California's statute provides for an effective period of only five years. *See supra* note 94 and accompanying text.

165. *See VA CODE* §§ 54-325.8:1 to :13 (Supp. 1984). The oral directive, however, must be made after a terminal illness diagnosis. *Id.* § 54-325.8:3 (Supp. 1984). In California, the patient can not execute a directive until fourteen days after the diagnosis of a terminal illness. *See supra* note 97 and accompanying text.

166. *RIGHT TO DIE HANDBOOK*, *supra* note 18, at 23.

167. *See supra* notes 156-66 and accompanying text.

168. *FLA. STAT. ANN.* §§ 765.01-.15 (Supp. 1985).

169. *LA. REV. STAT. ANN.* §§ 40:1299.58.1 to .10 (West Supp. 1985).

170. *FLA. STAT. ANN.* § 765.05(2) (Supp. 1985); *LA. REV. STAT. ANN.* § 40:1299.58.3(C)(1) (West Supp. 1985).

171. *FLA. STAT. ANN.* § 765.07 (Supp. 1985); *LA. REV. STAT. ANN.* § 40:1299.58.5 (West Supp. 1985).

172. *FLA. STAT. ANN.* § 765.04(1) (Supp. 1985); *LA. REV. STAT. ANN.* § 40:1299.58.3 (West Supp. 1985).

173. *See supra* notes 151-55 and accompanying text for a discussion of the Delaware statute.

174. The statute includes the option of appointing a proxy to make treatment decisions if the patient becomes comatose or otherwise incapable of doing so. *WYO. STAT.* § 33-26-145(d) (Supp. 1984).

175. *Id.* § 33-26-145 (Supp. 1984).

176. *GA. CODE ANN.* § 31-32-6 (Supp. 1984) (effective for seven years); *WIS. STAT.* § 154.03(1) (West Supp. 1984-1985) (effective for five years).

177. *ALA. CODE* §§ 22-8A-1 to -10 (1984); *DEL. CODE ANN.* tit. 16, §§ 2501-2508 (1983); *D.C. CODE ANN.* §§ 6-2421 to -2430 (Supp. 1984); *FLA. STAT. ANN.*

Florida, Georgia, Illinois, Wisconsin and Wyoming statutes specifically exclude nourishment/sustenance procedures along with procedures that provide comfort or alleviate pain from the definition of life-sustaining medical treatment that can be withdrawn from terminally ill patients.¹⁷⁸

IV. Development of the "Right to Die" in New York State

A. *Eichner v. Dillon*

In 1981, the New York State Court of Appeals held, in *Eichner v. Dillon*,¹⁷⁹ that a respirator could be withdrawn from an incompetent dying patient when there was no reasonable chance of recovery and there was "clear and convincing" evidence that the patient would have decided not to continue treatment if he were competent.¹⁸⁰ The court did not consider the wishes of family members, doctors, or an ethics committee regarding the withdrawal of the life-sustaining treatment, as the New Jersey Supreme Court had in *Quinlan*,¹⁸¹ though it implicitly provided judicial support for living wills.¹⁸²

The patient in *Eichner* was an eighty-three-year-old man who was placed on a respirator after lapsing into a permanent coma.¹⁸³ The local director of the religious society to which the comatose patient belonged¹⁸⁴ requested that the hospital remove the respirator.¹⁸⁵ The

§§ 765.01-.15 (Supp. 1985); ILL. ANN. STAT. ch. 110 1/2, §§ 701-710 (Smith-Hurd Supp. 1984-1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1984); VT. STAT. ANN. tit. 18, §§ 5251-5262 (Supp. 1984-1985); VA. CODE §§ 54-325.8:1 to :13 (Supp. 1984); W. VA. CODE §§ 16-30-1 to -10 (Supp. 1984); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1984).

178. FLA. STAT. ANN. §§ 765.03(3) (Supp. 1985); GA. CODE ANN. § 31-32-2(5) (Supp. 1984); ILL. ANN. STAT. ch. 110 1/2, § 702(c) (Smith-Hurd Supp. 1984-1985); WIS. STAT. ANN. § 154.01(5) (West Supp. 1984-1985); WYO. STAT. § 33-26-144(a)(iii) (Supp. 1984).

179. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

180. *Id.* at 378-79, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

181. For a discussion of *Quinlan*, see *supra* notes 20-37 and accompanying text.

182. See 52 N.Y.2d at 378-380, 420 N.E.2d at 71-72, 438 N.Y.S.2d at 274.

183. *Id.* at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269. The patient, Brother Joseph Fox, lapsed into a coma when he suffered cardiac arrest during an operation in 1979. *Id.*

184. Brother Fox was a member of the Society of Mary, a Roman Catholic religious order in Mineola, New York. *Id.*

185. *Id.* Father Phillip Eichner made this request after the attending physicians had informed him that "there was no reasonable chance of recovery and that Brother Fox would die in [a coma]." *Id.*

hospital refused to withdraw this life-saving treatment without court authorization.¹⁸⁶ The director thereupon petitioned to be appointed committee of the person and property of the patient with authority to order removal of the respirator.¹⁸⁷

