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Marguerite Ann Chapman*

I. INTRODUCTION

The graying of America and the greater incidence of life-threatening illness associated with aging have intensified interest in living wills and other legal mechanisms designed to give the patient, or a trusted proxy, control over the use of life-prolonging medical technology.¹ In addition, the AIDS epidemic has generated greater interest in advance planning to determine the degree to which life-extending treatment will be administered to terminally ill patients who no longer have

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¹ See Verbrugge, Longer Life but Worsening Health? Trends in Health and Mortality of Middle-Aged and Older Persons, 62 MILBANK MEMORIAL FUND Q. 475 (1984) (documenting an increase in the incidence and impact of life-threatening illness, such as cancer and stroke, as people live to more advanced ages). But see Fuchs, "Though Much Is Taken": Aging, Health, and Medical Care, 62 MILBANK MEMORIAL FUND Q. 143 (1984) (expressing reservations about the suggested causal relationship between chronic illness and increased longevity).

For an incisive and provocative examination of the proper goals of medicine in a rapidly aging society, see generally D. CALLAHAN, SETTING LIMITS, MEDICAL GOALS IN AN AGING SOCIETY 52-81, 159-200 (1987) (asserting that a disproportionate share of health-care resources is spent on extending the lives of the elderly with little thought for the quality of those lives). For an excellent resource on health-care planning considerations associated with aging and Alzheimer's disease and related dementing disorders, see UNDERSTANDING ALZHEIMER'S DISEASE 265-322 (M. Aronson ed. 1988).
capacity to make health-care decisions.² The completion of the Uniform Rights of the Terminally Ill Act³ (URTIA) was a significant milestone in nearly a decade of efforts by the states to fashion legislative solutions to the profound ethical and legal dilemmas presented by terminally ill or permanently unconscious patients.⁴

When the URTIA was approved in August of 1985 by the National Conference of Commissioners on Uniform State Laws, the initial three-year period following the promulgation of the act was viewed by some to be the most critical time frame in which to assess the impact of this new uniform law. Because 1987 marked a new biennium in which most states' legislatures would meet, that year was considered to be particularly significant.⁵ Now that the three-year mark has passed,

². See Special Report, Preferences of Homosexual Men with AIDS for Life-Sustaining Treatment, 314 NEW ENG. J. MED. 457 (1986). The AIDS patients surveyed in this study wanted their partners or friends, rather than family members, to confer with their attending physicians in making medical treatment decisions. Id. at 457. However, the report noted that the patient's partner or friend "has no legal standing to make decisions unless designated as a proxy through a durable power of attorney for health care." Id.

See also Malcolm, Letting Victims Halt Treatment, AIDS Brings Expanded Debate on Rights of the Terminally Ill, N.Y. Times, Oct. 4, 1987, at 6, col. 3 (nat'l. ed.); Johnson, Hospital Backed in AIDS Right-to-Die Case, N.Y. Times, July 28, 1987, at 9, col. 1 (nat'l. ed.) (discussing Evans v. Bellevue Hosp., a July 28, 1987, New York case denying the petition of the patient's attorney-in-fact for a court order directing the hospital to discontinue treatment of the patient on the grounds that the patient's non-statutory living will was ambiguous, and the evidence of the patient's wishes was not "clear and convincing").


5. Letter from John M. McCabe, Legislative Director, National Conference of Commissioners on Uniform State Laws, to Marguerite Chapman (June 28, 1986) [hereinafter McCabe Letter] (available through ARK. L. REV.). Mr. McCabe wrote:

The number of introductions in January, 1987, will tell us much about the potential for the Act. If we get between five and ten, it has real possibilities. If there are more, obviously we, here, will be delirious. If there are less than five, progress is likely to be slow.
it is appropriate to reexamine the work of the Uniform Law Commissioners (ULC) on this important subject.

Because the URTIA was not generated in a political, legal, or bioethical vacuum, the overall focus of this article is on the history, substantive content, and legislative impact of the Uniform Act. Part II describes the context in which the URTIA was drafted by the ULC by starting with the Karen Ann Quinlan case6 and briefly chronicling the judicial and legislative legacy of Quinlan from 1976 through 1985. Part II also reviews the work of the ULC in the development of laws regarding dying patients or medical decision-making and traces the formulation of the URTIA over several years.

Part III specifically examines the URTIA, comparing and contrasting the Uniform Act with living will laws enacted by various states between 1976 and August of 1985. Part III also discusses improvements in the Uniform Act as compared to many existing laws, and it comments upon the shortcomings of certain state laws incorporated in the URTIA.

Part IV reviews the reaction to the Uniform Act by the legal and medical communities, as well as by special advocacy groups. It also assesses the Uniform Act in terms of its influence upon state legislatures between 1985 and 1988.

Part V discusses the need for uniform legislation addressing the rights not only of the terminally ill but also of the permanently unconscious. Additionally, part V reviews developments during the past five years which have produced a consensus among the medical and ethical communities and the courts on many important issues regarding the care of the dying. In particular, this section evaluates the likely impact of the URTIA on the evolution of the legal ability of a dying patient to control his fateful medical treatment options after he has lost decision-making capacity.

In sum, this article endeavors not only to describe the development of URTIA by explaining and evaluating its provisions, but also to assess the influence of this uniform law in the history of the national movement to secure and enhance

the rights of patients to refuse life-prolonging treatment. After reviewing the shortcomings of the URTIA, the article concludes by calling for the ULC to return to the drafting table and develop a more comprehensive and useful uniform act addressing the rights of both the terminally ill and the permanently unconscious.

II. THE LEGACY OF KAREN ANN QUINLAN

A. Background and Impact of In re Quinlan

On April 15, 1975, twenty-one-year-old Karen Ann Quinlan lapsed into a coma. Karen Quinlan never emerged from that coma, existing for over ten years in a persistent vegetative state. When Karen Quinlan’s parents initially requested, in October of 1975, that her respirator be removed, the hospital and attending physicians unexpectedly resisted.


8. Dr. Fred Plum, Professor and Chairman of the Department of Neurology at Cornell Medical Center-New York Hospital and an internationally renowned authority on “persistent vegetative state,” described a patient in this condition as a “‘subject who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function.’” Quinlan, 70 N.J. 10, —, 355 A.2d 647, 654. More recently, Dr. Plum has further explained that:

Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscle and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.


9. President’s Commission Report, Deciding to Forego Life-Sustaining Treatment, infra note 46, at 171 n.2. In addition, the local prosecuting attorney and the Attorney General of New Jersey opposed the efforts of Mr. Quinlan to be appointed guardian of Karen’s person for the express purpose of authorizing the removal of her respirator. Id.

Four years before the Quinlan case arose, the New Jersey Supreme Court had equated with suicide a competent patient’s refusal of medical treatment. John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, —, 279 A.2d 670, 672 (1971). In Heston, the mother of a twenty-two-year-old accident victim objected to blood transfusions as contrary to the patient’s religious beliefs. The state supreme court found that though “religious beliefs are absolute . . . conduct in pursuance of religious beliefs is not.” Id.
Their resistance led to the litigation that resulted in a landmark decision by the New Jersey Supreme Court in March of 1976, affirming Karen Quinlan’s right to die by natural forces—a right the court viewed as a “valuable incident of her [constitutional] right of privacy.”

The New Jersey Supreme Court’s decision set forth procedures pursuant to which Karen Quinlan’s right to forgo treatment could be exercised by her father in his capacity as her guardian. When Karen Quinlan’s respirator was later removed, she was able to breathe on her own and continued to live in a “twilight” between life and death for nine years.
sustained by artificially supplied nutrition and hydration.\textsuperscript{12}

Paradoxically, Karen Quinlan, although silent and unable personally to participate in treatment decisions, personified perhaps the most difficult moral and legal conundrum of this century: the treatment and care of the permanently unconscious and the terminally ill. Her case provoked a national reexamination of personal and professional goals and assumptions among physicians, other health-care providers, theologians, and, ultimately, state courts and legislatures.\textsuperscript{13}

Prior to Quinlan, a patient's right of self-determination, that is, the right to decide what will or will not be done to one's body, was legally protected by the doctrine of informed consent.\textsuperscript{14} Increasingly, courts recognized that the right to refuse treatment is an essential corollary to the right to consent to treatment.\textsuperscript{15}

\textsuperscript{12} USA Today, June 12, 1985, at 1A, col. 2; A Long Twilight Comes to an End, NEWSWEEK, June 24, 1985, at 81.


\textsuperscript{14} See, e.g., Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J., declaring that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body"). For an exposition of the expansion in the United States of the informed consent doctrine from a simple concept to an extremely complex body of law, see F. ROZOVSKY, CONSENT TO TREATMENT, A PRACTICAL GUIDE (1984).


Most of the early right-to-refuse-treatment cases involved refusal of blood transfusions by patients who were Jehovah's Witnesses, members of a religious sect whose followers believe that taking blood in any form is prohibited by Biblical passages such as Leviticus 17:10 and Acts 15:28-29 and is punished by the loss of heaven. Thus, the fundamental right of religious belief and the free exercise of that belief were asserted in
By the time the ULC began work in earnest on the URTIA in 1983-84, a significant number of state courts in different jurisdictions had concluded that both the common law\textsuperscript{16} and the United States Constitution\textsuperscript{17} protect an individ-

For a review of the pre-Quinlan cases, see Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L. Rev. 1 (1975); Cantor, A Patient's Decision to Decline Life Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 Rutgers L. Rev. 228 (1973); Note, Compulsory Medical Treatment & Constitutional Guarantees: A Conflict?, 33 U. Pitt. L. Rev. 628 (1972); Note, The Dying Patient: A Qualified Right to Refuse Medical Treatment, 7 J. Fam. L. 644 (1968).


17. See, e.g., Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (recognizing a right to refuse treatment based in both the federal and California constitutions, as well as the law of actionable battery); John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984) (expressly recognizing that the constitutional right to refuse treatment extends to incompetent patients); In re L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Colyer,
ual's right to refuse life-prolonging treatment. However, the courts sometimes differed with regard to which legal approach should be pursued in cases involving patients who lacked decision-making capacity.18 Instances of health-care providers insisting upon administration of treatment despite prior


After Quinlan and many of these other decisions were rendered, one commentator suggested that living will statutes would become "superfluous." Gelfand, Euthanasia and the Terminally Ill Patient, 63 NEB. L. REV. 741, 750-51 (1984). More recently, Professor Gelfand reiterated that ". . . Quinlan and its progeny should have rendered living will statutes irrelevant" while acknowledging that "considerably more than half the statutes have been enacted in the three years since [his 1984 prediction]." Gelfand, Living Will Statutes: The First Decade, 1987 Wis. L. REV. 737, 796 & n.267 [hereinafter Gelfand, The First Decade].

18. Foody v. Manchester Mem. Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (Conn. Super. Ct. 1984) (addressing the role of a substitute decision-maker for a semicomatose patient and applying a hybrid approach derived from a combination of the "best interests" and "substituted judgment" standards); John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984) (recognizing a non-statutory living will as a significant factor in decision-making for an irreversibly comatose patient and authorizing family members or the legal guardian to make a decision based upon the "substituted judgment" standard after the patient's attending physician and at least two other physicians with appropriate specialties had concurred that the patient was in a "permanent vegetative state"); In re L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984) (ruling that the family or legal guardian of a terminally ill adult or child in a chronic vegetative state may authorize the termination of treatment without prior court approval and without review by a hospital committee when the diagnosis and prognosis have been made by the treating physician and two other physicians have concurred); Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980) (holding that the equitable powers of the Court of Chancery, after it had conducted a full evidentiary hearing, encompassed the authority to authorize the court-appointed guardian of a comatose patient to discontinue the use of a respirator and other life-sustaining supports).
patient objections continued to arise.\textsuperscript{19}

In order to enhance the right of individuals to refuse life-prolonging treatment, many commentators proposed the enactment of “living will” or “natural death” statutes.\textsuperscript{20} The central thrust of these proposals was the creation of a legal mechanism which would allow a competent individual to execute a living will or advance declaration\textsuperscript{21} directing that certain medical procedures or treatments be withheld or withdrawn in the event the patient was no longer able to make medical decisions. These proposals also afforded legal protection to health-care providers by granting immunity from civil and criminal liability when implementing a patient’s directive.\textsuperscript{22}

\textsuperscript{19} Tune v. Walter Reed Army Medical Hosp., 602 F. Supp. 1452 (D.D.C. 1985) (upholding the right of a military hospital patient with decision-making capacity to be removed from a respirator; the patient’s physicians had maintained that U.S. Army policy precluded the removal of life-sustaining equipment from such patients); Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984) (holding that as a matter of law the placing of a patient on life-support equipment against the specific wishes of a patient informed about a known terminal condition, constituted a battery for which the attending physician and the hospital could be liable in money damages); \textit{In re Lydia E. Hall Hospital}, 117 Misc. 2d 1024, 459 N.Y.S.2d 682 (N.Y. Sup. Ct. 1982) (requiring the hospital, which had defied the wishes of the patient and his family to forgo treatment, to pay the entire $1500 fee of the guardian ad litem appointed by the court when the hospital sought a court order to compel continued treatment); Foster v. Tourtellotte, No. CV 81-5046-RMT (C.D. Cal. Nov. 16-17, 1981) (granting an injunction requiring physician’s compliance with a patient’s withdrawal of consent to the continued use of a respirator; no final adjudication on the merits due to death of the patient after the order was stayed pending an appeal).


\textsuperscript{21} \textit{See, e.g.,} Kutner, supra note 20, at 552; Note, \textit{The “Living Will”: The Right to Death with Dignity?}, supra note 20, at 525-26; Note, \textit{Living Wills—Need for Legal Recognition}, supra note 20, at 377.

\textsuperscript{22} As the Legal Advisors Committee for Concern for Dying has observed, physicians may honor a terminally ill patient’s directive declining life-prolonging treatment in the absence of any statute. Legal Advisors Committee, Concern for Dying, \textit{The Right to Refuse Treatment: A Model Act}, 73 AM. J. PUB. HEALTH 918, 918 (1983). Thus, “... the current [living will] statutes do not so much enhance patients’ rights as
The Quinlan case profoundly influenced public opinion and the receptivity of state legislators to natural death legislation. Prior to 1975, "death with dignity" or "living will" bills had been introduced in about a dozen states. During the state legislative sessions which convened in the spring of 1976 following the lower court's denial of relief in Quinlan, seventeen right-to-die bills were introduced in different states. In October of 1976, California enacted the nation's first natural death act. During the following year, living will they enhance provider privileges (i.e., physicians typically are granted immunity if they follow a patient's directive, but are not required to follow it if they do not want to)." Id. (footnotes omitted). See also Gelfand, The First Decade, supra note 17, at 796-97 & nn.267, 270 & 274.


