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LIVE AND LET DIE: THE CONSTITUTIONAL VALIDITY OF A LIVING WILL

[An adult woman]¹ slipped and fell, suffering a fracture dislocation of the vertebrae in her neck. As a result, she became totally quadriplegic. She is unable to move her hands and feet, or her arms and legs. She is unable to toilet for herself. She is unable to feed herself. She is unable to breathe for herself. She will be, for the rest of her life, confined to a bed or wheelchair which contains a ventilator pumping air into her lungs through an opening in her trachea. The only time she can talk is between breathing cycles of the ventilator. She characterizes her state as a "living hell." . . . [She] is concerned that, in the future, when she goes to the hospital . . . she will be in such a state that she will not be able to communicate her true feelings concerning her treatment. It is her desire that she not be given any additional medical treatment, but rather that nature be allowed to take its course.²

In the event that this woman becomes comatose or is no longer able to personally express her wish to refuse medical treatment, how can she be guaranteed that her decision will be followed?³

The "living will"⁴ is a useful tool in ensuring that an individual's decision to determine how natural death will come when

1. The following fact pattern is taken from the case of *A. B. v. C.*, 124 Misc. 2d 672, 477 N.Y.S.2d 281 (Sup. 1984), in which the petitioner sought an order determining "that she was competent to determine her own medical needs; . . . allow[ing] her to refuse additional medical care, treatment and nourishment; and . . . direct[ing] medical personnel] to comply with stated desires of petitioner not to have any further medical care other than pain relief medication." The court did not grant the relief requested. *Id.* at 672-73, 477 N.Y.S.2d at 282.

2. *Id.* at 674, 477 N.Y.S.2d at 284.

3. In *A.B. v. C.*, the court reasoned that since the petitioner had executed "a living will . . . prior to her accident . . . if petitioner became incompetent a guardian . . . could seek judicial approval that no medical care or nourishment be given, in accordance with [her] wishes." *Id.* at 675-76, 477 N.Y.S.2d at 284.

4. "These documents are more properly known as 'advance directives' or 'instruction directives'." Johnson, *The Death-Prolonging Procedures Act and Refusal of Treatment in Missouri*, 30 St. Louis U.L.J. 805, n.1 (1986).

confronted with a terminal condition will be honored. Part I of this note will address the concept of a living will, defining its purpose and practical effect. Part II analyzes the constitutional basis of an individual's right to execute a "living will." Finally, Part III examines the right to die statutes and the technical considerations regarding the execution of a "living will" declaration.

I. THE FUNDAMENTALS OF A LIVING WILL

Throughout the years, individuals have gone from a passive role to an active role in taking command of their own destiny.⁵ Recently, people have become extremely active in determining whether or not to accept certain forms of medical treatment.⁶ Individuals, faced with a terminal condition, are deciding for themselves whether they will permit the rendering of medical treatment designed to prolong his or her life.⁷

Recent developments in medical technology may be applied to miraculously prolong the life of a patient in critical condition.⁸ Some of these patients go on to lead a relatively normal life.⁹ Others, however, have little or no hope of recovery. In these cases medical technology may in fact extend a life of misery.¹⁰

There is a great deal of skepticism over the use of artificial means to prolong life.¹¹ Such means often result in enormous suffering and financial burdens for the patient's family.¹² Consequently, many individuals have been induced to contemplate ways to avoid the negative consequences of extending the life of a terminal patient.¹³ Many individuals have come to rely on the use of a "living will" to instruct family members and medical

5. Note, *Living Wills - A Need for Statewide Legislation or a Federally Recognized Right?* 3 DET. C. L. REV. 781 (1983).

6. *Id.*

7. *Id.*

8. These technological devices include "respirators, heart-lung machines, pacemakers, antibiotics, defibrillators, chronic dialysis, hypothermia, and artificial or transplanted organs." Comment, *The Living Will: Already a Practical Alternative*, 55 TEX. L. REV. 665, 666 (1977).

9. Note, *supra* note 5, at 781.

10. *Id.*

11. *Id.* The note suggests that where prolonging life by artificial means is involved, the opinions of the individual, his family members and his treating physician should be taken into consideration. *Id.* at 781-82.

12. Comment, *supra* note 8, at 666.

13. *Id.*

personnel not to administer extraordinary¹⁴ medical treatment.¹⁵

The "living will" is a method of preventing the prolongation of life by artificial means.¹⁶ Its use allows a terminal patient to convey his or her wishes to family members and medical personnel while fully in control of his or her mental processes.¹⁷ The patient is given the opportunity to assess the circumstances and may choose for himself whether or not to allow his death to come naturally.¹⁸

It must be recognized from the outset that a "living will" does not authorize all types of euthanasia.¹⁹ The term euthanasia denotes the "taking of human life for other than malicious purpose," in which sympathetic impulse is the primary factor "in the taking."²⁰ Euthanasia can be voluntary or involuntary, depending on whether the patient consents, and either type of euthanasia can derive from an act of commission or omission.²¹ Active euthanasia, which is sometimes termed positive, illustrates the completion of some affirmative behavior that intentionally hastens death,²² and is therefore considered homicide.²³ Passive or negative euthanasia, on the otherhand, connotes the "taking of human life by the omission of something essential to

14. See *infra* note 28 and accompanying text.

15. Comment, *supra* note 8, at 667.

16. The use of a testamentary-type document by individuals to convey their wish to avoid the use of extraordinary medical treatment was first proposed by Dr. Luis Kutner. Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969). Dr. Kutner designated the document as the "living will." *Id.* at 551. Such a document would establish explicit instructions and procedures for medical personnel which would convey the wishes of the terminally ill patient. *Id.* Although Dr. Kutner first advocated public use of the "living will", the idea existed before this proposal, as evidenced by prior discussions and proposals. See Vodiga, *Euthanasia and the Right to Die - Moral, Ethical and Legal Perspectives*, 51 CHI-KENT L.REV. 1 (1974).

