

# LIVING WILLS: VALIDITY AND MORALITY

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*"I think, therefore I am"*<sup>1</sup>

## INTRODUCTION

My interest in the subject of living wills extends from my own experience with them, particularly my father's decision to write a living will after watching his father die of Alzheimer's disease. To begin, I would like to tell a story about my grandfather, his battle with Alzheimer's, and the events that followed from his death. I will start out by telling what I remember about his death. Then I will briefly discuss his life to illustrate the gravity of the situation and its importance to me. Lastly, I will discuss the ramifications of his death for my family, and specifically, my father's decision to sign a living will. In connection with this last point, I will review the law regarding living wills. The discussion will focus on what the courts have stated with regard to living wills and a living will's validity and purpose under state statutes. In the discussion, I will consider the legal question of a living will's validity, but I will also remain mindful of the moral inquiry that attends any discussion of death. I will conclude the discussion with some of my personal feelings regarding the choice to terminate lifesaving attempts.

## I. MY GRANDFATHER

On November 24, 1990, my grandfather, Sam J. Saad Sr., died after a long and ugly battle with Alzheimer's disease. At the time of his death, I was thirteen years old and only generally aware of his situation; I did not understand death or suffering, nor could I grasp the significance of the loss my dad felt looking at this once great man. I recall visiting the nursing

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1. RENÉ DESCARTES, *Discourse on the Method of Rightly Conducting the Reason and Seeking for Truth in the Sciences* (1637), reprinted in 31 GREAT BOOKS OF THE WESTERN WORLD 41, 51 (Robert Maynard Hutchins et al. eds., Elizabeth S. Haldane & G. R. T. Ross trans., Encyclopædia Britannica 1952).

home attached to Immanuel Hospital several times and seeing Gidi (Arabic for grandfather, pronounced jīdee) lying in bed with all of the various tubes running down his throat, up his nose, and many wires attached to him. I also recall his face; I always noticed how dry his lips were. I asked the nurse about his lips. Apparently, the tubes used to feed him prevented Gidi from licking them. Gidi was not dead or unconscious. He could still hear when I talked to him, and he could still respond to my questions. I do not know if Alzheimer's disease erased his memory of me. I would like to believe it did not because he was able to communicate with me, but Gidi could not talk; he communicated only by smiles and simple gestures. He would respond to my touch and my voice with smiles or other affirmations, but it was clear that he had lost nearly all of the depth and prowess he once possessed.

When I was young, Gidi drove himself to our house to have dinner with us. He would laugh and talk, and I never knew that he suffered from an illness as vile and terribly debilitating as Alzheimer's. I do not think anyone in our family knew, or could have known, he was ill before he entered a nursing home. Later, after his death, my parents and my aunts (his daughters) would talk about how he seemed more distant and less attentive before he entered the nursing home. At the time, they thought it was because Siti (Arabic for grandmother, pronounced sītee) had recently died, and Gidi was lonely. No one thought he suffered from any disease beyond old age and a broken heart.

To really understand the pain of watching Gidi suffer, and the gravity of my father's decision to sign a living will, I need to talk about Gidi's life and his background. He immigrated to the United States from Lebanon in 1910. He came through Mexico and moved to Chicago, Illinois. Gidi learned English by memorizing the dictionary. He told us later that he did this so no one would be able to use a word he did not know. He educated himself by taking correspondence courses while he was working for the Maytag Company selling washing machines. One story I heard about his sales efforts was about how he would sell a machine to farmers' wives. Gidi would carry the washing machine into the farmer's basement and do a load of laundry for the wife. Then, he would "sell the heck out of the machine," so he did not have to carry it back out. Gidi ended up as a sales manager for Maytag, and I recall a plaque on his wall saying he was a member of the "million dollar" club. Later, I found out that Gidi and others like him made Maytag the company it is today.

When my father was growing up, Gidi lived in one of the finest houses in River Forest, Illinois, one of the richest suburbs of Chicago. My father was the youngest of four children and had a very close relationship with his

father. Everything Gidi achieved in life was through hard work and ingenuity. My father described Gidi's attitude as one of "can-do, no quitting."<sup>2</sup>

Against this background came my father's pain in watching his father die. When Gidi could no longer sustain himself, my father had to agonize over the question of what this powerful, intellectual giant would do. From my point of view, my father had to look at a man who had achieved so much but now lay in bed helpless, able to breathe, with a beating heart; but unable to eat, and with a mind totally degenerated from Alzheimer's. My father had to decide what to do with no direction from Gidi. Because Gidi was such a fighter, and because he would have starved to death if removed from the machines, my father decided not to turn off the artificial hydration and nutrition.<sup>3</sup> The question for me now is what can the law do to ensure that I do not suffer the same pain and heartache that my father felt, and, more broadly, what can the law do to ensure that no one has to suffer that level of pain and anguish? It is in light of my own personal experience that I will discuss the law of living wills.

## II. THE LAW OF LIVING WILLS

All States have enacted legislation setting standards on what constitutes a valid advance directive, one type of which is a living will, and what is required to execute one.<sup>4</sup> Even before statutory enactments however, the courts had already constructed a common law regarding advanced directives including the landmark court case of *In re Quinlan*.<sup>5</sup> The first step in discussing a person's right to die is laying out the basic concepts of the law. The second step is a discussion of the case law and statutes. Because of the closeness of the living will issue to me, I will concentrate on that document and leave discussions of other advance directives for later. For this discussion, the focus will be on cases from various states covering different periods in the evolution of the right to die debate and, as an illustration, the Nebraska statutes with the Nebraska legislature's discussion of the right to die. The Nebraska Act is very similar to the Uniform Rights of the Terminally Ill Act, which some states have adopted, and the

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2. I reference certain portions of this article to a series of interviews I conducted with my father, Sam J. Saad, Jr., primarily in 2003 but beginning shortly after my grandfather's death. [hereinafter Sam J. Saad, Jr. interviews].

3. *Id.*

4. See 63 AM. JUR. *Trials* § 3 (1997) ("All states now have some legislation addressing end-of-life decisionmaking and advance[] directives.").

5. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

legislators' concerns appear similar to those of other states.<sup>6</sup> Looking at the case law and legislative enactments provides a summary of the law regarding living wills but with life and death at stake in these decisions there must be a deeper analysis. The last and most important step will be an examination of the morality of such laws that compares legislative intent, judicial reasoning, and public opinion to reach a consensus on the morality of the right to die. This part of the discussion will focus on the legislative debates, the legal arguments enunciated in judicial opinions, and commentary from outside the legal field.

### A. Basic Concepts of the Right to Die

There are many parts of the right to die debate and several terms that need defining. A living will is an advance health care directive that is a directive "either stat[ing] a person's wishes and instructions regarding future medical treatment in the event of incapacity or appoint[ing] someone to act as a proxy."<sup>7</sup> A living will is "[a]n instrument . . . by which a person states the intention to refuse medical treatment and to release healthcare providers from all liability if the person becomes both terminally ill and unable to communicate such a refusal."<sup>8</sup> A terminal condition has been defined as "an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serve only to postpone the moment of death."<sup>9</sup> Life-sustaining or life-prolonging procedures are medical procedures or treatments that use artificial means to supplant the body's vital functions and serve only to prolong the terminally ill patient's death.<sup>10</sup> Some, including various authorities within the Catholic Church, refer to these measures as extraordinary means.<sup>11</sup> The issue arises when a

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6. Bretton J. Horttor, *A Survey of Living Will and Advanced Health Care Directives*, 74 N.D. L. REV. 233, 236-38 (1998) (listing some of the states that have adopted the Uniform Rights of the Terminally Ill Act including Nebraska).

7. LAWRENCE A. FROLIK & ALISON MCCHRYSTAL BARNES, *ELDERLAW: CASES AND MATERIALS* 567 (2d ed. 1999).

8. BLACK'S LAW DICTIONARY 945-46 (7th ed. 1999).

9. FROLIK & BARNES, *supra* note 7, at 569 (quoting WIS. STAT. ANN. § 154.01(8) (West 1997)).

10. *Id.* at 571 (citing VA. CODE ANN. § 54.1-2982 (2005)).

11. See JON B. EISENBERG, *USING TERRI: THE RELIGIOUS RIGHT'S CONSPIRACY TO TAKE AWAY OUR RIGHTS* 53-67 (2005) (discussing the Catholic Church's evolving and sometimes polarized views on the proper care to give someone in a persistent vegetative state); DIOCESE OF WORCESTER, *FREQUENTLY ASKED QUESTIONS ABOUT ARTIFICIAL NUTRITION AND HYDRATION* (2005), available at <http://www.worcesterdiocese.org/bishopsoffice/ANH-atatement.pdf> (explaining that extraordinary means of preserving life, such as artificial nutrition and hydration, can be withdrawn when the burdens outweigh the benefits, and specifically when death is imminent).

patient is in a persistent vegetative state, which means only the patient's vegetative neurological functions occur without any higher cognitive functions.<sup>12</sup>

The law regarding living wills attempts to balance several state interests against every person's "right to be let alone."<sup>13</sup> In determining the outcome of cases involving the effectuation of living wills, the courts generally apply a balancing test.<sup>14</sup> The courts consider the right to self-determination found in the common law and the U.S. Constitution and balance that right against four state interests.<sup>15</sup> The first state interest, the preservation of life, focuses on the sanctity of life and on individual dignity and worth.<sup>16</sup> The second state interest, protection of third parties, focuses primarily on a person's choice to refuse treatment that would harm an unborn or minor child.<sup>17</sup> The third state interest, preventing suicide, relates

12. *In re Quinlan*, 355 A.2d 647, 654–55 (N.J. 1976). One of the experts in *Quinlan* discussed the difference between the vegetative and cognitive functions of the brain. The New Jersey Supreme Court reprinted portions of the testimony as follows:

We have an internal vegetative regulation which controls body temperature which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. Brain death necessarily must mean the death of both of these functions of the brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in laymen's terms might be considered purely vegetative would mean that the brain is not biologically dead.

*Id.*

13. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), *overruled by Katz v. United States*, 389 U.S. 347, 353 (1967), and *Berger v. New York*, 388 U.S. 41, 64 (1967) (Douglas, J., concurring); *see also Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 282 (1990) (weighing the state's interest in preserving human life against the individual's interest).

14. *See, e.g., John F. Kennedy Mem'l Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984) (balancing the state's interest in preserving life against the curability of the condition in the case of a terminally ill and comatose patient who had executed a living will); *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 691–92 (App. Div. 1987) (balancing an individual's right to refuse treatment against four categories of state interests); *Saunders v. State*, 492 N.Y.S.2d 510, 514 (Sup. Ct. 1985) (balancing the state's interests with the right to self-determination).

15. *In re Conroy*, 486 A.2d 1209, 1221–23 (N.J. 1985) (discussing the state's interest in preserving life and the common law and constitutional origins of a patient's right to reject life-sustaining medical treatment); *see also infra* notes 75–108 and accompanying text (detailing the balancing test performed by the court in *In re Conroy*).

16. *In re Conroy*, 486 A.2d at 1223.

17. *Compare In re President & Dirs. of Georgetown Coll., Inc.*, 331 F.2d 1000, 1002, 1006, 1008–10 (D.C. Cir. 1964) (granting a writ that allowed the hospital to give blood transfusions to a Jehovah's Witness with a minor child), *with St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666, 668–69 (Fla. Dist. Ct. App. 1985) (allowing a Jehovah's Witness to refuse treatment even though he was the father of a minor child).

back to the state's interest in preserving life.<sup>18</sup> This interest appears separately in the debate about living wills and the right to die because many people argue that removing life support is tantamount to suicide when parties in a position to preserve human life do not do everything possible. However, early on the courts rejected that argument stating that the withdrawal of treatment is not an act of suicide but an omission resulting in a preordained outcome.<sup>19</sup> The fourth state interest, maintaining the ethical integrity of the medical profession, is the least persuasive state interest and is often dismissed because the ethics of the medical profession do not require doctors to intervene at all costs.<sup>20</sup> Moreover, in many cases, by the time the right to die issue arises, the doctor's only duty to his patient is to provide comfort and ease dying.<sup>21</sup>

Against these four state interests is the right of a person to self-determination, the right to control one's own body.<sup>22</sup> In the great majority of cases, the state will lose because its asserted interests cannot surmount the great importance the courts place on an individual's right to liberty and privacy.<sup>23</sup> The Supreme Court initially elaborated on the importance of liberty in *Union Pacific Railway Co. v. Botsford* stating "[n]o 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."<sup>24</sup> Moreover, the specific right to determine what happens to one's self has been a cornerstone of American jurisprudence since at least 1914, when then Judge Benjamin Cardozo stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who

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18. *In re Conroy*, 486 A.2d at 1224.

19. *See Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 423, 426 n.11 (Mass. 1977) (describing situations where refusing medical treatment does not equal suicide); *In re Conroy*, 486 A.2d at 1224 ("[D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. . . . Refusing medical intervention merely allows the disease to take its natural course. . . ."); *see also Saunders*, 492 N.Y.S.2d at 514 (noting that all fifty states have laws prohibiting suicide).

20. *In re Conroy*, 486 A.2d at 1224–25; *see In re Quinlan*, 355 A.2d 647, 668–69 (N.J. 1976) (emphasizing the difficulties involved with physicians making ethical judgments and the court's limitations in confirming these decisions).

21. *In re Conroy*, 486 A.2d at 1225 (citing *In re Quinlan*, 355 A.2d at 667).

22. *Id.* at 1222–23; *Saunders*, 492 N.Y.S.2d at 514.

23. In *In re Conroy*, the New Jersey Supreme Court postulated that because "the 'sanctity of individual free choice and self-determination [are] fundamental constituents of life,' the value of life may [actually] be lessened rather than increased 'by the failure to allow a competent human . . . the right of choice.'" *In re Conroy*, 486 A.2d at 1223–24 (first alteration in original) (quoting *Saikewicz*, 370 N.E.2d at 426).

24. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

performs an operation without his patient's consent commits an assault, for which he is liable in damages."<sup>25</sup>

Judge Cardozo's statement could be considered the foundation for the current right to die debate.<sup>26</sup> The principles articulated in *Botsford* and by Justice Cardozo have formed the foundation of the right-to-self-determination side of the balancing test. Because these principles are so firm in American jurisprudence, the courts almost unanimously find that a patient may refuse treatment even in the face of death.

However, the issue becomes much harder when patients are no longer competent to make the decision regarding the right to die and have not previously articulated their wishes. The situation normally presents itself in the form of elderly people adjudged incompetent or so sick that they can no longer communicate. This was my grandfather's situation. It is in this context that the living will has its greatest importance because, as will be shown, a living will is the legally recognized method of communicating one's wishes when faced with death. What follows is the development of the case law showing the development and refinement of the right to die. Thereafter, some of the state statutes currently in effect will be examined to show how they have responded to the judiciary's need for guidance.

### *B. Living Wills and the Courts*

The courts have been grappling with the concept of individual autonomy and its various nuances throughout the twentieth century.<sup>27</sup> However, it was not until 1976, when Karen Ann Quinlan's father decided to remove the respirator from his comatose daughter that the courts began to focus on the right to die.<sup>28</sup> Previously, the right to die had not been an issue because people would get sick and die with little fanfare or surprise. This might still be the case if it were not for technological advancements in medicine. Now, doctors have the capability to hook people up to a machine that enables their heart to beat; allows them to breathe, to eat, to process blood, and even defecate while completely comatose or while in a persistent

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25. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 92-93 (N.Y. 1914) (citations omitted). Judge Cardozo was elevated to the U.S. Supreme Court in 1932.