24. One commentator has divided the introduction of natural death bills in state legislatures into three periods: the initial (or very early) stage, the pre-Quinlan phase, and the post-Quinlan period. Chapman, supra note 9, at 914 n.14. A bill dealing with euthanasia of adults of sound mind who have been fatally injured or are "suffer[ing] extreme physical pain without hope of relief" was introduced in 1906 in the Ohio legislature; it was defeated by a vote of 78 to 22 in the Committee on Medical Jurisprudence. HUMPHRY & WICKETT, supra note 23, at 12 (citing articles in the Independent, Feb. 1, 1906, and in the Outlook, Feb. 3, 1906, and an editorial in the New York Times, Feb. 3, 1906). In 1912, a woman who was suffering constant pain from an incurable illness created a sensation when she petitioned the New York state legislature to permit her doctor to put her to death and grant her physician immunity from criminal homicide. Id. Over two decades later, in 1937, the Voluntary Euthanasia Act was introduced in the Nebraska state legislature. NEBRASKA LEG. BILL 135, 52d Sess. (1937). After referral to committee, however, no action was taken on the bill. HUMPHRY & WICKETT, supra note 23, at 14. Then in 1947, a petition, signed by 1100 physicians, calling for the enactment of procedures for the voluntary euthanasia of patients with painful, terminal illnesses was presented to the New York Legislature. Id. at 34-36. For a description of the reactions to the New York proposal, see R. RUSSELL, FREEDOM TO DIE 94-97 (1975).

During the more immediate pre-Quinlan phase, Dr. Walter Sackett, a Florida legislator and medical doctor, was one of the strongest advocates of "death-with-dignity" legislation. HUMPHRY & WICKETT, supra note 23, at 95. Emphasizing the expenses of artificially prolonging life for patients who are "human vegetables," Dr. Sackett introduced these bills in several sessions of the Florida Legislature during the early 1970s. Id. During the pre-Quinlan period, right-to-die bills were introduced in at least fourteen state legislatures: California (1973); Delaware (1973); Florida (1971); Hawaii (1969); Idaho (1974); Kentucky (1974); Maryland (1974); Massachusetts (1973); Missouri (1974); Montana (1973); Oregon (1973); Washington (1973); West Virginia (1971); Wisconsin (1971). See id. at 98-99; Chapman, supra note 9, at 914 n.14.

25. HUMPHRY & WICKETT, supra note 23, at 108.

bills were proposed in forty-two states and enacted by seven.\textsuperscript{27}

B. Legislative, Judicial, and Other Developments, 1978-83

1. Action in the State Legislatures

Although they initially generated much response, living will laws were enacted at a halting pace from 1978 until 1983. By January of 1984, only seven additional states and the District of Columbia had adopted such laws.\textsuperscript{28} In addition, commentators suggested a number of “model” statutes, including the Medical Treatment Decision Act,\textsuperscript{29} prepared in 1978 by a

\textit{of Physicians’ Practices}, 31 STAN. L. REV. 913 (1979) (indicating that approximately fifty percent of the patients diagnosed with terminal conditions did not remain conscious long enough to become legally qualified to execute binding directives).


\textsuperscript{29} SRD HANDBOOK (1981), supra note 27, at 23-26. The Model Bill was subsequently amended to explicitly include a provision for the optional designation of a proxy empowered to make treatment decisions in the event the declarant lost the capacity to do so. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-1984 at 11-12, 36-37 (1984) [hereinafter SRD HANDBOOK FOR 1981-84]. As originally drafted by the Yale Law School Legislative Services Project, the SRD model bill permitted personalized instructions, which the Society for the Right to Die maintained could include the appointment of a proxy. Id. at 11. However, the Society concluded that the explicit provision of an optional proxy designation served “as a further extension of the
Yale Law School Legislative Services Project under the sponsorship of the Society for the Right to Die, and the Right to Refuse Treatment Model Act,\textsuperscript{30} published in 1983 by the Legal Advisors Committee of Concern for Dying.

2. Litigation over the "Feeding" Question and the Rights of the Permanently Unconscious

Although only two states, Illinois and Virginia, enacted living will laws in 1983, a number of other important developments affecting the rights of dying patients occurred that year. In February of 1983, courts in New Jersey and New Mexico addressed two important issues involving the rights of terminally ill patients who lacked decision-making capacity. In New Jersey, the question before the courts was whether nasogastric feeding and hydration could be discontinued from Claire Conroy, a severely mentally impaired and elderly nurs-

\textsuperscript{30} Legal Advisors Committee, Concern for Dying, \textit{supra} note 22, at 918, 921. The Model Right to Refuse Treatment Act prepared by the Legal Advisors Committee of Concern for Dying endeavored not only to incorporate the best features of various proposed model statutes, but also to draft language that included provisions necessary in "'second generation' legislation." \textit{Id.} at 918. In the view of this group, "second generation" natural death legislation should accomplish the following objectives. It should

- not be restricted to the terminally ill, but should apply to all competent adults and mature minors;
- not limit the types of treatment an individual can refuse (e.g., to "extraordinary" treatment) but should apply to all medical intervention;
- permit an individual to designate another person to act on his or her behalf and set forth the criteria under which the designated person is to make decisions;
- require health-care providers to follow the patient's wishes and provide sanctions for those who do not do so;
- require health-care providers to continue to provide palliative care to patients who refuse other interventions.

\textit{Id.} at 918-19.
ing home patient who was expected to die within a year. In New Mexico, the issue was whether the court-appointed guardian of James Robert Smith, a comatose, terminally ill patient, could authorize the discontinuance of hemodialysis treatment on behalf of Mr. Smith, who had not executed a living will under the New Mexico Right to Die Act.

In New Jersey, a superior court granted, in February of 1983, the request of Claire Conroy’s nephew and court-appointed guardian to discontinue artificially supplied sustenance. Before being implemented, however, the decision was stayed, and the case was appealed. Claire Conroy died, with the nasogastric tube in place, while the appeal was pending; however, the matter was considered by the appellate court because of the importance of the issue.

In July, 1983, the three-judge appellate panel reversed the lower court’s ruling. In the opinion of the Superior Court’s Appellate Division, the right to abate treatment was restricted to irreversibly comatose or brain dead patients; the right did not extend to patients, like Claire Conroy, whose decision-making capacity was only severely diminished. In addition, the Appellate Division determined that the withdrawal of artificially supplied sustenance from a patient in Claire Conroy’s condition would hasten death rather than merely permit illness to take its natural course. On appeal,

33. Thomas Whittemore, the nephew and legal guardian of Claire Conroy, was also her only living relative. He had known her for over fifty years during which time he had visited her “regularly” at the nursing home, and about once a week for the four or five year period preceding her commitment to the nursing home. In re Conroy, 98 N.J. 321, —, 486 A.2d 1219, 1218 (1985). The record included evidence of the financial situations of both Thomas Whittemore and Claire Conroy. Id. Based on such information, the court concluded that “there was no question that the nephew had good intentions and had no real conflict of interest due to possible inheritance when he sought permission to remove the tube.” Id.
35. Id. The Appellate Division observed that although cases like Claire Conroy’s were capable of repetition, they were likely to evade review due to frequent patient deaths while litigation was pending. Id.
37. Id. at 473, 464 A.2d at 303.
38. Id. at 473, 464 A.2d at 303-04.
the New Jersey Supreme Court reversed.\textsuperscript{39}

In \textit{New Mexico ex rel. Smith v. Fort},\textsuperscript{40} the New Mexico Supreme Court, in February of 1983, reversed the lower court's ruling that had granted the request of the legal guardian of James Robert Smith to authorize the discontinuance of hemodialysis for Smith's kidney-related ailments. Although Mr. Smith had not executed written instructions in accordance with the Right to Die Act, his family, doctors, and the court-appointed religious visitor unanimously agreed that he would opt to forgo continued hemodialysis if he had decision-making capacity.\textsuperscript{41} Moreover, his doctors agreed that no treatment could save his life or substantially benefit his health.\textsuperscript{42} Nevertheless, the supreme court held that the state lacked statutory authority to empower a legal guardian to authorize the abatement of life-prolonging treatment on behalf of an incompetent patient.\textsuperscript{43}

Later in 1983, the state legislature of New Mexico passed a bill amending the New Mexico Right to Die Act. The amendment established guidelines for the abatement of life-sustaining treatment in cases of irreversibly comatose patients who had not executed living wills.\textsuperscript{44} The 1983 bill was vetoed by the governor; however, during the next legislative session it was reintroduced, passed, and ultimately signed into law.\textsuperscript{45}

3. The Report of the President's Commission on "Deciding to Forego Life-Sustaining Treatment"

In March of 1983, the President's Commission for the

\textsuperscript{39} \textit{In re Conroy}, 98 N.J. 321, 486 A.2d 1209 (1985). The New Jersey Supreme Court granted the guardian's petition for certification, despite the death of the patient, because it concurred with the Appellate Division's assessment of the importance of the issues presented. \textit{Id.} at —, 486 A.2d at 1219. See \textit{infra} notes 78-83 and accompanying text (detailing the reversal decision).

\textsuperscript{40} No. 14,768 (N.M. Sup. Ct. Feb. 23, 1983).

\textsuperscript{41} \textit{SOCIETY FOR THE RIGHT TO DIE, RIGHT-TO-DIE COURT DECISIONS NM-1} (1986) [hereinafter SRD COURT DECISIONS (1986)].

\textsuperscript{42} \textit{Id.}

\textsuperscript{43} \textit{New Mexico ex rel. Smith v. Fort, summarized in SRD COURT DECISIONS} (1986), \textit{Id.} An amicus curiae brief was submitted on behalf of the Ethics Committee of St. Joseph Hospital, the New Mexico Medical Society, and the New Mexico Hospital Association. \textit{Id.}

\textsuperscript{44} \textit{Id.} at NM-1, NM-2. According to the Society for the Right to Die, the New Mexico legislature's response was immediate. \textit{Id.}

\textsuperscript{45} \textit{Id.} See also \textit{infra} notes 75-76 and accompanying text.
Study of Ethical Problems in Medicine and Biomedical and Behavioral Research completed its Report on *Deciding to Forego Life-Sustaining Treatment.* Although not part of its original mandate, the Commission decided to address this issue because it was closely related to mandated subjects and "seemed...to involve some of the most important and troubling ethical and legal questions in modern medicine." Among other topics discussed in this Report, the President's Commission evaluated the natural death acts of the fifteen jurisdictions which had adopted such legislation. Other decision-making mechanisms, particularly the use of proxy directives utilized pursuant to state durable power-of-attorney statutes, were also addressed.

The President's Commission recognized that both living wills and proxy directives "are important for medical decisionmaking that respects patients' wishes." However, it also observed that "[p]roxy directives allow patients to control decisionmaking in a far broader range of cases than the instruction directives authorized by most existing natural death acts." Furthermore, the Commission suggested the need for additional study of existing durable power-of-attorney statutes and the possible need to require greater procedural safeguards when applying these statutes to health-care decision-making for incapacitated patients.

The Commission's Report outlined four general considerations, including the use of a proxy arrangement, in

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47. Letter from Morris B. Abram, Chairman, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, to the President of the United States (Mar. 21, 1983), reprinted in *President's Commission Report, Deciding to Forego Life-Sustaining Treatment,* supra note 46.

48. *Id.* at 136-47. In the opinion of the President's Commission, "[t]he greatest value of the natural death acts is the impetus they provide for discussions between patients and practitioners about decisions to forego life-sustaining treatment." *Id.* at 145 (footnote omitted). However, the President's Commission also observed that "[t]his educational effort might be obtained...without making the documents binding by statute and without enforcement and punishment provisions." *Id.*

49. *Id.*

50. *Id.* at 147.
formulating or amending legislation authorizing advance directives. The Report was one of the most important resources available to the ULC in 1983 when they began their work on the URTIA.

4. The Attempted Prosecution of Two California Doctors for Discontinuing Artificial Sustenance

Concern by physicians about their potential legal liability for withdrawing artificial sustenance treatment was heightened in May of 1983 when the California Superior Court reinstated criminal charges against Dr. Neil Barber and Dr. Robert Nejdl. The doctors had been charged in 1982 with murder and conspiracy to commit murder for ordering the withdrawal of the respirator and intravenous tubes which provided hydration and nutrition to Clarence Herbert, a severely brain-damaged cancer patient. Herbert, who had suffered cardiac arrest in the recovery room following surgery, had not executed a directive to physicians and, therefore, did not fall within the scope of the California Natural Death Act.

The doctors had first taken Herbert off the respirator with the authorization of his family. Two days later, after further consultation with the family, the doctors also removed intravenous sustenance. The patient died six days later.

51. Id. at 149-53. The President's Commission recommendation focused on four areas: (1) requirements for a valid directive; (2) legal effect of directives; (3) characteristics and authority of a proxy health-care decision-maker; and (4) administrative aspects. Id.


53. Towers, Irreversible Coma and Withdrawal of Life Support: Is It Murder if the IV Line Is Disconnected?, 8 J. MED. ETHICS 203, 203 (1982). The patient had died in August, 1981 in a hospital owned by the Kaiser-Permanente System, the nation's largest prepaid health-care system of health maintenance organization (HMO). Id. at 203-04. The prosecutors contended that the two doctors' conduct was motivated in part by a desire "to save money for a prepaid health plan." HUMPHRY & WICKETT, supra note 23, at 252.


55. Towers, supra note 53, at 203. Although the patient was severely brain-damaged, his brain-stem function was sufficiently intact for spontaneous breathing to occur after the respirator was removed. Id.