17. Vodiga, *supra* note 16, at 11 (citing Kutner, *supra* note 16).

18. *Id.*

19. Euthanasia is defined as "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy." BLACK'S LAW DICTIONARY 497 (5th ed. 1979).

20. Vodiga, *supra* note 16, at 3.

21. See Comment, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALB. L. REV. 826, 826 n.1 (1975).

22. Vodiga, *supra* note 16, at 3.

23. *People v. Kirby*, 2 Parker Crim. Rep. 28 (N.Y. 1823). *Kirby* is the earliest reported euthanasia case. The defendant drowned children so that they would go to heaven. The court concluded that every wilful taking of human life, without justification, was murder.

the preservation of life."²⁴

A "living will" constitutes voluntary euthanasia because the patient conveys his wish to die. Also, because the cause of death is the omission or withdrawal of extraordinary medical treatment, it is considered passive euthanasia.²⁵ These categorizations act as limitations on when and how a "living will" becomes operative and are important for two reasons. First, individuals who execute the "living will" may be reassured that their instructions will be carried out only when there is no hope of eventual recovery.²⁶ Second, the public is more willing to accept the concept of a "living will" with knowledge that its purpose may only be effectuated under extreme scrutiny.²⁷

The distinction in the rendering of ordinary as opposed to extraordinary medical care must also be emphasized. Ordinary treatment has been defined as being any medical care which offers a moderate hope of recovery, while extraordinary is that treatment which does not offer a reasonable hope of recovery.²⁸ Just what treatment is ordinary as opposed to extraordinary is

24. Vodiga, *supra* note 16, at 3.

25. Note, *supra* note 5, at 784.

26. See Comment, *supra* note 8, at 668. As one law review commentator has stated: "Most people would be reluctant to sign a document that might result in someone's actively killing them. The same reluctance does not exist in the removal of mechanical 'corpse ventilators' that merely maintain a vegetative state." *Id.* at 668 n.14.

27. *Id.* at 668. See Vodiga *supra* note 16. (summarizing views of scholars and theologians regarding, among other issues, the moral and ethical implications of euthanasia.)

28. Collins, *Limits of Medical Responsibility in Prolonging Life*, 206 J. A.M.A. 389, 390 (1968). Collins states:

Ordinary measures of patient care are recognized as elements of essential care. They represent obligatory, proven, and justified therapies and procedures. They are denoted by the fact that the patient himself can obtain them and put them to his own use. They further represent measures which he can reasonably undergo with only minimal or moderate danger and maximal effectiveness. Such measures are also not an impossible or excessive burden.

Extraordinary measures, on the other hand, are complicated methods. They are impossible for the patient to use or apply by himself, and present a costly and difficult burden. In addition, they represent a high level of danger, and the results expected are not predictable, i.e., the effectiveness is minimal or moderate while the dangers are maximal.

Extraordinary measures sustain life artificially at the level it is found. If at this point in time there is no organic deterioration, the measures of resuscitation may then arrest the lethal process. They aim to gain time in order for natural restorative processes to operate.

Id.

determined on a case by case analysis.²⁹ As the *In re Quinlan*³⁰ court observed, "the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient, but 'extraordinary' in the context of the forced sustaining by cardio respiratory processes of an irreversibly doomed patient."³¹ *In re Conroy*³² the court noted that focusing on the type of treatment leads to different classifications of the same treatment as ordinary or extraordinary in different circumstances.³³ The court reasoned that since the "distinction between ordinary and extraordinary treatment is frequently phrased as one between . . . simple and complex treatment, . . . a particular treatment for a given patient may be considered both ordinary and extraordinary."³⁴ Further, since the "simple [and] complex distinctions among medical treatments exist on continuums with no precise dividing line, and the continuum is constantly shifting due to progress in medical care . . . [the court concluded] that disagreement will often exist about whether a particular treatment is ordinary or extraordinary."³⁵ As a result, the *Conroy* court rejected the distinction between ordinary and extraordinary treatment.³⁶

The directives of a "living will" may only be effectuated under circumstances where the condition of the patient is terminal and death is impending. The "will" may only direct the physician to withhold or withdraw extraordinary medical treatment.

29. It has been argued that the extraordinary-ordinary distinction should be discouraged because of the difficulty in formulating definitions of 'extraordinary' and 'ordinary' treatment in any particular case. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 260 (1973).

30. 70 N.J. 10, 355 A.2d 647 (1976), in which "the father sought to be appointed guardian of person and property of his 21-year-old daughter, who was in a persistent vegetative state, and sought the express power of authorizing the discontinuance of all extraordinary procedures for sustaining his daughter's vital processes." *Id.* at 10-11, 355 A.2d at 647.

31. *Id.* at 48, 355 A.2d at 667-68.

32. 98 N.J. 371, 486 A.2d 1209 (1985). In *Conroy*, the nephew, and guardian, of an incapacitated woman with severe and irreversible physical and mental impairments, sought authorization to remove a nasogastric feeding tube, the primary conduit for nutrients, from his ward. *Id.* at 335, 486 A.2d at 1216.

33. *Id.* at 371, 486 A.2d at 1235.

34. *Id.*

35. *Id.*

36. *Id.* at 370, 486 A.2d at 1234.

The ultimate inquiry in resolving whether the treatment is extraordinary will be determined by the specific facts and circumstances of each particular case.³⁷ In the *Quinlan* case, for example, the court held that the respirator constituted extraordinary treatment since it would not improve or cure the patient's condition,³⁸ while in *John F. Kennedy Memorial Hospital v. Heston*,³⁹ the court determined that a blood transfusion was ordinary treatment.⁴⁰ Once the determination of extraordinary treatment is made, then the "living will" comes into effect.