The supreme court ordered that the director be appointed as the committee of the person and property of the comatose patient and authorized him to order the respirator removed.¹⁸⁸ The trial judge based his decision on the patient's common law right to bodily self-determination, which in part consisted of the right to decline life-sustaining medical treatment.¹⁸⁹ The trial judge also relied on evidence of the patient's prior opposition to the use of a respirator in sustaining his life. In particular, the judge stressed that before the operation the patient had repeatedly discussed with members of his religious society his desire that extraordinary medical treatment not be used to keep him alive.¹⁹⁰

The appellate division unanimously affirmed, but it went beyond the trial court's decision and recognized a patient's right to die with dignity.¹⁹¹ The court found that this right of a terminally ill patient to refuse life-sustaining medical treatment "rest[ed] on a far more fundamental principle of law: the constitutional right to privacy."¹⁹²

186. *Id.*

187. *Id.* Father Eichner had applied to the Supreme Court, Nassau County, pursuant to article 78 of the New York Mental Hygiene Law. *Id.*

188. *In re Eichner*, 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. Nassau County 1979). The court stated that termination of the life-support systems would not "give rise to either civil or criminal liability on the part of any participant" *Id.* at 213, 423 N.Y.S.2d at 599. The authorization to withdraw the life-sustaining equipment, however, was confined to the respirator only. *Id.* at 213-14, 423 N.Y.S.2d at 599.

189. *Id.* at 196-203, 423 N.Y.S.2d at 589-93. The trial judge also found that this right was not outweighed by the state's interest in protecting life or in affording the medical profession a chance to carry out its functions. *Id.* at 203-04, 423 N.Y.S.2d at 593-94. See Byrn, *supra* note 11, at 16-35 for a discussion of these state interests.

190. 102 Misc. 2d at 192-93, 423 N.Y.S.2d at 586-87. During these meetings, "Brother Fox not only repeatedly expressed agreement with the [Roman Catholic C]hurch's teaching on the subject of the withdrawal of extraordinary life-support systems but also stated that he personally would not want any of this 'extraordinary business' done for him under such circumstances." *Id.* at 192, 423 N.Y.S.2d at 586. In 1957, Pope Pius XII concluded in a well-known allocution to a group of anaesthesiologists "that it was morally and spiritually proper for adherents of the Roman Catholic Church to direct that use of extraordinary life-support systems be terminated when there is no longer reasonable hope of recovery." *Id.*

191. *Eichner v. Dillon*, 73 A.D.2d 431, 454-62, 426 N.Y.S.2d 517, 536-41 (2d Dep't 1980).

192. *Id.* at 457, 426 N.Y.S.2d at 537 (footnote omitted). For a general discussion of the right to privacy, see *supra*, note 12 and accompanying text.

The appellate court also listed specific procedures to be followed by doctors and hospitals in determining whether to withhold or withdraw life-sustaining medical treatment from incompetent terminally ill patients.¹⁹³ These procedures included four requirements: (1) the attending physicians must certify that the patient is terminally ill; (2) this prognosis must be confirmed by a hospital committee of at least three doctors with specialties relevant to the patient's case; (3) upon confirmation, a guardian ad litem must be appointed to protect the patient's rights; and (4) the attorney-general and the appropriate district attorney must be notified, though their approval is not required.¹⁹⁴ The court concluded by stating that "[w]here this procedure is complied with, and where the court concludes . . . that the extraordinary life-sustaining measures should be discontinued, no participant—either medical or lay—shall be subject to criminal or civil liability as a result of the termination of such life-sustaining measures."¹⁹⁵

In March, 1981, the New York State Court of Appeals affirmed the lower court's decision to allow removal of the respirator¹⁹⁶ but chose not to decide the petitioner's right to privacy argument "because the relief granted to the petitioner . . . [was] adequately supported by common-law principles."¹⁹⁷ The court based its decision on the patient's common law right of bodily self-determination¹⁹⁸ and the "clear and convincing" proof of this patient's prior expressions of his desire not to be kept alive by extraordinary means.¹⁹⁹ The court of appeals also rejected the elaborate judicial procedures

193. *Id.* at 476-77, 426 N.Y.S.2d at 550.

194. *Id.* Individuals who may initiate proceedings on the patient's behalf include "a member of the patient's family, someone having a close personal relationship with [the patient], or an official of the hospital . . ." *Id.* at 476, 426 N.Y.S.2d at 550.

195. *Id.* at 477, 426 N.Y.S.2d at 550.

196. 52 N.Y.2d 363, 383, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 (1981).

197. *Id.* at 377, 420 N.E.2d at 70, 438 N.Y.S.2d at 273. This is a question which the Supreme Court has also declined to consider. *See, e.g., Garger v. New Jersey*, 429 U.S. 922 (1976) (denying certiorari to Karen Ann Quinlan case).

