The "Living Will" - An Individual's Exercise of His Rights of Privacy and Self-Determination

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The “Living Will”—An Individual’s Exercise of His Rights of Privacy and Self-Determination

INTRODUCTION

The deterioration of an individual’s physical condition to the point where medical prognosis indicates irreversible comatosis1 and life may be sustained only by mechanical means, necessitates recognition of the right of the individual to determine if he should be subjected to “extraordinary” medical treatment.2 At the time an individual’s life can only be described as vegetative,3 his family, treating physician and the hospital in which he is confined must be able to rely upon a testamentary-type document declining extraordinary treatment. Such a document would be executed by the patient in the expectation that his physical condition might later preclude a personal manifestation of his intent to decline extraordinary treatment. By expressing the intent that his bodily functions be allowed to pursue their natural course, the patient seeks to ensure that he is the one who makes the decision whether to employ extraordinary means to prolong his existence.

The concept of a testamentary-type document drafted and executed with the intent to prevent or cease extraordinary medical treatment was first proposed by Luis Kutner, who prefers that it

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1. In Skegg, Irreversibly Comatose Individuals: “Alive” or “Dead”? 33 CAMBRIDGE L.J. 130, 131 (1974), irreversible comatosis is defined as a condition where the individual has sustained such extensive brain damage that there is no possibility of returning to any form of consciousness. He divides those individuals into two broad categories: (1) those who have sustained brain damage to the extent which precludes a return to spontaneous respiration and (2) those who have not sustained such extensive damage. It is the former category with which this note deals.

2. Ordinary means are deemed to be all medicines, operations and treatments offering a reasonable hope of benefit and can be obtained and used without excessive expense, pain or other inconvenience. Extraordinary treatment is that which does not involve those factors or which, if employed, would not offer a reasonable hope of benefit. N. ST JOHN STEVAS, Euthanasia, in LIFE, DEATH AND THE LAW 275 (1961).

3. The physical condition described in this note parallels that presented in In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), a New Jersey case in which a father petitioned the court to have himself declared the guardian of his incompetent and irreversibly comatose daughter for the purpose of deciding to cease extraordinary medical treatment in the form of an artificial respirator. The trial court denied the petition of the father and held that he could not assert a right on behalf of his daughter in order to request the cessation of the mechanical respirator providing the means for prolonging her existence. The New Jersey Supreme Court reversed and held that although the father possessed no independent right of privacy to assert on his daughter’s behalf, he could assert her right of privacy as a surrogate and order the cessation of extraordinary treatment. Id. at 42, 355 A.2d at 664. This article will only deal with the right of an individual to manifest in written form his own desire not to be subjected to extraordinary treatment.
bear the appellation of "living will." Mr. Kutner's ideas have been adopted by various organizations such as the Euthanasia Educational Council and have been presented to the legislatures of numerous states for adoption.\textsuperscript{5} At the present time, however, no state has recognized the "living will" as a legally enforceable instrument\textsuperscript{6} and such a document has never been tested in court.\textsuperscript{7} This article will examine the rights of the individual to execute such a document and the rights of the family, treating physician and hospital to seek its enforcement on behalf of the comatose patient incapable of doing so himself.

THE CURRENT STATE OF THE LAW

The fact that many patients are allowed to die is well acknowledged. These situations most frequently arise where an individual is diagnosed as terminal and is either in extreme pain or unconscious and dependent upon artificial means for sustenance. Juries are reluctant to convict anyone who may have been involved in the administration of euthanasia,\textsuperscript{8} whether active or passive.\textsuperscript{9} Judges have also exhibited a great deal of leniency.\textsuperscript{10} Nevertheless, no state

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\textsuperscript{5} The Euthanasia Educational Council and other groups will supply forms and other information to those seeking guidelines for drafting a "living will," but none of these forms have a recognized legal effect.

\textsuperscript{6} Bills proposing the adoption in some form of a "living will" were unsuccessfully introduced into the legislatures of Florida, H.B. 239 (1975); Maryland, S. 700 (1974); Massachusetts, H. 3641 (1974); Oregon, H. 2997, Reg. Sess. (1973); Washington, S. 2449, 43rd Reg. Sess. (1973); and Wisconsin, S. 715 (1971).

\textsuperscript{7} The closest case on point is \textit{In re Quinlan}, 70 N.J. 10, 355 A.2d 647 (1976). However, in that case, the family of Ms. Quinlan was only able to prove that Karen had made statements that if she ever reached the state of irreversible comatosis, she would not want to be kept alive solely by artificial means. No document executed by Ms. Quinlan was introduced. The New Jersey Supreme Court deemed it unnecessary to decide whether it was error to admit into evidence the statements of Ms. Quinlan because they were not of sufficient probative weight.