26. *Cf. Bennan v. Parsonnet*, 83 A. 948, 949 (N.J. 1912) (noting the common law rule that a patient is "the final arbiter as to whether he shall take his chances with the operation or take his chances of living without it") (quoting 1 EDGAR B. KINKEAD, COMMENTARIES ON THE LAW OF TORTS § 375, at 736 (1903)).

27. *See Botsford*, 141 U.S. at 251 (recognizing the common law right of individuals to possess and control their own bodies).

28. *In re Quinlan*, 355 A.2d 647, 651, 654 (N.J. 1976).

vegetative state.<sup>29</sup>

Considering the patient's circumstances, the families involved, and the medical community's response to the situation, the courts have endeavored to set up standards for deciding each case. The first case focusing on the right to die was *In re Quinlan* in 1976.<sup>30</sup> The Supreme Court did not step in until 1990, when the Court decided *Cruzan v. Director, Missouri Department of Health*.<sup>31</sup> In *Cruzan*, the Supreme Court held that the States could decide the standards by which an incompetent person's wishes should be carried out.<sup>32</sup> In the period between 1976 and 1990, the courts shouldered the responsibility of defining the right to die and determining who has this right. The following cases illustrate the difficulty the courts have had in dealing with an individual's right to die.

### 1. From *Quinlan* to *Cruzan*

*In re Quinlan* was the first case to decide a patient's right to die.<sup>33</sup> In *Quinlan*, the New Jersey Supreme Court had to decide whether Karen Ann's father could remove her from ventilator tubes allegedly ending her ability to breathe.<sup>34</sup> Mr. Quinlan's opposition included Karen's doctors, her *guardian ad litem*, the hospital, the county prosecutor, and the New Jersey Attorney General.<sup>35</sup> Mr. Quinlan based his appeal on equity, constitutional rights to privacy, the free exercise of religion, and protection from cruel and unusual punishment.<sup>36</sup> The New Jersey Supreme Court took as fact, based on a trial stipulation, that Karen was alive as defined under the legal standards recognized in New Jersey, but that she was incompetent.<sup>37</sup>

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29. See *Compassion in Dying v. Wash.*, 79 F.3d 790, 811–12 (9th Cir. 1996) (discussing the ability of medical technology to diagnose disease and sustain life better now than ever before); see also PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMED. & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 16–18 (1983) (describing the changing causes of death and circumstances surrounding the dying process) [hereinafter STUDY OF ETHICAL PROBLEMS].

30. *In re Quinlan*, 355 A.2d at 651.

31. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

32. *Id.* at 280.

33. See *In re Quinlan*, 355 A.2d at 664 (stating that the patient's right to privacy can overcome the state's interest in preserving life); FROLIK & BARNES, *supra* note 7, at 579 (stating that the New Jersey Supreme Court "ushered in the modern era").

34. *In re Quinlan*, 355 A.2d at 651, 656; cf. William E. Phipps, *Defining Death: Ethical, Moral, and Legal Factors*, USA TODAY, Jan. 1996, at 34, 34 (noting that Karen Ann lived ten years after the removal of life support).

35. *In re Quinlan*, 355 A.2d at 651.

36. *Id.* at 653.

37. *Id.* at 652–53.



Karen's condition was, and still is, something of a mystery.<sup>38</sup> She stopped breathing twice during the night of April 15, 1975, and received CPR.<sup>39</sup> Her friends took her to the hospital where on arrival she required a respirator to breath and suffered from anoxia, which is a lack of oxygen in the blood stream.<sup>40</sup> She was unconscious on arrival and never awoke from her coma.<sup>41</sup> Karen was in a persistent vegetative state.<sup>42</sup>

The New Jersey Supreme Court had a very difficult question to consider because the court essentially had a new issue to address: the definition of death.<sup>43</sup> The court looked at three disciplines for guidance: religion, law, and medicine.<sup>44</sup> The New Jersey Supreme Court addressed each of Mr. Quinlan's arguments separately, beginning with the right to the free exercise of religion.<sup>45</sup> The court recognized the right of an individual to the free exercise of religion, but found extensive authority limiting such free exercise when the court had to weigh the public interest in the preservation of life against the "religious 'neutrality'" displayed by the church.<sup>46</sup> However, because Mr. Quinlan held deep religious convictions, the viewpoint of the Roman Catholic Church was relevant to show his competence as a guardian, thus the court spent some time examining the Church's views on artificial life-sustaining measures.<sup>47</sup> The court recognized the medical and religious implications of the decision Mr. Quinlan was making, but maintained that they were relevant only to Mr. Quinlan's ability to act as his daughter's guardian and that the law would have to decide Karen's case.<sup>48</sup> The Roman Catholic Church conceded that it relied on medical standards to define death and not its own religious edicts but determined that terminating "extraordinary means of treatment" was not euthanasia.<sup>49</sup> The Church argued that a patient held the ultimate decision whether to receive treatment and that because the treatment was extraordinary, the patient had no obligation to accept the treatment.<sup>50</sup> Additionally, Mr. Quinlan's duty was to follow the patient's presumed

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38. *See id.* at 653–54 (describing the mysterious circumstances surrounding the onset of Karen Ann's condition).

39. *Id.*

40. *Id.* at 654.

41. *Id.*

42. *Id.* at 655.

43. *Id.* at 656.

44. *Id.* at 659.

45. *Id.* at 661.

46. *Id.*

47. *Id.* at 658–59.

48. *Id.* at 660.

49. *Id.* at 658 (internal quotation marks omitted) (citation omitted).

50. *Id.* at 659 (citation omitted).

wishes, and the Church only bound him to using ordinary means to sustain his daughter's life.<sup>51</sup> In addition, the Church argued that interruption of resuscitation would only be an "indirect cause of the cessation of life" and therefore Mr. Quinlan's choice was moral as defined by the Catholic Church.<sup>52</sup>

Next, the New Jersey Supreme Court looked at Karen's legal rights, beginning with the right to privacy, which concerned the court greatly.<sup>53</sup> The court first noted that had Karen been lucid enough, even for a brief moment, to understand her condition and express her will, then her wishes would control her fate and no state interest would have been compelling enough to force Karen to "endure the unendurable."<sup>54</sup> Since Karen's choice was not explicit, the court initially attempted to discern her choice.<sup>55</sup> However, the court was not able to determine that choice based on the evidence provided.<sup>56</sup> Mr. Quinlan's only evidence were insufficiently probative statements made by Karen to her friends expressing her wish not to be kept alive.<sup>57</sup> Therefore, the court was forced to allow Karen's guardian under the circumstance, her father, and her family to decide for her because the court had found that she had a right to privacy in her body and did not wish to nullify that right by not providing her a means to express her wishes regarding her rights.<sup>58</sup> In addition, the court noted that if the guardian and the family decided that Karen would have wished to discontinue treatment, society would accept that decision because an overwhelming majority of people would want to be able to make the same decision in similar circumstances.<sup>59</sup> The New Jersey Supreme Court appointed Mr. Quinlan, Karen's father, as Karen's guardian despite the lower court's reservations about Mr. Quinlan's judgment.<sup>60</sup> The lower court's reservations were that the obligations would entail too much mental

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51. *Id.* (emphasizing the Church's view that extraordinary means were not required by the Church's doctrines) (citation omitted).

52. *Id.* at 658 (quoting Pope Pius XII, Roman Catholic Church, Address to International Congress of Anesthesiologists (Nov. 24, 1957), available at <http://digbig.com/4fwhp>).

53. *Id.* at 662.

54. *Id.* at 663 (distinguishing *Quinlan* from another case, *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670, 671 (N.J. 1971), where a young lady only needed surgery and a blood transfusion to regain vitality *but* had religious convictions against such intrusions). The court appeared to be drawing a line between the "unendurable," which is a life in a persistent vegetative state, with the relatively simple need for a minor invasion of privacy to regain a full, productive life.

55. *See id.* at 664 (providing that they could not "discern her supposed choice based on the testimony of her previous conversations with friends").

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.* at 671.

anguish for him to be able make rational decisions based on Karen's best interests.<sup>61</sup>

Having concluded its analysis of the constitutional arguments, the court looked to another new and more difficult dilemma—that of the medical community's responsibility with regard to the patient's medical decisions.<sup>62</sup> Traditionally, medical authorities associated death with the cessation of a heartbeat because without a heartbeat no other function could last; but modern resuscitative measures have confounded that principle.<sup>63</sup> The medical community had recently switched its focus from the heart as the primary organ to the brain redefining death to be when "brain death" occurred.<sup>64</sup>

The New Jersey Supreme Court had to decide whether to instruct the medical community on how to handle a patient's right to end life and, if so, how they should so instruct it.<sup>65</sup> First, the New Jersey Supreme Court distinguished suicide from the present circumstance arguing that self-inflicted death is not the same as "a self-determination against artificial life support or radical surgery . . . in the face of irreversible, painful and certain imminent death."<sup>66</sup> After discussing whether the medical malpractice standard should serve as the law's judge of whether a medical decision was properly executed regarding life-sustaining treatment, the court concluded that it would be inappropriate to confirm medical decisions like Karen's under the malpractice standard because the process would be "cumbersome" and a "gratuitous encroachment upon the medical profession's field of competence."<sup>67</sup> The court concluded that medical practices, standards, and traditions would not bind it in determining the right to refuse life-sustaining treatment.<sup>68</sup> The court opined "that the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of [a] biological[ly] vegetative existence."<sup>69</sup> Then, the New

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61. *Id.* at 670–71.

62. *Id.* at 664–65.

63. *Id.* at 656 (citing Ad Hoc Comm. of the Harvard Med. Sch. to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 337, 339 (1968)) [hereinafter Ad Hoc Comm.].

64. *Id.* (citing Ad Hoc Comm., *supra* note 63, at 338). Brain death has been variously defined as the absence of response to pain or other stimuli, flat EEG scans, or a lack of reflex actions. *Id.* (citing Ad Hoc Comm., *supra* note 63, at 338).

65. *Id.* at 664–65 (citing Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 1 (1975)).

66. *Id.* at 665.

67. *See id.* at 668–69 (discussing physician decision-making).

68. *Id.* at 669.

69. *Id.* The court went on to discuss the issue of criminal liability for those involved in the

Jersey Supreme Court concluded that Karen's father, as her guardian, with the help of her family and attending physician, could decide Karen's fate based on their belief of what her wishes might have been.<sup>70</sup>

After the New Jersey Supreme Court's decision in *Quinlan*, the Florida Supreme Court decided *John F. Kennedy Memorial Hospital, Inc. v. Bludworth* using very similar analysis.<sup>71</sup> In *Bludworth*, the Florida Supreme Court held that a comatose and terminally ill person who executed a living will did not need a court-appointed guardian and approval from the court to terminate life-sustaining treatment; thus the family could exercise a patient's right on the patient's behalf.<sup>72</sup> The case arose from wishes of a terminally ill patient's family wanting to execute his "Mercy Will and Last Testament."<sup>73</sup> The court opined that the rights to self-determination of a once-competent adult remain intact even when that person is no longer able to assert those rights or appreciate their effect.<sup>74</sup>

Nine years after the New Jersey Supreme Court decided *Quinlan*, the New Jersey Supreme Court again had to decide the fate of an incompetent person wishing to refuse medical treatment.<sup>75</sup> *In re Conroy* involved an eighty-four-year-old bedridden woman residing in a nursing home with serious mental and physical impairments.<sup>76</sup> In *Quinlan*, the New Jersey Supreme Court determined the rights of a patient in a persistent vegetative state with no prognosis of recovery.<sup>77</sup> *Quinlan* left open the question of whether its principles would apply to incompetent patients while "not necessarily involving the hopeless loss of cognitive or sapient life."<sup>78</sup> Here, Claire Conroy, while severely mentally and physically handicapped and whose prognosis was dim even with treatment, was awake and conscious.<sup>79</sup> Thus, her capacities were not as limited as those of a comatose

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decision, but the decisions since *Quinlan* appear to virtually erase the possibility of criminal liability. *Id.*

70. *Id.* at 671.

71. See *John F. Kennedy Mem'l Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) (depending on *Quinlan* and its progeny to support the conclusion that the right of a comatose and terminally ill patient to refuse extraordinary life-sustaining measures may be exercised by her family members once the patient's condition has been certified by her primary treating physician and at least two other physicians whose specialties are relevant to the patient's condition).

72. *Id.* at 926.

73. *Id.* at 922.

74. *Id.* at 924 (stating that the rights of terminally ill patients to self-determine "should not be lost when they suffer irreversible brain damage, become comatose, and are no longer able to personally express their wishes to discontinue the use of extraordinary artificial support systems").

75. *In re Conroy*, 486 A.2d 1209, 1216 (N.J. 1985).

76. *Id.*

77. *In re Quinlan*, 355 A.2d 647, 655 (N.J. 1976).

78. *In re Conroy*, 486 A.2d at 1228 (quoting *In re Quinlan*, 355 A.2d at 671 n.10).

79. *Id.* at 1228-29.

patient and her death, while near, was not necessarily imminent.<sup>80</sup> The issue was whether life-sustaining treatment, in this case artificial hydration and nutrition, could be withheld from an elderly nursing home resident suffering from mental and physical incapacitation.<sup>81</sup> The court had to decide on the guidelines for making the treatment decisions required and the procedures for making those decisions.<sup>82</sup>

The New Jersey Supreme Court began with the idea that all persons may control their own body and that informed consent was required for medical procedures.<sup>83</sup> As a corollary, the court recognized the right to informed refusal and the fact that each person has a right to privacy.<sup>84</sup> However, the court also recognized that the right to refuse treatment was not absolute and articulated the four state interests that might counterbalance an individual's right to die.<sup>85</sup> The court found that despite such a patient's inability to speak, she still had a right to self-determination and inasmuch as her ability to exercise that right had diminished, the family could determine and effectuate a decision on her behalf.<sup>86</sup> The New Jersey Supreme Court cautiously advanced three tests that surrogate decision makers could satisfy if they wished to withdraw or withhold life-sustaining treatment.<sup>87</sup> The New Jersey Supreme Court articulated a subjective test, a limited-objective test, and pure-objective test that a surrogate could meet to prove the intentions of the comatose ward.<sup>88</sup> In these tests, the presence of a living will was only persuasive evidence of the patient's wishes and had to be coupled with other evidence of the patient's intent.<sup>89</sup> However, now most states have enacted living will statutes that provide standards of enactment and recognition of living wills.<sup>90</sup> Thus, the value of *In re Conroy* lies in its discussion of the state's interests and the rights of a person to self-determination.<sup>91</sup>

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80. *Id.* at 1229.

81. *Id.* at 1216. Claire Conroy died while the case was on appeal, but the court chose to hear the case because the issue was important and the fact that many people died while their cases were in review is not a sufficient reason for the parties not to receive justice. *Id.* at 1219.

82. *Id.* at 1220.

83. *Id.* at 1221–22.

84. *Id.* at 1222 (citing *Griswold v. Connecticut*, 381 U.S. 479, 483–86 (1965)).

85. *Id.* at 1223.

86. *Id.* at 1229.

87. *Id.* at 1229, 1231–32.

88. *Id.*

89. *Id.* at 1229–30.

90. See 63 AM. JUR. *Trials* § 3 (1997) (“All states now have some legislation addressing end-of-life decisionmaking and advance[] directives.”).