198. 52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273. Common law rights are not as closely protected as constitutional rights when balanced against strong state interests. *See generally* Note, *Live or Let Die: Who Decides an Incompetent's Fate?* In re Storar and In re Eichner, 1982 B.Y.U. L. REV. 387, 390-92 (1982) (defending court's choice of common law right to refuse treatment over constitutional right to privacy); Note, In re Storar: *The Right to Die and Incompetent Patients*, 43 U. PITT. L. REV. 1087, 1097 (1982) (common law and constitutional rights are quite different in extent of judicial protection).

199. 52 N.Y.2d at 378-80, 420 N.E.2d at 71-72, 438 N.Y.S.2d at 274; *see supra* note 90 and accompanying text.

detailed by the appellate division²⁰⁰ for cases involving incompetent patients.²⁰¹ Judge Wachtler, writing for the majority, stated that the reason for rejecting these guidelines was that “[u]nlike the Legislature, the courts are neither equipped nor empowered to prescribe substantive or procedural rules for all, most, or even the more common contingencies. Our role, especially in matters as sensitive as these, is limited to resolving the issues raised by facts presented in particular cases.”²⁰² By rejecting the standards developed by the appellate division, the court of appeals refused to create a judicial precedent as powerful as that established by the New Jersey Supreme Court in *Quinlan*.²⁰³

B. *In re Storar*

In a companion case to *Eichner*, the court of appeals, in *In re Storar*,²⁰⁴ ruled that the “clear and convincing” standard of proof of a patient’s wishes, described in *Eichner* had not been satisfied²⁰⁵ in the case of a fifty-two-year-old incompetent, terminally ill patient.²⁰⁶ The patient’s mother had requested that the blood transfusions for her son be discontinued²⁰⁷ so that the remainder of his life would not be full of pain and suffering. The director of the development center then brought a declaratory suit seeking authority to continue the transfusions, claiming that death would result without them.²⁰⁸

200. See *supra* notes 193-94 and accompanying text for a discussion of these procedures.

201. 52 N.Y.2d at 370, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.

202. *Id.* (footnote omitted). Judge Jones dissented as to the companion case of *In re Storar*. *Id.* at 383-91, 420 N.E.2d at 74-79, 438 N.Y.S.2d at 276-81. For a discussion of this case, see *infra* notes 204-17 and accompanying text. Judge Fuchsberg also dissented and would have dismissed both cases as moot since both patients subsequently had died. 52 N.Y.2d at 391-93, 420 N.E.2d at 79, 438 N.Y.S.2d at 281.

203. For a discussion of the *Quinlan* decision, see *supra* notes 20-37 and accompanying text.

204. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

205. 52 N.Y.2d at 380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75.

206. The patient, John Storar, was retarded and also had cancer of the bladder. *Id.* at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

207. *Id.* at 373, 420 N.E.2d at 69, 438 N.Y.S.2d at 271. The patient’s physician had “diagnosed the cancer as terminal, concluding that after using all medical and surgical means then available, the patient would nevertheless die from the disease.” *Id.*

208. *Id.* at 373-74, 420 N.E.2d at 69, 438 N.Y.S.2d at 271. Mrs. Storar then cross-petitioned for a court order prohibiting the blood transfusions. *Id.* at 374, 420 N.E.2d at 69, 438 N.Y.S.2d at 271.

The trial court decided that the transfusions could be discontinued based on the patient's right to bodily self-determination.²⁰⁹ Since the patient was incompetent, the court agreed with the opinion of the patient's mother that her son's best interests would be served by terminating the blood transfusions.²¹⁰ The court also emphasized that the transfusions would not cure the patient's disease, that they caused a great deal of pain, and that the patient had submitted to the transfusions with reluctance.²¹¹ The appellate division affirmed the lower court's decision in a memorandum opinion.²¹²

The New York State Court of Appeals reversed and held that the transfusions had to be continued based on the *Eichner* decision.²¹³ The court, structuring an analogy between the role of the state in protecting this patient and its interest in protecting the health and welfare of a child,²¹⁴ ruled that the mother's decision to discontinue the blood transfusions to her son must yield to the state's interest in protecting the life of her son.²¹⁵ The court also noted that the state interest predominated in this patient's case because, unlike the comatose patient in *Eichner*, the retarded patient had never been competent in his lifetime and had never been able to make a decision concerning his medical treatment or voice his opposition to life-sustaining treatment.²¹⁶ Thus, the court, in part, rejected the substituted judgment approach adopted by the Massachusetts Supreme Judicial Court in *Saikewicz*.²¹⁷

209. *In re Storar*, 106 Misc. 2d 880, 885-86, 433 N.Y.S.2d 388, 393 (Sup. Ct. Monroe County 1980).

210. *Id.* at 886, 433 N.Y.S.2d at 394.

211. *Id.* at 883-84, 433 N.Y.S.2d at 392-93.

212. *In re Storar*, 78 A.D.2d 1013, 434 N.Y.S.2d 46 (4th Dep't 1980). The appellate division used the same reasoning as the trial court to reach the same conclusion. *Id.* at 1013, 434 N.Y.S.2d at 47.