56. Id. Although press accounts differed on this point, the family of the patient apparently demanded that all life-support systems be stopped, including artificially supplied nourishment and hydration. After the doctors discontinued artificial hydration
Initially, a municipal court had dismissed the criminal charges, ruling that Dr. Barber and Dr. Nejdl had acted properly, exercising their best medical judgment.57 After the Superior Court reinstated the charges in May of 1983, the case was elevated to the California Court of Appeal.58 The medical community anxiously awaited the decision of whether or not the doctors would have to stand trial.59 Then, in October of 1983, the Court of Appeal's three-judge panel ruled in favor of the doctors and ordered the charges dismissed.60

The California Court of Appeal held that life-sustaining procedures may be discontinued under circumstances other

and sustenance and ordered only "ordinary" nursing care, spontaneous breathing continued for a week. The autopsy findings listed "dehydration" as a factor contributing to the patient's death. Id. Sandra Bardenilla, an intensive care nursing supervisor at the hospital, objected to the management of the patient, particularly the orders not to mist his endotracheal tube and, later, the orders to discontinue artificial hydration and nourishment. Gianelli, Nurse Who Challenged MDs' Action Wins Case, Am. Med. News, Sept. 9, 1988, at 10, col. 1. After discussing the management of the patient with her supervisor, the director of nursing, the director of personnel, and the chief of staff, Nurse Bardenilla reported the case to the Department of Health Services when the patient died. In bringing the murder charges against the two doctors, prosecutors in the office of the Los Angeles District Attorney contended that the two doctors had pressured the patient's wife to agree to withdraw life support to cover up hospital malpractice. Id. See also HUMPHRY & WICKETT, supra note 23, at 252. The prosecutors maintained that the patient's brain damage was caused by lack of adequate oxygen supply following anesthesia, which would have been managed properly but for an understaffing problem in the recovery room. Gianelli, supra, at 11. In their defense, the two doctors asserted that they were implementing the wishes of the family of an irreversibly comatose patient. HUMPHRY & WICKETT, supra note 23, at 252.

58. Id.
59. SRD HANDBOOK FOR 1981-84, supra note 29, at 8.
60. Barber, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). Although criminal charges were dropped, questions of civil liability for negligence remained. Gianelli, supra note 56, at 11, col. 1. In March of 1988, a three-member Los Angeles Superior County arbitration panel unanimously agreed the recovery room understaffing constituted negligence. The arbitration panel ordered Kaiser Foundation Hospital to pay $325,000 to the family of Clarence Herbert. However, with regard to the doctors' decision to remove all life support systems, the arbitration panel ruled two to one in favor the doctors. Id.

More recently, on August 24, 1988, Sandra Bardenilla, the nursing supervisor who objected to Mr. Herbert's care, won a trial court verdict of $114,000 against Kaiser Foundation Hospital officials, including damages for lost earnings, emotional damages, and punitive damages. The jury found that Kaiser had treated Bardenilla maliciously and oppressively. Id. at 10, col. 1.
than those specified in the California Natural Death Act. More importantly, the court held that artificially supplied nutrition and hydration are indistinguishable from the use of a respirator or other artificial life support. Finally, the court concluded that a physician is under no duty to continue artificial life support treatment when there is no hope that the patient will recover.

5. American Hospital Association Survey of Public Attitudes Toward the Abatement of Life-Sustaining Treatment

Public support for the abatement of life-prolonging treatment of terminally ill patients was gauged by the American Hospital Association (AHA) in a 1983 survey of 1800 adults in all age groups. The AHA survey indicated that approximately three of every four Americans thought that physicians should discontinue life-support systems of patients for whom there was little or no hope of recovery to a normal life. In addition, two of three survey respondents thought that families should act as surrogate decision-makers for patients who lacked capacity. Finally, fifty percent of those queried by

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61. Barber, 147 Cal. App. 3d at 1017, 195 Cal. Rptr. at 490.
62. Id. at 1021-22, 195 Cal. Rptr. at 493.
63. Id. at 1017-18, 195 Cal. Rptr. at 490. The withdrawal of artificially supplied nourishment and hydration from patient Clarence Herbert has been the subject of extensive commentary in both the medical and legal communities. See, e.g., Annas, Fashion and Freedom: When Artificial Feeding Should Be Withdrawn, 75 AM. J. PUB. HEALTH 685 (1985) [hereinafter Annas, Fashion and Freedom]; Dresser & Boisaubin, Ethics, Law, and Nutritional Support, 145 ARCHIVES INTERNAL MED. 122 (1985); Cranford, Termination of Treatment in the Persistent Vegetative State, 4 SEMINARS IN NEUROLOGY 36 (1984); Meilaender, On Removing Food and Water: Against the Stream, 14 HASTINGS CENTER REP. 11 (December, 1984); Steinbock, The Removal of Mr. Herbert's Feeding Tube, 13 HASTINGS CENTER REP. 13 (October, 1983).
64. Barber, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.
65. SRD HANDBOOK FOR 1981-84, supra note 29, at 7.
66. Id. While seventy-one percent of the respondents supported the termination of life support systems, the survey revealed that younger adults were more likely than older adults to prefer continued administration of life-sustaining procedures. HUMPHRY & WICKETT, supra note 23, at 119 (discussing the results of the 1983 AHA survey).
the AHA opposed decision-making by a committee of physicians and clergy. 67

C. Important Developments, 1984-85

1. The Emergence of Consensus Among Ten Prominent Physicians

While work by the ULC was progressing on a uniform natural death act, ten distinguished physicians with diverse professional and institutional backgrounds co-authored guidelines on "The Physician's Responsibility Toward Hopelessly Ill Patients." These guidelines were published in April of 1984 in the New England Journal of Medicine. 68 Due to the prestige of both the writers and their forum, the article received national attention. 69

The article delineated medical treatment which the doctors considered ethical and appropriate in various medical situations, ranging from emergency resuscitation and intensive care to utilization of only comfort care. 70 The comprehensive guidelines included those for patients who lacked capacity to make health-care decisions, as well as for those who retained


69. See, e.g., SRD HANDBOOK FOR 1981-84, supra note 29, at 4. Preparation of the article by the ten physicians was part of a project sponsored by the Society for the Right to Die. The doctors had assembled at an SRD conference to formulate guidelines on medically and ethically appropriate care for patients in various stages of irreversible and incurable illness. Ultimately, the Society for the Right to Die republished the article in its entirety, along with other information, in a handbook. See SOCIETY FOR THE RIGHT TO DIE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT: LEGAL, MEDICAL & ETHICAL GUIDELINES 4 (1985).

70. Wanzer & Adelstein, The Physician's Responsibility, supra note 68, at 956-58. The authors described four general levels of care:

(1) emergency resuscitation;
(2) intensive care and advanced life support;
(3) general medical care, including antibiotics, drugs, surgery, cancer chemotherapy, and artificial hydration and nutrition; and
(4) general nursing care and efforts to make the patient comfortable, including pain relief and hydration and nutrition as dictated by the patient's thirst and hunger.

Id. at 958.
such capability. The doctors placed primary emphasis upon the decision-making role of the patient or the surrogate decision-maker. The article also recognized the value of a living will or proxy appointment.

2. Legislative Activities in 1984

Seven additional states enacted natural death bills in 1984. Among these states was Florida, where Dr. Walter Sackett had first introduced a living will bill in 1968. Additionally, New Mexico amended its Right to Die Act in 1984 by adding "irreversible coma" as an alternative condition qualifying a patient for the removal of maintenance medical treatment. The New Mexico amendment created a procedure for obtaining substituted consent for the removal of maintenance treatment from an incompetent, terminally ill, or irreversibly comatose patient who had not executed a living will. The procedure allowed the abatement of treatment "when all family members who can be contacted through reasonable diligence agree in good faith that the patient, if competent, would choose to forgo that treatment."

71. Id. at 958-59. In discussing "the incompetent patient," the ten co-authors distinguished among brain dead patients, patients in persistent vegetative states, severely and irreversibly demented patients, and elderly patients whose competence is mildly but permanently impaired. Id.

72. Id. at 955-56. The article also described the role of the physician in the decision-making process: "He or she has the knowledge, skills, and judgment to provide diagnosis and prognosis, to offer treatment choices and explain their implications, and to assume responsibility for recommending a decision with respect to treatment." Id. at 956.

73. Id.


76. Id. at § 24-7-8.1. The statute defines "family members" as the spouse and children over the age of eighteen; if none, the term refers to the parents of the incompe-
3. The New Jersey Supreme Court's Decision in *Conroy*

The year 1985 was an important benchmark in the evolution of the rights of patients wishing to refuse life-sustaining medical treatment. As the new year dawned, Karen Quinlan was still alive in a persistent vegetative condition, sustained by artificially supplied nourishment in a nursing home. The dramatic impact of her case upon the rights of permanently comatose and terminally ill patients continued to grow.

On January 17, 1985, the New Jersey Supreme Court added its decision in *In re Conroy* to the judicial legacy of *Quinlan*. Whereas *Quinlan* had only addressed the removal of the respirator, *Conroy* set forth circumstances and procedures for withdrawing or withholding other life-sustaining treatment—particularly nasogastric feeding—from elderly, incompetent, nursing home patients for whom death was expected within a year even if treatment continued. The New Jersey Supreme Court reversed the Appellate Division which had
ruled in 1983 that withdrawal of Claire Conroy's nasogastric tube would be tantamount to killing her—not simply letting her die—and that such active euthanasia was ethically impermissible.\textsuperscript{80}

In \textit{Conroy} the New Jersey Supreme Court also rejected "any distinction between withholding and withdrawing life-sustaining treatment"\textsuperscript{81} and criticized the utility of prior efforts to distinguish between ordinary and extraordinary treatment.\textsuperscript{82} Most significantly, the supreme court made no distinction between the termination of artificial feedings and the termination of other forms of life support.\textsuperscript{83} The decision

cians affiliated with neither the nursing home nor the attending physician and appointed by the Ombudsman or the courts. \textit{Id.} at —, 486 A.2d at 1242.

On August 30, 1988, the New Jersey Ombudsman's Office for the Institutionalized Elderly issued a directive outlining how the office would implement the New Jersey Supreme Court's decisions in \textit{Conroy} and other cases. See Gianelli, \textit{Medical Ethics Debate: "Right to Die" vs. "Right to Kill"?}, Am. Med. News, Jan. 6, 1989, at 4, col. 4. The directive said that any decision to withdraw or withhold life-prolonging treatment from an elderly patient lacking capacity to make such decisions would be investigated as "a possible case of patient abuse." \textit{Id.} at 5, col. 1 (quoting the directive). Although the stated purpose of safeguards established by the ombudsman's office was "to protect the vulnerable elderly who may be the victims of malicious or uncaring relatives or caregivers," many physicians were upset by the approach taken in the directive. \textit{Id.}

81. \textit{Conroy}, 98 N.J. at —, 486 A.2d at 1234. Some had maintained that stopping life-sustaining treatment after it had been initiated was morally more problematic than failing to begin the treatment. \textit{See}, e.g., Clouter, \textit{Allowing or Causing: Another Look}, 87 \textit{Annals Internal Med.} 622, 624 (1977). The New Jersey Supreme Court said that "[t]his distinction is more psychologically compelling than logically sound." \textit{Conroy}, 98 N.J. at —, 486 A.2d at 1234. Moreover, the supreme court noted that a rule forbidding physicians from \textit{discontinuing} treatment under circumstances in which the treatment could permissibly be \textit{withheld} "could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die." \textit{Id.} (citing Lynn & Childress, \textit{Must Patients Always Be Given Food and Water?}, 13 \textit{Hastings Center Rep.}, 17, 19-20 (October 1983)).

82. \textit{Conroy}, 98 N.J. at —, 486 A.2d at 1235 (concluding that "[t]he terms 'ordinary' and 'extraordinary' have assumed too many conflicting meanings to remain useful").
83. \textit{Id.} at —, 486 A.2d at 1236-37. The supreme court observed:

Once one enters the realm of complex, high-technology medical care, it is hard to shed the "emotional symbolism" of food. . . . However, artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoon-feeding—they are medical procedures with inherent risks and possible side effects, instituted by skilled health care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator.
may be one of the most far reaching rendered by a state high court in the right-to-die area.

4. Reaction of Special Advocacy Groups to Conroy

The most controversial aspect of the Conroy decision was the inclusion of artificially supplied nutrition and hydration in the category of life-sustaining treatment which may be declined by a patient or surrogate decision-maker. Consequently, as states experienced a resurgence in the introduction of proposed living will laws with the beginning of new legislative sessions in January of 1985, Conroy galvanized right-to-life activists to seek legislative amendments prohibiting or severely restricting the withholding or withdrawal of food and water from incompetent patients.

The Committee for Pro-Life Activities of the National Conference of Catholic Bishops approved guidelines on provisions which church officials were to seek inclusion of in any proposed state living will legislation. One guideline suggested that right-to-die bills should specifically exclude the withdrawal of nutrition and hydration from the definition of life-sustaining procedures. Such an exclusion would mean that these measures could not be withheld from a terminally ill, incompetent patient—even if the patient had previously executed a living will.

5. Legislative Activities in 1985

As the ULC was completing the draft of a uniform living

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Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.

*Id.* at —, 486 A.2d at 1236 (citing Barber v. Superior Court, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (1983)).

84. For incisive discussions of the ethical, medical, and legal considerations involved in withholding artificial sustenance, see Annas, *Fashion and Freedom,* supra note 63, at 686-87 and Dresser & Boisaubin, supra note 63, at 123-24.