91. *In re Conroy*, 486 A.2d at 1223.

The state's first interest articulated by the New Jersey Supreme Court was the preservation of life—the patient's life and the sanctity of all life.<sup>92</sup> The court called the preservation of life the most significant of the four state interests.<sup>93</sup> Interestingly, the court noted a paradox in the state's interest, stating “insofar as the ‘sanctity of individual free choice and self-determination [are] fundamental constituents of life,’ the value of life may be lessened rather than increased ‘by the failure to allow a competent human being the right of choice.’”<sup>94</sup> Thus, the court maintained that the individual's choice to refuse treatment of the individual's own body was paramount to any state interest.<sup>95</sup>

The second state interest the court stated was the prevention of suicide.<sup>96</sup> The court was reluctant to consider the interest of prevention of suicide as independent from the interest of preserving life, considering that the state's first interest implicitly includes the prevention of self-destruction.<sup>97</sup> The court differentiated suicide from the right to die opining that the right to die did not implicate suicide because, as it stated in *Quinlan*, death comes from the underlying disease and not some affirmative act by the patient.<sup>98</sup> Very often the patient does not harbor the “specific intent” to die that a person committing suicide does; thus, the court reasoned that patients exercising their right to die simply wish to live free from “unwanted medical technology, surgery, or drugs, and without protracted suffering.”<sup>99</sup>

The third state interest was the “safeguarding [of] the integrity of the medical profession.”<sup>100</sup> The court dismissed this interest, stating that a patient's refusal of treatment did not threaten medical ethics because “[m]edical ethics [does] not require medical intervention . . . at all costs.”<sup>101</sup> The court reached back to 1624 to quote Francis Bacon where he noted that a doctor's only duty may be “to make a fair and easy passage.”<sup>102</sup> The court also noted that if a patient were competent, the doctor's duty would be

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92. *Id.*

93. *Id.*

94. *Id.* at 1223–24 (alteration in original) (quoting Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977)).

95. *Id.* at 1223.

96. *Id.* at 1224.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* at 1224–25 (quoting FRANCIS BACON, OF THE PROFICIENCY AND ADVANCEMENT OF LEARNING DIVINE AND HUMANE (1605), reprinted in 30 GREAT BOOKS OF THE WESTERN WORLD 1, 52 (Robert Maynard Hutchins et al. eds., Encyclopædia Britannica 1952)).

to inform the patient of the risks of refusing treatment and then accept the decision if the patient chose to refuse treatment.<sup>103</sup>

The fourth state interest was protecting innocent third parties, individuals such as unborn babies or minor children, whom the patient's decision to forego treatment might harm.<sup>104</sup> The court found that this state interest could override the patient's right to refuse treatment.<sup>105</sup> The court cited cases where the patient had small children or where it was necessary to protect the public health.<sup>106</sup> In these cases, society has an overriding interest in preserving the patient's life. The court distinguished these cases however, holding that no third party would be harmed in this case.<sup>107</sup> The court concluded its discussion by reminding all that a competent person's rights did not depend on the quality of life or value of the person's life.<sup>108</sup>

Next, in *Delio v. Westchester County Medical Center*, the wife of a thirty-three-year-old man in a vegetative state with no cognitive awareness and no hope for improvement unsuccessfully petitioned a New York court for permission to terminate his care.<sup>109</sup> The man, Daniel Delio, could breathe without a respirator but could not ingest food, and had to be fed through artificial hydration and nutrition.<sup>110</sup> On appeal from that order, an appellate court held that Daniel's wife could act according to her husband's clearly expressed wishes not to be kept alive and could terminate his treatment.<sup>111</sup>

Daniel did not have a living will, but had clearly expressed his wishes not to be kept alive by artificial means to his wife, relatives, and colleagues.<sup>112</sup> The medical evidence showed severe brain damage resulting from cardiac arrest during a routine surgery; there was no hope for

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103. *Id.* at 1225.

104. *Id.*

105. *Id.*

106. *Id.*; see, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 26–27 (1905) (finding that a statute requiring compulsory vaccinations was necessary to protect the public health); *In re President & Dirs. of Georgetown Coll., Inc.*, 331 F.2d 1000, 1001–02, 1008–09 (D.C. Cir. 1964) (giving as one reason for granting an emergency writ to provide a blood transfusion the fact that the patient had a seven-month-old child).

107. *In re Conroy*, 486 A.2d at 1226.

108. *Id.*

109. *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 679–80 (App. Div. 1987).

110. *Id.* at 680.

111. *Id.*

112. *Id.* at 681–83. In fact, Daniel's first comments came after he followed the publicity surrounding the *Quinlan* decision. *Id.* at 681. He had a Ph.D. in exercise physiology and clearly understood and articulated his choice to his wife, explaining that he thought the cessation of cortex was the cessation of life itself. *Id.* at 681–82. After Karen Ann Quinlan died seven years later, Daniel repeated his convictions against being kept alive by artificial means. *Id.* at 682.

recovery, but with feeding tubes he could live indefinitely.<sup>113</sup> The lower court, exercising judicial restraint, refused to allow Daniel's wife to remove the tubes, requesting further legislative or judicial guidance.<sup>114</sup> The appellate court heard the case in order to decide the issue of whether Daniel's wife could terminate his treatment.<sup>115</sup>

The court left alone the constitutional rights to privacy arguments and instead concentrated on the common law germane to self-determination.<sup>116</sup> The court began with the *Quinlan* decision, noting that in the intervening eleven years since *Quinlan*, courts had placed the rights of incompetents on par with those of competent patients arguing that human dignity extends to both the competent and the incompetent giving both the right to bodily integrity and self-determination.<sup>117</sup> In addition, the court mentioned two cases relevant to its analysis, *In re Storar* and its companion, *Eichner v. Dillon*.<sup>118</sup> In those cases, the Court of Appeals held that an incompetent person had a right to terminate life-sustaining treatment when "clear and convincing evidence" proved that the person, while competent, expressed a desire not to be kept alive so long as no countervailing state interest existed.<sup>119</sup>

In *Delio*, the hospital argued that in those cases the court only attempted to remove a respirator, not hydration and nourishment; but the appellate division noted that in *Quinlan*, *Eichner*, and *Storar* the courts focused on the patients' desires and not the type of treatment being withheld.<sup>120</sup> In addition, the *Delio* court cited *In re Conroy*, in which the New Jersey Supreme Court determined that Claire Conroy's wishes not to be kept alive by artificial means is permissible even if that included withholding artificial hydration and nutrition.<sup>121</sup> The New York court noted that the New Jersey Supreme Court focused on the patient's desires and experience of pain and not the type of treatment, specifically rejecting any difference in treatment between respiration and hydration and nutrition.<sup>122</sup> The New York court found analogous precedent maintaining that the type of life-sustaining procedure was not the issue; the patient's desire to

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113. *Id.* at 679, 683.

114. *Id.* at 685.

115. *Id.* at 679–80.

116. *Id.* at 686.

117. *Id.*

118. *Id.* at 686–87.

119. *Id.* at 687 (citing *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1981)).

120. *Id.* at 687–88.

121. *Id.* at 688 (citing *In re Conroy*, 486 A.2d 1209, 1236).

122. *Id.* (citing *In re Conroy*, 486 A.2d at 1233, 1235–37).



succumb to those procedures was the issue.<sup>123</sup> Beyond that question, the court would evaluate the decision to withdraw or withhold artificial hydration and nutrition as any other medical procedure.<sup>124</sup>

The appellate court also stated that Daniel's age and medical condition did not affect the "panoply of rights" associated with the right to self-determination.<sup>125</sup> A person's age and medical condition could factor into whether that person made an informed decision to terminate treatment, but the court ruled that it was not determinative.<sup>126</sup> The court concluded that Daniel had a common law right to refuse medical treatment even if it was in the form of artificial hydration and nutrition.<sup>127</sup> Thus, the appellate court held that Daniel Delio's wife could act for Daniel according to his clearly expressed wishes not to be kept alive by artificial means, and that the lower court's finding of clear and convincing evidence of Daniel's choice to terminate life was correct.<sup>128</sup>

In 1990, the United States Supreme Court entered the debate over the right to refuse life-sustaining treatment.<sup>129</sup> In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court held that the United States Constitution did not forbid the states from requiring clear and convincing evidence of a person's desire to withdraw life-sustaining treatment.<sup>130</sup> Nancy Cruzan suffered severe injuries from a car accident and went into a persistent vegetative state in a Missouri state hospital.<sup>131</sup> At the time of Nancy's accident, Missouri had enacted a living will statute, but Nancy had not drafted such a will.<sup>132</sup>

The Missouri Supreme Court found that the constitutions of Missouri and the United States could not be read so broadly as to include a right to refuse treatment in every circumstance.<sup>133</sup> The Court held that in light of Missouri's living will statute, the State's interest in preserving life required

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123. *Id.* at 687–88 (citations omitted).

124. *Id.* at 689.

125. *Id.* at 690.

126. *Id.*

127. *Id.* at 691. The court continued to discuss the four state interests asserted in *Conroy*, using the same analysis as the New Jersey Supreme Court. *Id.* at 691–93 (citing *Conroy*, 486 A.2d at 1223–25). The court concluded that none of those interests outweighed Daniel Delio's right to refuse treatment. *Id.* at 693.

128. *Id.* at 693.

129. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 265 (1990) (granting certiorari to the case in 1989 where parents were seeking to withdraw life-sustaining treatment).

130. *Id.* at 284.

131. *Id.* at 266.

132. *Id.* at 268–69 (mentioning a statement made by the Missouri Supreme Court finding that someone must enact a living will or meet a clear-and-convincing-evidence standard to express their choice concerning life-sustaining treatment).

133. *Id.* at 268.

clear and convincing evidence that the patient would want life-sustaining treatment terminated in the absence of a living will.<sup>134</sup> The United States Supreme Court granted certiorari to consider whether “[Nancy had] a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment.”<sup>135</sup> In its analysis, the Court canvassed state court cases covering the right to die, but maintained that while those courts could look to state constitutions, state statutes, and state common law, the Supreme Court could look only to the United States Constitution for guidance.<sup>136</sup>

The Supreme Court began its analysis with the Fourteenth Amendment and observed that a person has a due process liberty interest in refusing unwanted medical treatment.<sup>137</sup> Citing cases as early as 1905, the Court determined that a person has a substantial liberty interest in refusing medical treatment.<sup>138</sup> However, the Court noted that finding an interest was only the first step; a person’s right must be balanced against relevant state interests.<sup>139</sup> The Court assumed that the Constitution would grant a competent person the right to refuse artificial hydration and nutrition and began its consideration of the parties’ arguments.<sup>140</sup>

Cruzan argued that an incompetent person should have the same rights as a competent person, but the Court found that this was impossible because, by definition, an incompetent person had to have someone else make the decision for them.<sup>141</sup> Missouri recognized that under certain circumstances a surrogate may act for a patient electing to refuse treatment, but the State must have assurance, received through procedural safeguards, that the actions of the surrogate conform to the expressed wishes of the patient while competent.<sup>142</sup> Thus, the Court concluded that the question was whether the Constitution forbade the State’s establishment of procedural safeguards.<sup>143</sup> The Court held that there was no such restriction.<sup>144</sup>

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134. *Id.* at 268–69.

135. *Id.* at 269.

136. *Id.* at 270–77 (discussing *Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *In re Conroy*, 486 A.2d 1209 (N.J. 1985); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988); *In re Storar*, 420 N.E.2d 64 (N.Y. 1981)).

137. *Id.* at 278.

138. *Id.* (citing *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905)).

139. *Id.* at 279 (citing *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

140. *Id.*

141. *Id.* at 279–80.

142. *Id.* at 280.

143. *Id.*

144. *Id.*

In explaining its holding, the Court first analyzed whether Missouri's restriction, its requirement of clear and convincing evidence, furthered a permissible state interest.<sup>145</sup> Missouri's state interest was the preservation of human life and, as the Court noted, this was a very legitimate state interest especially considering that Cruzan was a physically able adult who would starve to death if her guardian were allowed to decide to withdraw life-sustaining treatment.<sup>146</sup> It was not novel to the Court that a higher degree of certainty was required of the fact-finder when such an important decision as Cruzan's was being made.<sup>147</sup> The Court opined that a decision such as Nancy Cruzan's, where life or death was at stake, validated the State in requiring a higher standard of proof.<sup>148</sup> The Court concluded that when a person or a surrogate is making such an important decision as life or death, the State could require a heightened evidentiary standard such as "clear and convincing evidence."<sup>149</sup>

## 2. After *Cruzan*: Still a Struggle

By 1990, when the Supreme Court decided *Cruzan*, many states had enacted living will statutes or similar laws concerning a patient's right to refuse treatment.<sup>150</sup> Now, all states have laws addressing advance directives.<sup>151</sup> Since the Supreme Court's decision in *Cruzan*, many state courts have had to wrestle with the issue of the right to refuse treatment. In 1997, the Wisconsin Supreme Court decided *In re Edna M.F.*, holding that a guardian could only direct a physician to withdraw treatment, including artificial hydration and nutrition, if the ward was in a persistent vegetative

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145. *Id.*

146. *Id.* at 267–68, 280 (citing George P. Smith II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS. L. REV. 275, 290–91 (1989) for the proposition that the majority of states have prohibited assistant suicide). The medical testimony in the case suggested that a person in a persistent vegetative state is able to perform all of life's functions, such as maintain body temperature and pulmonary activity, and is only in a non-cognitive state. *Id.* at 266 n.1.

147. *See id.* at 283 (finding that a higher degree of certainty may be required since this decision cannot be corrected).

148. *Id.*

149. *Id.* at 283–84. The Supreme Court also rejected Cruzan's argument for the substituted judgment doctrine stating that while the record shows that the Cruzans are the perfect case for its application, the due process clause only requires the states to repose judgment on the patient. *Id.* at 286.

150. *E.g.*, ALA. CODE § 22-8A-4 (LexisNexis 1997 & Supp. 2004) (enacted in 1981); MO. ANN. STAT. § 459.015 (West 1992) (enacted in 1985); UTAH CODE ANN. § 75-2-1104 (1993) (enacted in 1985); *see* Jill Hollander, Note, *Health Care Proxies: New York's Attempt to Resolve the Right to Die Dilemma*, 57 BROOK. L. REV. 145, 160 (1991) (noting that forty-two states and the District of Columbia have passed legislation recognizing the validity of living wills).

151. 63 AM. JUR. *Trials* § 3, at 16 (1997).

state and the surrogate made the decision that was in the best interests of the ward.<sup>152</sup> In addition, the court held that when a person is not in a persistent vegetative state it is not in the ward's best interest to have medical treatment withdrawn, and without an advance directive or a clear statement of intent the surrogate cannot have treatment withdrawn.<sup>153</sup>

In *Edna M.F.*, Edna was a seventy-one-year-old woman diagnosed with Alzheimer's disease.<sup>154</sup> She was bedridden, could not move, and required artificial hydration and nutrition, but she could breathe on her own and responded to stimuli.<sup>155</sup> Her doctors testified that she did not meet the medical definition of being in a persistent vegetative state but that her condition was not likely to improve.<sup>156</sup> Edna's sister, Betty Spahn, was her guardian and sought the court's permission to withhold life-sustaining artificial hydration and nutrition.<sup>157</sup> Spahn's only evidence of her sister's intent was her sister's statements made thirty years earlier in a conversation when Spahn's mother-in-law was dying of cancer.<sup>158</sup> Spahn asked the court's permission to withhold treatment because Edna's niece would not sign the consent form as required for termination of medical treatment.<sup>159</sup> The circuit court denied Spahn's petition, and she appealed directly to the Wisconsin Supreme Court.<sup>160</sup>

The court began by looking at *Quinlan* and *Cruzan* as the foundations of the right to refuse treatment.<sup>161</sup> Then the court examined its own precedent, *In re Guardianship of L.W.*, where it concluded "that an incompetent individual in a persistent vegetative state has a constitutionally protected right to refuse unwanted medical treatment, including artificial nutrition and hydration, that a court-appointed guardian may consent to withdrawal of such treatment where it is in the 'best interests' of the ward to do so."<sup>162</sup> Spahn wanted the court to extend the holding of *L.W.* to include wards that were not in a persistent vegetative state, based on the court's conclusion that the right to refusal applies to incompetent and

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152. *In re Guardianship & Protective Placement of Edna M.F.*, 563 N.W.2d 485, 486 (Wis. 1997) [hereinafter *Edna M.F.*].