213. 52 N.Y.2d 363, 383, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 (1981).

214. *Id.* at 380-81, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. For legal purposes the patient, John Storar, was deemed a child with a mental capacity of eighteen months. *Id.* at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. The legal construction of the state's role as surrogate parent is known as the doctrine of *parens patriae*. *Id.* at 380-81, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. For a discussion of the state's interest in protecting incompetent patients, see Byrn, *supra* note 11, at 24-28.

215. 52 N.Y.2d at 380-81, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

216. *Id.* at 380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75.

217. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 275. "[I]t is unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent." *Id.* For a discussion of the *Saikewicz* decision and its use of the substituted judgment approach, see *supra* notes 40-49 and accompanying text.

New York courts require "clear and convincing" evidence in situations where it is claimed that an incompetent patient would have desired to withdraw life-sustaining medical treatment if he became terminally ill.²¹⁸ In effect, the high court's decisions in *Eichner* and *Storar* "affirmed that even in the absence of a living will law in the state, New York residents' living will declarations carry legal weight as evidence of their preferences about terminal treatment."²¹⁹ However, the court's refusal to adopt standards and guidelines leaves situations in which incompetent patients do not have living wills or in which the family or guardian is unable to show prior intent without solutions. Also, doctors and hospitals continue to suffer uncertainty in their decisions to remove life-sustaining treatment even where the patient has stated his intentions since a living will without statutory authorization is not conclusive proof of a patient's preferences.

C. Recent Developments in New York

Currently, New York has no "living will" statute. On September 17, 1984, the New York State Health Commissioner, Dr. David Axelrod, announced that he was drafting proposals for new legislation that would allow hospitals and doctors to withhold life-saving medical treatment from terminally ill and dying patients fully immune from civil and criminal prosecution.²²⁰ In October, 1984, Governor Mario Cuomo announced his intention to establish a task force on "life and the law" to recommend legislation on such issues as the "right to die."²²¹ In December, the Governor appointed twenty-three people to this task force and named Dr. Axelrod as the chairman.²²²

Doctors and hospitals in New York state have voluntarily followed the Medical Society of New York (Society) guidelines issued on

218. *Id.* at 378-80, 420 N.E.2d at 71-72, 438 N.Y.S.2d at 274; *see also In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 487-88, 455 N.Y.S.2d 706, 712-13 (Sup. Ct. Nassau County 1982) (decision to terminate life-prolonging procedures would be honored where there is evidence that patient had made rational decision to forego such treatment before becoming comatose).

219. RIGHT TO DIE HANDBOOK, *supra* note 18, at 10.

220. Sullivan, *supra* note 4, at A1, col. 1.

221. Oreskes, *supra* note 1, at A1, col. 1. Another important issue that will be considered is the legal rights of embryos formed outside the womb. *Id.*

222. Severo, *supra* note 2, at A22, col. 1. A report is due from the panel by May 1, 1985.

September 20, 1982.²²³ These guidelines involve "instructions sometimes given hospital staffs to withhold cardiopulmonary resuscitation from terminally ill patients in the event they suffer acute cardiac or respiratory arrest."²²⁴ These instructions, known as "Do Not Resuscitate" (DNR) orders, are defined in the guidelines.²²⁵ The Society's guidelines state four requirements for a medically appropriate DNR decision: (1) the DNR decision must be "written as a formal order by the attending physician;"²²⁶ (2) the facts and considerations involved in reaching a DNR decision must be entered in the patient's medical record; (3) the attending physician is responsible for making certain that the DNR order is discussed with the appropriate hospital staff members; and (4) the "DNR order shall be subject to review at any time by all concerned parties on a regular basis and may be rescinded at any time."²²⁷

One concern of the Society in implementing its guidelines is how the decision to issue a DNR order is reached. The guidelines require the decision to be made jointly by the doctor and the terminally ill patient, or the doctor and the patient's family if the patient is unable to make his own decision due to incompetence.²²⁸ The guidelines also provide that "[i]f a patient disagrees, or, in the case of a patient incapable of making an appropriate decision, the family member(s) disagree, a DNR order should not be written."²²⁹

Although these procedures provide guidance for the withholding of cardiopulmonary resuscitation, doctors and hospitals still fear the legal consequences of their decisions in these emergency treatment situations.²³⁰ The guidelines evidence the medical profession's concern

223. Sullivan, *supra* note 4, at A1, col. 1; see Medical Society of the State of New York, News Release (Sept. 20, 1982) [hereinafter cited as Medical Society Guidelines]. The Society is a "federation of 61 county medical societies in New York representing some 27,000 physicians in the state." Medical Society Guidelines, *supra* at 1. Since these procedures are only guidelines, it is impossible to determine with any certainty how many doctors and hospitals actually follow them.

224. *Id.*

225. *Id.* at 3. "DNR . . . means that, in the event of a cardiac or respiratory arrest, cardiopulmonary resuscitative measures will not be initiated or carried out."
Id.