85. Otten, *New “Wills” Allow People to Reject Prolonging of Life in Fatal Illness,* Wall St. J., July 2, 1985, at 23, col. 4 [hereinafter Otten, *New Wills*]. For a description of the membership and role of right-to-life groups that opposed living will legislation, see Otten, “Living Will” Bills Fought in States, Wall St. J., May 3, 1984, at 52, col. 1. Many of these groups characterized living will legislation as “an opening wedge of the euthanasia movement” and as “advancing ‘the concept of euthanasia (mercy killing) and rational suicide.’” *Id.*

86. Otten, *New Wills,* supra note 85.

87. *Id.*
will law, the first half of 1985 witnessed the enactment of state living will statutes in legislative chambers across the nation at a pace unprecedented in the history of American natural death legislation. The acceleration of legislative activity during 1985 resulted in the adoption of natural death laws by thirteen states during the four-month period between March 4 and July 1, 1985. The right-to-life activists apparently enjoyed a lot of influence because, contrary to Conroy, many of the 1985 laws expressly excluded artificially supplied nutrition and hydration from the life-sustaining procedures which could be declined pursuant to a treatment directive. In sum,


89. The statutes of Colorado, Connecticut, Maine, and Missouri explicitly provide that artificial nutrition and hydration are not life-sustaining procedures which may be rejected under each state's living will law. COLO. REV. STAT. § 15-18-103(7) (Repl. 1987); CONN. GEN. STAT. § 19a-571(1) (Supp. 1988); ME. REV. STAT. ANN. tit. 22, § 2921(4) (Supp. 1988); MO. ANN. STAT. § 459.010(3) (Vernon Supp. 1989). Language clearly prohibiting the abatement of artificial nourishment is also found in the statutes of Georgia and Wisconsin, both adopted in 1984, and in Idaho's recently amended law. GA. CODE ANN. § 31-32-2(5) (Supp. 1988); IDAHO CODE § 39-4503(4) (1985 & Supp. 1986); WIS. STAT. ANN. § 154.01(5)(b) (West 1988). The legislation enacted in Arizona, Indiana, Iowa, Maryland, New Hampshire, Oklahoma, and Utah exclude artificially administered nourishment from life-sustaining procedures that may be withheld or withdrawn. These statutes also exclude from the category the administration of medication and the performance of any medical procedure deemed necessary to provide comfort care. ARIZ. REV. STAT. ANN. § 36-3201(4) (1986); IND. CODE ANN. § 16-8-11-4 (Burns Supp. 1988); IOWA CODE ANN. § 144A.2(5)(b) (West Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-605(1) (Supp. 1988); N.H. REV. STAT. ANN. § 137H:2(2) (Supp. 1988); OKLA. STAT. ANN. tit. 63, § 3102(4) (West Supp. 1989); UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1988). Similar provisions associating artifi-
thirty-five states and the District of Columbia\textsuperscript{90} had living will laws, many varying significantly in scope, when the ULC convened in August of 1985 to give final consideration and approval to the URTIA.

D. The Drafting by the ULC of the URTIA and Related Laws

1. The Development of Uniform Laws Relative to Dying Patients and Medical Decision-Making

For over two decades, the National Conference of Commissioners on Uniform State Laws has produced laws to ad-

dress specific problems relating to dying patients and medical decision-making. The problems addressed by these uniform and model laws have included the donation of organs removed from cadavers, the recognition of the concept of "whole brain" death, and the concept of consent to health care.

a. The Uniform Anatomical Gift Act

In 1968 the ULC approved the Uniform Anatomical Gift Act (UAGA), thereby creating a legal mechanism to facilitate the donation of organs of deceased patients for transplantation purposes. The UAGA was adopted by all fifty states and the District of Columbia by 1971 and has been one of the most well-received uniform acts in the ninety-seven year history of the Uniform Law Conference.

b. Development of a "Whole Brain" Death Law

In 1978, a decade after the approval of the UAGA, the ULC completed work on the Uniform Brain Death Act. However, even after this Act was submitted to the states for consideration, several states continued to implement their own somewhat idiosyncratic approaches in enacting brain death laws. Because of the problems created by the variations in these laws, another effort was undertaken to draft a uniform act more broadly acceptable to the states.

In May of 1980, the Executive Director of the President's Commission for the Study of Ethical Problems in Medicine

92. See infra note 229 and accompanying text.
93. Unif. Brain Death Act, (act superseded 1983 by Unif. Determination of Death Act) reprinted in Handbook of the National Conference of Commissioners on Uniform State Laws and Proceedings of the Annual Conference Meeting in Its Eighty-Seventh Year 145 (1978) [hereinafter 1978 Handbook]. The act was approved by the ULC on August 3, 1978, by a vote of forty-seven to one. Id. at 75-77. The Prefatory Note to the Act stressed its narrowness and noted subjects not addressed by it, including "living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in case of pregnant women or of organ donors, and protection accorded the dead body." Prefatory Note, Unif. Brain Death Act, reprinted in id. at 144.
and Biomedical and Behavioral Research met with representatives of the American Bar Association (ABA), the American Medical Association (AMA), and the ULC to draft a better brain death proposal. The combined efforts of these organizations ultimately produced the Uniform Determination of Death Act, which was approved by the ULC in 1980. The 1980 Act, which superseded the Uniform Brain Death Act, has been much more widely accepted.

c. The Model Health Care Consent Act

In 1982, two years after the Uniform Determination of Death Act was approved, the ULC completed work on yet another law involving health-care decisions, the Model Health Care Consent Act. It establishes a mechanism for the appointment of a health-care representative to make medical treatment decisions on behalf of a patient lacking decisional capacity. The title of the Model Health Care Consent Act is very misleading. Although the title suggests that consent is its central focus, the model Act should more accurately be labeled a “substitute authority to decide” act. As a result, the

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99. President's Commission Report, Deciding to Forego Life-Sus-
model Act has been criticized for its narrow scope and imprecision.\textsuperscript{100} The states thus far have shown very little enthusiasm for this model Act.\textsuperscript{101}

d. \textit{The Need for a Uniform "Natural Death" Act}

As more and more states followed the lead of California in enacting state living will or natural death acts, the ULC became concerned with the tremendous variation in state laws. In addition, the increasing mobility of American citizens presented the possibility that a person who had signed a living will or declaration declining life-sustaining actions in one state might be critically injured or become seriously ill in another state which was unwilling to honor the declaration. As the President’s Commission had observed with regard to the great variation in state brain death laws: "In most areas of the law, provisions that diverge from one state to the next create, at worst, inconvenience and the occasional failure of a finely honed business or personal plan to achieve its intended result. But on the subject of death, nonuniformity has a jarring effect."\textsuperscript{102} One commentator remarked in a 1982 article\textsuperscript{103} that the same considerations which led to the formulation of the Uniform Determination of Death Act similarly compelled the drafting of a uniform natural death act.\textsuperscript{104} Because the technology employed to extend life is fairly uniform throughout the United States, the author recommended a uniform act which would incorporate the best features of the existing state

\begin{footnotesize}
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\item \textsuperscript{100} \textit{See Capron, Uniform Law Commissioners' Model Health-Care Consent Act—Considerations Against Adoption, 4 J. Legal Med. 513, 514 (1983).}
\item \textsuperscript{101} \textit{See Capron, supra note 99, at 514-24. See also Annas & Glantz, infra note 237, at 145. For a favorable assessment of the model act, see Pickle, Uniform Law Commissioners' Model Health-Care Consent Act—Considerations in Favor of Adoption, 4 J. Legal Med. 501 (1983).}
\item \textsuperscript{102} \textit{The ULC's Prefatory Note to the model act indicates that it is “procedural in nature and purposefully narrow in scope” and that “[i]ts primary aim is to provide authorization to consent to health care.” See Prefatory Note, 9 U.L.A. 453 (1988).}
\item \textsuperscript{103} \textit{PRESIDENT'S COMMISSION REPORT, DEFINING DEATH, supra note 94, at 72.}
\item \textsuperscript{104} \textit{Freamon, Death with Dignity Laws: A Plea for Uniform Legislation, 5 SETON HALL LEGIS. J. 105 (1982).}
\end{itemize}
\end{footnotesize}
In 1983, the preparation of a uniform natural death act became a central focus of the ULC.

2. The ULC at Work: The History of the URTIA

a. Assessing the Need for a Uniform Living Will Law

The task of drafting any uniform or model law is carried out by an elaborate committee structure within the ULC. Initially, the Scope and Review Committee of the ULC screens requests for new drafting projects. Interest in a uniform act addressing the "withdrawal of life support measures (the living will issue)" was evidenced as early as February of 1977 in a committee report of the ULC.106

In 1978 the ULC Executive Committee authorized the appointment of a special committee to study the practicality and necessity for a Uniform Natural Death Act.107 This committee was directed to obtain input by contacting the appropriate representatives of the American Bar Association, the Catholic Hospital Association, and the Society for the Right to Die. This study committee concluded in 1982 that "there is a need for uniform legislation addressing the right of a terminally ill competent adult to control the use of life-sustaining procedures that merely prolong life."108

b. The Drafting of the URTIA

The Executive Committee of the ULC authorized the appointment of a Drafting Committee on the Rights of the Terminally Ill Act in February, 1983.109 A twelve-member

105. *Id.* at 137-40.


committee was appointed to draft the new law. Members were selected to ensure expertise, as well as divergent viewpoints. Both legal and nonlegal experts and such groups as the American Hospital Association, the United States Catholic Conference, the ABA’s Committee on Legal Problems of the Elderly, the Catholic Health Association of the United States, and the Society for the Right to Die were invited to provide specialized knowledge to the drafting committee. However, all decisions were made by the commissioners, who represented only the people of their states.

Preliminary drafts were prepared and circulated to committee advisors, individuals and organizations interested in the committee’s work, and all uniform law commissioners. Eventually, the drafting committee presented its tentative draft, for initial consideration by the ULC, at an annual meeting in August of 1984.

The committee’s tentative draft of the URTIA was read “line by line” at the 1984 annual meeting and then discussed and debated. With more than 200 commissioners participating in the annual meeting, it is not surprising that the initial draft of the URTIA was amended during the process. Controversial issues or questions were decided by polling state delegations, each state having one vote.

After the initial consideration at the August, 1984, an-
annual meeting, the ULC committees resumed their work, incorporating changes made during the annual meeting and addressing new problems posed by commissioners. The URTIA, like all proposed uniform laws, was subjected to this rigorous procedure for at least two annual meetings before it became eligible for designation as an ULC product.

The final decision on whether any proposal, such as the URTIA draft, is ready for "promulgation" to the states is made near the end of an annual meeting; again, each jurisdiction has one vote. A majority of states present, but no fewer than twenty states, must approve an act before it can be officially adopted by the ULC as a uniform or model proposal.\(^{114}\) The URTIA was approved in August of 1985, with thirty-seven jurisdictions voting for the Act and only ten voting against it. Two states abstained, while three jurisdictions failed to vote.\(^{115}\)

III. THE UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (URTIA)

A. Overview of the URTIA

As previously described, the ULC’s multi-year study and two-year drafting effort culminated in the 1985 approval of the URTIA. Although the Quinlan case had stimulated interest in the adoption of the nation’s first living will law in California in 1976, ironically the Uniform Act does not encompass patients like Karen Quinlan, in a permanently unconscious but not terminally ill state.\(^{116}\) Consequently, a significant category of patients cannot benefit from the Uniform Act.


\(^{115}\) See Marzen, infra note 232, at 441 n.1 (listing those states voting for and against the approval of the URTIA).

\(^{116}\) Cf. Annas & Glantz, infra note 237, at 142-44 (discussing similar state living will laws).
The title of the Uniform Act suggests that it encompasses all terminally ill patients; however, its scope is actually quite narrow. Most succinctly stated, the URTIA authorizes an adult (a person age eighteen or older) who is of sound mind to control decisions regarding administration of life-prolonging treatment. The adult may exercise such control by executing a written declaration instructing a physician to withhold or withdraw life-sustaining treatment in the event the declarant is in a terminal condition and is unable to participate in medical treatment decisions.\textsuperscript{117}

A terminal condition is one that is "incurable and irreversible" and that will result in death "within a relatively short time" if life-sustaining treatment is not administered.\textsuperscript{118} The medical procedures or interventions which may be forgone are those that "serve only to prolong the process of dying."\textsuperscript{119} Thus, just as the California Natural Death Act has been criticized for covering "only patients . . . who are on the edge of death despite the doctor's efforts," a major defect of the Uniform Act is its application to such a narrow and less problematic group of dying patients.\textsuperscript{120}

As a result, the URTIA is most significant for the individuals whose situations it does not encompass and whose rights it does not address. Those individuals include: (1) minors; (2) persons who have not executed an advance directive; (3) adults who have never had decisional capacity to execute a declaration; and, (4) non-terminal patients who are permanently unconscious.\textsuperscript{121} Unfortunately the ULC has not offered any substantively meaningful law to fill the legislative void left by such groupings.

The vehicle utilized in the Uniform Act for the implementation of a terminally ill patient's decisions is also very restrictive. When the Act was being drafted, natural death acts in seven states\textsuperscript{122} explicitly recognized two types of ad-

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\item \textsuperscript{117} URTIA, supra note 3, Prefatory Note.
\item \textsuperscript{118} \textit{Id.} § 1(9).
\item \textsuperscript{119} \textit{Id.} § 1(4).
\item \textsuperscript{120} Capron, \textit{The Development of Law on Human Death} 315 \textsc{Annals of N.Y. Academy of Science} 45 (1978).
\item \textsuperscript{121} URTIA, supra note 3, Prefatory Note.
\item \textsuperscript{122} The states were Delaware (\textsc{Del. Code Ann.} tit. 16, §§ 2501-2508 (1983)), Florida (\textsc{Fla. Stat. Ann.} §§ 765.01-.15 (West Supp. 1986)), Louisiana (\textsc{La. Rev.}
vance declarations, a treatment directive and a proxy directive. A treatment directive sets forth the medical treatments or interventions that the declarant desires to forgo in the event the declarant is in a specified condition and lacks decisional capacity. A proxy directive is the declarant’s written appointment of another individual to make medical decisions for the declarant if the declarant becomes incapable of making medical decisions.

Because of the wide range of variations in medical conditions and the vagaries of patient responses to medical treatment, the ideal natural death act should provide patients with the flexibility to execute an advance declaration which includes both treatment and proxy features. As discussed earlier, the President’s Commission Report, which was completed well before serious drafting was under way on the Uniform Act, recognized the importance of a personally appointed proxy decision-maker familiar with the patient’s values and wishes and able to promote the underlying principles of autonomy and self-determination of the declarant. As the President’s Commission observed, “by combining a proxy directive with specific instructions, an individual could control both the content and the process of decisionmaking about care in case of incapacity.”

In addition, the Right to Refuse Treatment Act, developed in 1983 by the Legal Advisers Committee of Concern for Dying, recognized the utility of providing both treatment directives and proxy directives. Unfortunately, the Uniform Act authorizes only treatment directives. The mission of


123. Hastings Center Guidelines, infra note 302, at 141, definition 14. A living will is one type of treatment directive. Id.