153. *Id.* at 489–90.

154. *Id.* at 487.

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.* at 487–88 (citing *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976)).

162. *In re Guardianship of L.W.*, 482 N.W.2d 60, 63 (Wis. 1992).

competent persons equally.<sup>163</sup>

According to the Wisconsin Supreme Court, the issue was whether a surrogate could decide to withhold or withdraw life-sustaining treatment from an incompetent person who was not in a persistent vegetative state.<sup>164</sup> The court had previously decided that an incompetent person, at least in the context of sterilization, was a distinct class of persons who deserved special concern by the state.<sup>165</sup> Thus, while the incompetent have the same rights as the competent, they do not have the same ability to exercise them, and someone must act in their stead.<sup>166</sup> However, the court ruled that, as a matter of law, persons not in a persistent vegetative state should not have life-sustaining treatment withdrawn because it is not in their best interest, unless that person properly executed an advance directive or provided a clear statement of intent while competent.<sup>167</sup>

After *Edna M.F.*, the rule in Wisconsin was that a ward's guardian could withdraw life-sustaining treatment if the ward was in a persistent vegetative state and it was in the best interest of the ward.<sup>168</sup> A guardian could not withdraw life-sustaining treatment if the ward was not in a persistent vegetative state unless the guardian could show "by a preponderance of the evidence a clear statement of [the ward's] desires in [the] circumstances."<sup>169</sup> The court concluded its review stating that Edna's statement thirty years ago under different circumstances did not meet the clear statement standard; thus Spahn was not authorized to withhold artificial hydration and nutrition.<sup>170</sup>

In another post-*Cruzan* decision, the California Supreme Court in *Conservatorship of Wendland* held that a conservator had to show by clear and convincing evidence that the conservatee would refuse life-sustaining treatment or show that refusing treatment would be in the conservatee's best interest.<sup>171</sup> In *Wendland*, Robert Wendland injured himself in a car accident while driving drunk and suffered brain damage.<sup>172</sup> He was in a coma for several months, but eventually regained part of his motor skills—he was sporadically able to communicate by blinking.<sup>173</sup>

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163. *Edna M.F.*, 563 N.W.2d at 489.

164. *Id.*

165. *Id.* (citing *In re Guardianship of Eberhardy*, 307 N.W.2d 881, 897 (Wis. 1981)).

166. *Id.*

167. *Id.* at 489–90.

168. *Id.* at 490.

169. *Id.*

170. *Id.* at 492.

171. *Conservatorship of Wendland*, 28 P.3d 151, 175 (Cal. 2001).

172. *Id.* at 154.

173. *Id.* at 154–55. Robert Wendland died before the California Supreme Court heard his case. *Id.* at 154 n.1.

The court, having found no legal impediment to a competent person refusing medical treatment, looked at California state law to determine if and how an incompetent person could refuse the same treatment.<sup>174</sup> The court noted that California had given competent persons the power to enact formal health care directives since 1976, and, as of July 2000, California's Health Care Decisions Law has given competent adults "broad power to direct all aspects of their health care in the event they become incompetent."<sup>175</sup> Conversely, a conservator's power to make decisions derived from the *parens patriae* power of the state.<sup>176</sup> Thus, conservators, as court-appointed guardians, were limited in their ability and not allowed the freedoms agents or other surrogates might have.<sup>177</sup> A conservator must follow the state law, specifically section 2355 of California's probate code, which allows the conservator to make health care decisions for the conservatee in accordance with the conservatee's instructions or, if the conservatee's instructions are not known, the conservatee's best interests.<sup>178</sup> The statute did not specifically state whether a conservator had the power to withdraw life-sustaining treatment, but the comments to the law inferred that the drafters had in mind California precedent allowing a conservator to refuse life-sustaining treatment on behalf of a conservatee including artificial hydration and nutrition.<sup>179</sup>

After establishing that a conservator could withdraw life-sustaining treatment, the court proceeded to discuss how the withdrawal could be accomplished.<sup>180</sup> The court determined that the evidentiary standard was not clear from the statute; thus to avoid any potential constitutional issues the standard should be a clear and convincing standard.<sup>181</sup> Thus, because of the gravity of the decision and the wish to err on the side of caution, the conservator had to show the conservatee's wishes with clear and convincing evidence.<sup>182</sup> The court finished its analysis by determining that Wendland's two prior statements that he would not want to live like a vegetable were not clear and convincing evidence of a desire to withdraw life-sustaining

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174. *Id.* at 160.

175. *Id.*

176. *Id.* at 161. *Parens patriae* means, "[t]he state regarded as a sovereign; the state in its capacity as provider of protection to those unable to care for themselves." BLACK'S LAW DICTIONARY 1137 (7th ed. 1999).

177. *Wendland*, 28 P.3d at 161, 168.

178. *Id.* at 164 (citing CAL. PROB. CODE § 2355 (West 2002)).

179. CAL. PROB. CODE § 2355 & cmt. (mentioning Conservatorship of Drabick, 245 Cal. Rptr. 840 (Ct. App. 1988)).

180. *Wendland*, 28 P.3d at 166.

181. *Id.*

182. *Id.* at 171.

treatment.<sup>183</sup>

The latest pronouncement on living wills and the right to refuse life-sustaining treatment came from Florida in 2005. On March 31, 2005, Theresa Marie Schiavo died after fifteen years in a coma,<sup>184</sup> ending years of litigation that culminated in action by the U.S. Congress and a storm of appeals to the Florida state courts and the United States Supreme Court.<sup>185</sup> The *Schiavo* case began in 1990 when Theresa Schiavo, age twenty-seven, suffered a cardiac arrest and went into a coma.<sup>186</sup> Theresa was in a persistent vegetative state and was fed via feeding tubes.<sup>187</sup> Her condition

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183. *Id.* at 173. The California Supreme Court also looked at the best-interest test stated in section 2355. *Id.* In accordance with the statute, the court maintained that the conservator was to determine the conservatee's best interests based on the personal values of the conservatee "in accordance with the conservator's determination of the conservatee's best interest." *Id.* at 173–74 (emphasis in original) (quoting § 2355). The court concluded the conservator had to show what the best interests of the conservatee were by clear and convincing evidence, and the conservator failed, in this case, to show what Roger Wendland's best interests were by that standard. *See id.* (noting that the conservator provided no evidence whatsoever "other than her own subjective judgment that the conservatee did not enjoy a satisfactory quality of life").

184. *Assessing Terri Schiavo: She Opened Pandora's Suitcase*, ECONOMIST, Apr. 2nd–8th 2005, at 28.

185. For purposes of dealing with the extensive legal history of this case, the author has labeled the cases discussed as *Schiavo I–Schiavo IV*. In the subsequent footnotes, the courts refer to "Schiavo I" and others in the sequence. The reader should not confuse them with the numbers used in this paper. *In re Guardianship of Schiavo (Schiavo I)*, 780 So. 2d 176 (Fla. Dist. Ct. App. 2001), *appeal denied*, 789 So. 2d 348 (Fla. 2001); *In re Guardianship of Schiavo (Schiavo II)*, 792 So. 2d 551 (Fla. Dist. Ct. App. 2001); *In re Guardianship of Schiavo (Schiavo III)*, 800 So. 2d 640 (Fla. Dist. Ct. App. 2001), *appeal denied*, 816 So. 2d 127 (Fla. 2002); *Schindler v. Schiavo ex rel. Schiavo*, 829 So. 2d 220 (Fla. Dist. Ct. App. 2002) (table citation denying motion); *In re Guardianship of Schiavo*, No. 90-2908-GD-003, 2002 WL 31876088 (Fla. Cir. Ct. Nov. 22, 2002); *In re Guardianship of Schiavo*, No. 90-2908-GB-003, 2002 WL 31817960 (Fla. Cir. Ct. Nov. 22, 2002); *Schiavo v. Schiavo*, No. 8:03-cv-1860-T-26TGW, 2003 WL 22469905 (M.D. Fla. Sept. 23, 2003); *In re Guardianship of Schiavo (Schiavo IV)*, 851 So. 2d 182 (Fla. Dist. Ct. App. 2003), *appeal denied*, 855 So. 2d 621 (Fla. 2003); *Schindler v. Schiavo*, 865 So. 2d 500 (Fla. Dist. Ct. App. 2003) (table decision denying prohibition); *Advocacy Ctr. for Persons with Disabilities, Inc. v. Schiavo*, 17 Fla. L. Weekly Fed. 291, *available at* 2003 U.S. Dist. LEXIS 19949, at \*1, \*5 (M.D. Fla. Oct. 21, 2003) (denying the center injunctive relief); *Schiavo v. Bush*, No. 03-008212-CI-20, 2003 WL 22762709 (Fla. Cir. Ct. Nov. 4, 2003); *Bush v. Schiavo*, 861 So. 2d 506, 507, 509 (Fla. Dist. Ct. App. 2003) (denying a writ of prohibition that would have removed a lower court judge); *Schiavo v. Bush*, No. 03-008212-CI-20, 2004 WL 628663 (Fla. Cir. Ct. 2004); *Bush v. Schiavo*, 866 So. 2d 136 (Fla. Dist. Ct. App. 2004); *Schindler v. Schiavo*, 866 So. 2d 140, 141 (Fla. Dist. Ct. App. 2004) (correcting a failure to follow the appropriate application of intervention rule); *Bush v. Schiavo*, 871 So. 2d 1012 (Fla. Dist. Ct. App. 2004); *Schiavo v. Bush*, No. 03-008212-CI-20, 2004 WL 980028 (Fla. Cir. Ct. May 5, 2004); *Bush v. Schiavo*, 885 So. 2d 321 (Fla. 2004), *cert. denied*, 125 S. Ct. 1086 (2005); *Schindler v. Schiavo*, No. 2D04-3451, 2004 WL 2726107, at \*1 (Fla. Dist. Ct. App. Nov. 24, 2004); *In re Guardianship of Schiavo*, No. 90-2908-GD-003, 2005 WL 459634 (Fla. Cir. Ct. Feb. 25, 2005). The author has singled out the cases that began the Schiavo ordeal for discussion, believing that while the later legal maneuvering and media circus surrounding the Schiavo case was good television, it did little to change the law of living wills, see *infra* note 235.

186. *Schiavo I*, 780 So. 2d at 177.

187. *Id.*

was poor and she suffered from numerous health problems, but when the fight over her refusal of life-sustaining treatment began, her death was not imminent.<sup>188</sup> However, her cerebral cortex had deteriorated so that only cerebral spinal fluid was left.<sup>189</sup> Indeed, the court noted that medicine could not cure Theresa's condition and "[u]nless an act of God, a true miracle, were to recreate her brain, Theresa [would] always remain in an unconscious, reflexive state."<sup>190</sup> The court also observed that Theresa's parents, the plaintiffs in the lawsuit, knew only a miracle would return their daughter to a sapient existence.<sup>191</sup>

The case stemmed from a difference of opinion between Michael Schiavo, Theresa's husband and lawful guardian, and Theresa's parents.<sup>192</sup> Michael wished to terminate her treatment in accordance with the wishes Theresa orally expressed to her friends and family.<sup>193</sup> Theresa's parents wished to keep her attached to the nutrition and hydration tubes and wait for the miracle that would save her.<sup>194</sup> However, the case became more complicated than a simple difference of opinion because of a sizable monetary settlement Theresa received in a medical malpractice suit.<sup>195</sup> The settlement could have allowed Theresa to continue her medical treatment for several years, despite no hope of recovery, and Michael and Theresa's parents had potentially different motivations for arguing as they did.<sup>196</sup> If Michael terminated her treatment while remaining married to her, he would receive the remainder of Theresa's settlement, but if Michael divorced Theresa, her parents would receive the money after her death.<sup>197</sup>

Proceeding under Florida's statutes for terminating life-sustaining procedures and the Florida Constitution, the second district discussed three issues raised by Theresa's parents.<sup>198</sup> First, the family argued that the court should have appointed a *guardian ad litem* for Theresa because Michael, her legal guardian, stood to gain financially from Theresa's death.<sup>199</sup> The court found that in most cases where the terminally ill patient had no living

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188. *Id.*

189. *Id.*

190. *Id.*

191. *See id.* at 178 ("No one questions the sincerity of [Theresa's parents'] prayers for the divine miracle that now is Theresa's only hope to regain any level of normal existence.").

192. *Id.*

193. *Id.* at 178, 180.

194. *Id.* at 177-78.

195. *Id.* at 178.

196. *Id.*

197. *Id.*

198. *Id.*; *see* FLA. STAT. ANN. § 765.305 (West 2005) (authorizing the termination of life-sustaining procedures after statutory prerequisites are met where no living will was executed).

199. *Schiavo I*, 780 So. 2d at 178.



will it was likely that a close family member would inherit from the patient and such circumstances did not compel the appointment of a *guardian ad litem*.<sup>200</sup> Moreover, the court found that Michael was not making a decision, but had invoked the circuit court's jurisdiction to serve as a surrogate decision maker under the second district's decision in *In re Guardianship of Browning*.<sup>201</sup> In its final determination, the court held that terminating life-prolonging procedures did not require the appointment of a *guardian ad litem*, despite the fact that Michael stood to inherit should Theresa die, because the court served as the patient's guardian.<sup>202</sup> Thus, a *guardian ad litem* would duplicate the court's function, add little of value to the process, and confound the process with hearsay and matters outside the record.<sup>203</sup>

Second, Theresa's parents argued that the trial court should not have heard the testimony of an expert on the opinions and attitudes about the decision to discontinue life-sustaining treatment.<sup>204</sup> While the second district doubted that Theresa's parents preserved the issue or that the testimony was relevant, the court determined that the trial court judge did not give undue weight to the testimony.<sup>205</sup> Therefore, the court found that there was some risk of a judge using the testimony to make a "best interests" decision instead of a proper decision as surrogate, but that the judge made the correct decision based on the proper factors.<sup>206</sup>

The third issue Theresa's parents argued was that the conflicting testimony did not amount to "clear and convincing evidence" as required by the Florida Supreme Court.<sup>207</sup> The second district determined that a court could find clear and convincing evidence in the face of conflicting evidence, but reaffirmed its assertion from *Browning* that in cases of doubt the court must find that the patient would have chosen life.<sup>208</sup> In its determination, the court reviewed evidence presented to the trial court

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200. *Id.*

201. *Id.* at 178–79; *In re Guardianship of Browning*, 568 So. 2d 4, 16 (Fla. 1990) (discussing how a court may make a decision regarding written or oral instructions). In its affirmance, the Florida Supreme Court recognized two circumstances for invoking the circuit court's jurisdiction when there are legitimate questions pertaining to the written or oral instructions: "[f]irst, the surrogate or proxy may choose to present the question to the court for resolution. Second, interested parties may challenge the decision of the proxy or surrogate." *Id.*

202. *Schiavo I*, 780 So. 2d at 179.