The moral and ethical connotations of "living wills" seem to advocate the utilization of such documents. The Roman Catholic Church has espoused a view which may be considered as support for the position that an individual may freely choose to refuse extraordinary treatment.⁴¹ Several churches have also adopted positions regarding death and euthanasia. The American Lutheran Church,⁴² the United Church of Christ,⁴³ and the United

37. 98 N.J. at 371, 486 A.2d at 1235. The *Conroy* court noted that the withholding or withdrawal of medical treatment will be determined by whether the burdens of the treatment clearly outweigh any possible benefits the patient could derive from treatment. *Id.*

38. 70 N.J. at 48, 355 A.2d at 667-68.

39. 58 N.J. 576, 279 A.2d 670 (1971).

40. *Id.* at 581-82, 279 A.2d at 673. The court found a blood transfusion to be "a simple established procedure." *Id.* It is plausible that this illustrates that a blood transfusion is considered ordinary care. Note, *supra* note 5, at 793.

41. Note, *supra* note 5, at 787. "The [former] head of the [Roman] Church, Pope Pius XII, stated in 1957, that '[i]n order to permit the patient, already virtually dead, to pass on in peace, when death becomes inevitable, the physician need not make further efforts to stave off death.'" *Id.* at 787 n.20 (quoting N.Y. Times, Nov. 25, 1957, at 1, col. 3). Furthermore, "Pope Pius XII stated the position of the Roman Catholic Church regarding the prolongation of life: 'The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission. The technique of resuscitation which concerns us here does not contain anything immoral in itself. Therefore, the patient, if he were capable of making a personal decision, could lawfully use it and, consequently, give the doctor permission to use it. On the other hand, since these forms of treatment go beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them or, consequently, that one is bound to give the doctor permission to use them.'" Vodiga, *supra* note 16, at 17 (quoting *The Prolongation of Life*, 4 The Pope Speaks 393, 397-98 (Spring 1958)).

42. Vodiga, *supra* note 16, at 18 (quoting Lutheran Hosp. A., *Ethical and Policy Guidelines* for a Lutheran Hospital, (1966) wherein the American Lutheran Church states: "While life is precious, there comes for every person that time when his earthly existence must end. The Lutheran Hospital . . . believes that he is entitled to die with dignity.").

43. Vodiga, *supra* note 15, at 18 (quoting Council for Christian Social Action, United

Methodist Church⁴⁴ all favor an individual's choice to sustain or forego extraordinary medical treatment. The "living will" gives the patient faced with a terminal condition the security that his choice to determine how natural death will come, will be honored. It enables the individual to die with dignity. The proposition of the "living will" has also been supported by the general public and the medical community.⁴⁵ The acceptance of living wills is demonstrated by the expansion in the number of states giving effect to these documents,⁴⁶ and consequently, the actual utilization of such documents. These views consider the terminal condition of the patient with no realistic chance of recovery.⁴⁷ However, the American Medical Association [AMA] has recently stated that it was "ethically appropriate to withhold life-sustaining treatment from patients who were terminally ill, as well as patients who were in an irreversible coma, but not necessarily terminally ill."⁴⁸ In connection with the medical treatment of an extraordinary kind, several issues are raised as to the constitutionality of the "living will."

II. THE LIVING WILL AS A CONSTITUTIONAL RIGHT

A. Free Exercise Clause

Cases which address the right of a patient to decline medical treatment usually involve a religious belief as the justifica-

Church of Christ, *The Rights and Responsibilities of Christians Regarding Human Death*, (June 25, 1973). The United Church of Christ expresses its position:

We believe it is ethically and theologically proper for a person to wish to avoid artificial and/or painful prolongation of a terminal illness and for him or her to execute a living will or similar document.

Id.

44. Vodiga, *supra* note 16, at 18 (quoting The United Methodist Church Report of the Social Principle Study Commission, United Methodist Church, (1973)) states: "We assert the right of every person to die in dignity, with loving personal care and without efforts to prolong terminal illness merely because the technology is available to do so."

45. Note, *supra* note 5, at 787 nn. 24-25.

46. See, *infra* note 129.

47. Note, *supra* note 5, at 788.

48. *Living Longer? Or Just Dying Slower?* N.Y. Times, Mar. 20, 1986, at 26, col. 1. The AMA asserts that it would not be unethical to discontinue medical treatment where a patient's coma is beyond doubt irreversible, even if his or her death was not imminent. However, adequate safeguards should confirm the accuracy of the diagnosis. *Rasmussen v. Fleming*, No. 86-0450, slip op. at 14.

tion to refuse such treatment.⁴⁹ This right is grounded upon the 'free exercise' of religion clause of the first amendment.⁵⁰ This freedom of religion enjoins the Government from intervening in the religious beliefs of any individual.⁵¹

In *Reynolds v. United States*,⁵² the Supreme Court held that individuals have an absolute constitutional right to choose to follow a religious belief.⁵³ The right to choose is absolute. However, the right to practice is limited to non interference with the rights of others.⁵⁴ Therefore, although an individual has a right to religious freedom, that right is not absolute, and can be subject to governmental restraint in particular situations.

Individuals have refused blood transfusions grounded upon religious assertions, and these situations have consistently been brought before the courts for a resolution.⁵⁵ Most courts have resolved this issue in favor of the hospitals and have ordered the transfusion based on the state's interest in the preservation of life.⁵⁶ In *Application of President and Directors of Georgetown College*,⁵⁷ a federal court ordered the administration of a blood transfusion to an emergency patient, who was not consented to

49. See *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962); In *Application of President and Directors of Georgetown College Inc.*, 331 F.2d 1000 (D. Cir.), *cert. denied*, 377 U.S. 978 (1964); In *re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971); In *re Osborne*, 294 A.2d 372 (Dist. Ct. App. 1972).