124. Id. at 78-81, 141, definition 20. A “durable power of attorney” is a common form of proxy directive, but it is not the only form. Id. at 80.

125. President’s Commission Report, Deciding to Forego Life-Sustaining Treatment, supra note 46, at 149.

126. Legal Advisers Committee, Concern for Dying, supra note 22, at 918.

127. URTIA, supra note 3, at §§ 1(2), 2(a). While proxy directives are not expressly authorized, it should be noted that the form of declaration set forth in the statute is not mandatory. Id. § 2(b). Thus, it can be argued that the declarant retains the
the URTIA Drafting Committee, however, apparently was not to formulate a comprehensive and practical uniform natural death act but, instead, to draft a narrow one.

B. Procedural and Substantive Operation of the URTIA

1. The Execution of a Declaration

An adult of sound mind may execute at any time a declaration governing the abatement of life-sustaining treatment. The declaration must be in writing, signed by the declarant or by someone at the declarant’s direction, and witnessed by two individuals. These requirements are very similar to, although somewhat simpler than, those set forth in the Uniform Probate Code for the execution of a formally attested property will.

The utilization of property will requirements as a model for a living will or advance directive incorporates at least one potential problem. The choice of the term “sound mind,” without a definition of its meaning in the context of a treatment directive, is somewhat problematic. While state will acts typically do not define “sound mind,” there is a body of common law that has carefully defined this term for purposes of capacity to execute a property will.

In the context of informed refusals of medical treatment, several different approaches have been suggested to ascertain a patient’s competence. The President’s Commission Report identified three common methods for assessing decisional capacity: (1) “outcome approach,” whereby decisions not right to modify the declaration to designate a proxy decision-maker. See Cohen, Appointing a Proxy for Health-Care Decisions, Society for the Right to Die Monograph No. 6 (Sept. 1986). Because it remains largely untested legally, this approach to designating such a proxy is risky.

128. URTIA, supra note 3, at § 2(a) (1987).
129. Id. §§ 1(2), 2(a).
131. W. MCGOVERN, S. KURTZ, & J. REIN, WILLS, TRUSTS, & ESTATES 274 (1988). Most cases employ the following formula in defining testamentary capacity: One has the requisite capacity to execute a will if, at the time of execution, she or he can understand (1) the nature and extent of her/his property; (2) the persons who are the natural objects of her/his bounty; and (3) the disposition she or he is making of her/his property in the will. Id. at 274-76.
reflecting community values are used as evidence of lack of competence; (2) "status approach," whereby an individual’s competence is based on his physical or mental status, considering factors such as consciousness, age, mental or physical diagnosis; and (3) "functioning approach," which focuses on the individual’s actual functioning in decision-making situations. In the context of the URTIA, a more precise term than “sound mind” or “competence” is needed. “Decision-making capacity” is a viable alternative. If used, this term should be expressly defined, based on the “functioning” or “process” approach, to mean the ability or capacity of the declarant to understand and appreciate the nature and consequences of his decisions. While “sound mind” may connote a process standard, patient rights are better protected with a more precise and appropriate term.

The witnesses to a treatment declaration, executed pursuant to the URTIA, do not have to meet any specific qualifications. In this regard, the Act is a major improvement over many existing state laws which preclude a number of individuals—including the declarant’s spouse, blood relatives, heirs apparent or prospective devisees and legatees, and employees of a health-care provider—from serving as witnesses to a living will.

The URTIA is designed to make the execution of a living will as uncomplicated as possible. The absence of more stringent witness requirements is intended to relieve physicians of the difficult burden of determining whether the legalities of the witness requirements have been met. The inclusion of elaborate qualifications could create understandable hesitancy by physicians to make decisions based upon a declaration. Thus, more complex execution requirements pose the risk of jeopardizing the effectiveness of a patient’s declaration.

Patient autonomy is much better served by the Uniform....

133. President's Commission Report, Deciding to Forego Life-Sustaining Treatment, supra note 46, at 152.
134. Annas & Densberger, supra note 132, at 591.
135. URTIA, supra note 3, at § 2 comment at 614.
137. URTIA, supra note 3, at § 2 comment at 615.
138. Id. comment at 616.
Act than by the statutes that preclude certain categories of witnesses. In fact, the experience with organ donor cards suggests the desirability of having family members serve as witnesses. A potential organ donor’s wishes are less likely to be frustrated when the matter has been discussed with family members who have then served as witnesses to the execution of the organ donor card. Similarly, if a declarant first discusses treatment preferences with family members who then witness the execution of the living will, these same witnesses will likely better understand the document and insist that the dying patient’s preferences are respected by health-care providers.

The Uniform Act’s provisions dealing with the form of the declaration also promote the patient’s right of self-determination. Although the Act includes a sample form, an individual’s actual declaration need not comply with the form. Because use of the form is not mandatory, an individual’s declaration may be more elaborate. The Act does not prohibit the inclusion of language designating a proxy for health-care decision-making purposes. However, inclusions and modifications of this nature are essentially untested.

Ideally, a living will should be tailored to each declarant, specifically explaining preferences about life-sustaining treatment. The drafting flexibility afforded by the Uniform Act seems to promote the individualized expression of the declarant’s treatment choices more effectively than would a statutory form allowing little or no deviation.

In sum, the Uniform Act’s provisions regarding the form and execution of a treatment declaration are a major improvement over those of many statutes. Legislation of this nature should promote the declarant’s autonomy and right of self-determination. The simplified witness provisions, the absence

139. A report by the Hastings Center noted that “while the aim of current public policy is to maximize the right of each person to control what happens to his body upon death, the reality is that families continue to play a central role in deciding whether organ donation will take place.” THE HASTINGS CENTER, ETHICAL, LEGAL, & POLICY ISSUES PERTAINING TO SOLID ORGAN PROCUREMENT, A REPORT OF THE PROJECT ON ORGAN TRANSPLANTATION 16 (1985).
140. URTIA, supra note 3, at § 2(b) & comment at 614.
141. See discussion supra at note 127.
142. Hastings Center Guidelines, infra note 302, at 82.
of a mandatory form, and the lack of burdensome execution features such as a notarization requirement are all designed to facilitate the execution of an instrument which expresses the specific preferences of the declarant.

The Uniform Act also permits a physician or other health-care provider to presume that a declaration complies with the act and is valid in the absence of knowledge to the contrary. Thus, the streamlined execution provisions, coupled with the presumption of validity, greatly minimize the possibility that a treatment declaration will be challenged on formalistic grounds.

2. Safeguards Against Abuse, Duress, or Wrongdoing

Because the execution of a valid declaration is quite simple under the URTIA, the ULC was cognizant of the potential for abuse, duress, or wrongdoing by overreaching family members, caretakers, or health-care providers. The ULC addressed the potential for abuse with two different approaches: (1) a simplified revocation procedure, and (2) imposition of criminal sanctions for specifically defined conduct not otherwise covered by state criminal codes.

a. The Provision of Criminal Penalties to Protect Patients

The potential for abuse created by the simplified execution requirements is addressed by the criminal penalties prescribed by the Uniform Act. Any person who falsifies or forges a declaration or willfully conceals or withholds personal knowledge of a revocation is guilty of a misdemeanor. Coercing or fraudulently inducing another to execute a declaration is also a misdemeanor. Similarly, anyone "who requires or prohibits the execution of a declaration as a condition for being insured [for health care services] or receiving health care services" is guilty of a misdemeanor. Finally, the penalties set forth in the Act supplement rather than

143. URTIA, supra note 3, at § 11.
144. Id. § 2 comment at 615.
145. Id. § 9(d).
146. Id. § 9(f).
147. Id. § 9(e).
displace any sanctions applicable under other civil or criminal laws. Proscribed conduct, such as the willful forgery of a declaration or the willful concealment of a revocation, need not actually cause the death of a declarant in order to be sanctioned as a criminal misdemeanor under the Uniform Act.

b. URTIA Revocation Procedures

The ULC also simplified and streamlined revocation requirements. The document may be revoked "at any time and in any manner by the declarant, without regard to the declarant's mental or physical condition." This approach departs markedly from the legal requirements for the revocation of property wills, of which an essential element is adequate legal capacity. The recognition of a revocation without regard to capacity reflects the policy choice of "err[ing] on the side of prolonging life." Unfortunately, the failure to require adequate capacity to revoke may ultimately frustrate some patients' rights of self-determination.

The URTIA permits revocation by a broad range of methods—a marked departure from existing state statutes. Virtually every other living will law, following the pattern of state statutes governing property wills, delineates specific examples of how a declaration can be revoked. Unlike the typical provisions governing the revocation of property wills, the URTIA permits oral revocations, as well as those revocations manifested "by physical sign communicating intention to revoke." The intent of the revocation provisions is to freely allow revocation and to avoid procedural complications. However, the authorization of revocations "in any manner" and without regard to the patient's decision-making

148. Id. § 9(g).
149. Id. § 9 comment at 620.
150. Id. § 4(a).
151. See infra note 217 and accompanying text.
152. Marzen, infra note 232, at 472.
153. See, e.g., Okla. Stat. Ann. tit. 63, §§ 63-3104(A) (West Supp. 1989) (methods include, but are not limited to, "[b]eing canceled, defaced, obliterated, burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction").
154. URTIA, supra note 3, at § 4(a) & comment at 616.
capacity may present serious problems of interpretation when a patient has fluctuating decisional capacity. Needless to say, vague and ambiguous communication by a patient who lacks capacity or whose decision-making abilities are questionable is to be construed as a revocation. Again, the better policy seems to support erring on the side of prolonging life.

The simplified but more "liberalized" revocation provisions create the potential for misrepresentation that a revocation has occurred. In an effort to curb such abuses, the URTIA prescribes a misdemeanor penalty for any individual "who willfully conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent or who falsifies or forges a revocation."  

Finally, "[a] revocation is effective only upon communication to the attending physician or other health care provider by the declarant or a witness to the revocation." A healthcare professional enjoys immunity from civil or criminal liability and professional disciplinary actions for carrying out a declaration in the absence of knowledge of a revocation.

3. Persons Unaffected by the Act

The URTIA is not intended to affect the existing rights and responsibilities of any patient to make medical treatment decisions as long as the patient is able to do so. Nor is the Act intended to impair or supersede any right or responsibility that a person has to effect the withholding or withdrawal of medical care. Finally, while the URTIA does not apply to some patients—such as the permanently unconscious—the rights of these patients have been greatly enhanced by progressive judicial interpretation of the constitutional right of privacy, as well as by the cumulative nature of living will legislation.

155. Annas & Glantz, infra note 237, at 150; Marzen, infra note 232, at 472.  
156. URTIA supra note 3, at § 9(c).  
157. Id. § 4(a).  
158. Id. § 8(a).  
159. Id. § 10(e).  
160. Id.  
C. Preconditions to the Declaration Becoming Operative

1. Criteria Triggering Operative Effect of a Living Will

A patient’s living will or declaration becomes operative when two criteria are fulfilled: (1) the communication of the declaration by a qualified patient to the attending physician, and (2) the determination by the attending physician that the declarant is in a terminal condition and is no longer able to make decisions regarding the administration of life-sustaining treatment. The Uniform Act departs significantly from the approach taken in a number of state statutes in that the Act does not require that a physician other than the attending physician concur in the prognosis that the patient’s condition is terminal.

Dispensing with the requirement of a second confirmatory diagnosis should promote patient autonomy in smaller or rural health-care facilities where a second qualified physician may not be readily available to confirm the attending physician’s determination. However, the established practice of most physicians is to request either a second opinion or review by an institutional ethics committee. The Uniform Act neither prohibits nor discourages this practice. The ULC based their decision on the premise that requiring a specific form of review of the attending physician’s decision would be an unnecessary regulation of normal hospital procedures.

The heart of the Uniform Act is found in the definitions of three key terms: (1) “qualified patient,” (2) “terminal condition,” and (3) “life-sustaining treatment.” The interdependency of these definitions may prove to be a source of

nom., Lincoln Park Nursing & Convalescent Home v. Kahn, 108 S. Ct. 6 (1987). See also In re Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); Foody v. Manchester Memorial Hosp., 40 Conn. Super. 127, 482 A.2d 713 (1984); Corbett v. D’Allesandro, 487 So. 2d 368 (Fla. App. 1986). But see Cruzan v. Harmon v. McCanse, 760 S.W.2d 408 (Mo. 1988) (three regular justices and one special member of the seven-member court concluding that there are “grave doubts as to the applicability of [federal constitutional] privacy rights to decisions to terminate the provision of food and water to an incompetent patient”).

162. URTIA, supra note 3, at § 3.
163. Id. § 1(7).
164. Id. § 5 comment at 617.
165. Id.
166. Id.
confusion in implementing the URTIA.167

A "qualified patient" is an individual, age eighteen or older, who has executed a declaration and who has been determined to be in a terminal condition.168 In accordance with a 1987 amendment to the URTIA,169 "terminal condition" is 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. "Life-sustaining treatment" is any medical procedure or intervention that serves only to prolong the process of dying.170

The choice of "terminal condition" rather than "terminal illness" is intentional.171 While "terminal illness" connotes a disease process that will lead inevitably to death, "terminal condition" is not limited to disease. As explained previously, the terminal condition definition is further limited by the requirement that it be incurable and irreversible. Thus, a condition which is reversible but incurable (e.g., diabetes for which insulin is used as a treatment) is not a terminal condition. Finally, the terminal condition element is also limited by the requirement that the condition must be one which causes the death of the patient within a relatively short period of time.172

The use of "relatively short period of time" as a qualifier of terminal condition differs in degree from the language employed in most existing state statutes. A number of states require that death be "imminent" with or without the application of life-sustaining procedures.173 In contrast, the determination of "relatively short time" under the Uniform Act is to be made without considering the possibilities of extending life with life-prolonging treatment.174 Thus, the

168. URTIA, supra note 3, at § 1(7).
169. Id. § 1(9) (1988 Supp.). Previously, the statutory language had read "incurable or irreversible condition." URTIA § 1(9) (1985) (emphasis added). The original wording had been the focus of sharp criticism. See Marzen, infra note 232, at 144-47.
170. URTIA, supra note 3, at § 1(4).
171. Id. § 1 comment.
172. Id.
173. Id. See also Annas & Glantz, infra note 237, at 139.
174. URTIA, supra note 3, at § 1.
Uniform Act’s approach represents a modest improvement over the more restrictive state laws.