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. See Sullivan, *supra* note 4, at D14, col. 1. In March, 1984, a Queens County grand jury investigated two cases at La Guardia Hospital in which resus-

in withholding life-saving medical treatment, yet they fail to address two major problems. First, they do not specify what to do if the patient is incompetent and has no family.²³¹ Second, the guidelines do not define doctor-hospital liability for withholding other life-saving procedures such as respiratory support and artificial feeding from terminally ill and dying patients. The best and only possible resolution of this controversy lies with the New York State Legislature's enactment of a comprehensive "living will" statute.²³² In the words of one court:

Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type [sic] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized.²³³

V. Recommendations for a New York Natural Death Act

In 1981, the New York State Court of Appeals, in *In re Storar*,²³⁴ remarked: "[i]f it is desirable to enlarge the role of the courts in cases involving discontinuance of life sustaining treatment for incompetents by establishing . . . a mandatory procedure of successive approvals by physicians, hospital personnel, relatives and the courts, the change should come from the Legislature."²³⁵ The legislature should enact a natural death act setting the necessary procedures to be followed by physicians and hospitals in withholding or withdrawing life-sustaining medical treatment from terminally ill and dying patients.²³⁶ The legislature should examine closely the "right

citation was withheld from two elderly, terminally ill patients. Although the grand jury did not issue any indictments, it did urge the state to establish procedures for withholding medical care from terminally ill patients. *Id.*

231. See Medical Society Guidelines, *supra* note 223, at 3.

232. For a discussion of proposals and recommendations for a New York Natural Death Act, see *infra* notes 234-77 and accompanying text.

233. *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980). For a discussion of this case, see *supra* notes 61-67 and accompanying text.

234. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

235. *Id.* at 382-83, 420 N.E.2d at 74, 438 N.Y.S.2d at 276; see *supra* notes 179-219 and accompanying text.

236. See *Living, Dying, and the Law*, N.Y. Times, Dec. 28, 1984, at A30, col. 1 (editorial).

to die" cases and "living will" statutes of other states to avoid the ambiguities and failures of prior laws.²³⁷

A. Recent Legislative Proposals

"Living will" bills recently have been introduced in several states,²³⁸ including New York²³⁹ and New Jersey.²⁴⁰ The New Jersey bill introduced on November 19, 1984, by Senators Matthew Feldman and Wayne Dumont recognized the right of the individual to "execute an oral or written declaration instructing an attending physician to withhold or withdraw life-sustaining procedures in the event that the person is diagnosed and certified as suffering from a terminal condition."²⁴¹ The bill also granted immunity from civil and criminal liability to all medical or health care professionals who comply with the act.²⁴² This immunity is inapplicable, however, if "it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures was negligent or did not in good faith comply with the provisions of this act."²⁴³

Under this bill, the declaration remained effective until revocation.²⁴⁴ Also provided was a standard living will form which must

237. For a discussion of the "right to die" cases of other states, see *supra* notes 20-83 and accompanying text. For a discussion of the New York cases, see *supra* notes 179-219 and accompanying text. For a discussion of the "living will" statutes, see *supra* notes 84-178 and accompanying text.

238. The eighteen states which have considered such proposals in 1984 are: Alaska, Arizona, Colorado, Connecticut, Hawaii, Indiana, Iowa, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, and Utah. RIGHT TO DIE HANDBOOK, *supra* note 18, at 2.

239. S.B. 7697, 207th Leg., Reg. Sess. (New York Feb. 14, 1984) [hereinafter cited as New York Bill]; see also A.B. 8008, 206th Leg., Reg. Sess. (New York Jun. 6, 1983); S.B. 2401, 206th Leg., Reg. Sess. (New York Feb. 8, 1983); A.B. 1948, 206th Leg., Reg. Sess. (New York Jan. 20, 1983).

240. S.B. 2387, 201st Leg., 1st Ann. Sess. (New Jersey Nov. 19, 1984) [hereinafter cited as New Jersey Bill].

241. New Jersey Bill § 2. The oral declaration "may be made by a person at any time subsequent to the diagnosis of a terminal condition in the presence of a physician and two witnesses." *Id.* § 4(b).

242. *Id.* § 9(a).

243. *Id.* § 9(b). This bill, like the Texas statute, explicitly makes negligence an exception to the immunity provision. See *supra* notes 122-29 and accompanying text for a discussion of the Texas statute.