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*; see *In re Guardianship of Browning*, 568 So. 2d 4, 15 (Fla. 1990) (requiring a surrogate to support the decision to forego treatment with "clear and convincing evidence").

208. *Schiavo I*, 780 So. 2d at 179; *In re Guardianship of Browning*, 543 So. 2d 258, 273 (Fla. Dist. Ct. App. 1989).

relating that Theresa had not prepared a will or a living will, that she was Catholic but did not have any religious guidance that would have assisted the court in determining what her decision might be, and that her statements on death were few and oral.<sup>209</sup> However, the court found that the real evidence was the fact that Theresa had been in a persistent vegetative state for ten years, that she had lost most of her cerebrum, and she had no hope of a medical cure.<sup>210</sup> Thus, the real issue to the court was whether Theresa would choose to continue in such a state hoping for “a miracle [that] would . . . recreate her . . . brain tissue, or whether she would wish to permit a natural death process to take its course.”<sup>211</sup> The second district found the trial court had clear and convincing evidence to find that she would have chosen the latter.<sup>212</sup>

After the Florida Supreme Court denied review of the case, Theresa’s parents “began a multipronged attack upon the trial court’s final judgment.”<sup>213</sup> In *Schiavo II*:

[t]hat attack included filing a motion in the guardianship court seeking relief from the judgment pursuant to [Florida Rules of Civil Procedure] 1.540(b)(2) and (3), based upon allegations of newly discovered evidence and intrinsic fraud, and filing a separate complaint in the civil division of the circuit court seeking to challenge the final judgment of the guardianship court.<sup>214</sup>

In *Schiavo II*, the Second District Court of Appeal held that the:

[G]uardianship court had appropriately denied the [Florida Rules of Civil Procedure] 1.540 motion as untimely on its face but that the Schindlers, who [were] technically ‘interested parties’ in [the] proceeding, had standing to file either a motion for relief from judgment under rule 1.540(b)(5) or an independent action in the guardianship court to challenge the judgment on the grounds that it [was] no longer equitable that the judgment should have prospective application.<sup>215</sup>

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209. *Schiavo I*, 780 So. 2d at 180.

210. *Id.*

211. *Id.*

212. *Id.*

213. *Schiavo III*, 800 So. 2d 640, 642 (Fla. Dist. Ct. App. 2001).

214. *Id.*

215. *Id.* (citing *Schiavo II*, 792 So. 2d 551, 554 (Fla. Dist. Ct. App. 2001)).

Following the court's directions, Theresa's family commenced *Schiavo IV*, filing a Florida Rules of Civil Procedure 1.540 motion seeking relief from the original judgment.<sup>216</sup>

In their motion, Theresa's parents challenged the original four findings of the second district but focused their attack on the court's fourth finding: that Michael had presented "clear and convincing evidence" of support for his argument that Theresa would have chosen to withdraw life-sustaining treatment.<sup>217</sup> Specifically, the parents' motion for relief from judgment alleged "evidence of a new treatment that could dramatically improve Mrs. Schiavo's condition and allow her to have cognitive function to the level of speech."<sup>218</sup> In *Schiavo III*, the second district permitted Theresa's parents to present medical testimony concerning the new treatment.<sup>219</sup> The court required that Theresa's family "must prove only by a preponderance of the evidence that [*Schiavo I's*] judgment is no longer equitable."<sup>220</sup>

On review in *Schiavo IV*, the guardianship court heard extensive medical testimony from five neurological experts including four board-certified neurologists.<sup>221</sup> None of the experts testified that Theresa's brain damage was reversible.<sup>222</sup> The experts selected by Theresa's family testified that some treatments could increase blood flow and oxygen to the damaged areas, but dead tissue could not be replaced.<sup>223</sup> In remanding the case, the second district anticipated expert medical testimony on the issue of whether new treatments existed that could restore Theresa's cognitive function such that she would elect to undergo the treatments rather than discontinue life-prolonging procedures.<sup>224</sup> Instead, Theresa's family presented expert medical testimony suggesting that Theresa was *not* in a persistent vegetative state.<sup>225</sup> However, the guardianship court determined that Theresa remained in a persistent vegetative state and no treatment offered such promise of success that Theresa would have elected to undergo the treatment.<sup>226</sup> The court also ordered the removal of the hydration and nutrition tube.<sup>227</sup> Theresa's family appealed the decision.<sup>228</sup>

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216. *Schiavo IV*, 851 So. 2d 182, 183 (Fla. Dist. Ct. App. 2003).

217. *Id.* at 183–84 (citing *Schiavo III*, 800 So. 2d at 645).

218. *Id.* at 184 (quoting *Schiavo III*, 800 So. 2d at 645).

219. *Schiavo III*, 800 So. 2d at 645.

220. *Id.*

221. *Schiavo IV*, 851 So. 2d at 184.

222. *Id.* at 185.

223. *Id.*

224. *Id.*

225. *Id.*

226. *Id.*

227. *In re Guardianship of Schiavo*, No. 90-2908-GB-003, 2002 WL 31817960, at \*5 (Fla. Cir. Ct. Nov. 22, 2002).

In *Schiavo IV*, the second district explained that it entered final judgment in Theresa's case several years earlier, and thus, the court would limit its review to the order denying relief from judgment.<sup>229</sup> When the second district first heard the case in January 2001, the court affirmed the guardianship court's conclusions that:

(1) [Theresa's] medical condition was the type of end-stage condition that permits the withdrawal of life-prolonging procedures, (2) she did not have a reasonable medical probability of recovering capacity so that she could make her own decision to maintain or withdraw life-prolonging procedures, . . . and (4) [that] *clear and convincing evidence* at the time of trial supported [the trial court's] determination that [Theresa] would have chosen . . . to withdraw the life-prolonging procedures.<sup>230</sup>

When the second district heard the case again in 2003, it evaluated a substantial amount of medical testimony concerning Theresa's ability to regain cognitive ability and reached the same conclusion: that clear and convincing evidence established that Theresa would have wanted treatment terminated.<sup>231</sup> Following an abuse of discretion standard, the second district "closely examined" the evidence in the record.<sup>232</sup> The court reviewed the brain scans and the transcripts of the lower court's proceeding and concluded that even if it were to review the trial court's findings de novo, it would affirm.<sup>233</sup>

After affirming, the second district acknowledged its sympathy for Theresa's family, but reiterated that the "case [was] not about the aspirations that loving parents have for their children," but "about Theresa Schiavo's right to make her own decision, independent of her parents and independent of her husband."<sup>234</sup> The court noted that when families disagree, the law allows the court to act as a surrogate and make decisions about life-prolonging procedures.<sup>235</sup> In such an instance, the judge must make the decision that *clear and convincing evidence* demonstrates the choice the patient would have made.<sup>236</sup> The court also found damning that

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228. *Schiavo IV*, 851 So. 2d at 183.

229. *Id.* at 185–86.

230. *Schiavo III*, 800 So. 2d 640, 642 (Fla. Dist. Ct. App. 2001) (emphasis added) (footnotes omitted).

231. *Schiavo IV*, 851 So. 2d at 187.

232. *Id.* at 186.

233. *Id.*

234. *Id.*

235. *Id.* at 186–87 (citing *In re Guardianship of Browning*, 568 So. 2d 4, 16 (Fla. 1990)).

236. *Id.* at 187 (citing FLA. STAT. ANN. § 765.401(3) (West 2005)).

the best solution society has when families disagree is to provide a public forum for such a private and personal decision where a judge with no personal connection to the patient is the decision maker.<sup>237</sup>

In the subsequent legal proceedings and debates, the courts, Congress, and the country debated the policy of living wills, but little changed with regard to the actual law of living wills.

### *C. Living Will Statutes*

From reading the cases determining a patient's right to refuse life-sustaining treatment, one cannot help but notice the great strain such decisions place on families. Theresa Schiavo's case is only the latest example. All of the cases cited are examples of conflicts between people who love and care for their incapacitated family member and who want to do what is best for their loved ones. However, as the cases and my own story illustrate, the presence of a directive or some other indication of the incapacitated person's wishes would have prevented a great deal of needless suffering. Within this context, the living will has its greatest importance. Through the recognition of living wills, the law has provided a vehicle by which patients may clearly express their wishes not to be kept alive by artificial means.

The relevant case law began with the common law right to self-determination and gradually shifted to a statutory analysis as the states began to enact laws. Today, many states use the Uniform Rights of the Terminally Ill Act<sup>238</sup> (Uniform Act) as their model statute for drafting legislation governing living wills.<sup>239</sup> Nebraska has adopted a modified version of the Uniform Act, and its legislative discussions prior to the Act's adoption provide a good example of the concerns legislators had in enacting the Uniform Act.<sup>240</sup> Below is an examination of the Uniform Act followed by the Nebraska version of the Act and some of the discussion that occurred in the Nebraska Legislature before the Act's enactment.

The drafters of the Uniform Act listed four purposes of the Act.<sup>241</sup>

The purposes of the Act are (1) to establish a procedure which is simple, effective, and acceptable to persons who desire to execute a declaration, (2) to provide a statutory framework that is

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237. *Id.*

238. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9C U.L.A. 315-36 (2001).

239. Wikipedia, Uniform Rights of the Terminally Ill Act (Oct. 21, 2005), [http://en.wikipedia.org/wiki/Uniform\\_Rights\\_of\\_the\\_Terminally\\_Ill\\_Act](http://en.wikipedia.org/wiki/Uniform_Rights_of_the_Terminally_Ill_Act).

240. Horttor, *supra* note 6, at 238.

241. UNIF. RIGHTS OF THE TERMINALLY ILL ACT prefatory note, 9C U.L.A. 312 (2001).

acceptable to physicians and health-care facilities whose conduct will be affected, (3) to provide for the effectiveness of a declaration in states other than the state in which it is executed through uniformity of scope and procedure, and (4) to avoid the inconsistency in approach that has characterized early state statutes in the area.<sup>242</sup>

The drafters of the Uniform Act “designed [the Act] to provide various means by which an individual’s preferences can be carried out with regard to administration of life-sustaining treatment.”<sup>243</sup> The Act includes provisions that allow individuals to execute a declaration, such as a living will, instructing their physician and family to withhold or withdraw life-sustaining treatment should the individual become terminally ill and unable to participate in medical treatment decisions.<sup>244</sup> In the alternative, the Act permits the individual to execute a declaration designating another individual to make decisions regarding the withholding or withdrawal of life-sustaining treatment.<sup>245</sup> Finally, in the absence of a declaration, the Act authorizes an attending physician to withhold or withdraw life-sustaining treatment when there is consent by a close relative that does not conflict with the known intent of the individual.<sup>246</sup>

The drafters made the scope of the Act narrow.<sup>247</sup> The Act’s “impact is limited to treatment that is merely life-prolonging, and to patients whose terminal condition is incurable and irreversible, whose death will soon occur, and who are unable to participate in treatment decisions.”<sup>248</sup> The drafters did not intend to “affect any existing rights and responsibilities of persons to make medical treatment decisions”; the Act was to provide alternatives for fulfilling a terminally ill patient’s desires concerning the use of life-sustaining procedures.<sup>249</sup>

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242. *Id.*

243. *Id.* The National Conference of Commissioners on Uniform Laws published the original Uniform Act in 1985 and updated it in 1989. Horttor, *supra* note 6, at 236–38. The Act has many provisions dealing with the rights of the terminally ill. However, this article’s focus is specifically living wills, and only the provisions of the Uniform Act dealing with declarations of intentions will be discussed. The complete Act is available on many websites, including <http://www.law.upenn.edu/bl/ulc/fnact99/1980s/urtia89.pdf>. This article will concentrate mainly on the Nebraska version of the Rights of the Terminally Ill Act and the statutes enacted pertaining to living wills.

244. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9C U.L.A. 318–19 (2001).

245. *Id.* § 2, at 319.

246. *Id.* § 7, at 328.

247. UNIF. RIGHTS OF THE TERMINALLY ILL ACT prefatory note, 9C U.L.A. 312 (2001).

248. *Id.*

249. *Id.*

The Nebraska legislature generally followed the format of the Act.<sup>250</sup> The Nebraska Act recognizes a person's living will, but only gives effect to the document when the person becomes incompetent.<sup>251</sup> The Bill's Principal Introducer, Senator David Landis, recognized that many Nebraskans have signed living wills, but that the documents were not legally binding and the document's legal invalidity was causing some health care providers to ignore the wishes of their patients for fear of liability.<sup>252</sup> Senator Landis also pointed to the major difference between the Uniform Act and the Nebraska Act: the Nebraska Act allows artificial life support to be withdrawn or withheld in the case that a person enters into a "persistent vegetative state."<sup>253</sup>

During the Nebraska Committee on Judiciary's hearings, many senators raised issues concerning the passage of a living will statute. For example, Senator Bernice Labeledz asked Senator Landis about a living will's effect on a person suffering from both Alzheimer's and diabetes who was receiving artificial hydration and nutrition.<sup>254</sup> Senator Labeledz was concerned because a relative of hers lived for ten years with Alzheimer's and twenty years with diabetes.<sup>255</sup> Senator Landis pointed out that the Nebraska Act's provisions applied to conditions that, in a physician's medical judgment, "will result in death within a relatively short time."<sup>256</sup>

Senator Labeledz also inquired into the living will's affect on nutrition and hydration as a "medical procedure" that could be withheld or withdrawn.<sup>257</sup> In response, Senator Landis noted that the Nebraska Act would require the attending doctor to continue to provide "comfort, care or the alleviation of pain," and that the presence of a living will would not interrupt a doctor's duty to provide such care.<sup>258</sup> Senator Landis further noted that it would be up to the doctor to determine whether nutrition and hydration constitute "comfort, care, or the alleviation of pain."<sup>259</sup> Another state senator inquired into the possibility that a person might execute a valid

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250. See SENATOR DAVID LANDIS, INTRODUCER'S STATEMENT OF INTENT TO THE COMMITTEE ON JUDICIARY FOR LB 671, Leg. 92, 1st Sess. (Neb. 1991) (stating that "LB 671 follows generally the format of the Uniform Rights of the Terminally Ill Act").

251. *Id.*

252. *Id.*

253. *Id.*

254. *Rights of the Terminally Ill Act: Hearing on L.B. 671 Before the Leg. Comm. on Judiciary*, 92nd Leg., 1st Sess. 65-66 (Neb. 1991) (statement of Sen. Bernice Labeledz).

255. *Id.* at 65. Senator Labeledz commented that her sister was in a nursing home with both diabetes and Alzheimer's. *Id.*

256. *Id.* at 66 (statement of Sen. David Landis).

257. *Id.* (statement of Sen. Bernice Labeledz).

258. *Id.* (statement of Sen. David Landis).