\textsuperscript{8} Euthanasia in its literal sense means happy death. In common usage, its meaning encompasses any killing done with the motive of releasing the victim from a painful, handicapped or meaningless existence. \textit{Survey, Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations, 48 Notre Dame Law} 1202, 1203 (1972) [hereinafter cited as Survey].


\textsuperscript{10} In People v. Werner, Crim. No. 58-3636 (Cook Co. Ct., Ill. 1958), the defendant entered a plea of guilty to voluntary manslaughter for suffocating his crippled and bedridden wife when he learned they were being sent to a nursing home. The judge, after hearing testimony of the defendant's devotion and care for his wife, suggested that he withdraw his
has legalized the non-employment of extraordinary means or permits its cessation upon request or belief that further treatment would serve no useful purpose.\[^{11}\] It is understandable that courts and legislatures have been reluctant to acknowledge and sanction any active practice of euthanasia. If such practice were condoned, many fear that the law would evolve to the extremes which existed in Nazi Germany.\[^{12}\] However, when the patient is irreversibly comatose and his life processes can only be prolonged by the employment or continuation of extraordinary treatment, legal scholars cannot agree as to the degree of liability which attaches to "not plugging in or unplugging a machine." Failure to utilize a machine is often characterized as an omission, while discontinuing its usage on a patient exhibiting similar symptoms is deemed an act.\[^{13}\] The former, referred to as antidysthanasia,\[^{14}\] would under common law standards impose liability only if there is a duty to act on behalf of the patient.\[^{15}\] However, some commentators take the position that once the physician has undertaken the administration of a course of treatment he has the duty to continue it as long as the patient's life can be sustained.\[^{16}\] It has been suggested that liability can be circumvented if the patient effects a discharge of the physician and thereby ends the physician's duty.\[^{17}\]

\[^{11}\] See note 6 supra; and In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), where the court sanctioned the cessation of extraordinary treatment and set forth guidelines to be followed in future cases. The decision of the guardian who seeks termination of extraordinary medical treatment must be supported by medical opinion stating that there is no reasonable possibility that the patient can return to sapient cognitive functioning. The medical decision is to be reviewed by a hospital ethics committee composed solely of medical personnel. The court made no mention of possible legislative action as offering a solution to the dilemma of an individual's need for assurance that his rights of privacy and self-determination will always be protected and enforced on his behalf should he become incapable of doing so himself.

\[^{12}\] For a discussion of the atrocities performed in Nazi Germany and characterized as "euthanasia" see Kamisar, Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation, 42 MINN. L. REV. 969, 1029-39 (1958) [hereinafter cited as Kamisar]; Kutner, supra note 4, at 546.


\[^{14}\] S. SHINDELL, THE LAW IN MEDICAL PRACTICE 118 (1966). Antidysthanasia is defined as failing to take positive action in order to prolong the life of a terminally ill patient.

\[^{15}\] Survey, supra note 8, at 1207.

\[^{16}\] Id.; Kamisar, supra note 12, at 983n.41. Contra, Fletcher, supra note 13 at 1008.

\[^{17}\] Survey, supra note 8, at 1208.
Conversely, cessation of mechanical supports has been denoted as constituting an act rendering the perpetrator both civilly and criminally liable for causing the patient’s death.\(^{18}\) To distinguish between the failure to utilize extraordinary treatment and discontinuing its employment is untenable. Since the state’s interests do not differ in either case, liability in these cases should not depend upon the traditional act or omission distinction.

Because the present state of the law is in flux, it is incumbent upon legislatures and courts to formulate guidelines for the exercise of the choice not to prolong a vegetative existence. The lack of standards and unpredictable application of the law mandates such a development.

\section*{The Different Bases for the Right of the Individual to Decline Extraordinary Treatment}

\subsection*{The Right of Privacy}

In \textit{Union Pacific Ry. v. Botsford}\(^{19}\) the Supreme Court for the first time held that each individual possesses a right of privacy. No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.\(^{20}\)

The Court again recognized an individual’s right of privacy in \textit{Griswold v. Connecticut}.\(^{21}\) The Court identified the existence of this right as arising from several of the specific rights enumerated in the first eight amendments of the Constitution and also deemed its existence to be supported by the language of the ninth amendment.\(^{22}\) Therefore, courts must take cognizance of a general and fundamental right of privacy encompassed by the Bill of Rights and applicable to the states through the fourteenth amendment.