The President’s Commission noted in 1983 that definitions requiring “imminent” death severely limit the group of terminally ill patients able to benefit from natural death acts.175 Living will laws should not be made wholly ineffective with respect to the situations they purport to address. However, interpreted literally, the more restrictive provisions appear to have that effect.

The Virginia natural death act is illustrative of a more narrowly drafted and, hence, potentially limiting statute because it employs the term “imminent.”176 A circuit court in Virginia recognized that interpreting “imminent” as “immediate, at once, within a day” would destroy the intent of the state’s act.177 Although the Virginia court concluded that a comatose patient “within a few months” of death met the requirements of the Virginia statute,178 a better approach is to avoid this interpretation problem by drafting a more flexible and realistic standard.

The “relatively short time” qualifier is employed as an alternative not only to the unduly constricting term, “imminent,” but also as an option to the artificiality of fixed periods.179 Circumstances and inevitable variations in illness and prognosis make fixed time frames unrealistic.180 Under narrowly prescribed time frames, physicians are understandably more hesitant to make predictions about how long a patient will live. The Uniform Act approach affords somewhat greater flexibility and is intended to focus the physician’s judgment without unduly narrowing it.181

Curiously, the “relatively short time” qualifier has been criticized as being too ambiguous. The criticism focuses upon the meaning of the term “relatively.” To what does the term refer?

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175. President’s Commission Report, Deciding to Forego Life-Sustaining Treatment, supra note 46, at 143.
176. VA. CODE ANN. § 54.1-2982 (Repl. 1988).
178. Id.
179. URTIA, supra note 3, at § 1 comment at 612-13.
180. Id.
181. Id.
refer? Relative to other AIDS patients, other Alzheimer's pa-
tients, other lung cancer patients, or the patient population in
general?\textsuperscript{182}

The application of any natural death statute to a particu-
lar patient inevitably involves judgment calls. On balance, the
flexible language employed in the Uniform Act is more likely
to enhance the patient's right of self-determination than are
the more restrictive alternatives.

2. Scope of Treatment that May Be
Withheld or Withdrawn

Life-sustaining treatment is defined by the URTIA to in-
clude any medical procedure or intervention serving only to
prolong the dying process. A separate provision states that
the responsibility of the physician to administer treatment, in-
cluding nutrition and hydration, for a patient's comfort care
or alleviation of pain remains unaffected by the Uniform
Act.\textsuperscript{183}

The URTIA differs markedly from most existing stat-
utes, especially those of recent vintage, which exclude comfort
care from the definition of life-sustaining treatment.\textsuperscript{184} The
ULC addressed comfort care procedures separately because
they determined that many such procedures are life-sustaining
and do not involve a fixed group of procedures applicable in
all circumstances.\textsuperscript{185} Thus, comfort care procedures may be
applied as dictated by reasonable medical standards to ensure
comfort and freedom from pain, notwithstanding an order di-
recting the physician to discontinue life-sustaining
treatment.\textsuperscript{186}

The comfort care provision is not intended to establish a
separate rule governing the administration of nutrition or hy-
dration. Instead, the provision of artificial sustenance is
subject to the same considerations of necessity for comfort
care and alleviation of pain as are all other forms of

\begin{footnotes}
\footnotetext[182]{Marzen, infra note 232, at 465-66.}
\footnotetext[183]{URTIA, supra note 3, at § 6(b).}
\footnotetext[184]{Id. § 6 comment at 617-18.}
\footnotetext[185]{Id.}
\footnotetext[186]{Id.}
\end{footnotes}
life-prolonging treatment.\textsuperscript{187} Artificially supplied nourishment may be withdrawn if unnecessary for the patient’s comfort or alleviation of pain. This approach contrasts sharply with a number of existing state statutes that either treat nutrition and hydration, in all cases, as comfort care that may not be stopped, or explicitly exclude artificial sustenance from the definition of life-sustaining treatment.\textsuperscript{188}

The URTIA was drafted during a time of national debate among health-care professionals and medical ethicists over the status of artificial sustenance. The debated issue was whether the provision of nourishment through artificial means, such as an intravenous feeding apparatus or a nasogastric tube, is comfort care in \textit{all} cases, or whether such procedures in some cases merely extend the dying process.\textsuperscript{189} In the final analysis, the drafters of the Uniform Act determined that the attending physician should decide whether such procedures should be considered life-sustaining treatment or comfort care.\textsuperscript{190}

Subsequent to the approval of the Uniform Act, the AMA’s Council on Ethical and Judicial Affairs issued a major ethical opinion in March of 1986. The opinion unanimously stated that it would be ethical for doctors to withhold all means of life-prolonging medical treatment, including artificial nutrition and hydration, from either terminally ill or irreversibly comatose patients.\textsuperscript{191} This AMA Opinion allows life-prolonging medical treatment to be discontinued, even if death is not imminent, where there is adequate medical confirmation of the diagnosis that a patient’s coma is irreversible.\textsuperscript{192} Under this AMA Opinion, physicians determine whether the benefits of treatment to the patient outweigh the burdens, while maintaining the dignity of the patient.\textsuperscript{193}

\textsuperscript{187} Id.
\textsuperscript{188} See infra text accompanying note 263.
\textsuperscript{190} URTIA, \textit{supra} note 3, at § 6 comment.
\textsuperscript{191} Opinion of the AMA Council on Ethical and Judicial Affair on Withholding or Withdrawing Life Prolonging Medical Treatment (Mar. 15, 1986) (par. 4) [hereinafter AMA Opinion]. See also Wallis, \textit{To Feed or Not to Feed, TIME}, Mar. 31, 1986, at 60.
\textsuperscript{192} AMA Opinion, \textit{supra} note 191.
\textsuperscript{193} Id.
No physician nor other health-care provider is required to take any action contrary to reasonable medical standards. Some commentators have expressed concern that this language may provide physicians with a potential escape hatch to do what they wish, without regard to a patient's expressed directions. On the other hand, one can argue that the AMA Opinion previously discussed establishes a national standard of reasonableness within the profession. Thus, the influential weight and persuasive value of the AMA Opinion may reduce any potential tendency of physicians to arbitrarily invoke this escape hatch.

3. The Pregnancy Limitation

In some circumstances, the Uniform Act limits the operative effect of a pregnant patient’s order directing the discontinuance of life-sustaining treatment. The Act states that unless the declaration otherwise provides, the declaration of a qualified patient, known to the attending physician to be pregnant, must not be given effect as long as it is probable that, with continued application of life-sustaining treatment, the fetus could develop to the point of live birth. Thus, the Act expressly allows a declarant to address the issue of pregnancy in advance.

The drafters comment that if a qualified patient has been pregnant for only a few weeks, treatment may be withheld if the physician, using reasonable medical standards, determines that it is improbable that even with life-sustaining procedures the fetus could develop to the point of viability.

The application of this provision, prior to fetal viability, to terminally ill, pregnant women is subject to constitutional

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194. Annas & Glantz, infra note 237, at 144.
195. Cf. Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968) (abandoning the strict geographic locality rule in medical malpractice actions and commenting that the medical profession should no longer be subject to varying geographic standards in malpractice cases). Given the trend in tort law to utilize a national standard in medical malpractice actions, there is no compelling reason not to require the same standard in analyzing a physician's refusal to treat cases. Moreover, what better definition of "reasonable medical standards" exists than that set forth in an opinion of the Ethical and Judicial Affairs Council of the AMA, the nation's largest professional organization of medical doctors.
196. URTIA, supra note 3, at § 6(c).
197. Id. § 6 comment at 612.
challenge on both privacy and equal protection grounds. However, the ULC did not overtly address such constitutional issues. Instead, the Act's focus is on practical medical considerations involving the fetus. The drafters were concerned that a more widely applicable limitation might inadvertently cause more harm than benefit to the fetus. They hypothesized a scenario in which the administration of a life-sustaining treatment, such as medication, might prove harmful or fatal to a fetus.

In drafting this provision, the ULC attempted to strike a balance between honoring the autonomy of qualified patients and protecting the likelihood of life for the fetus. As a result, the pregnancy provision in the URTIA is much more complicated and differs significantly from many existing state laws.

Existing state statutes which have addressed the pregnant patient situation typically stipulate that the declaration is given no force or effect during pregnancy. Such a broad pregnancy limitation, applied to the period of pregnancy preceding fetal viability, would certainly raise constitutional issues.

198. See Annas & Glantz, infra note 237, at 143. However, these two commentators seem to ignore the qualifier in the statute "unless the declaration otherwise provides" and the comment by the drafters. Cf. In re A.C., 533 A.2d 611 (D.C. App. 1987) (analyzed the rights of a terminally ill woman who was forced to undergo a caesarian section to deliver her twenty-six week fetus). For a discussion of In re A.C., see Annas, She's Going to Die: The Case of Angela C, 18 HASTINGS CENTER REP., 23-25 (February 1988).

199. URTIA, supra note 3, at § 6 comment at 618.

200. Id. at 617-18.

201. See, e.g., Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. § 16-8-11-11(e) (Burns Supp. 1988).

D. Role of Attending Physician and Health-Care Providers

1. Specific Duties and Responsibilities

Once a physician or other health-care provider is furnished with a copy of a patient's declaration, the declaration must be added to the patient's medical record. If the attending physician or other health-care provider is unwilling to comply with the declaration, the declarant must promptly be so advised.

However, no section explicitly requires that the physician inform the patient of the terminal condition. The decision to advise the patient of his terminal condition is left to the physician's professional judgment under existing standards of care. The common law doctrine of informed consent generally recognizes a physician's therapeutic privilege to withhold information that would be harmful to the patient.

As previously explained, the attending physician is responsible for determining when the declarant is in a terminal condition and no longer able to make treatment decisions. When the living will becomes operative by virtue of such a determination, the attending physician, or other health-care provider must act in accordance with its provisions or "as promptly as practicable take all reasonable steps" to transfer care of the declarant to another physician or health-care provider. A physician or health-care provider who willfully fails to transfer the patient may be found guilty of a misdemeanor.

Upon determining that the condition of the declarant is terminal, the attending physician who knows of a declaration must record his determination of the patient's condition and

203. URTIA, supra note 3, at § 2(c).
204. Id. § 2(c).
205. Annas & Glantz, infra note 237, at 143.
206. See M. McCafferty & S. Meyer, Medical Malpractice Bases of Liability 277, § 11.09 (1985). Given the reliance upon the doctrine of informed consent that underlies the right of self-determination to refuse medical treatment, the courts would logically draw upon the therapeutic privilege cases in determining the reasonableness of the physician's action.
207. URTIA, supra note 3, at § 7.
208. Id. § 9(a).
the terms of the declaration in the patient's medical record.\textsuperscript{209} A physician who willfully fails to record this determination may also be subject to a misdemeanor sanction.\textsuperscript{210}

2. Immunities Afforded to Health-Care Providers

The immunities afforded under the URTIA are similar to those found in most existing natural death statutes. In the absence of knowledge of the revocation of a declaration, a person carrying out a declaration pursuant to the Uniform Act is subject neither to civil or criminal liability nor to discipline for unprofessional conduct.\textsuperscript{211} Moreover, as previously explained, a physician or other health-care provider whose acts are in accord with reasonable medical standards is similarly immune from liability, as well as from professional discipline.\textsuperscript{212}

The URTIA extends these immunities not only to physicians, but also to persons acting under the physician's direction or authorization, as well as to hospitals and other institutions in which the abatement of treatment occurs.\textsuperscript{213} Following the standard guiding all decisions made under the Act,\textsuperscript{214} immunity exists as long as reasonable medical standards are maintained.\textsuperscript{215}

E. Other Significant Provisions of the URTIA

1. Relationship of Treatment Abatement to Suicide, Homicide, Insurance, and Provision of Health-Care Services

The Uniform Act parallels the approach of most existing statutes regarding the relationship of treatment abatement to matters involving suicide, homicide, life insurance, and the availability of health-care services. The Act stipulates that death resulting from the withholding or withdrawal of treatment pursuant to a declaration, and in accordance with the Act, does not constitute for any purpose a suicide or

\textsuperscript{209} Id. § 5.
\textsuperscript{210} Id. § 9(b).
\textsuperscript{211} Id. § 8(a).
\textsuperscript{212} Id. § 8(b).
\textsuperscript{213} Id. § 8 comment at 619.
\textsuperscript{214} Id.
\textsuperscript{215} Id.
homicide; nor does it legally impair or invalidate a life insurance policy or annuity. The execution of a living will by a patient does not affect the sale, procurement, or issuance of a life insurance policy, annuity, or the terms of existing policies. No one can prohibit or require the execution of a declaration as a condition for health insurance or the receipt of health-care services.

2. Extraterritorial Recognition of Declarations

Americans enjoy greater mobility than ever as a result of the urbanization of the United States. It is not unusual for a patient with a terminal condition to seek or require care from a health-care facility in a state other than the patient’s domicile. Unfortunately, most living will statutes enacted prior to 1985 failed to address the problem of the extraterritorial effect of living wills. Consequently, one important feature of the Uniform Act is its provision expressly recognizing the extraterritorial validity of a patient’s living will. The URTIA provides that a living will executed in another state in compliance with the law of that state or of the enacting state is validly executed for purposes of the Act. However, the operation of the declaration in the enacting state is subject to the substantive policies of the enacting state’s law.

3. Effect of Living Wills Executed Prior to the URTIA

Another positive feature of the URTIA is a grandfather clause which validates instruments executed before the effective date of a state’s adoption of the URTIA. However, the prior instrument must substantially comply with the execution requirements of the Uniform Act. In view of the vast numbers of living will forms distributed by organizations such as the Society for the Right to Die, Concern for Dying, and the Hemlock Society, the grandfather clause is a potentially

216. Id. §§ 10(a), (b).
217. Id.
218. Id. § 10(c).
219. Id. § 12 comment at 621.
220. Id. § 12.
221. Id. § 12 comment at 621.
222. Id. § 13.
223. See President’s Commission Report, Deciding to Forego Life-
important provision supporting the self-determination rights of patients who previously used these forms to execute living wills.