244. *Id.* § 4(e). "Unless revoked, a declaration is effective and binding from the date of execution." *Id.* Four existing statutes make the directive effective for a specific number of years. The states that have such provisions in their "living will" statutes are California, Georgia, Idaho and Wisconsin. See *supra* notes 94, 140 & 176 and accompanying text.

be substantially followed by a patient in order to be enforceable.²⁴⁵ Unlike the California, Texas and Idaho natural death acts, the bill did not require a terminal illness determination before execution of a written directive,²⁴⁶ although it did require such a prognosis for an oral directive to be effective.²⁴⁷ The bill also provided for invalidation of the directive if the declarant were pregnant at the time of exercise.²⁴⁸

Like the Virginia priority procedure,²⁴⁹ the New Jersey bill provided a procedure for the withdrawal of medical treatment from a terminally ill, incompetent patient who had not executed an advance declaration.²⁵⁰ The bill, however, did not provide for the possibility of a proxy appointment executed by the patient before he became incompetent or comatose.²⁵¹ While the bill did not specify whether artificial feeding was a "life-sustaining procedure,"²⁵² the New Jersey Supreme Court recently held that artificial feeding is the kind of life-sustaining medical treatment that could be withdrawn from terminally ill patients.²⁵³

The New York bill introduced by Senator Andrew Jenkins on February 14, 1984, recognized "the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition."²⁵⁴ The bill also allows doctors and hospitals to act on such directives, fully immune from civil and criminal liability.²⁵⁵ The Jenkins' bill contains two restrictive provisions, however, which originated in the California law: (1) the directive can not be executed until fourteen days after a terminal illness diagnosis;²⁵⁶ and (2) the directive is only

245. New Jersey Bill § 5. Fifteen of the "living will" statutes have a standard form directive (or living will) which must be substantially followed. See *supra* note 120 and accompanying text.

246. See New Jersey Bill §§ 1-21.

247. *Id.* § 4(b).

248. *Id.* § 4(f).

249. See *supra* notes 161-63 and accompanying text for a discussion of the priority procedure in the Virginia statute.

250. New Jersey Bill 2387 § 18.

251. See *id.* §§ 1-21. Delaware was the first state to utilize this proxy system. See *supra* notes 152-55 and accompanying text for a discussion of this provision in the Delaware statute.

252. See New Jersey Bill § 3(c).

253. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). For a discussion of the court's decision in *In re Conroy*, see *supra* notes 76-83 and accompanying text.

254. New York Bill § 4600.

255. *Id.* § 4605.

256. *Id.* § 4606(2). See *supra* note 97 and accompanying text for a discussion of this provision in the California statute.

effective for five years.²⁵⁷ Both of these provisions are counter-productive to the purposes of a natural death act since they fail to recognize the potential for a sudden coma and do not accept the logical presumption that a person would revoke a living will if his feelings changed subsequent to the initial execution.²⁵⁸

The New York proposed bill fails to address many of the major problems in the withdrawal of life-sustaining medical treatment from terminally ill patients. Unlike the New Jersey bill,²⁵⁹ the Jenkins' bill does not provide for an oral directive, and it does not establish procedures for terminally ill, incompetent patients who have not executed a directive,²⁶⁰ thus continuing the "clear and convincing" evidence standard enunciated in *Storar*.²⁶¹ Finally, the bill does not provide for proxy appointments²⁶² and it does not mention whether artificial or tube feeding is a life-sustaining procedure.²⁶³ The current New York case law also fails to adequately provide for proxy appointments and does not determine whether tube feeding is a life-sustaining procedure.²⁶⁴

B. Proposal for Natural Death Act

Using the Virginia "living will" statute as a model,²⁶⁵ the New York State Legislature should enact a natural death act which considers five important areas. First, the statute must grant immunity from civil and criminal liability to all health professionals who withhold treatment in "good faith" compliance with the statute. This "good faith" standard would better relieve doctors and hospitals of the fear of legal consequences for withholding such treatment than would a negligence standard.²⁶⁶

257. New York Bill § 4604. See *supra* note 94 and accompanying text for a discussion of this provision in the California statute.

258. See *supra* notes 109-11 and accompanying text.

259. New Jersey Bill §§ 1-21.

260. See New York Bill §§ 4601-4608.

261. For a discussion of *In re Storar* and its companion case, *Eichner v. Dillon*, see *supra* notes 179-219 and accompanying text.

262. See New York Bill §§ 4601-4608.

263. See *id.* § 4601(3). See *supra* notes 76-83 and accompanying text for a discussion of this problem in the *Conroy* decision.

264. See *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

265. For a discussion of the Virginia statute, see *supra* notes 156-67 and accompanying text.

266. The Texas statute makes use of a negligence standard. See *supra* note 125 and accompanying text.

Second, the statute must provide for a written²⁶⁷ or oral²⁶⁸ directive by a competent adult to withdraw life-sustaining treatment if he enters a terminal condition. Adult individuals have the fundamental right to control decisions relating to their own medical care, including the choice to withdraw or withhold life-sustaining procedures.²⁶⁹

Third, the statute must permit a patient to make an advance declaration appointing a proxy to refuse or accept life-sustaining medical treatment for the patient if the patient becomes incompetent.²⁷⁰ This provision would allow the patient to designate another to exercise his right to make decisions concerning his own medical treatment.