The execution of a “living will” is an exercise of an individual’s right of privacy. It is exclusively his prerogative to determine that he does not wish to submit to extraordinary medical treatment in the event that such a decision must be made. While the “living will”

\footnotesize
\begin{itemize}
  \item \textit{See Kamisar, supra note 12, at 1029-39. In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976) the court specifically held that a death resulting from the withdrawal of extraordinary treatment would be outside the scope of the homicide statutes. Moreover, anyone involved would not be subject to civil liability.}
  \item 141 U.S. 250 (1891).
  \item \textit{Id. at 251.}
  \item 381 U.S. 479 (1965).
  \item \textit{Id. at 484.}
\end{itemize}
has not been recognized as an exercise of the right of privacy, it is analogous to the decision of a woman to have an abortion. In *Roe v. Wade*, the Supreme Court held that the right of privacy encompasses the right of a woman to exercise control over her own body in deciding whether to terminate her pregnancy. The Court's characterization of the right of privacy as fundamental requires any regulation limiting the right to be justified by a compelling state interest. A woman may exercise her rights of privacy and self-determination, but may not do so indiscriminately. As the pregnancy advances towards full term, the state's interest in preserving the life of the fetus and the health of the mother becomes compelling.

Counterbalancing the right of the individual to execute a "living will" are the state's interests in protecting the patient, dependents, public morals, and the preservation of each citizen's productivity for society's benefit. In conflict with interests asserted by the state are the individual's right to exert control over his own body, concern that his loved ones will be subjected to severe and excessive emotional and financial strain, as well as his desire to preserve his dignity in life which is threatened with destruction if he is forced to exist in a persistent vegetative state with no hope of functioning cognitively again.

25. 410 U.S. 113, at 163. The Court divided the entire term of pregnancy into trimesters and held that in the first trimester, the state cannot assert an interest compelling enough to override the right of the woman during that period to terminate an unwanted pregnancy.
26. Id.
27. *In re Estate of Brooks*, 32 Ill. 2d 361, 372-73, 205 N.E.2d 435, 442 (1965); Cantor, *A Patient’s Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 Rutgers L. Rev. 228, 245-46 (1973) [hereinafter cited as Cantor].
28. See, e.g., *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *reh. en banc denied*, 331 F.2d 1010 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). In this case the court of appeals upheld an order requiring the mother of minor children to submit to a blood transfusion, despite her refusal based upon religious beliefs. The court reasoned that since the patient had minor children, the state had an interest as *parens patriae* in preventing those minors from becoming wards of the state simply because the patient's rejection of the transfusions might result in her death. In Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964), the court denied a woman in her thirty-second week of pregnancy the right to refuse a blood transfusion which violated her religious beliefs. The court deemed that the lives of the woman and the quickened fetus were so intertwined that the state had a compelling interest sufficient to supersede the right asserted by the woman.
However, in *In re Osborne*, 294 A.2d 372 (D.C. App. 1972), where the patient had adequately provided for his minor children, the court found no compelling state interest.
The state’s alleged interest in the patient’s responsibility for the support of dependents must yield to the realization that the individual who is in a state of irreversible comatosis is incapable of caring or providing for his dependents at that time. Prolongation of his vegetative state through the employment of mechanical supports imposes an emotional and financial drain on the very people whom the state seeks to protect and the patient sought to shield from such hardship by executing a “living will.” The state’s claimed interest in providing for dependents is subsumed by the individual’s concern to spare them any further hardship than that inevitably imposed by his present condition.

The incurable patient not reduced to a vegetative state and the individual who deems that his life is no longer worth living pose significantly different questions than the irreversibly comatose and mechanically dependent individual. The state’s interest in maintaining public morals is recognizable in the former cases. Allowing those individuals to die would be tantamount to judging the quality of their lives while they are cognitive and capable of comprehending surrounding events. As long as the individual exhibits cognitive behavior, he has a recognizable impact on society. The state’s interest in preserving the life of such an individual is greater than in the case of a patient who is incapable of consciously affecting society. Similarly, while the state may be able to assert an interest in preserving each citizen’s productivity for the benefit of society, a prognosis of irreversible comatosis with no hope of life independent of artificial supports deprives this claim of all validity. It is difficult, if not impossible, to comprehend that this alleged interest could supersede the exercise by the individual of his rights of privacy and self-determination.