IV. REACTION TO AND INFLUENCE OF THE UNIFORM ACT, 1985-88

Receptivity to the URTIA may be gauged by the responses and reactions of a number of sources: the legal and medical communities, professional and scholarly literature, and special advocacy groups. In the final analysis, the most important barometer is the influence which a uniform law has upon state legislation adopted within the first few years following the ULC approval of the act.

A. Receptivity to the URTIA

1. Response of the Legal and Medical Communities

The ABA House of Delegates approved the URTIA without debate at its mid-year meeting in 1986. In addition, the Uniform Act has received the endorsements of various ABA subgroups including the Section on Real Property, Probate and Trust Law, the Torts and Insurance Practice Section, and the Council on Legal Problems of the Elderly. Given the commonality of membership that exists between the ABA and the ULC, these endorsements are not surprising.

SUSTAINING TREATMENT, supra note 46, at 139-40. In addition to the Society for the Right to Die, Concern for Dying, and the Hemlock Society, other organizations which have promulgated living will forms include the American Protestant Hospital Association, the American Catholic Hospital Association, the American Public Health Association. Id. at 139 n.51. Recently, the president of Concern for Dying reported that this group has distributed living will forms to over eight million people in response to requests. Letter of James R. Sheffield, President, Concern for Dying, to Friends of Concern for Dying (Nov. 22, 1988). A.J. Levinson, the immediate past executive director of Concern for Dying, has also instituted the Living Will Registry. A-J Levinson Retires as Executive Director, CONCERN FOR DYING NEWSLETTER, Fall 1988, at 2, col. 1 (Vol. 14, no. 3).


226. See 1978 HANDBOOK, supra note 93, at 267 (describing the historical role of the ABA in establishing the National Conference). Uniform Law Commissioners “are chosen from the legal profession, being lawyers and judges of standing and experience, and teachers of law in some of the leading law schools.” Id.
Within the health-care community, the Uniform Act has been officially endorsed only by the American Hospice Association. While a perception exists that the medical community is generally supportive of the Uniform Act, their low key response to the URTIA stands in stark contrast to earlier reaction to the Uniform Anatomical Gift Act. In part because of the health-care community's concerted efforts, all fifty states and the District of Columbia had adopted the UAGA, without major modification, by 1971—just three years after ULC approval.

The issuance of AMA Council on Ethical and Judicial Affairs Opinion on Withholding and Withdrawing Life-Sustaining Treatment, along with the formulation of similar guidelines by state and local medical associations, may have lessened interest in the Uniform Act among the medical profession. Certainly, the URTIA does not seem to be a priority issue for the medical profession and other health-care providers.

2. Commentary on the Uniform Act in the Literature

Assessments of the URTIA in professional and scholarly journals have been mixed. One of the earliest analyses was written by Thomas Marzen in 1986. Mr. Marzen, legal counsel for the National Legal Center for the Medically

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228. Id.
229. The Uniform Anatomical Gift Act was completed on July 30, 1968, and approved by the ABA on August 7, 1968. Sadler & Sadler, Organ Donation: Is Voluntarism Still Valid?, 14 HASTINGS CENTER REP., 6, 7 (October 1984). In September of 1968, the National Research Council called a national meeting to mobilize support for the UAGA; the meeting brought together representatives of the medical academic community and major scientific organizations involved in organ recovery and transplantation. Id. Articles about the UAGA were written and published in medical and legal journals. Id. During 1969 forty-one of forty-four state legislatures which met adopted the UAGA.
230. See supra text accompanying notes 191-95 (discussing the issuance, significance, implications of the AMA Opinion).
231. In January of 1986, the Los Angeles County Medical Association and the Los Angeles County Bar Association developed guidelines to address the confusion faced by health-care professionals when dealing with treatment abatement decisions. Blodgett, Guidance for L.A. Physicians, A.B.A. J., 24 (Sept. 1, 1986). The Massachusetts Medical Society has developed similar guidelines.
Dependent & Disabled, was quite critical of the Uniform Act. Consonant with the goals of his organization, he focused on what he perceived to be (1) the lack of adequate protection against "the prospect that the declaration was invalidly executed by reason of incompetence, minority, fraud, or coercion," and (2) the "exceedingly broad discretionary authority... granted to the attending physician to determine when a declaration would become effective." In his view, the "lack of safeguards pose the potential that the Act could occasion abuse by those who wish to see treatment foregone from others." Mr. Marzen concluded that in most respects, the act "represents a step away from autonomous patient medical decisionmaking and a step toward logical confusion, unbalanced physician discretion, and potential abuse.

Professors George Annas and Leonard Glantz, two highly respected bioethicists, have also been highly critical of the URTIA, but from a perspective entirely different from that of Mr. Marzen. Commenting on the rights of elderly patients to refuse life-prolonging treatment, Annas and Glantz list a number of shortcomings of the URTIA. These deficiencies include the impractical and overly restrictive definitions of "life sustaining treatment" and "terminal condition"; revocation of an instrument without regard to the mental condition of the declarant; constitutional problems associated with the pregnancy limitation; and the failure to provide a course of action for a physician to follow when there is disagreement with the wishes of the declarant and an inability to transfer

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233. An Introduction to the National Legal Center for the Medically Dependent & Disabled, Inc., 1 Issues Law & Med. 1, 9 (1985). The National Legal Center for the Medically Dependent and Disabled, Inc., is a non-profit, publicly supported foundation, a primary goal of which is "to insure that the right of medically dependent persons to beneficial medical treatment without regard to age, health, function, condition of dependency or disability is adequately represented and fully protected." Id. at 2, 9, 10. Issues Law & Medicine, a bimonthly publication of the Center, was first published in July, 1985. Id. at 11. The president of the National Legal Center and chief executive officer of the corporation is James Bopp, Jr. Id. at 9. Mr. Bopp is also General Counsel of the National Right to Life Committee. N.Y. Times, Apr. 14, 1988, at 10, col. 6 (nat'l ed.).

234. Marzen, supra note 232, at 475.

235. Id.

236. Id.

the patient to someone who will honor those wishes.238

Professors Annas and Glantz are also troubled by the "reasonable medical standards" qualification, based on the physician's potential to rely on this provision "to do whatever he or she wants regardless of the patient's stated views in the declaration."239 They are also particularly critical of the application of the URTIA "to tiny categories of patients and treatments"; the failure to provide for a health-care proxy or standards for surrogate decision-making; the lack of penalties for health-care professionals who do not follow the terms of a declaration; and the omission of language explicitly requiring the provision of palliative care.240 In sum, "the act addresses only one major shortcoming of current laws: the lack of uniformity. It leaves the other . . . shortcomings intact; worse, it seems to institutionalize and approve them."241

On the positive side, Professor Carol Ann Mooney of the Notre Dame Law School has recommended that the Indiana legislature replace its Living Wills and Life-Prolonging Procedures Act with the URTIA. In a recent article,242 Professor Mooney carefully compares and contrasts the provisions of the Indiana statute with the Uniform Act, finally determining that "[t]he Uniform Act is superior to the existing Indiana Act in several ways."243 This superiority results from broader definitions of terms such as "terminal condition," "life-sustaining procedures," and "qualified patient." Additionally, under the URTIA, physicians are not burdened with the necessity of determining the legal validity of a declaration, as they are under Indiana law.

In another recent article by Professor Gregory Gelfand of the Delaware Law School, references to the Uniform Act are

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238. Id. at 142-44.
239. Id. at 144.
240. Id.
241. Id.
contained throughout a meticulous analysis of all thirty-nine state living will laws. Gelfand concludes by offering his own model statute.\textsuperscript{244} Gelfand’s model statute includes more complete definition of terms and incorporates the author’s resolution of some competing concerns left unaddressed by various state statutes.

3. Reactions of Special Advocacy Groups to the URTIA

Support for and opposition to the Uniform Act have come from expected special advocacy groups. Derek Humphry and Ann Wickett, co-founders of the Hemlock Society of Los Angeles, listed the URTIA as one of the three “best examples” of “laws that enhance the rights of the dying” in their 1986 book, \textit{The Right to Die, Understanding Euthanasia}.\textsuperscript{245} The Society for the Right to Die has also commented favorably on the URTIA,\textsuperscript{246} and, according to one report, the Grey Panthers of California, an activist senior citizens group, have endorsed the URTIA and have actively sought its legislative consideration in California.\textsuperscript{247}

On the other hand, the entire right-to-life movement has reportedly mobilized to oppose the URTIA.\textsuperscript{248} Apparently, the individuals and groups within the movement have coalesced around the nutrition and hydration issue to gain popular support for their position.

In June of 1986, the Committee for Pro-Life Activities of the National Conference of Catholic Bishops issued a statement on the URTIA which cautioned that the Act “raise[s] new and significant moral problems, highlighting the need for serious debate on the purpose and risks of legislation on this

\textsuperscript{244} Gelfand, \textit{The First Decade}, \textit{supra} note 17, at 802-21.
\textsuperscript{245} Humphry \& Wickett, \textit{supra} note 23, at 314.
\textsuperscript{246} Society for the Right to Die, \textit{Handbook of 1985 Living Will Laws} 14-15 (1986). Although the Society for the Right to Die observed that the Uniform Act “clearly emphasizes and encourages patient autonomy,” the Society for the Right to Die also noted that “[t]wo significant provisions are not included in the [ULC] Act: 1) the added protection that could be offered through appointment of a proxy; and 2) procedures for decisionmaking on behalf of incompetent patients who have not made a prior declaration.” Society for the Right to Die, \textit{Handbook of Living Will Laws}, 1987 Edition 14 (1987).
\textsuperscript{247} McCabe Letter, \textit{supra} note 5.
\textsuperscript{248} \textit{Id.}
subject." After "assessing the proposed Act in the light of Catholic moral principles," the Committee identified "at least three serious problems not always encountered in laws of this kind." These problems are (1) the possible application of the URTIA to authorize "withdrawal of life-sustaining treatment in cases where the patient could live a long time with treatment but will die quickly without it"; (2) the failure to require the continued administration of artificial nourishment; and (3) the possible use of the pregnancy provision by a pregnant woman to refuse treatment that could save the life of her fetus. According to the Committee, other problem areas are: (1) the lack of a preamble asserting a presumption in favor of life; (2) the failure to define "euthanasia"; (3) the Act's "bias toward withdrawing treatment and even encourag[ing] such withdrawal in doubtful cases"; (4) the failure to encourage communication among patient, family, and physician; and (5) the lack of a warning in the form directive, which would caution a declarant that the directive may authorize the abatement of artificial sustenance and may apply in circumstances where the patient could live a long time with continued treatment.

As later discussion of recently enacted living will laws will reveal, a number of compromises between opposition groups have been made during the past several years. Many of these compromises have operated to preclude the adoption of the Uniform Act in its original form.

B. Influence of the URTIA on Laws Enacted from 1985-88

1. Role of the Uniform Law Commissioners

The work of the ULC does not end with the final approval of a uniform act. Commissioners are expected to return to their home states and try to influence state legislatures to enact the newly approved uniform law. The major problems in securing state adoption of the URTIA have been

250. Id. at 5.
251. Id. at 5-8.
252. Id. at 8-9.
(1) the inherent opposition to anything new by a legal system which is slow to change; (2) the completion of the Uniform Act during the midst of a national debate over the nutrition and hydration issue; (3) the relatively recent, but pre-URTIA, adoption of living will laws in many states and the correlative lack of enthusiasm to renew old battles without compelling reasons to do so; and (4) a deeply rooted opposition to the concept of living will legislation in most of the thirteen states which have not enacted such laws. 253

2. Overview of Legislative Activity Between 1985-88

Living will legislation has been enacted in sixteen states 254 since the first draft of the URTIA was circulated at the annual meeting of the ULC in August of 1984. Three of these states, South Carolina, Alaska, and Hawaii, 255 adopted their laws in 1986, after the URTIA had been officially approved. Since its approval in August of 1985, the URTIA has been introduced in at least seven other states: Arkansas, Kansas, Minnesota, Nebraska, North Dakota, Pennsylvania, and Rhode Island. However, none of these states has enacted it in its official form. 256

During this same time frame, several states have

253. McCabe Letter, supra note 5.


256. Letter from John M. McCabe, Executive Director, National Conference of Commissioners on Uniform State Laws, to Marguerite Chapman (Sept. 25, 1987) (discussing Nebraska and North Dakota); Hite Letter, supra note 225 (discussing legislative activities in many states).
amended significantly their existing living will statutes. In May of 1985, the Texas legislature passed a bill substantially modifying its 1977 act by deleting the more restrictive provisions and by adding mechanisms for (1) the appointment of a health-care proxy and (2) decision-making on behalf of patients who have never executed directives. Amendments to existing living will laws were also enacted in 1985 and 1986 by the state legislatures of Idaho, Georgia, Louisiana, and Wisconsin. In April of 1987, Arkansas replaced its 1977 legislation with the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

A close analysis of the sixteen living will statutes adopted in 1985 and 1986, as well as the amendments to existing laws, indicates that the influence of the Uniform Act has been somewhat limited. The Uniform Laws Annotated lists seven states—Alaska, Arkansas, Iowa, Maine, Missouri, Montana,
and Oklahoma—as jurisdictions which have adopted the Uniform Act. However, the table of adopting jurisdictions is somewhat misleading, as shown by the fact that the General Statutory Notes to the URTIA in Uniform Laws Annotated acknowledge that these statutes are “substantial adoption[s] of the major provisions of the Uniform Act.”

The living will statutes adopted in Iowa, Maine, Missouri, and Montana appear to be based predominantly upon the tentative draft of the URTIA. However, Iowa, Maine, and Missouri depart from the Uniform Act by specifically excluding artificial sustenance from the definition of life-sustaining treatment. In addition, Iowa goes beyond the URTIA by creating a decision-making mechanism for treatment abatement of qualified patients who have never executed living wills. In an unusual departure from the URTIA, Missouri provides for forfeiture of testamentary gifts and devises by anyone who, with actual knowledge of a declaration, acts contrary to the expressed intention of the patient’s declaration.