259. *Id.* at 66-67.

living will requesting that artificial means of life support be withheld, then orally revoke the living will, and without executing any documentation lapse into a coma.<sup>260</sup> Senator Landis replied that the Nebraska Act would provide for such a situation noting that the oral revocation would supercede the living will making it ineffective.<sup>261</sup>

The Nebraska Act's provisions allow an adult to execute a living will and require either the declarant's signature or that of another person designated by the declarant.<sup>262</sup> The Act also requires the living will's execution to be witnessed by two people or a notary public.<sup>263</sup> The Nebraska Act forbids an employee of a declarant's insurance company from acting as a witness.<sup>264</sup> The Act provides that a declaration becomes operative when the physician determines that the declarant has a terminal condition, the declarant can no longer make life-sustaining treatment decisions, and the physician has notified a member of the declarant's immediate family or the declarant's guardian.<sup>265</sup> Once the living will has become operative, the attending physician must comply with its provisions or transfer the declarant to a physician willing to comply with the declarant's wishes.<sup>266</sup> In Nebraska, a declarant may revoke a living will "at any time and in any manner without regard to the declarant's mental or physical condition" when the revocation is communicated to the attending physician.<sup>267</sup> The presence of a living will does not alleviate a physician's responsibility to provide for the patient's comfort or the alleviation of pain, specifically including hydration and nutrition.<sup>268</sup>

#### D. A Summary of the Law

From before *In re Quinlan*, to *Cruzan* and beyond, the courts have been in agreement that people have a right to self-determination, including the right to refuse unwanted medical treatment.<sup>269</sup> From the case law, it

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260. *Id.* at 73–74 (statement of Sen. Jerry Chizek).

261. *Id.* at 74 (statement of Sen. David Landis).

262. NEB. REV. STAT. § 20-404(1) (1997).

263. *Id.*

264. *Id.*

265. *Id.* § 20-405.

266. *Id.* §§ 20-405, -409.

267. *Id.* § 20-406(1).

268. *Id.* § 20-408(2). In addition, the Nebraska Act forbids a doctor from withdrawing or withholding treatment from a pregnant patient so long as there is a probability that the fetus will continue to develop and the patient will have a live birth. § 20-408(3). This ties in with the judiciary's concern that innocent third parties might be hurt if a terminally ill person were allowed to die.

269. *See* *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251, 257 (1891) (holding that plaintiff in a personal injury action may not be forcibly subjected to a medical examination); *Cruzan v. Dir., Mo.*



also appears that the courts were wary of the implications of their decisions and chose to tread cautiously. From *Quinlan* to *Cruzan*, the courts took steps to ensure that incompetent person's rights were protected and carefully balanced against the states' interests. After *Cruzan*, state legislatures recognized the need to enact laws clarifying a person's right to refuse treatment. *Cruzan* made it clear that a state could enact procedural safeguards to ensure that an incompetent's wishes were properly carried out.<sup>270</sup> After *Cruzan*, the courts appeared uniform in their desire to seek clear evidence of a patient's wishes before allowing the termination of medical treatment. Since the Supreme Court in *Cruzan* held that a state could set the requirements for a person wishing to terminate life-sustaining treatment, every state has enacted law setting forth requirements for patients or surrogates who wish to terminate such treatment.<sup>271</sup> Thus, the great majority of the cases litigated today concern people who have not executed some form of healthcare directive. Of those cases that are litigated, the issue is often whether a surrogate may terminate the life-sustaining treatment provided to the ward and what must be shown to prove that the ward would have wanted the treatment withdrawn.<sup>272</sup>

Only in *Edna M.F.* did a court find that a preponderance of the evidence was required for the court to terminate life-sustaining procedures.<sup>273</sup> Most, if not all, of the other cases required the guardian to show clear and convincing evidence of the patient's wishes.<sup>274</sup> However, even in *Edna M.F.* the Wisconsin Supreme Court looked for the guardian to demonstrate "by a preponderance of the evidence a clear statement of [the

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Dep't of Health, 497 U.S. 261, 278 (1990) (noting that the court's prior decisions had inferred "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment"); *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) (providing that a patient's decision to allow a "non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy"); *Edna M.F.*, 563 N.W. 2d 485, 489 (Wis. 1997) (noting that one of its prior opinions had concluded that a person "'in a persistent vegetative state has a constitutionally protected right to refuse unwanted medical treatment'" (quoting *In re Guardianship of L.W.*, 482 N.W.2d 60, 63 (Wis. 1992))).

270. *Cruzan*, 497 U.S. at 280.

271. *Id.* at 284; see 63 AM. JUR. *Trials* § 3 (1997) ("All states now have some legislation addressing end-of-life decisionmaking and advance[] directives.").

272. See, e.g., *Edna M.F.*, 563 N.W.2d at 486 (asking "[w]hether the guardian of an incompetent person who has not executed an advance directive and is not in a persistent vegetative state has the authority to direct withdrawal of life sustaining medical treatment from the incompetent person" and whether "there is a clear statement evidenced in the record of [the ward's] desire to die rather than have extreme measures applied to sustain her life under circumstances such as these"); *Conservatorship of Wendland*, 28 P.3d 151, 154 (Cal. 2001) (holding that there must be clear and convincing evidence of the conservatee's wishes in order for a conservator to terminate artificial nutrition and hydration).

273. *Edna M.F.*, 563 N.W.2d at 490.

274. See *supra* notes 119, 128, 130, 171, 181, 208 and accompanying text.

ward's] *desires in these circumstances.*"<sup>275</sup> Thus, the court did not accept the patient's statements, made while competent, that she would not want to be kept alive.<sup>276</sup> The court stated several times that it looked for a clear statement of the patient's desires.<sup>277</sup> Therefore, the conclusion could be that while Wisconsin only requires a guardian to prove a patient's wishes by a preponderance of the evidence, the clarity in the patient's statements required by the court suggests that Wisconsin's standard is similar to the other states that require clear and convincing evidence.

Whatever the burden required by the court, there is still a question as to the evidence a guardian must produce to prove the patient's wishes. Of all the cases surveyed, only a New York court in *Delio v. Westchester County Medical Center* and a Florida court in *In re Guardianship of Schiavo* took the spoken word of the patient as enough evidence of the patient's wishes not to be kept alive by artificial means.<sup>278</sup> In *Delio*, Daniel Delio's comments were made in connection with a discussion he had with his wife concerning Karen Ann Quinlan and the circumstances of her case.<sup>279</sup> In addition, Daniel had a Ph.D. in exercise physiology, so he clearly understood the difference between higher and lower brain functions, and he clearly articulated his position that the cessation of high-order brain function was tantamount to death.<sup>280</sup> In each of the cases, other than *Schiavo*, testimony of a patient's oral statements was not considered to be sufficient evidence of a patient's wishes not to be kept alive. If not for *Schiavo*, the conclusion could be drawn that laypeople, without a Ph.D. could not meet the burden of proving their wishes without having signed a living will. However, that would not account for the Florida court's decision in *Schiavo*.

In *Schiavo I*, the Florida District Court of Appeal determined that Theresa's few oral statements along with "other evidence" were enough to find that Theresa would have refused life-sustaining treatment.<sup>281</sup> However, the court did not articulate what this "other evidence" was.<sup>282</sup> The court mentioned that while Theresa was Catholic, she had not attended

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275. *Edna M.F.*, 563 N.W.2d at 490 (emphasis added).

276. *See id.* at 491 (determining that statements made approximately 30 years ago during a time of family crisis, that the ward "would rather die of cancer than lose [her] mind" were not dispositive of the ward's desires (alteration in original)).

277. *Id.* at 491.

278. *Schiavo I*, 780 So. 2d 176, 180 (Fla. Dist. Ct. App. 2001), *Delio v Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 681-82, 693 (App. Div. 1987).

279. *Delio*, 516 N.Y.S.2d at 681-82.

280. *Id.*

281. *Schiavo I*, 780 So. 2d at 180.

282. *Id.*

church or sought guidance from a religious counselor, that she was young and healthy when the tragedy struck, and she had no will or living will.<sup>283</sup> These facts do not appear to add much weight to the court's acceptance of a few oral statements as clear and convincing proof of Theresa's wishes. Therefore, without the "other evidence" the court considered, it is difficult to draw a general conclusion as to the evidence required for a person wishing to show by clear and convincing evidence that a patient wished to refuse life-sustaining treatment. However, erring on the side of safety and based on the other cases, including my own, one could conclude that having a living will is the surest way to avoid the pain and family strife associated with end-of-life decisions.

#### IV. THE MORALITY OF LIVING WILLS

The law appears clear with regard to living wills. When a living will is present, a patient's directives must be carried out; without a living will, assuming the patient is incompetent, a surrogate decision maker must present clear evidence of what the patient's wishes would have been.<sup>284</sup> However, is it right to terminate life? Or, as the courts phrase it, is it right to let death occur while we passively watch? Is the law morally correct? Any discussion of living wills or health care directives must consider these questions. After all, the decision to honor such a document as a living will means that someone will die before all that can be done to keep that person alive has been done. Remarkably few discussions of living wills have addressed the fact that someone will die.

Any discussion concerning the morality of living wills must seek to define death. The medical profession had a difficult time grappling with the precise definition of death throughout the 1980s and, to some extent, still does.<sup>285</sup> When talking about terminating life-sustaining treatment and the requirements of terminal illness, terminal becomes difficult to define too because death need not be imminent depending on the definition of it. Only after considering death and terminal illness, can we look at a living will's role in the process and ask whether the process is right.

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283. *Id.* at 179–80.

284. For the various tests the states use, see for example *In re Tavel*, 661 A.2d 1061, 1068–69 (Del. 1995); *In re Guardianship of Hamlin*, 689 P.2d 1372, 1375, 1378 (Wash. 1984).

285. See Phipps, *supra* note 34, at 34–36 (discussing the evolving definitions of death).

### A. Defining Death

One of the main issues in the right to die debate is the question: what is death?<sup>286</sup> Since the dawn of human thought, humankind has asked this question, and for the majority of that time it has agreed upon the answer.<sup>287</sup> In ancient Egypt, when morticians prepared a body, they focused on preserving the heart while discarding the brain.<sup>288</sup> Throughout history, some religions and philosophies have pointed to the heart as life's epicenter producing one's personality, emotions, and intellect.<sup>289</sup> However, modern medicine has changed the focus.

Up to the first half of the twentieth century, death was simple.<sup>290</sup> Most people became ill and died, usually at home with their families, and in a relatively short period after the onset of illness.<sup>291</sup> However, today many people do not die immediately when an illness strikes.<sup>292</sup> Thanks to modern medical technology, a person may survive for years in a persistent vegetative state or coma while attached to life-support machines.<sup>293</sup> Now that bodily organs could potentially last forever, the definition of death has shifted focus to brain activity.<sup>294</sup>

Thus, the question now is: what is brain death? In 1968, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death adopted the term "irreversible coma," which is similar to brain death, and set forth criteria for determining when a person has entered that

286. See PLATO, PHAEDO (n.p., n.d), *reprinted in* THE COLLECTED DIALOGUES OF PLATO 47 (Edith Hamilton & Huntington Cairns eds., Lane Cooper et al. trans., 1961) (discussing the philosophical debate about when death occurs).

287. See Bryan A. Kelley, *The Right to Die: Definitional Inquiry and the Search for Truth*, 2 PEPP. DISP. RESOL. L.J. 285, 293 (2002) (noting mankind's ancient struggle to understand the dying process).

288. Phipps, *supra* note 34, at 34.

289. *Id.*

290. See Vicki Joiner Bowers, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, 682-83 (1996) (discussing how advances in medical technology have complicated the natural cause of death).

291. *Id.* at 682.

292. *Id.* (explaining that fifty percent of Americans died of a disease that was diagnosed at least two years in advance).

293. See *Compassion in Dying v. Washington*, 79 F.3d 790, 811-12 (9th Cir. 1996) (noting that many diseases which previously killed in the United States are now unknown in this country and many other diseases which are now treatable often resulted in a painful death and/or a lengthy period of coma); see also Adam A. Milani, *Better Off Dead than Disabled?: Should Courts Recognize a "Wrongful Living" Cause of Action When Doctors Fail to Honor Patients' Advance Directives?*, 54 WASH. & LEE L. REV. 149, 155 (1997) ("It is now possible for patients to continue living for years even when much of their physical and mental capacity has been irrevocably lost.").

294. Kelley, *supra* note 287, at 295.

state.<sup>295</sup> These criteria included “absence of response to pain or other stimuli, pupillary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as ‘flat’ or isoelectric electroencephalograms and the like, with all tests repeated ‘at least 24 hours later with no change.’”<sup>296</sup> Despite the Committee’s best efforts, the debate did not end because later research showed that the brain had two parts—the cognitive and the vegetative.<sup>297</sup> Thus, upper brain death could occur erasing a person’s cognitive abilities including thinking, awareness, rationality, and perhaps feeling pain, while leaving only the brain stem functioning allowing only simpler functions like laughing, yawning, grimacing, moving eyes, and swallowing.<sup>298</sup> In 1981, the President’s Commission for the Study of Ethical Problems, Medicine and Biomedical and Behavioral Research determined that “whole brain” death, defined as death of the cerebral cortex and the brain stem (i.e. termination of vegetative and cognitive functions), would be the better standard to avoid terminating a seemingly alive person.<sup>299</sup> Nevertheless, that did not end the debate over when death occurs.

### *B. Which Death is “Death”?*

Depending on one’s values, death can mean many things. Modern medicine has identified two types of brain death that one could suffer from, and the President’s Commission recommended that both are required for “death.”<sup>300</sup> However, one commentator has argued:

The reasons for adopting the “whole brain death” standard are not based on a belief that a person with a functioning brain stem, but no function in the cerebral cortex, has a “life” that is worth preserving. Once the cerebral cortex dies, along with it die all psychological attributes of personhood—emotion, awareness of environment, and the ability to entertain thought or experience pain. The brain stem regulates respiration, circulation, and certain involuntary reflexes. Thus persons who experience upper brain—but not whole brain—death (i.e., PVS patients) may laugh, cry, grimace, yawn, swallow, and open their eyes. Their

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295. Ad Hoc Comm., *supra* note 63, at 337–38.

296. *In re Quinlan*, 355 A.2d 647, 656 (N.J. 1976) (quoting Ad Hoc Comm., *supra* note 63, at 337–38).

297. *Id.* at 654–55 (discussing expert testimony concerning how the brain works in two ways).

298. Douglas O. Linder, *The Other Right-to-Life Debate: When Does Fourteenth Amendment “Life” End?*, 37 ARIZ. L. REV. 1183, 1193 (1995).

299. STUDY OF ETHICAL PROBLEMS, *supra* note 29, at 9 & n.7.

300. *Id.*

eyeballs cannot track or focus, however, and no visual input is sent to the brain.<sup>301</sup>

This statement has physiological truth but may not be accurate. Once the cerebral cortex fails, is there a life worth preserving? The commentator noted that even though the eyeballs may be moving, no signals go to the brain.<sup>302</sup> What else is there if one can no longer move, interact with one's environment, or entertain rational thought? Even if your eyes can move, what is their purpose if you cannot see?

Before attempting to answer these questions, one must consider Plato's *Phaedo*, where Socrates described death:

[Socrates:] Do we believe that there is such a thing as death?

[Simmias:] Most certainly . . . .

[Socrates:] Is it simply the release of the soul from the body? Is death nothing more or less than this, the separate condition of the body by itself when it is released from the soul, and the separate condition by itself of the soul when released from the body? Is death anything else than this?