Fourth, the statute must further provide for specific procedures to be followed in deciding who could refuse or accept life-sustaining treatment for the patient when he is comatose or incompetent and no advance declaration has been executed.²⁷¹ Most of the judicial decisions in this area have stated that their respective legislatures should establish guidelines on the withdrawal of life-sustaining procedures from terminally ill, incompetent patients with no directives.²⁷²

Finally, the legislature must determine whether all forms of life-sustaining treatment, including artificial feeding, could come under the statute's definition of "life-sustaining treatment."²⁷³ Arguably, artificial feeding should be included because "the primary focus should be on the patient's desires and experience of pain and enjoyment—not the type of treatment involved."²⁷⁴

267. In the case of a written directive, a form declaration must be followed substantially. See *supra* note 120 and accompanying text.

268. The oral declaration must be made by a competent adult in the presence of the attending physician and two other witnesses.

269. For a discussion of the right to privacy, see *supra* note 12 and accompanying text.

270. Only five states currently have this provision. They are: Delaware, Florida, Louisiana, Virginia and Wyoming. See *supra* note 147 and accompanying text.

271. Only seven states have a provision dealing with this issue. They are: Arkansas, Florida, Louisiana, New Mexico, North Carolina, Oregon and Virginia. See *supra* note 131 and accompanying text. Two states recently were advised of the lack of such a provision in their statutes. See, e.g., *Barber v. Superior Court of California*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (noting that there are no established guidelines in living will statute for this situation); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (court established its own guidelines to deal with incompetent patient).

272. See *supra* notes 38-83, 179-219 and accompanying text for a discussion of these cases.

273. The New Jersey Supreme Court recently held that artificial feeding could be withheld from a terminally ill patient. See *supra* notes 76-83 and accompanying text for a discussion of *In re Conroy*.

274. *In re Conroy*, 98 N.J. 321, 369, 486 A.2d 1209, 1233 (1985).

The legislature should not include the two restrictive provisions found in some of the statutes.²⁷⁵ First, the directive should remain effective until revoked to relieve the patient of the burden of re-executing the directive every time the effective period expires.²⁷⁶ Second, the statute should not require that the directive only be effective if executed *after* a terminal illness diagnosis, whether the waiting period is one day or fourteen days.²⁷⁷ Such provisions fail to recognize the possible situations where a patient is brought into a hospital in a comatose state *before* being diagnosed as terminally ill. The issue is not the diagnosis of a terminal illness, but the individual's right to terminate life-sustaining medical treatment.

VI. Conclusion

Specific guidelines must be enacted by the New York State Legislature to enable doctors, patients, and families to confront with legal certainty the question of when life-sustaining medical treatment can be withheld or withdrawn from terminally ill patients. Such a statute must protect the conflicting interests of the state, the patient and health professionals.²⁷⁸ As several state judiciaries have noted, the legislature should solve this difficult problem because such guidelines cannot be formulated without serious debate and discussion.²⁷⁹ Special attention also should be given to existing "living will" statutes and their ambiguities.²⁸⁰ If drafted pursuant to the proposal presented in the following appendix, a comprehensive New York Natural Death Act would allow a terminally ill patient to die with dignity and allow a doctor to remove life-sustaining treatment from a terminally ill patient without fear of civil and criminal liability.

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275. See *supra* notes 109-11 and accompanying text for a discussion of these provisions in the California statute.

276. For a discussion of a provision in the California, Georgia, Idaho, and Wisconsin statutes which limits the effective period of a written directive, see *supra* notes 110-11, 176-77 and accompanying text.

277. For a discussion of this terminal illness diagnosis provision, see *supra* notes 109-11, 149 and accompanying text.

278. For a discussion of these competing interests, see *supra* notes 11-13 and accompanying text.

279. For a discussion of the "right to die" cases, see *supra* notes 20-83 and accompanying text. For a discussion of the New York cases, see *supra* notes 179-219 and accompanying text.

280. For a discussion of these statutes, see *supra* notes 84-178 and accompanying text.

Appendix

New York Natural Death Act

Section 1. Policy statement. The Legislature finds that every competent adult has the fundamental right to control the decisions relating to his own medical care, . . . [including the decision to withhold or withdraw medical treatment or procedures designed] to prolong his life. [The Legislature further finds that t]his right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. . . . In order that the rights and intentions of a person with [a terminal] condition may be respected even after he is no longer able to participate actively in decisions concerning himself, and to encourage communication among such patient, his family, and his physician, the Legislature declares that the laws of [New York] recognize the right of a competent adult to make an oral or written declaration instructing his physician to provide, withhold, or withdraw [life-sustaining] procedures, or to designate another to make the treatment decision for him, in the event that such person should be diagnosed as suffering from a terminal condition.²⁸¹

Section 2. Definitions. For the purposes of this act, the term:

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

(2) "Declaration" means a witnessed document in writing [or a witnessed oral statement], voluntarily executed by the declarant in accordance with the requirements of [Section 3].

(3) "Life-sustaining procedure" means any medical procedure or intervention, which, when applied to a qualified patient, would serve only to prolong artificially the dying process and where, in the judgment of the attending physician and a second physician, death will occur whether or not such procedure or intervention is utilized. [The term "life-sustaining procedure" includes, but is not limited to, respiratory support, artificial feeding tubes and cardiopulmonary resuscitation.] The term "life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

(4) "Physician" means a person authorized to practice medicine in the [State of New York].