50. U.S. CONST. amend. I, cl. 2: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."

51. *Id.*

52. 98 U.S. 145 (1878). The Supreme Court held that a federal law which enjoined the practice of polygamy engaged in by members of the Mormon religion was valid. Additionally, the Court stated that Congress was permitted to regulate religion as long as it did not actually prohibit a belief. *Id.* at 166.

53. *Id.*

54. *Id.*

55. See *supra* note 49.

56. See, e.g., In *Application of President and Directors of Georgetown College Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965).

57. 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). The patient, suffering from a ruptured ulcer, was brought to the emergency room. It was determined that the patient had lost two thirds of her body's blood supply, and the hospital sought to administer blood transfusions. The patient, and her husband, were both Jehovah's Witnesses, and based on their religious beliefs, would not give their permission for a blood transfusion. Death of the patient became imminent, and the hospital sought a court order for permission to administer blood transfusions. *Id.* at 1006.

on the grounds of religious convictions, to a mother of a seven month old child.⁵⁸ The court specifically found that the patient had sought medical care by voluntarily being in the hospital, but just refused certain medical treatment, here, a blood transfusion.⁵⁹ The court authorized the transfusion based on the interest of the state in preserving the life of the mother for the benefit of the child.⁶⁰

In line with *Georgetown College*, a blood transfusion was ordered in *United States v. George*.⁶¹ The patient was the father of four, and based on religious assertions, would not permit a blood transfusion to save his life.⁶² The court found that the "patient voluntarily submitted himself to, and insisted upon medical care,"⁶³ but sought to promulgate to treating physicians a method of treatment essentially equivalent to medical malpractice.⁶⁴ The court opined that the professional oath of the physician and mandates of the physician's conscience in treating patients, must take precedence over the religious freedom asserted by the patient.⁶⁵

In other cases, however, the courts have held that an adult has the right to refuse medical treatment. In *Erickson v. Dilgard*,⁶⁶ the court held that a patient, with no minor children, had complete discretion over his own body, and permitted him to decline a blood transfusion based on religious convictions, even though the refusal placed him in danger of death.⁶⁷ The

58. *Id.* at 1006.

59. *Id.* at 1009.

60. *Id.* at 1008.

61. 239 F. Supp. 752 (D.C. Conn. 1965). The patient, who was suffering from a bleeding ulcer, admitted himself to the hospital of his own volition, but would not consent to blood transfusions grounded upon his religious convictions. His ailment deteriorated, and any additional bleeding would have led to shock and probable death. The patient stated that he would not agree to a blood transfusion, but would not refuse if the court ordered it because then it would not be by his own will. *Id.* at 753.

62. *Id.* at 753.

63. *Id.* at 754.

64. *Id.*

65. *Id.* The court held that the patient may knowingly refuse treatment, but he may not demand mistreatment. The court "determined to act on the side of life." *Id.*

66. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (N.Y. Sup.Ct. 1962). The hospital applied for an order authorizing administration of a blood transfusion to a patient who had upper gastrointestinal bleeding. The patient refused to consent to a blood transfusion, but was willing to submit to an operation. *Id.* at 27-28, 252 N.Y.S.2d at 705-06.

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

court argued that the government has given the individual the greatest possible protection, and therefore, the individual has the ultimate decision regarding his medical treatment.⁶⁸

*In re Estate of Brooks*⁶⁹ also upheld the right of an adult, with no dependents, to refuse a blood transfusion based on her right to religious freedom.⁷⁰ The court concluded that an individual's religious principles in declining a blood transfusion were to be protected where the refusal did not result in a definite and present danger to public health, welfare or morality.⁷¹ The court reasoned that holding otherwise would not be constitutionally countenanced.⁷²

It appears from the cases that the decision to resist medical care, based on religious assertions, will only be honored where the patient has no dependents which would justify the state's interest in overriding his or her expressed wishes,⁷³ does in fact want to decline the treatment, and is competent to make the decision. However, the right to execute a "living will" and the right to have it followed, does not rest on that individual's religious convictions. Rather, it is premised on that individual's right to privacy and right to determine what is to be done with his or her own body.

B. Right of Privacy

The right of an adult to control his or her own body is a basic societal concept, long recognized in the common law.⁷⁴ "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable, au-

68. *Id.*

69. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

70. *Id.* at 373, 205 N.E.2d at 442.

71. *Id.* at 372-73, 205 N.E.2d at 442.

72. *Id.*

73. The intervention in family affairs is based upon the doctrine of *parens patriae*; "the role of state as sovereign and guardian of persons under legal disability." BLACK'S LAW DICTIONARY 1003 (5th ed. 1979).

74. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914); see also *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972).

thority of law.”⁷⁵ Furthermore, “every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”⁷⁶

The doctrine of informed consent⁷⁷ was established as a legal basis for the protection of an individual’s personal interest in the integrity of his or her body.⁷⁸ Simply, medical treatment may not be administered without a patient’s consent.⁷⁹ The physician must fully explain the nature of the treatment, and risks inherent with that treatment.⁸⁰ The physician must also discuss alternatives with the patient.⁸¹ The patient’s consent is considered objectionable unless he is fully informed of all pertinent information.⁸² The patient may then decide to have the treatment administered or refuse. The doctrine encompasses the patient’s right to informed refusal.⁸³ Thus, a competent adult has the right to sustain or forego any medical treatment.⁸⁴

The federal Constitutional right of privacy also secures an individual’s determinations concerning his or her own body.⁸⁵ This right was first realized by Justice Brandeis in *Olmstead v.*

75. *Union Pacific Ry. v. Botsford*, 141 U.S. 250, 251 (1891).