If the reasoning in Roe is applied to the issue of when a person may direct the non-employment or withdrawal of supportive machines to allow bodily functions to follow their own course, it appears that as an individual’s physical condition dissipates, so do the interests asserted by the state in opposition to the individual’s decision. A fortiori, the rights of the individual to determine the extent of medical treatment to which he desires to be subjected are no longer encumbered and must prevail over any competing interests.

It has also been argued that the risk of abuse and mistake provides the state with a sufficiently compelling interest to take precedence over a decision rendered by the patient. Underlying this posi-
tion is the belief that the seriously ill patient cannot make a voluntary choice. It is feared that the individual's capacity for rational thought may be diminished by the pain and suffering associated with his illness and the knowledge that his death is imminent. Moreover, it is questioned whether consent given by the patient in advance of the cessation of treatment can be deemed informed consent and, therefore, a satisfactory solution to the problem faced by families, doctors and hospitals. Although this point of view recognizes the right of an individual to make a voluntary choice concerning the extent of treatment which he will receive, no provision is made for a suitable means by which the decision may be effectuated.

In some cases the accuracy of the prognosis may be in doubt. Legitimate differences in medical opinions do exist, as evinced in the continuing debate over when death occurs. However, authorities will agree that certain measurable medical criteria can be used to establish that death has occurred. Similarly, there exists a point at which medical opinions will concur in a prognosis of irreversible comatosis without hope of viable functioning independent of mechanical aid. It is submitted that at this point the state no longer has the right to intervene and force an individual to submit to extraordinary medical treatment which he has consciously declined in recognition of its futility. If, according to prevailing medical standards, the prognosis is conclusive that brain damage is so extensive that a return to consciousness is precluded, then a previously made decision by the patient not to indefinitely exist in such a state must be given effect.

The Free Exercise Clause

The most notable line of cases dealing with the right to decline medical treatment are those where a patient has asserted a religious belief as the basis for such refusal. In re Estate of Brooks upheld the right of a Jehovah's Witness to refuse a blood transfusion where the refusal presented no clear and present danger to public health,
living or morals. In *John F. Kennedy Memorial Hospital v. Heston*, the court affirmed the grant of a petition by the hospital to administer a blood transfusion necessary to save the life of a severely injured unmarried young woman. The patient and her family objected to the administration of the transfusion on the grounds that such treatment was forbidden by their religion. The New Jersey Supreme Court discounted the patient’s refusal since she was in the state of shock at the time it was given and ignored the family’s opposition to the proposed treatment. In affirming the grant of the hospital’s petition, the court said, “It seems correct to say there is no constitutional right to choose to die.”

In contrast, in *In re Osborne*, the District of Columbia Court of Appeals upheld the right of a 34-year-old patient to execute a statement refusing a blood transfusion and releasing the hospital from liability. The court deemed that the patient had the right to adhere to the tenets of his religion even if the result would be death. Since he had provided for the future well-being of his minor children, any compelling interest asserted by the state had been negated. While the majority in *Osborne* upheld the patient’s right to refuse the transfusions on the basis of the free exercise clause, Judge Yeagley, in his concurring opinion, stated he believed the decision should rest upon “... freedom of choice whether founded on religious beliefs or otherwise.”

**Informed Consent**

The doctrine of informed consent was formulated in a line of cases involving medical malpractice. The doctrine is based upon the right of every competent adult to determine what shall be done to his own body. The essential requirements which courts impose are: (1) that the physician inform the patient of the treatment proposed, including the attendant risk; and (2) that he obtain the patient’s

37. *Id.* at 372-73, 205 N.E.2d at 442. However, the court in this case has been criticized for employing the clear and present danger test instead of the compelling state interest test. Comment, 44 Tex. L. Rev. 190, 192-93 (1965).


39. *Id.* at 578, 279 A.2d at 671.

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


42. *Id.* at 375.

43. *Id.*

44. *Id.* at 376 (Yeagley, J., concurring).

consent before administering any treatment. The patient’s consent must be given voluntarily and with knowledge of the nature, extent and reasonably foreseeable consequences of the proposed treatment. While courts recognize the individual’s prerogative to decline treatment, they also employ a balancing test to determine whether the rights of the patient are subsumed by the interests asserted by the state.

**JUDICIAL RECOGNITION OF THE RIGHT TO REFUSE TREATMENT**

In situations where the patient is fully conscious and aware of the attendant circumstances, his right of self-determination is legally the strongest. In *Erickson v. Dilgard*, a New York court upheld the patient’s right to control his own body and allowed him to refuse a blood transfusion which placed him in danger of death. The court asserted that our system of government permits the individual to freely make a medical decision, so long as he is competent to render such a decision.