281. FLA. STAT. ANN. § 765.02 (Supp. 1985).

(5) "Qualified patient" means a patient who has executed a declaration in accordance with this [Act] and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom shall be the attending physician.

(6) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve [sic] only to postpone the moment of death of the patient.²⁸¹

(7) "Witness" means a person who is not a spouse or blood relative of the patient.²⁸³

Section 3. Procedure for making a declaration; notice to physician. Any competent adult may, at any time, make a written declaration directing the withholding or withdrawal of [life-sustaining] procedures in the event such person should develop a terminal condition. A written declaration shall be signed by the declarant in the presence of two subscribing witnesses. An oral declaration may be made by a competent adult in the presence of a physician and two witnesses by any nonwritten means of communication.

It shall be the responsibility of the declarant to provide for notification to his attending physician that a declaration has been made. In the event the declarant is comatose, incompetent or otherwise mentally or physically incapable, any other person may notify the physician of the existence of a declaration. An attending physician who is so notified shall promptly make the declaration or a copy of the declaration, if written, a part of the declarant's medical records. If the declaration is oral, the physician shall likewise promptly make the fact of such a declaration a part of the patient's medical record.²⁸⁴

Section 4. Suggested form of written declaration. A declaration executed pursuant to this [Act] may, but need not, be in the following form, and may include other specific directions including, but not limited to, a designation of another person to make the treatment decision for the declarant should he be (i) diagnosed as suffering from a terminal condition and (ii) comatose, incompetent or otherwise

282. D.C. CODE ANN. § 6-2421 (Supp. 1984).

283. VA. CODE § 54-325.8:2 (Supp. 1984).

284. *Id.* § 54-325.8:3 (Supp. 1984).

mentally or physically incapable of communication. Should any other specific directions be held to be invalid, such invalidity shall not affect the declaration.

Declaration made this _____ day of _____ (month, year).
I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

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

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

[If I have been diagnosed as pregnant, this declaration shall have no force and effect during the course of my pregnancy.]

Signed _____

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

Witness _____

Witness _____²⁸⁵

Section 5. Revocation of Declaration. A declaration may be revoked at any time by the declarant by (i) a signed, dated writing; or (ii) physical cancellation or destruction of the declaration by the declarant or another in his presence and at his direction; or (iii) an oral expression of intent to revoke. Any such revocation shall be effective when communicated to the attending physician. No civil or criminal liability shall be imposed upon any person for a failure to act upon a revocation unless that person has actual [notice] of such revocation.²⁸⁶

285. *Id.* § 54-325.8:4 (Supp. 1984).

286. *Id.* § 54-325.8:5 (Supp. 1984).

Section 6. Procedure in absence of declaration. Nothing in this [Act] shall be construed in any manner to prevent the withholding or the withdrawal of life-sustaining procedures from an adult patient with a terminal condition who is comatose, incompetent, or otherwise physically or mentally incapable of communication and has not made a declaration in accordance with this [Act], provided there is an agreement for the withholding or the withdrawal of life-sustaining procedures between the attending physician and any of the following individuals in the following order of priority if no individual in a prior class is reasonably available, willing, and competent to act:

(1) The judicially appointed [guardian] of the patient if one has been appointed. This subparagraph shall not be construed to require such appointment in order that a treatment decision can be made under this Section.

(2) The patient's spouse not judicially separated.

(3) An adult child of the patient.

(4) The parents of the patient.

(5) The patient's sibling.

(6) The patient's other ascendants or descendants. . . .

In any case where the treatment decision is made by a person specified in subparagraphs [(2), (3), (4), (5), or (6)] there shall be at least two witnesses present at the time the treatment decision is made. The absence of a declaration by an adult patient shall not give rise to any presumption as to the intent to consent or to refuse life-sustaining procedures. [This Section will not apply if there is clear and convincing evidence of the patient's desires to accept or refuse life-sustaining medical treatment. If such evidence exists, it alone will determine whether or not life-sustaining medical treatment should be withheld or withdrawn.]²⁸⁷

Section 7. Immunity from liability. No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration which purports to have been made in accordance with this Act shall, as a result thereof, be subject to criminal or civil liability or be found to have committed an act of unprofessional conduct.²⁸⁸

Section 8. Suicide; mercy killing or euthanasia prohibited. The withholding or withdrawal of life-sustaining procedures in accordance

287. LA. REV. STAT. § 40:1299.58.5 (West Supp. 1985).

288. ILL. ANN. STAT. ch. 110 1/2, § 707 (Smith-Hurd Supp. 1984).

with the provisions of [this Act] does not, for any purpose, constitute a suicide.²⁸⁹ Nothing in [this Act] shall be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.²⁹⁰

289. FLA. STAT. ANN. § 765.11(2) (Supp. 1985).

290. *Id.* § 765.11(1) (Supp. 1985).