76. *Schloendorff*, 211 N.Y. at 129-30, 105 N.E. at 93; *see also* *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

77. “Informed consent is the name for a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternate treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.” BLACK’S LAW DICTIONARY 701 (5th ed. 1979).

78. *Conroy*, 98 N.J. at 346, 486 A.2d at 1222.

79. *Id.*, 486 A.2d at 1234 (citing Cantor, *A Patient’s Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973)).

80. *Id.*

81. *Id.*

82. *Id.*

83. *Conroy*, 98 N.J. at 347, 486 A.2d at 1222 (citing Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1648 (1974)).

84. *Conroy*, 98 N.J. at 47, 486 A.2d at 1222. *See also* *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 738, 370 N.E.2d 417, 425 (1977); *In re Quackenbush*, 156 N.J. Super. 282, 290, 383 A.2d 785, 790 (1978).

85. *Conroy*, 98 N.J. at 348, 486 A.2d at 1236.

United States.⁸⁶ Justice Brandeis believed that the right of individuals to be free of government interference in personal decisions affecting their own lives was a basic protection guaranteed by the Constitution.⁸⁷ The United States Supreme Court has identified a right of privacy emanating from the penumbra of the specific guarantees of the Bill of Rights, and from the language of the first, fourth, fifth, ninth, and fourteenth amendments.⁸⁸ The Supreme Court first articulated the right of privacy in *Griswold v. Connecticut*,⁸⁹ a decision which declared a state statute prohibiting the use of contraceptives unconstitutional.⁹⁰ The Court invalidated the statute reasoning that the Bill of Rights created zones of privacy that the states could not infringe upon without a compelling state interest.⁹¹

The Court expanded this zone of privacy in *Eisenstadt v. Baird*⁹² by recognizing the individual's right of equal access to contraceptives, regardless of marital status.⁹³ The Court felt it was improper for government to interfere in the personal decision of a couple on whether or not to have children.⁹⁴ In *Roe v. Wade*,⁹⁵ the Court held that the right of privacy also protects a woman's decision to end her pregnancy through abortion.⁹⁶ The Court determined that a woman's decision to terminate her pregnancy was personal in nature and could not be interfered with unless there was "countervailing, compelling state inter-

86. 277 U.S. 438 (1928).

87. *Id.* at 478 (Brandeis, J., dissenting).

88. *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965).

89. 381 U.S. 479. The state of Connecticut had enacted a statute which prohibited the use of contraceptives by married couples, and made it a crime to distribute birth control information and devices. Directors of a Planned Parenthood office had been convicted, as accessories, for giving advice and information on contraceptives to married couples. *Id.* at 480.

90. *Id.* at 485.

91. *Id.* at 497 (Goldberg, J., concurring).

92. 405 U.S. 438 (1972). A Massachusetts statute, which prohibited the distribution of contraceptives to unmarried persons, was disputed. The respondent was convicted for violating this statute when he gave a package of contraceptive foam to a woman following a lecture at Boston University. *Id.* at 440.

93. *Id.* at 453.

94. *Id.*

95. 410 U.S. 113 (1973). A pregnant single woman brought a class action challenging the constitutionality of a Texas statute which prohibited abortion, except when necessary to save the mother's life. She argued that the statute was void for vagueness and infringed on her personal privacy right.

96. *Id.* at 155.

est.”⁹⁷ The Supreme Court cases demonstrate a widening of the right of privacy from a restricted concentration on the marital relationship, to an expansion of protection for decision making, at least in the context of abortions.⁹⁸ This gradual change is evidence of the growing recognition and acceptance of the right of privacy as a personal right of self-control and self-determination.⁹⁹

Many state courts have reasoned that the privacy right is broad enough to include a patient's decision to decline medical treatment under certain circumstances.¹⁰⁰ In the *Quinlan* case, the Supreme Court of New Jersey secured an incompetent's right to discontinue the use of life support systems grounded upon the individual's right of privacy.¹⁰¹ The court reasoned that if the right of privacy protects the right to obtain certain types of health care, referring to *Roe v. Wade*,¹⁰² then it must also secure the right to decline certain types of treatment.¹⁰³

The execution of a “living will” is an exercise of an individual's right of privacy. It is a person's exclusive choice to determine that he does not wish to submit to extraordinary treatment in the event such a decision must be made. While the “living will” has not been recognized as an exercise of the right of privacy, it is analogous to the decision of a woman to have an abortion.¹⁰⁴ The *Roe* decision established that the right of privacy encompasses the right of a woman to exercise control over her own body in deciding whether to terminate her pregnancy.¹⁰⁵ The right of privacy can be said to include the execution of living wills based on the right of an individual to die with dignity. If the right of privacy enables an individual to secure specific medical treatment, as was held in the *Roe* decision, then that

97. *Id.* The state's interest in preserving the life of the fetus becomes compelling as the pregnancy advances towards full term. *Id.* at 162-65.

98. Note, *Constitutional Law: Removing Courts from the Decision to Terminate Life Support Systems*, 60 NOTRE DAME L.REV. 122, 125 (1984).

99. *Id.* at 125 & n.25.

100. See *Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Conroy*, 98 N.J. 321, 486 A.2d at 1209 (1985); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quackenbush*, 156 N.J. 282, 383 A.2d 785 (1978).

101. 70 N.J. at 42, 355 A.2d at 665.

102. 410 U.S. 113 (1973).

103. 70 N.J. at 40, 355 A.2d at 663.

104. *Roe*, 410 U.S. 113 (1973).