In *In re Quinlan*, the New Jersey Supreme Court distinguished its decision in *Heston* which granted the hospital’s petition to administer a blood transfusion. The court stated that in *Heston* the treatment involved minimal invasion of bodily integrity and the prognosis for recovery was excellent. However, in the *Quinlan* case, Ms. Quinlan’s existence was being prolonged through the administration of extraordinary medical treatment with no hope of her regaining consciousness and functioning cognitively again. The court deemed that in such a case, the individual’s rights of privacy and self-determination overcome any interest asserted by the state.

Where the patient is conscious and suffering from severe emotional distress, physical pain or shock, courts will not give substantial weight to his decision. If the refusal makes death a certainty and the treatment would incur minimal risks courts may deem it necessary to override a patient’s election to forego a certain type of treatment. However, where a patient is unconscious and incapable of

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47. Bang v. Charles T. Miller Hospital, 251 Minn. 427, 88 N.W.2d 186, 190 (1958).

48. See, e.g., Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964).

49. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).

50. *Id.* at 28, 252 N.Y.S.2d 705 at 706.


52. *Id.* at 41, 355 A.2d at 664.

53. See United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965). The court questioned the competency of the patient to refuse a blood transfusion and ordered that the treatment be administered.
Living Wills

giving consent, courts will order treatment if there is immediate danger of death and the treatment involves a minimal invasion of bodily integrity. In such a situation it is presumed that the patient would want to live and would, if capable, consent to life saving treatment.\(^{54}\) Thus, courts are hesitant to undermine an individual’s exercise of his right of self-determination, and carefully balance this fundamental right against the interests asserted by the state.

Several informed consent cases involved situations where refusal of treatment necessarily lead to death.\(^{55}\) Nevertheless, the competent individual’s right to choose among the available alternatives has consistently been judicially recognized with few exceptions.\(^{56}\) Generally, a compelling state interest must be found before a court will disregard a rational decision to refuse treatment.\(^{57}\) The basis for honoring the patient’s decision has sometimes been the free exercise clause and other times a recognition of the rights of privacy and self-determination. While those decisions upholding a patient’s right to decline treatment for religious reasons are not disputed, the foundation of the free exercise clause does not afford a broad enough basis to accord everyone the right to decide whether to accept or refuse treatment. A sounder analysis would be one that recognizes the rights of privacy and self-determination as the source for the exercise of choice by the individual.\(^{58}\) This approach avoids the requirement that an individual establish that the proposed medical treatment is proscribed by his religion in order to make his refusal of treatment an exercise of religious beliefs. By basing their decisions upon the rights of privacy and self-determination, courts would evaluate each case under the same standards. Thus, atheists and those whose religions have no tenet opposing such treatment would be able to refuse extraordinary medical procedures.

The recognition of the right to refuse extraordinary treatment requires that the individual be afforded the means by which he can exercise such right. Where the patient is irreversibly comatose, it is obvious that he is incapable of making or manifesting a decision

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57. *In re Osborne*, 294 A.2d 372, 375 (D.C. App. 1972); *but see In re Estate of Brooks*, 32 Ill. 2d 361, 372-73, 205 N.E.2d 455, 442 (1965) (the court utilized a “clear and present danger” test).

concerning the treatment he is to receive. However, a competent individual should be allowed to execute a document describing the extent of treatment to which he is willing to be subjected. The legalization of the “living will” would accomplish such an end, and a carefully drafted statute can provide the individual and the state with the necessary safeguards to protect the rights and interests of each.

**Some Proposed Guidelines for the Legalization of the “Living Will”**

The anomaly between the practice of not subjecting a patient to treatment without his consent, and the rule that his consent is presumed when he is incapable of manifesting his intent, may be resolved in part by providing legally enforceable means to effectuate the prior written intent of an irreversibly comatose patient. The “living will” offers a resolution by enabling a person to execute a document specifying that in the event that his condition is reduced to a persistent vegetative state no machines or other extraordinary treatment are to be utilized to intervene with his natural bodily functions. The distinct advantage of the “living will” is that an individual can execute the instrument prior to the occurrence of unforeseeable events, such as an accident or stroke, and be assured that his expressed desire not to be subjected to treatment beyond the extent described in the instrument will be honored. In addition, the document could incorporate a Jehovah’s Witness’ opposition to blood transfusions as well as a Christian Scientist’s wish not to receive any medical treatment.