[Simmias:] No, just that.<sup>303</sup>

Plato thought death ended when the soul left the body, and that the soul left in the last breath.<sup>304</sup> Death was simple—the separation of the soul from the flesh.<sup>305</sup> The separation is significant because of the definition of soul. The soul is “[t]he spiritual, rational, and immortal part in man.”<sup>306</sup> It has also been defined as, “an animating, separable, surviving entity, the vehicle of individual personal existence.”<sup>307</sup>

Today, it seems that the concept of the soul has been skewed, perhaps lost, but the concept of consciousness has not. The ability to think and interact with your surroundings, to be conscious, and to be a part of society seem to be the best part of being alive. Hence, when religion and philosophy ask why we are here, or what is the purpose of life, neither answers that life's purpose is to “lay there like a vegetable.” “Lay there like a vegetable” has become a euphemism for “don't be lazy,” but it is exactly

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301. Linder, *supra* note 298, at 1193 (footnotes omitted).

302. *Id.*

303. PLATO, *supra* note 286, at 47.

304. *Id.*

305. *Id.*

306. BRAINY DICTIONARY (2005), <http://digbig.com/4fman>.

307. WEBSTER'S REVISED UNABRIDGED DICTIONARY OF THE ENGLISH LANGUAGE 1374 (Noah Porter ed., 1913), *available at* <http://digbig.com/4fmap>.

what one does in a vegetative state, and, like the euphemism suggests, this is no way to live.<sup>308</sup>

Another philosopher, Karen Gervais, defined death as “the permanent cessation of consciousness.”<sup>309</sup> Some philosophers, including Gervais, “hold that the *sine qua non* of human life is consciousness.”<sup>310</sup> In other words, without consciousness there can be no life. Thus, the answer to what is worth preserving when consciousness fails (i.e. when the cerebral cortex fails) is “nothing.” Brain stem functions have not changed since man’s brain developed millennia ago.<sup>311</sup> The essence of humanity is conscious interaction with one’s environment and being a part of the community.<sup>312</sup> William Phipps stated it best:

The hallmark of life is the capacity for consciousness. When it is erased, there are only mortal remains to be disposed of. Biological life ceases with the loss of respiration and blood pressure, but personal existence concludes with the end of psychological awareness. Psychic as well as physical capabilities are needed for personhood.<sup>313</sup>

Thus, if the psychic and physical capabilities are needed for personhood, then by the time a person is declared “terminally ill,” that person may already be dead.

### C. Terminal Illness

In the broadest mission of the medical establishment, it seems that all medical advances seek to sustain life or prolong the onset of death. Thus, the question becomes: at what point is the attempt futile? When is death so imminent that we must let go and let death occur? Advances in medical technology have made this issue more difficult. Moreover, the issue of death’s imminence will continue to be difficult because advancements in medical technology and the near-exponential rate of those advancements are making death even less imminent.<sup>314</sup>

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308. See *In re Martin*, 538 N.W.2d 399, 412, 413 (Mich. 1995) (noting that the incapacitated but conscious patient could not be removed from his life-sustaining treatment even though he told co-workers and his spouse/legal guardian that if incapacitated he did not want to “live ‘like a vegetable’”).

309. KAREN GRANDSTRAND GERVAIS, REDEFINING DEATH 17 (1986).

310. Phipps, *supra* note 34, at 36.

311. *Id.* (“Brain stem functions have been virtually unchanged over hundreds of millions of years of humans’ evolutionary history.”).

312. *Id.*

313. *Id.*

314. See *Schiavo I*, 780 So. 2d 176, 180 (Fla. Dist. Ct. App. 2001) (“[W]hether Theresa Marie

The Uniform Act requires that a physician certify a patient as “terminally ill” for a declaration to become operative.<sup>315</sup> However, if people can be kept alive for years on artificial machines, is their condition terminal? A “[t]erminal condition’ means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.”<sup>316</sup> The Act defines “terminal condition” as “an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.”<sup>317</sup> The definition of terminal illness requires that a doctor diagnose a patient’s death as imminent. However, the imminence of death depends on the care given to the patient. Thus, the debate could become circular. So long as care is not given, the patient remains terminally ill, the living will controls, and the patient is allowed to die. However, if care is given, death is no longer imminent, the living will no longer controls, and the doctor may do what he believes is medically necessary for the patient.

The courts have determined that the type of care given, whether ordinary or extraordinary, and the quality of the patient’s life are not determinative factors as to whether a patient’s condition is terminal such that life-sustaining treatment may be withdrawn or withheld.<sup>318</sup> Thus, the

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Schindler Schiavo, not after a few weeks in a coma, but after ten years in a persistent vegetative state that has robbed her of most of her cerebrum and all but the most instinctive of neurological functions, with no hope of a medical cure but with sufficient money and strength of body to live indefinitely, would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives.”).

315. See UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 3, 9C U.L.A. 323 (2001) (stating that a living will becomes operative when “the declarant is determined by the attending physician to be in a terminal condition . . .”); see also FLA. STAT. ANN. § 765.304(2) (West 2005) (requiring a determination prior to execution of a living will that a principal has either “a terminal condition, has an end-stage condition, or is in a persistent vegetative state”); NEB. REV. STAT. § 20-405 (1997) (“A declaration shall become operative when . . . the declarant is determined by the attending physician to be in a terminal condition or in a persistent vegetative state . . .”).

316. WIS. STAT. ANN. § 154.01(8) (West 1997)).

317. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1(9), 9C U.L.A. 316 (2001).

318. See *Cruzan v. Dir., Mo. Dep’t. of Health*, 497 U.S. 261, 282 (1990) (declaring that “a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy”); *In re Conroy*, 486 A.2d 1209, 1234–35 (N.J. 1985) (discussing the semantic difficulties in defining “extraordinary” and “ordinary” care and how the distinction between the types of care is irrelevant). But see *Cruzan*, 497 U.S. at 337 (Stevens, J., dissenting) (“It is appropriate to consider the quality of life in making decisions about the extraordinary medical treatment.” (quoting *Cruzan v. Harmon*, 760 S.W.2d 408, 429 (1988) (Blackmar, J., dissenting))); *Barber v. Superior Court*, 195 Cal. Rptr. 484, 491 (Ct. App. 1983) (noting a change in this approach and suggesting that evaluating the proportionality of the care would be a better method); SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, DECLARATION ON EUTHANASIA 4 (1980) (pronouncing that the means of treatment, whether



only remaining test in deciding when to terminate treatment is whether “the application of life-sustaining procedures serve[s] only to postpone the moment of death.”<sup>319</sup> Unfortunately, however, this definition leaves much to ponder because now instead of addressing the imminence of death, the debate turns back to the definition of death.

#### D. The Role of a Living Will

Living wills have an important function in the debate about death and the use of extraordinary treatments to sustain life because they can express the incapacitated patient’s wishes.<sup>320</sup> Recall in *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, the Florida Supreme Court held that a comatose and terminally ill person who had executed a living will did not need a court-appointed guardian and approval from the court to terminate life-sustaining treatment; rather, the family could exercise the patient’s right on his behalf.<sup>321</sup> Thus, a properly executed living will would in all likelihood end the debate regarding the declarant’s wishes because behind all of the debate over the right to die is the right to privacy and the right to self-determination.<sup>322</sup>

Moreover, the importance of a living will, especially a detailed one, is great. Until doctors, theologians, and judges sort out the definitions of death and terminal-illness care and provide a definitive answer, a person’s protection from the possibility of being left a lifeless corpse in a nursing home or hospital depends on the legal viability of the living will. Recall that in *Delio v. Westchester Medical Center*, Daniel Delio had a Ph.D. in exercise physiology and clearly understood his choice to refuse life-sustaining treatment and articulated this choice to his wife; however, he had not executed a living will.<sup>323</sup> Daniel had a Ph.D. and a clear understanding of the implications of his choice, and his wife still had to go to court to get his artificial hydration and nutrition terminated.<sup>324</sup>

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ordinary or extraordinary, are determinative factors along with the consideration of the results expected from the means of treatment).

319. UTAH CODE ANN. § 75-2-1103(7) (1993).

320. Anita Cava, *Advance Directives: Taking Control of End-of-Life Decisions*, 14 ST. THOMAS L. REV. 5, 5 (2001).

321. *John F. Kennedy Mem’l Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 926 (1984).

322. See *supra* notes 83–84 and accompanying text.

323. *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 681–82 (App. Div. 1987).

324. *Id.* at 680–82.

Thus, the question arises: what happens when lesser-educated people need the protections of a living will but have not clearly expressed their wishes?<sup>325</sup> In *Edna M.F.* and *Conservatorship of Wendland*, the courts of Wisconsin and California decided cases in which an incompetent person had not provided a living will, but the surrogate felt it was in the ward's best interest to terminate life-sustaining treatment.<sup>326</sup> In each of these cases, the surrogate had to go to court and prove what the wishes of the family member would have been.<sup>327</sup> Both Wisconsin and California had enacted living will statutes.<sup>328</sup> Thus, had either of these individuals declared their intentions through a living will, their families would have been spared going to court to fight for their right to self-determination. Similarly, in *Schiavo*, had Theresa had a living will, her family would not have been ripped apart by the agonizing decision of whether to terminate her treatment and let her die a natural death or to allow doctors to experiment on her in attempts to stimulate her brain tissue.<sup>329</sup>

#### 1. Why Are We Deciding if We Should Terminate Life-Sustaining Treatment When We Have the Ability to Sustain Life?

It is possible to concede that when people are competent and have clearly articulated their desires not to be kept alive by artificial means, they should be allowed to die as per their directives. However, as the case law has indicated, the state has an interest in the prevention of suicide,<sup>330</sup> but the courts are not entirely clear what the difference is between the desire to die naturally and committing suicide. It is true, as the cases have pointed out, that withholding or withdrawing life-sustaining treatment is not actively killing oneself but a passive acquiescence to death.<sup>331</sup>

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325. See generally *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 268 (1990) (noting that Nancy Cruzan had stated her wish not to be kept alive by artificial means, *but* did not do so in such a manner that the Missouri Supreme Court would have to honor her wishes).

326. *Edna M.F.*, 563 N.W.2d 485, 487 (Wis. 1997) (citing the guardian's wish to terminate life-sustaining treatment in accordance with the ward's desire); *Conservatorship of Wendland*, 28 P.3d 151, 155 (Cal. 2001) (citing Robert's family's discussion about what his wishes would have been in this situation).

327. *Edna M.F.*, 563 N.W.2d at 487; *Conservatorship of Wendland*, 28 P.3d at 155.

328. CAL. PROB. CODE §§ 4670–4678 (1999) (original version at 1976 Cal. Stat. 6478); WIS. STAT. ANN. §§ 154.01–.15 (West 1997).

329. See *Schiavo I*, 780 So. 2d 176, 177–78 (Fla. Dist. Ct. App. 2001) (noting that both Theresa's husband and her family loved her very much and only had her best interests at heart); *Schiavo IV*, 851 So. 2d 182, 185 (Fla. Dist. Ct. App. 2003) (recounting testimony of medical experts that experimental treatment might restore some of her brain functions).

330. *E.g.*, *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (noting that New Jersey has a "general interest in preserving life [and] . . . a particular legislative policy of preventing suicide").

331. See *id.* ("[D]eclining life-sustaining medical treatment may not properly be viewed as an

The cases stop at the differentiation between active and passive death without asking more. If the state really has an interest in the prevention of suicide, then should the state not require more of a person than a desire not to live? Fortunately, for those who cherish life above all else, the Uniform Act, and the States that have enacted a version of it, require as a prerequisite for the patient's living will to operate that a physician first certify the patient's condition as terminal.<sup>332</sup> However, these provisions do not take into account the possibility that a cure might be found sometime in the future. Medical research reveals continuing innovations in life-sustaining and life-saving treatments every day.<sup>333</sup> Is it not reasonable to assume that, given time, a cure could be found for the persistent vegetative state, for reviving the comatose, or for brain diseases like Alzheimer's?<sup>334</sup> Even now, some experts, such as the ones called on to testify in Theresa Schiavo's case, believe that they can restore cognitive functions in vegetative patients.<sup>335</sup>

When a patient's condition is terminal, despite life-sustaining treatment, those who wish to terminate the treatment argue that this person will die anyway, so it is better to allow the person to die with dignity, esteem, and respect. Is it not more respectful to patients and of a higher esteem to allow them to fight for their life until there are no more chances? A young person in a coma or a persistent vegetative state could survive years, perhaps a decade like Karen Quinlan or for fifteen years as Terri Schiavo did, with life-sustaining treatment. Are we giving up hope that a

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attempt to commit suicide.”). If suicide is defined as the intentional killing of oneself, see Dictionary.com, <http://dictionary.reference.com/search?q=suicide> (2005), the opposite of suicide would be intentionally living or attempting to live and doing all that one can to sustain life. I am not advocating for a state-sponsored exercise program or for mandated physical and health requirements, but I am asking why a court would find a state interest in preventing suicide and in the preservation of life, then not assert that right when the patient's desires are unknown.

332. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 3, 9C U.L.A. 323 (2001); NEB. REV. STAT. § 20-405 (1997). Actually, the Nebraska Act is more lenient than the Uniform Act because the Nebraska Act allows for the operation of the living will when the patient is in a persistent vegetative state, but not necessarily terminally ill. *Id.* § 20-405.

333. See NAT'L RESEARCH COUNCIL, NAT'L ACADS., MEDICAL INNOVATION IN THE CHANGING HEALTHCARE MARKETPLACE: CONFERENCE SUMMARY app. at 68–69 (Philip Aspden ed., 2002), available at <http://www.nap.edu/books/0309084164/html/> (describing the broad range of developments since World War II and their impact).

334. See David L. Goldin, *Brain Injury News Summaries*, <http://www.headlaw.com/recent-brain-injury-news.htm> (2005) (summarizing scientific research attempting to cure brain injuries including regaining use of paralyzed limbs as the result of a stroke); see also *Conservatorship of Wendland*, 28 P.3d 151, 154–55 (Cal. 2001) (stating that Robert Wendland could at one point throw and catch a ball, operate an electric wheelchair with assistance, and communicate by blinking); *Schiavo IV*, 851 So. 2d 182, 185 (Fla. Dist. Ct. App. 2003) (discussing testimony of medical experts who stated that experimental procedures could restore some of Schiavo's cognitive functions).

335. *Schiavo IV*, 851 So. 2d at 185.

cure could be found if we let such a person die? Is not a young person's life worth enough to hold out for the chance at saving that person? What happens when the person in the coma or persistent vegetative state is old? How is letting that person die dignifying? If we value the preservation of human life, and abhor suicide, why not sustain life for as long as possible? When people are in a persistent vegetative state, why do we make a judgment that their cognitive functions are worth more than their vegetative functions, so when the cognitive functions cease it is acceptable to let people die?