105. *Id.* at 155.

right of privacy should also protect an individual's choice to refuse specific medical treatment, as the "living will" would set forth. The "living will" upholds a person's privacy right to determine what is to be done with his or her own body.

C. State Interests

Counterbalancing the right of the individual to execute a "living will" are the state's interests in the preservation of life, the protection of interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession.¹⁰⁶

The most powerful state interest, the preservation of life, has triumphed over a patient's refusal of treatment to require lifesaving medical care for that patient.¹⁰⁷ However, the interest is not absolute and loses power where continued treatment serves only to prolong a life inflicted with a hopeless condition.¹⁰⁸ In the *Quinlan* case, the court balanced the degree of bodily invasion against the state's interest in preserving and sanctifying life.¹⁰⁹ The court held that the state's interest in the preservation of life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."¹¹⁰ In *Superintendent of Belchertown State School v. Saikewicz*,¹¹¹ the court determined that it was not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness,¹¹² and found a right of privacy and

106. *Saikewicz*, 373 Mass. at 741, 370 N.E. at 430. See generally *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

107. See, *supra* note 57 and accompanying text.

108. See, e.g., *Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

109. *Quinlan*, 70 N.J. at 40-41.

110. *Id.* at 41, 355 A.2d at 663-64.

111. 373 Mass. 728, 370 N.E.2d 417.

112. The patient, a 67-year old mentally retarded man, suffered from leukemia, an incurable condition. The hospital alleged that the patient was incapable of giving informed consent for treatment, in this case, chemotherapy. A court appointed guardian ad litem concluded that the painful side effects and discomfort of chemotherapy clearly outweighed any benefit from such treatment. The court approved the guardian's recommendation, finding that the fear and suffering to which Mr. Saikewicz would be subjected to was not justified by the possibility of temporary remission. *Id.* at 729-30, 370 N.E.2d at 420. But see *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, cert. denied 454 U.S. 858 (1981).

individual free choice to be fundamental constituents of life, sufficient to outweigh the state's interest in the preservation of life.¹¹³

A second significant interest is protection of third parties, particularly minor children, from the emotional and financial damage which may result by the decision of a competent adult to refuse or discontinue lifesaving treatment.¹¹⁴ This interest has dominated in the blood transfusion cases where dependents were involved. In the *Georgetown College* case, the court would not permit a parent to abandon a child and held that the state interest of protecting third parties must triumph.¹¹⁵ However, the use of life support systems as a basis to prolong an incurable condition only inflicts emotional and financial burdens on the patient's family, and serves no compelling state interest.¹¹⁶ The state's interest in protecting third parties is outweighed by the patient's right to privacy and his decision to avoid the additional burdens to his family.

The decision of an adult to forego extraordinary medical treatment is not synonymous with a decision to commit suicide.¹¹⁷ A patient who refuses this type of treatment does not wish to die. He declines only for legitimate and practical reasons.¹¹⁸ However, "even if he did, to the extent that the cause of death was from natural causes, the patient [is not responsible for setting] the death producing agent in motion with the intent of causing his own death."¹¹⁹ Such persons merely die their natural deaths. The prevention of suicide does not pertain to a competent adult exercising his or her right to forego medical treatment if that treatment offers no hope of cure and death is imminent.¹²⁰

The final state interest is that of the maintenance of the

113. *Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 424.

114. The leading case in this area is *Georgetown College*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

115. *Id.* at 1008.

116. Note, *The "Living Will" - An Individual's Exercise of His Rights of Privacy and Self-Determination*, 7 Loy. U. Chi. L.J. 714, 719 (1976).

117. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11. See also *Bartling v. Superior Court of California*, 209 Cal.Rptr. 220, 226, 163 Cal. App. 3d 186, 192 (Cal. App. 2d Dist. 1984).

118. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 432 n.11.

119. *Id.*

120. *Id.*

ethical standards of the medical profession. In *United States v. George*,¹²¹ the court alluded to the doctor's professional oath and conscience in caring for patients, and held that an individual's rights must succumb to the state's interest in safeguarding the integrity of its medical profession.¹²² However, in *Saikewicz*, the court held that the effect of this interest is weakened by the present ethical principles of the medical profession which recognize that the dignity of the dying should be maintained at all times.¹²³ Existing medical mores recognize the right to refuse lifesaving treatment in appropriate circumstances.¹²⁴ The right to refuse necessary treatment "does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients, or the State's interest in protecting the same."¹²⁵ The concept of the "living will" is today's practical application of that notion.

The interests of the State are balanced against the individual's right of privacy and his right to make decisions affecting his bodily integrity.¹²⁶ The "living will" acts as a manifest of personal decisions constituting elements of control over one's destiny in which no one should interfere. The individual's freedom in the ability to select amongst the available alternatives has consistently been recognized, with few exceptions, justified by the constitutional rights of the individual.¹²⁷ Generally, before a court will disregard a reasonable choice to forego or sustain medical treatment, the state must establish a compelling interest, and that interest must offset any right asserted by the individual. The recognition of the right to refuse medical treatment is significant only when the individual is furnished with the resources by which he or she can exercise that right.¹²⁸ The "living will" enables the individual to carry out that right.

121. 239 F. Supp. 752. See *supra* note 62 and accompanying text.

122. 239 F. Supp. at 754.

123. *Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 432. See *Rasmussen v. Fleming*, No. 86-0450, slip.op. at 14 (Ariz. 1987)(WESTLAW, Allstates library).

124. 373 Mass. at 743-44.

125. *Id.* at 744, 370 N.E.2d at 432.

126. *Id.* at 744-45.