The fatal consequences of exercising this right demand that formal procedures be instituted in order to impress upon the individual the seriousness of his decision and to insure against fraud and coercion. The following safeguards are commonly recommended: (1) the document must be notarized and attested to by at least two witnesses; (2) the individual must carry the document on his person and/or a procedure must be instituted whereby the individual can file the executed instrument with the clerk of the

59. See text accompanying notes 45 through 48 supra.
60. Morse, supra note 54, at 752.
61. Kutner, supra note 4, at 550.
62. Id. at 550-51.
63. Id. at 551.
64. Id. In most of the proposed legislation legalizing the “living will” this requirement has been included. See, e.g., Washington, S. 2449, 43d Reg. Sess. (1973); Wisconsin, Senate Substitute Amendment 1 to S. 715 (1971).
65. Kutner, supra note 4, at 551.
county in which he resides and in return receive a card attesting to
the execution of a "living will"; and (3) the document must specify
those persons whom the maker desires to be contacted in the event
that he reaches a comatose state.67

By adherence to such guidelines, the validity of the document can
properly be determined at the time of enforcement. The witnesses
can be called to attest to the competency of the maker and his
independence of action at the time of execution.68 Personal posses-
sion of the document or a card evidencing its execution would create
a strong presumption that the maker regards the "living will" as
binding.69 However, the "living will" must be at all times revocable
by the maker and such revocation may be either written or oral.70

Because the rights of privacy and self-determination form the bases
for the legalization of such a document and the result of its enforce-
ment is admittedly fatal,71 regardless of the mental state of the
person at the time he or she expresses an intent to revoke, such
revocation must be given effect.72

The crucial time which must be scrutinized is the time of execu-
tion.73 An individual not suffering from the ailment which leads to
his comatose condition, is otherwise possessed of sound mental ca-
pacity and has complied with the formalities of execution can be
presumed to possess the requisite capacity and intent to direct the
cessation of extraordinary treatment.74 A more difficult situation is
encountered when the patient executes a "living will" while suffer-
ing from an ailment diagnosed as terminal.75 In such a case, the
witnesses can supply testimony as to the state of mind of the patient
at the time of execution.76 Courts may also deem that expert testi-

66. This procedure has been included in several of the proposed bills for legalization of
"living wills". See, e.g., Washington, S. 2449, 43d Reg. Sess. (1973); Wisconsin, Senate
Substitute Amendment 1 to S. 715 (1971).
67. Kutner, supra note 4, at 551-52.
68. Id. at 551.
69. Id.
70. Id.
71. See Kamisar, supra note 12, at 976.
72. Kutner, supra note 4, at 552, acknowledges the problem which is encountered when
the individual becomes mentally ill. He suggests that the person may provide for such a
contingency and limit his consent to treatment accordingly. In the case where the individual
is adjudicated incompetent and the court appoints a guardian and the individual has pro-
vided for the contingency of mental illness, Mr. Kutner believes that the guardian may not
unilaterally nullify the instrument, but may do so if requested to by the incompetent. Id. at
551.
73. Id. at 551.
74. Id.
75. For a case where the court questioned the competency of the patient to refuse treat-
ment see United States v. George, 239 F. Supp. 752 (D. Conn. 1965).
76. Kutner, supra note 4, at 551.
mony is necessary to establish whether the patient was, at that time, capable of voluntarily executing the instrument and fully cognizant of its import. If there appears to be some doubt as to the intent of the patient, treatment should be administered pending resolution of the dispute.\textsuperscript{77}

Because the individual alone possesses the right to determine the extent of treatment to which he desires to be subjected, the state has an interest in protecting that right in cases where fraud, coercion or incompetence is possible.\textsuperscript{78} Therefore, procedures must be instituted whereby the validity of the "living will" can be determined and its enforcement denied in the event that the preponderance of the evidence\textsuperscript{79} discloses that the document does not represent the true intent of the patient. Each case could be referred to a committee to determine the patient's intent and whether the patient's condition has reached the state at which a clearly expressed intent not to submit to further treatment must be given effect.\textsuperscript{80} It seems advisable for the committee members to be drawn from the medical community since the prognosis of the patient's condition is clearly a medical decision. A "living will" executed in conformance with statutory provisions and in the possession of the maker will afford prima facie evidence of the requisite intent. In the event that the validity of the document is challenged, the proper forum for resolution of the matter would be a court of law.\textsuperscript{81}