Perhaps there is a simple answer to these questions: money. Perhaps what is at work here is the same cost-benefit analysis, risks-versus-rewards breakdown which occurs everyday in our society and governs all that we do.<sup>336</sup> Simple economics requires that we balance the value of life versus the cost of that life. How much does it cost to keep a person on life-sustaining treatment for a year? How much for Karen Ann's decade or Terri's decade and a half?<sup>337</sup> Medical professionals and medical corporations have attempted to answer this question. Indeed, today the debate about health care largely focuses on medical costs rather than benefits.<sup>338</sup>

Recall the case of the "\$6,000,000 woman" who lay unconscious after suffering a concussion in 1956 when she was twenty-seven years old.<sup>339</sup> She survived for eighteen years with hospital-administered artificial hydration, nutrition and antibiotics through catheters, in addition to attendants who provided extensive skin care.<sup>340</sup> Neurologists at the time agreed that her chances of recovering cognitive functions were non-existent.<sup>341</sup> Considering inflation alone, without including the rising cost of health care, the "\$6,000,000 woman" would be the "\$22,000,000 woman" in 2003 dollars.<sup>342</sup>

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336. See NAT'L RESEARCH COUNCIL, *supra* note 333, at 17 (citing a study using data "on what workers are paid in occupations with differing risks of job-related death," the estimated value of an additional life-year was determined to be about \$150,000, "a figure that varies with age"). Using these age-dependent values of an additional life-year they estimated that increased life expectancy over the period 1970-1990 is valued at "roughly \$57 trillion or about \$2.8 trillion per year." *Id.*

337. See, e.g., Diana Lynne, *Life and Death Tug of War: The Whole Terri Schiavo Story*, WORLDNETDAILY, Mar. 24, 2005, [http://worldnetdaily.com/news/article.asp?ARTICLE\\_ID=43463](http://worldnetdaily.com/news/article.asp?ARTICLE_ID=43463) (providing that originally Michael Schiavo had asked for \$20 million to pay for 50 years of care for his wife who suffered in a persistent vegetative state).

338. See NAT'L RESEARCH COUNCIL, *supra* note 333, at 15 ("There appears to be much greater emphasis in the public debate on the costs than the benefits of health care.").

339. Phipps, *supra* note 34, at 35.

340. *Id.*

341. *Id.*

342. The \$22,000,000 figure comes from adjusting the \$6,000,000 in 1974 dollars to 2003 dollars using 3% as the rate of inflation.

Once that kind of money is involved, there are serious economic considerations that weigh into the decision to terminate life. How many Americans can afford a \$22,000,000 hospital bill because they want to keep a comatose and terminally ill family member alive? When a person cannot afford health care for minor medical issues, the government pays the bill through Medicare or Medicaid.<sup>343</sup> Should society really be expected to pay \$22,000,000 for someone to lie in a bed with a statistically nil chance of recovery? Everyday, economic decisions are made to allocate resources to one cause or another, and, in the final analysis, treating the terminally ill is just another allocation decision.<sup>344</sup>

Of course, there are other, more sinister, arguments for why we choose to terminate life-sustaining treatment. The cost-benefit argument is at least based on economic principles. What about the base motives of the terminally ill patient's family? In the *Schiavo* case, Michael Schiavo, as Theresa's guardian, had filed a medical malpractice lawsuit against the doctors who treated her after her coma, seeking \$20 million for 50 years of care.<sup>345</sup> That case resulted in a \$1.3 million award, \$700,000 of which was placed into a trust earmarked for Theresa's medical care; and neither Michael nor Theresa's family could have the money while Theresa lived.<sup>346</sup> Under Florida law, her husband would inherit the money under the laws of intestacy; however, had Michael divorced Theresa the fund remaining at the end of Theresa's life would presumably have gone to her parents.<sup>347</sup> In the malpractice case, Michael testified of his love and devotion to Theresa as he spoke of their wedding vows.<sup>348</sup> Yet, eight months later, he asked the hospice that was caring for Theresa to terminate her medication for an

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343. Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and that varies from state to state. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., GLOSSARY, <http://digbig.com/4fmnw>. Medicare is a federal program for persons sixty-five and older and certain younger people with disabilities or End-Stage Renal Disease. *Id.*

344. A speaker at the Medical Innovation in the Changing Healthcare Marketplace Conference attempted to estimate "the social benefits of medical research by placing a value on aggregate improvements in longevity." NAT'L RESEARCH COUNCIL, *supra* note 333, at 17. The speaker first estimated the average amount Americans would pay to add an extra year to their lives. *Id.* Using data on what workers were paid in occupations with varying risks of job-related death, the speaker estimated the value of an additional life-year to be about \$150,000 depending on the worker's age. *Id.* Using the age-dependent values of an additional life-year he estimated that increased life expectancy over the period 1970–1990 was valued at roughly \$57 trillion, or about \$2.8 trillion per year. *Id.* Thus, the speaker concluded, "improvements in life expectancy over the period 1970–1990 contributed about as much to overall welfare as did improvements in material wealth." *Id.* at 18.

345. Lynne, *supra* note 337.

346. *Id.*

347. *Schiavo I*, 780 So. 2d 176, 178 (Fla. Dist. Ct. App. 2001).

348. Lynne, *supra* note 337.

infection, and after they refused, Michael put a “Do Not Resuscitate” order in her charts.<sup>349</sup> His brother defended him saying that he believed that Michael had lost hope,<sup>350</sup> and there is no reason to doubt either Michael or his brother. Even the second district noted the sincerity of both Michael and Theresa’s parents.<sup>351</sup> However, when such large sums are at stake, anyone could question the motives of another.

#### V. MY FATHER’S DECISION AND HIS LIVING WILL

Trying to define death and examining medical, theological, or philosophical texts are useful exercises for attempting to answer some of life’s questions but there is also a practical side to the debate. What effect does the law have on people? What happens when the rubber meets the road? To answer these questions I will return to my family’s story.

Several years after Gidi died, while I was in high school, my dad showed me a document. He had me read it very carefully several times, and then he explained to me what it was and what my responsibility would be in the event that he ended up like Gidi: lifeless in a bed and dependant on machines for life. The document my dad showed me was his living will stating his intention not to be placed on life support or to be kept alive by any artificial or heroic means. My father mentioned how Gidi had asked not to be kept alive if he were suffering and dying, but explained how he was unable to pull the plug because his dad was so tough and such a fighter that he knew Gidi would survive if there were any chance at all. Later, when my father and I spoke on the subject again, my father recalled that he really had had no direction on how to handle Gidi’s incapacitation, so he had fallen back on Gidi’s “would not quit” attitude.<sup>352</sup> My father also recalled that Gidi could breathe on his own and did not require a heart monitor. Gidi’s only medical assistance was artificial feeding and hydration, and my father would not let his father starve to death. My dad also explained to me that he did not want my siblings and I, or my mother, to have to make the decision to terminate his life.

My father’s living will clearly states that he does not want to be kept alive by artificial means, and specifically lists the conditions in which he does not wish to live.<sup>353</sup> His living will lists five non-disease-specific

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349. *Id.*

350. *Id.*

351. *Schiavo I*, 780 So. 2d at 177 (“Theresa has been blessed with loving parents and a loving husband.”).

352. Sam J. Saad, Jr., interviews, *supra* note 2.

353. *See infra* app. A.

scenarios under which he would not want to be kept alive: a persistent vegetative state, a coma, a terminal-incapacitating-brain disease, a non-terminal-incapacitating-brain disease, or any other illness from which there is no reasonable expectation of recovery from incapacitating-physical or -mental disability.<sup>354</sup> My father does not want artificial or heroic means used to keep him alive.<sup>355</sup> Moreover, because he does not fear death and does not want to suffer painfully, he asks that he be relieved of pain even if it would hasten his death.<sup>356</sup>

My father wants to enjoy “a reasonably high quality of life” and if illness should strike him, my father’s standard for keeping him alive through artificial means is a “reasonable chance of a reasonably high recovery.”<sup>357</sup> My father’s intent in his will was to remove all decision making from his children and his wife.<sup>358</sup> Specifically, my father does not want his children to have to ask: “should I kill my dad?” He does not want there to be an issue—he wants it “cut and dry so my kids do not have to decide because the only thing I care about is being around them.”<sup>359</sup>

My father's rationale for making such a concrete and tightly worded living will is that he does not want his children to have to go through the same anguish he went through. Gidi left no instructions for my father on how to handle the situation should it arise. My father was forced to fall back on what he thought Gidi might do and to rely on the knowledge that his father was not a quitter. With his living will, my father has, in effect, removed the burden of the decision to terminate his life from his children.

However, does his living will make the process easier? My father believes that now that I am removed from the process, I will not have to ask: “should I kill my father?” Therefore, my father thinks that the process is easier. My first inclination is to disagree with him. I will still be a part of the process. I, or someone in my family, will have to make my father’s living will a part of his medical record in order for it to be operative.<sup>360</sup> Someone in my family will probably be asked to sign off on insurance and liability waivers for the hospital, and the attending physician will have to notify my family of the physician’s intentions to effectuate the living will.<sup>361</sup> Thus, I will be an integral part of the process.

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354. *Id.*

355. *Id.*

356. *Id.*

357. Sam J. Saad, Jr., interviews, *supra* note 2.

358. *Id.*

359. *Id.*

360. NEB. REV. STAT. §§ 20-404(3), -405 (1997).

361. *Id.* § 20-405.

However, after contemplating my father's recollection of Gidi's illness and after carefully reading my father's living will, I feel that the most important part of my father would have already died by the time his living will began to operate. Recalling that he does not want to be hooked up to the machines in the first place, I would not view "turning off the machine" as killing my father if he were already incapacitated and suffering from a terminal illness.<sup>362</sup>

In my view and, to some extent my father's, the point of life is to live. When one is laying there like a vegetable, one is not living; though technically alive, there is no point to that person's life.<sup>363</sup> A person in a persistent vegetative state or a coma is not contributing to society in any way. Therefore, when viewed in the light of the fact that my father would already be dead, the living will does make the decision process easier. My siblings and my mother know what his wishes are because they have been discussed. My father has carefully and thoughtfully laid out his wishes on paper. Because the living will would be a part of my father's medical record, the attending physician will not have to ask us, "what do you want to do?" This is essentially like asking, "should I kill my dad?" In addition, I will already be mourning my father's passing. His "final death" will make that process much easier for me because I will have closure.

#### CONCLUSION

In choosing to write on the topic of living wills, I thought I might discover something in the process that would help me decide what to do when I have to decide my father's fate and when I have to decide my own. Watching my grandfather waste away in a nursing home was not easy, but I did not and could not know what was happening. I was too young. Now that I am old enough to appreciate death and its significance, its finality, I am grateful to my father for making his decision, so that I will not have to anguish and watch a great man die as he did. His living will makes clear that he does not wish to be kept alive by artificial or heroic means of any

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362. In one interview with my father, he claimed that he would not even want to live in a wheelchair because for him that is no way to live. I explained to him that if he did fall into a persistent vegetative state, he would be placed on artificial hydration and nutrition and whatever else was necessary to keep him alive for a short time until his living will could be examined and executed. I assured him that in order to effectuate his wishes I would see that the process was as swift as possible.

363. While the idea of not contributing to society can be extended to include several groups of people, particularly the incarcerated, the mentally ill, or the homeless, when people are in a persistent vegetative state or coma, as defined in my father's will, they are not contributing to society and will never have that chance again because they are physically dead, if not brain dead. However, I am not arguing that one's relative "contribution to society" should be a measure for determining a person's rights.



kind.<sup>364</sup> The language leaves no doubt about the fact that he does not want his life prolonged one moment by artificial means, and his will specifies no artificial hydration or nutrition. He only wishes to have his pain alleviated.<sup>365</sup>

After researching the legal morass that is the law of living wills, I have decided to follow my father's lead. Being an optimist, I thought I would end up like my father, not wanting to give up hope until there was none. However, as the debate about the basic definition of death suggests, there is too much ambiguity in medicine and too much unpredictability in the law to leave the circumstances of my death to chance. As René Descartes postulated, "[f]or as to reason or sense, inasmuch as it is the only thing that constitutes us men and distinguishes us from the brutes, I would fain believe that it is to be found complete in each individual . . . ."<sup>366</sup> It is my belief that man is a beast, same as any other, the only thing making us any different being our cognitive abilities. Thus, when my mind goes, so do I.

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364. *See infra* app. A.

365. *Id.*

366. DESCARTES, *supra* note 1, at 41.

## APPENDIX A: LIVING WILL

TO: My family, my physicians, my attorney, my clergyman, and any medical facility in whose care I happen to be:

Death is as much a reality as birth, growth, maturity and old age; it is the one certainty of life. If the time comes when I, Samuel John Saad, Jr., can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If I am in a coma or a persistent vegetative state and sound medical opinion determines that I have no known hope of regaining awareness and higher mental functions no matter what is done, then I request that I be allowed to die naturally and not be kept alive by artificial means or “heroic measures,” be they surgical, mechanical, chemical, or of some other type, including without limitation the use or administration of cardiopulmonary resuscitation (the use of drugs and electric shock to keep the heart beating), mechanical breathing, artificial nutrition and hydration (the giving of nutrition and fluid through a tube in the veins, nose, or stomach), kidney dialysis, and chemotherapy.

If I am in a coma and sound medical opinion determines that I have a small likelihood of recovering fully, a slightly larger likelihood of surviving with permanent brain damage, and a much larger likelihood of dying, then I request that I be allowed to die naturally and not be kept alive by artificial means or “heroic measures,” be they surgical, mechanical, chemical, or of some other type, including without limitation the use or administration of cardiopulmonary resuscitation (the use of drugs and electric shock to keep the heart beating), mechanical breathing, artificial nutrition and hydration (the giving of nutrition and fluid through a tube in the veins, nose, or stomach), kidney dialysis, and chemotherapy.

If I have brain damage or some brain disease which makes me unable both to recognize people and to communicate understandably and sound medical opinion determines that such damage or disease cannot be reversed, and if I also have a terminal illness such as but not limited to incurable cancer that will likely be the cause of my death, then I request that I be allowed to die naturally and not be kept alive by artificial means or “heroic measures,” be they surgical, mechanical, chemical, or of some other type, including without limitation the use or administration of cardiopulmonary

resuscitation (the use of drugs and electric shock to keep the heart beating), mechanical breathing, artificial nutrition and hydration (the giving of nutrition and fluid through a tube in the veins, nose, or stomach), kidney dialysis, and chemotherapy.

If I have brain damage or some brain disease that makes me unable both to recognize people and to communicate understandably and sound medical opinion determines that such damage or disease cannot be reversed, but I have no terminal illness and I can live in this condition for a long period of time, then I request that I be allowed to die naturally and not be kept alive by artificial means or “heroic measures,” be they surgical, mechanical, chemical, or of some other type, including without limitation the use or administration of cardiopulmonary resuscitation (the use of drugs and electric shock to keep the heart beating), mechanical breathing, artificial nutrition and hydration (the giving of nutrition and fluid through a tube in the veins, nose, or stomach), kidney dialysis, and chemotherapy.

Because it is impossible for me to express my wishes for every conceivable medical situation that may confront me, it is also my desire that if a situation not specifically described in this document should arise in which sound medical opinion determines that there is no reasonable expectation of my recovery from incapacitating physical or mental disability, then I request that I be allowed to die naturally and not be kept alive by artificial means or “heroic measures,” be they surgical, mechanical, chemical, or of some other type, including without limitation the use or administration of cardiopulmonary resuscitation (the use of drugs and electric shock to keep the heart beating), mechanical breathing, artificial nutrition and hydration (the giving of nutrition and fluid through a tube in the veins, nose, or stomach), kidney dialysis, and chemotherapy.

I do not fear death itself as much as the indignities of deterioration, dependence, and hopeless pain. I ask, therefore, that medication be mercifully administered to me to alleviate my suffering in the event a situation described herein should arise even though this may hasten the moment of my death. I believe that when my death is inevitable, it should be permitted to occur in dignity without adding to the anguish of my family and the wasteful depleting of our family resources.

I have made this statement after careful consideration. I hope that you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the

intention of relieving you of such responsibility and placing it upon myself in accordance with my strong convictions that this statement is made.

I am depositing a copy of this statement with my spouse and with my attorney, . . . .

I have signed this statement this \_\_\_\_ Day of 1990.

WITNESS:

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