127. See, *supra* note 100 and accompanying text.

128. Note, *supra* note 113, at 723.

III. LIVING WILL STATUTES

A. Legislative Overview

Since the 1970s, thirty-eight states¹²⁹ and the District of Columbia¹³⁰ have enacted laws which statutorily recognize under certain circumstances the right of privacy and the right of self-

129. Alabama Natural Death Act. ALA. CODE, §§ 22-8A-1 to -10 (1976); Alaska Rights of Terminally Ill Act. ALASKA STAT. §§ 18.12.010 to .100 (1986); Arizona Medical Treatment Decision Act. ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1985); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act. 1987 ARK. ACTS 713 (1987); California Natural Death Act. CAL. HEALTH & SAFETY CODE, §§ 7185-95 (West Supp. 1988); Colorado Medical Treatment Decision Act. COLO. REV. STAT. §§ 15-18-101 to -113 (1985); Connecticut Removal of Life Support Systems Act. CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (Supp. 1988); Delaware Death With Dignity Act. DEL. CODE ANN. tit. 16, §§2501 - 09 (1983); Florida Life Prolonging Procedure Act. FLA. STAT. ANN. §§ 765.01 to .15 (West 1986); Georgia Living Wills Act. GA. CODE ANN. §§ 31-32-1 to -12 (1985); Hawaii Medical Treatment Decisions Act. HAWAII REV. STAT. §§ 327D-1 to -27 (Supp. 1987); Idaho Natural Death Act. IDAHO CODE §§ 39-4501 to -4508 (1977 & Supp. 1987); Illinois Living Will Act. ILL. ANN. STAT. ch. 110 ½ §§ 701 - 10 (Supp. 1987); Indiana Living Wills and Life-Prolonging Procedures Act. IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns Supp. 1987); Iowa Life-Sustaining Procedures Act. IOWA CODE ANN. §§ 144A.1 to .11 (West Supp. 1987); Kansas Natural Death Act. KAN. STAT. ANN. §§ 65-28.101 to .109 (1986); Louisiana Declarations Concerning Life-Sustaining Procedures Act. LA. REV. STAT. §§ 40:1299.58.1 to .10 (Supp. 1988); Maine Living Wills Act. ME. REV. STAT. ANN. tit. 22 §§ 2921 -31 (Supp. 1987); Maryland Life-Sustaining Procedures Act. MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (1987); Mississippi Withdrawal of Life-Saving Mechanisms Act. MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1987); Missouri Declarations, Life Support Act. MO. ANN. STAT. §§459-010 to -055 (Vernon Supp. 1988); Montana Living Will Act. MONT. CODE ANN. §§ 50-9-101 to -104, §§ 50-9-201 to -206 (1987); Nevada Withholding or Withdrawal of Life-Sustaining Procedures Act. NEV. REV. STAT. §§ 449.540 to .690 (1985); New Hampshire Terminal Care Document Act. N.H. REV. STAT. ANN. §§ 137-H:1 to :16 (Supp. 1987); New Mexico Right to Die Act. N.M. STAT. ANN. §§24-7-1 to -11 (1978); North Carolina Right to Natural Death Act. N.C. GEN. STAT. §§ 90-320 to -323 (1985); Oklahoma Natural Death Act. OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West 1988); Oregon Rights with Respect to Terminal Illness Act. OR. REV. STAT. §§ 97.050 to .090 (1987); South Carolina Death with Dignity Act. S.C. CODE ANN. §§44-77-10 to -160 (Supp. 1987); Tennessee Right to Natural Death Act. TENN. CODE ANN. §§ 32-11-101 to -110 (1987); Texas Natural Death Act. TEX. REV. CIV. STAT. ANN. art. 459OH (Vernon Supp. 1988); Utah Personal Choice and Living Will Act. UTAH CODE ANN. §§75-2-1101 to -1118 (1987); Vermont Terminal Care Document Act. VT. STAT. ANN. tit. 18, §§ 5251-5262, (Supp. 1986); Virginia Natural Death Act. VA. CODE §§ 54-325.8:1 to :13 (1987); Washington Natural Death Act. WASH. REV. CODE ANN. §§ 70.122.010 to .905 (Supp. 1988); West Virginia Natural Death Act. W.VA. CODE §§ 16-30-1 to -10 (1985); Wisconsin Natural Death Act. WISC. STAT. ANN. §§ 154.01 to .15 (West Supp. 1987); Wyoming Life-Sustaining Procedures Act. WYO. STAT. §§ 35-22-101 to 109 (1987).

130. District of Columbia Natural Death Act of 1981. D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1987).

determination relative to medical treatment in the event of terminal illness. These statutes, known as "right to die," "living will," "natural death," or "death with dignity" laws, authorize the use of "living wills" and other forms of advance directives.¹³¹ These laws allow a competent individual to execute a "living will" specifying that no medical treatment is to be rendered to him or her in the event of terminal illness where the treatment serves only to prolong a hopeless condition.

California was the first state to pass legislation giving effect to the "living will."¹³² The legislative findings, incorporated into the California Natural Death Act, leave no doubt as to the intentions of the Legislature:

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recog-

131. Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 630 (1986).

132. Note, *supra* note 5, at 800 n.127. The California Natural Death Act was enacted on September 30, 1976, and became effective on January 1, 1977.

nize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.¹³³

Such legislation assures individuals, who execute "living will" directives, that their determination as to how natural death will occur when confronted with a terminal condition will be carried out, even if they become incompetent.

Other states have used the California law as a model for their own statutory enactments.¹³⁴ Although there were only fourteen states which enacted similar statutes by the close of 1982,¹³⁵ presently there are thirty-eight states which recognize the individual's right to determine how the natural death process will occur. This growing popularity is due in part to an individual's concerns if faced with a terminal illness, and the assurances given to an individual through the use of a "living will" that his or her decision to withhold or withdraw life-sustaining procedures will be honored.