Those who can seek enforcement of the "living will" or challenge its validity should include the immediate family,\textsuperscript{82} treating physician and the hospital in which the patient is confined. Inclusion of the latter two offsets greedy or callous relatives who seek to hasten what they believe to be the patient's imminent demise.\textsuperscript{83} Thus, the comatose patient would be protected from fraudulent executions of "living wills" and the interests of the physician and the hospital,

\textsuperscript{77.} Id.
\textsuperscript{78.} Cf. Roe v. Wade, 410 U.S. 113, 154 (1973). Although the state may not possess an interest compelling enough to prevent a woman from obtaining an abortion, it does retain the right to regulate the manner and circumstances under which the abortion is performed.
\textsuperscript{79.} This standard is suggested in order to afford more protection to both the rights of the individual and the interest asserted by the state.
\textsuperscript{80.} Kutner, supra note 4, at 551.
\textsuperscript{81.} Id. at 554.
\textsuperscript{82.} Family members who would possess standing would include: spouse, mother, father, children over the age of eighteen and brothers and sisters over the age of eighteen. It is interesting that no proposed legislation has made any provision for children under eighteen to seek or challenge enforcement by guardian.
\textsuperscript{83.} It has traditionally been doctors and hospitals who have petitioned the courts to administer life-saving treatment. Courts have consistently recognized their rights to preserve their professional integrity. United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965).
involuntary hosts operating under high professional standards,\textsuperscript{84} are safeguarded.

The following bill is suggested as a model which incorporates those safeguards necessary to protect both the rights of the individual and the interest of the state.

A BILL FOR ACT

to amend the public health law and the criminal code to permit the execution of a document known as a “living will” by an individual desiring non-employment or discontinuance of extraordinary medical treatment in the event of extensive and irreparable brain damage resulting in irreversible comatosis.\textsuperscript{85}

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF :

SECTION 1.

The decision not to employ or to cease employment of artificial means or heroic measures to prolong the life of the body belongs to the patient. Such a decision will inevitably be unique, since the determination of what constitutes “extraordinary treatment” or “heroic measures” is dependent upon available medical resources, the condition of the patient and prevailing medical opinion. In order to ensure that the rights of patients may be respected even after they are incapable of actively participating in decisions concerning themselves, they may indicate their wishes regarding refusal of treatment in a written statement as contained in Section 4 of this Act.\textsuperscript{86}

SECTION 2.

As used in this Act, unless the text indicates otherwise:

(1) “Physician” means an individual licensed by the Board of Medical Examiners for the State of ........................................ \textsuperscript{87}

(2) “Qualified patient” means an individual, over the age of eighteen, in respect of whom two physicians have certified in writing that the patient appears to be in a state of irreversible comatosis.\textsuperscript{88}

\textsuperscript{86} Massachusetts, H. 3641, § 1 (1974).
\textsuperscript{87} Society for the Right to Die, Suggested Model Bill § 1, I(2) (copy on file with Loyola University of Chicago Law Journal Office).
(3) "Extraordinary treatment" means medical treatment designed solely to sustain the life processes. 89
(4) "Irreversible comatosis" means extensive brain damage which precludes a return to any form of consciousness. 90
(5) "Living will" means a witnessed declaration in writing made substantially in the form set forth in Section 4 of this Act. 91

SECTION 3.

Subject to the provisions of this Act a living will may be made by any individual on the form described in Section 4 of this Act declaring that he voluntarily authorizes the non-employment or withdrawal of extraordinary treatment if he should become a qualified patient. The declaration shall not be effective unless:

(1) It has been filed with the clerk in the county of the individual's residence;
(2) It has been filed at least thirty (30) days prior to cessation of extraordinary treatment;
(3) It has not in any way been revoked. 92

SECTION 4.

The living will shall be a sworn declaration, duly notarized, and executed in the presence of two witnesses who shall sign the living will. It shall be made substantially in the following form:

"DECLARATION made this day of ....................... (date) by ........................................ (person's name) of ....................................... (place of residence) I, ......................................................... , DECLARE that I voluntarily subscribe to the code set out under the following articles:

ARTICLE I

If I should at any time suffer from such extensive brain damage which precludes a return to any form of consciousness, I request the withdrawal of life sustaining mechanisms and/or the cessation of all extraordinary medical treatment. 93

89. Society for the Right to Die, Suggested Model Bill § 1, I(1) (copy on file with Loyola University of Chicago Law Journal Office).
90. See note 1 supra.
ARTICLE II

In the event of my suffering from the conditions specified in Article I, I request that no active steps should be taken, and in particular that no resuscitatory techniques should be used, to prolong my life.\(^{94}\)

ARTICLE III

This declaration is to remain in effect unless I revoke it, which I may do at any time, and any request which I may make regarding action to be taken or withheld in connection with this declaration will be made without any further formalities.

I desire that it be understood that I have the utmost confidence in the good faith of my relatives and physicians, and fear denigration and indignity far more than I fear what some may deem a premature death. Therefore, I ask and authorize my family members and the physician in charge of my case to bear these statements in mind when considering what my wishes would be in any uncertain situation.\(^{95}\)

Family members to be contacted prior to enforcement of this declaration:

\begin{tabular}{ll}
(name) & (relationship) \\
\hline
Signed & (name) (relationship) \\
Witness & \\
Witness & \\
\hline
\end{tabular}

(Notary Public)

Subscribed and sworn to before me this ............... of ....... . . . . , 19 . . .

SECTION 5.

An individual who has executed a living will may, at any time subsequent to its execution, revoke the instrument by destruction, by oral or written statement provided that it be witnessed by one person, or by filing a revocation with the county clerk where he then resides and the will is on file. When the county clerk is satisfied that the person requesting the revocation is the same person who made the living will, he shall mark the living will “REVOKED” in large

letters across the face of it, and a signed revocation request shall be filed with the revoked living will.96

SECTION 6.

Upon certification in writing by at least two (2) physicians, the case shall pass to a committee comprised of three (3) physicians (not including the two who executed the certificate) established within the hospital of confinement to determine:

(1) That the individual's condition is irreversibly comatose; and,
(2) That a living will has been executed.97

Those who may challenge the enforcement of the living will on the grounds that it was fraudulently executed, the patient was under duress at the time of execution, or that the patient was incompetent at the time of execution are:

(1) Family members: spouse, mother, father, children over the age of eighteen, children under eighteen by guardian and brothers and sisters over the age of eighteen;98
(2) Treating physician(s);99 and
(3) The director or administrator of the hospital in which the patient is confined.100

Should the committee find cause to challenge the validity of the living will, its enforcement shall be suspended until proper resolution of the matter is had in a court of law.101

SECTION 7.

Any reliance upon a living will executed under this Act, where the parties have no actual notice of revocation or contrary indication, will be presumed to have been in good faith. Unless it is alleged and proved that the parties' actions violated the standard of reasonable professional care and judgment under the circumstances, such parties will be immune from civil or criminal liability when, in reliance upon such instrument, medical treatment was withheld.102
SECTION 8.

(1) Any person who willfully conceals, destroys, falsifies or forges a living will or revocation thereof is guilty of an offense punishable by life imprisonment. 103

(2) Any person who wrongfully witnesses a living will or revocation thereof shall be deemed to have committed perjury. 104

SECTION 9.

This Act shall take effect upon enactment.

CONCLUSION

As long as a person is capable of cognitively functioning, society has an interest in preserving his life. However, just as each individual’s rights of privacy and self-determination are not absolute, neither are the interests of the state. 105 When the individual’s exercise of his fundamental right to determine the extent of his medical treatment conflicts with the state’s interests, it is necessary to balance these competing interests in order to determine which shall prevail. When circumstances are such that the individual’s interests should prevail over those of the state, the means should be afforded by which he can effectuate an exercise of his rights. Mere recognition of the rights of privacy and self-determination in the area of refusal of extraordinary medical treatment will serve to protect neither the patient’s rights nor the interests of the state. It is acknowledged that although the individual should possess the right to determine whether he may be subjected to extraordinary treatment, the state retains an interest in regulating the manner in which that right will be exercised. 106 Thus, it is incumbent upon the legislatures of the various states to implement the means whereby an individual is free to exercise his rights and the interests of the state are adequately safeguarded.

It is suggested that such legislation at its inception be confined only to adults who are capable of rationally deciding and thoughtfully executing a “living will”. 107 If such legislation is passed, it may reduce the number of cases in which the family has had to assert the rights of the individual since they were the only ones who were aware of the patient’s intent. 108 Legalization of the “living will”

105. See notes 27 through 30 supra and accompanying text.
107. Kutner, supra note 4, at 553.
would allow the individual to express his own intent in a legally recognized instrument. In this way an individual would be assured that he need only rely upon family and doctors to effectuate it.

A "living will" would assure many that their dignity will be preserved in life, and those for whom they care the most will not be subjected to undue emotional, physical and financial strain.

MARGARET J. ORBON