B. Procedural Aspects

The process by which a "living will" declaration is validly executed is similar to the formalization of a last will and testament. The instrument must be witnessed and in writing, and clearly express the intentions of the person executing the will that certain medical treatment should be withheld or withdrawn in the event he or she is diagnosed terminal and death is imminent.¹³⁶ The making of a last will and testament requires the individual to have the capacity to make such a document.¹³⁷ The Uniform Probate Code states that "[a]ny person 18 or more years of age who is of sound mind may make a will."¹³⁸ Although all "living will" statutes do not have an age requirement, it is mandatory that an individual have the capacity to execute such

133. CAL. HEALTH & SAFETY CODE, §§ 7186.

134. Note, *supra* note 5, at 800.

135. *Id.* at 800. The states which had enacted "right to die" statutes were Alabama, Arkansas, Delaware, District of Columbia, Idaho, Kansas, Nevada, New Mexico, North Carolina, Oregon, Texas, Vermont, and Washington.

136. *Id.* at 802.

137. *Id.* at 805.

138. UNIF. PROBATE CODE, § 2-2501 (6TH ED. 1986).

a document. Capacity has been defined to be the "ability to understand the nature and effects of one's acts,"¹³⁹ and is interpreted as having a sound mind. Capacity and sound mind, as defined above, are essential to the valid execution of "living will" declarations.

An additional requirement for the effectuation of "living wills" is that the document be in writing,¹⁴⁰ and witnessed by at least two persons.¹⁴¹ Each state has excluded certain persons from acting as qualified witnesses. Although the exclusions vary from state to state, physicians, potential heirs, and blood relatives are generally prohibited from witnessing the declaration.¹⁴²

The "living will" document can be brought into effect if the foregoing requirements are met and the individual is confronted with a terminal condition. The definition of terminal condition is provided in all of the statutes, with the exception of Arkansas, and the California Natural Death Act provides a typical definition:

"Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, with-
ing reasonable medical judgment, produce death, and
where the application of life-sustaining procedures serve
only to postpone the moment of death of the patient.¹⁴³

Furthermore, some statutes require the treating physician to certify that the patient has a terminal condition prior to the "living will" coming into effect.¹⁴⁴ The declaration will be of no force if the physician does not affirm that the patient is suffering from a terminal illness.

The "living will" remains effective until revoked, and most right to die laws establish procedures to be followed for revocation.¹⁴⁵ However, the expressed present desires of the patient

139. BLACK'S LAW DICTIONARY 188 (5th ed. 1979).

140. See *supra* note 129.

141. *Id.*

142. See, e.g., CAL. HEALTH & SAFETY CODE § 7188.

143. CAL. HEALTH & SAFETY CODE § 7187(f). See R. REIMER, LEGAL ANALYSIS OF THE RIGHT TO DIE 3 (June 12, 1985)(obtainable at Library of Congress, Congressional Research Service, Washington, D.C.).

144. See, e.g., IDAHO CODE §§ 39-4503(3), 39-4504.

145. See, e.g., CAL. HEALTH & SAFETY CODE § 7189.

will always vitiate the desires declared in the patient's "living will." Furthermore, many of the statutes provide that pregnancy causes the provisions of a living will to become inoperative during that time period.¹⁴⁶

The living will statutes provide immunity to physicians from liability if the physician carries out the explicit instructions of a properly drawn declaration.¹⁴⁷ Furthermore, many of the statutes require the physician to follow the instructions of the declaration. Where a physician is unable or unwilling to do so, the patient must be transferred to another physician who will comply with provisions of the "will."¹⁴⁸

The "living will" remains the only method through which an individual can express his or her desires before becoming incapacitated. In jurisdictions with "living will" statutes, these declarations are recognized as legal channels to refuse extraordinary medical treatment. If all of the statutory formalities are satisfied, the "living will" is entirely enforceable in the courts.

CONCLUSION

Because medical technological advances have developed faster than the morality needed to handle it, considerable attention is vital in helping the dying, their family and their physicians. The "living will" is one solution to the ever increasing number of cases that courts across the country are confronted with in determining the rights of terminally ill patients to choose a natural death.

While this author believes that the "right to die" is as strong as the "right to live," there are still twelve states which do not recognize the "right to die."¹⁴⁹ In the jurisdictions which do not recognize "living will" statutes, an individual is not given the security that his choices regarding treatment in a terminal situation will be followed.

Where a person is in a vegetative state, it is obvious that he is not able to voice his decision specifying that no treatments of

146. See, e.g., KANSAS STAT. ANN. 65-28.103.

147. See, e.g., CAL. HEALTH & SAFETY CODE § 7190.

148. See, e.g., CAL. HEALTH & SAFETY CODE § 7191(b).

149. These states are Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New York, New Jersey, North Dakota, Ohio, Pennsylvania, Rhode Island and South Dakota.

an extraordinary kind are to be utilized to intervene with his natural bodily functions. However, a competent individual should have the right to draft a document stating what medical treatment he would forego in the event that his condition is reduced to an incapacitated state. The "living will" is a means to this end. It provides the individual and the state with the necessary safeguards to protect the rights and interests of each.

The constitutional recognition of the right to die a natural death can serve to provide all persons with the requisite right to make choices regarding the disposition of their bodies in the event of terminal illness. It would serve to assure every individual, in every state, the choice to decide for himself what is to happen in the event he or she is confronted with a terminal condition. However, "[w]ith more and more Americans living to great age, and with artificial means proliferating that stave off death, the debate is only just beginning."¹⁵⁰

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150. *Living Longer? Or Just Dying Slower?*, N.Y. Times, Mar. 20, 1986, at 26, col.2.