While the Alaska statute closely tracks the Uniform Act, the Alaska legislature substantially strengthened its law by adding a provision that financially penalizes physicians who fail to comply with the act. Another unique provision prohibits

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261. Id. at 610 (emphasis added).
265. MO. ANN. STAT. § 459.045(2) (Vernon Supp. 1989). Section 459.045(2) further delineates that the penalty of loss of “rights of inheritance to the extent such loss is provided for by the patient’s last will and testament” only occurs where the action contrary to the patient’s expressed intention is “without serious reason . . . consistent with the best interests of the patient.” Id. (emphasis added).
266. ALASKA STAT. § 18.12.070(a) (Supp. 1988). This section specifically provides: An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arrangements to effect a transfer . . . has no right to compensation for medical services provided to a qualified patient after withdrawal should have been effective or after transfer should have occurred and may be liable to the qualified patient and to the heirs of the qualified
charging a fee for preparation of a living will.\textsuperscript{267} Finally, the Alaska act, unlike the URTIA, provides specifically that declarants indicate whether life-sustaining procedures subject to abatement should include artificially administered nutrition or hydration.\textsuperscript{268}

3. Arkansas Rights of the Terminally Ill or Permanently Unconscious Act of 1987

Although the replacement statute adopted by Arkansas in 1987 reflects the influence of the Uniform Act in several respects,\textsuperscript{269} the new Arkansas law goes substantially beyond the URTIA's provisions and is a much better law. Specifically, the 1987 Arkansas statute authorizes the appointment of a health-care proxy\textsuperscript{270} and includes the permanently

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  \item patient for a civil penalty not to exceed $1,000.00 plus the actual costs associated with the failure to comply with the declaration, and this shall be the exclusive remedy at law for damages.
  
  However, physicians, health-care professionals, and health-care facilities are immune from civil or criminal liability for actions under the Alaska Rights of the Terminally Ill Act “that are in accord with reasonable medical standards.” \textit{Id.} § 18.12.060(b).
  
  Finally, section 18.12.070(b) states that any person who “wilfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant’s consent or who falsifies or forges a revocation of the declaration of another may be civilly liable to the qualified patient and to the heirs of the qualified patient.” \textit{Id.} § 18.12.010(a).
  
  \textit{Id.} § 18.12.010(c). The form of declaration set forth in this section includes a paragraph which the declarant may check indicating whether he does or does not “desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.” However, a patient’s declaration need not follow this form. \textit{Id.} § 18.12.060(b).

  \textit{Id.} § 18.12.070(b). A health-care proxy is someone who is age 18 or older “appointed by the patient as attorney-in-fact to make health care decisions including the withholding or withdrawal of life-sustaining treatment if a qualified patient, in the opinion of the attending physician, is permanently

\end{itemize}
unconscious within its scope.\textsuperscript{271} It also establishes a mechanism for executing a declaration on behalf of (1) a minor, or (2) an adult lacking decisional capacity who has never executed a treatment declaration or appointed a health-care proxy.\textsuperscript{272}

These additions follow the recommendations of the President’s Commission and other prominent authorities.\textsuperscript{273} As a result, the new Arkansas statute is considered by some to be one of the best laws in the nation\textsuperscript{274} and should serve as a model for improving the Uniform Act.

4. Oklahoma Natural Death Act of 1985

The Oklahoma Natural Death Act\textsuperscript{275} differs so significantly from the Uniform Act that any resemblance is

\begin{itemize}
  \item \textsuperscript{271} Id. § 20-17-201(10).
  \item \textsuperscript{272} Id. §§ 20-17-202(b), (c). Life-sustaining treatment that may be abated includes “any medical procedure or intervention that, when administered to a qualified patient, will serve only . . . to maintain the patient in a condition of permanent unconsciousness.” Id. § 20-17-201(4). “Qualified patient” includes patients age 18 or older who have been determined by the attending physician to be in “a permanently unconscious state.” Id. § 20-17-201(7). “Permanently unconscious” is defined as “a lasting condition, indefinitely without change in which thought, feeling, sensations, and awareness of self and environment are absent.” Id. § 20-17-201(11).
  \item \textsuperscript{273} President’s Commission Report, Deciding to Forego Life-Sustaining Treatment, supra note 46, at 136-53, 193-94, 196.
  \item \textsuperscript{274} See Clarke, The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus, 13 Creighton L. Rev. 795 (1980); Note, The Right to Die a Natural Death and the Living Will, 13 Tex. Tech. L. Rev. 99 (1982) (criticisms of the failure of existing statutes to include minors and adult patients who lack capacity).
  \item \textsuperscript{277} Arkansas Enacts “Model” Statute. Society for the Right to Die Newsletter, Summer 1987, at 2 (commenting that the 1987 act “includes the best features of the Uniform Rights of the Terminally Ill Act” . . . and improves on it significantly . . . ”).
\end{itemize}
superficial at best. Under the Oklahoma statute, the minimum age for declarants is twenty-one years,\textsuperscript{276} rather than eighteen as provided by the URTIA. The statute also requires that death be "imminent whether or not [life-sustaining] procedures are utilized,"\textsuperscript{277} thus becoming operative for a much narrower category of declarant's than does the URTIA. Also, unlike the Uniform Act, Oklahoma expressly excludes "the administration of nourishment, hydration and medication, or the performance of any medical procedure deemed necessary to alleviate pain" from the definition of life-sustaining treatment.\textsuperscript{278}

The Oklahoma law's witness provisions are also much more restrictive than those of the URTIA. Included among the eight disqualifying criteria are provisions stipulating that witnesses cannot be under twenty-one years of age or related to the declarant by blood or marriage,\textsuperscript{279} and that the declaration must be notarized.\textsuperscript{280} Oklahoma also departs from the Uniform Act in terms of the scope and type of pregnancy

\textsuperscript{276.} OKLA. STAT. ANN. tit. 63, §§ 3102(2)(5) to -3103(D) (West Supp. 1989).
\textsuperscript{277.} Id. § 3102(4).
\textsuperscript{278.} Id. More recently, the Oklahoma legislature in 1987 enacted the Hydration and Nutrition for Incompetent Patients Act, which applies to all "incompetent" patients, regardless of whether they have executed a treatment declaration. Id. §§ 3080.1 to .5. With this law, Oklahoma became the first and only state to directly prohibit court authorization of withdrawal of artificially supplied sustenance and hydration from incompetent patients. Id. § 3080.5. The constitutionality of the 1987 Oklahoma Nutrition and Hydration for Incompetent Patients Act is questionable in view of the many judicial decisions holding that the right of the patient or surrogate decision-maker to refuse artificial nourishment and hydration is protected by the federal constitutional privacy right to die. See, e.g., Gray v. Romeo, 57 U.S.L.W. 1065, 2256 (D.R.I. Oct. 17, 1988) (No. 87-0573B); In re Jobes, 529 A.2d 434 (N.J. 1987); In re Peter ex rel. Johanning, 108 N.J. 365, 529 A.2d 419 (1987); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). See also, Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986), review denied, 492 So. 2d 1331 (Fla. 1986) (holding that the right of the surrogate decision-maker of a patient in a persistent vegetative state to refuse sustenance is constitutionally protected and is not abrogated by the Florida Life-Prolonging Procedure Act).

\textsuperscript{279.} OKLA. STAT. ANN. tit. 63, § 3103(B) (West Supp. 1989). This section also disqualifies as a witness any person who is: (1) financially responsible for the declarant's medical care; (2) entitled to part of the declarant's estate under a will, codicil, or by operation of law; (3) the declarant's attending physician; (4) an employee of the attending physician or an employee of a health-care facility in which the declarant is a patient; (5) another patient in the same health-care facility where the declarant is a patient; or (6) someone who has a claim against part of the declarant's estate at the time the directive is executed. Id.

\textsuperscript{280.} Id. § 3103(C).
limitation which may be included. 281

In Oklahoma, two physicians must certify in writing that
the patient is in a terminal condition. 282 Furthermore, unless
a patient executes or reexecutes a declaration after having
been certified as in a terminal condition, the directive is not
binding on the attending physician. 283 Moreover, even when
the directive has been executed or reexecuted subsequent to a
terminal diagnosis, Oklahoma stipulates that “[n]o physician
or health care professional . . . shall be civilly or criminally
liable for failing to comply with the directive of a qualified
patient.” 284 Unlike the Uniform Act’s misdemeanor penalties
for willfully failing to transfer a qualified patient or to record
the determination of a terminal condition, the most severe

281. Id. § 3103(D). The Oklahoma law’s only pregnancy limitation is in the stat-
ute’s “Directive to Physicians,” with which form a declarant’s directive shall “substan-
tially” comply. The pertinent paragraph of the statutory form provides that if the
declarant has been diagnosed as pregnant and the declarant’s physician knows of the
diagnosis, the directive shall have no force or effect during the course of the declarant’s
pregnancy. Id.

The Oklahoma statute does not indicate to what extent a female declarant may
modify the pregnancy clause and still “substantially” follow the statutory form. Under
federal constitutional law, a terminally ill declarant should retain the right to modify
the clause by making it apply only when the fetus is viable. Cf. Akron v. Akron Center
for Reproductive Health, Inc., 462 U.S. 416 (1983); Planned Parenthood v. Danforth,
428 U.S. 52 (1976); Roe v. Wade, 410 U.S. 113 (1973); In re A.C., 533 A.2d 611 (D.C.
Ct. App. 1987). For a thoughtful analysis of the ethical and legal issues presented by
advances in neonatal care that have lowered the age of viability to twenty-four weeks
and occasionally to twenty-two or twenty-three weeks, see Callahan, How Technology Is
Reframing the Abortion Debate, 16 HASTINGS CENTER REP., 33 (February 1986).

282. OKLA. STAT. ANN. tit. 63 § 3102(7) (West Supp. 1989). The written determi-
nation that the patient is afflicted with a terminal condition must be signed, dated, and
filed with the patient’s chart, and one copy must be given to the patient’s hospital or
nursing home. The two physicians include the attending physician and another chosen
either by the patient or by the attending physician. All requirements to attain the status
of “qualified patient” must be fulfilled before the full panoply of legal protections af-
forded the attending physician are effectuated. Id.

283. Id. § 3107(B), (C). With regard to patients who were determined to be in a
terminal condition and who lost decisional capacity after a declaration had been ex-
ecuted, the attending physician is given some discretion. In these circumstances, “the
attending physician may give weight to the directive as evidence of the directions of the
patient” regarding the abatement of life-sustaining treatment and “may consider other
factors such as information from the affected family or the nature of the illness, injury,
or disease of the patient in determining whether the totality of circumstances known to
the attending physician justifies effectuating the directive.” Id. § 3107(C) (emphasis
added).

284. Id. § 3107(B). However, an attending physician who refuses to comply with a
qualified patient’s directive is required to transfer the patient to another physician. Id.
sanction for an attending physician in comparable circumstances is a determination of unprofessional conduct.285

Finally, the Oklahoma Natural Death Act lacks provisions recognizing declarations executed in compliance with the laws of other states; giving effect to instruments executed prior to the operative date of the new statute; or expressly preserving the right of a patient to make treatment abatement decisions as long as the patient is able to do so. Oklahoma's new statute is one of the most restrictive such laws in the nation. The Oklahoma modifications of the Uniform Act are so radical that any similarities between the two are difficult to discern.

5. Relationship of URTIA to Other Aspects of State Laws

Many recently adopted and amended statutes reflect approaches included in a number of older statutes and incorporated into the Uniform Act. Thus, it is hard to say whether their influence was more from the Uniform Act or the pre-dating statutes of other states. For example, the newly enacted laws of eight states—Arizona, Colorado, Indiana, Maryland, New Hampshire, Oklahoma, Tennessee, and Utah—all require that the directive of a qualified patient be incorporated into the declarant's medical records.286 Provisions requiring

285. Id. §§ 3107(B), (D) (emphasis added). The physician's behavior may constitute unprofessional conduct if (1) the physician fails to comply with the directive and either refuses to make the necessary arrangements to transfer the patient or fails to transfer the patient to another physician who will comply with the directive of the qualified patient, and/or (2) the physician fails either to provide written certification of the terminal condition of the declarant or to transfer the declarant to another physician who will so certify the declarant's condition. Id.


286. ARIZ. REV. STAT. ANN. § 36-3202(B) (1986); COLO. REV. STAT. § 15-18-104(1) (Repl. 1987); IND. CODE ANN. § 16-8-11-14(b) (Burns Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-602(b)(3) (Supp. 1988); N.H. REV. STAT. ANN. § 137-H:5 (Supp. 1988) (placed into medical record upon request of person executing the doc-
physicians who decline to honor a living will to transfer care to another physician are included in the new laws of these same eight states, although the statutes vary with regard to sanctions for failure to comply. Finally, Indiana, New Hampshire, Tennessee, and Utah, like the URTIA, provide that nothing in the act shall impair or supersede any right or responsibility of a person to have medical treatment abated.

6. Summary of Legislative Trends

Twenty-five statutes concerning this topic have been adopted by states since January of 1983. Nearly two-thirds
of these were enacted since the draft of the URTIA was read for the first time at the 1984 annual meeting of the ULC. In addition, a number of states have passed significant amendments or replacements to their older laws.

Although there are exceptions, such as the 1987 Arkansas act, many of the state statutes and amendments of recent vintage reflect a number of compromises which have been made in adopting the laws. A number of these compromises have apparently resulted from the changing tactics and emphasis of the Committee for Pro-Life Activities of the National Conference of Catholic Bishops. The Committee for Pro-Life Activities reportedly considered state court decisions such as Conroy to be "odious." Consequently, the Committee worked to influence new living will legislation which


292. Otten, New Wills, supra note 85 at 33, col. 4 (describing the "significant switch in tactics and emphasis, if not a reversal of position" made by the Committee for Pro-Life Activities during the fall of 1984). Father Edward Bryce, the director of the Committee for Pro-Life Activities, reportedly explained that while the Committee continued to view living will legislation as unnecessary, this position "has to be processed through the realities in each state." Id.

293. Id. Father Bryce, the director of the Committee, said: "'States without legislation were having problems that were being handled by the courts, often with decisions we found really odious.'" Id.
would preclude similar results in the future. Typical of these were provisions (1) specifying that living will declarations had no force if the patient were pregnant, and (2) excluding artificially supplied nutrition and hydration from the life-sustaining procedures that may be withdrawn.\textsuperscript{294} The Oklahoma legislation, for example, reflects the work of such activists.

Unfortunately, as the Executive Director of Concern for Dying has noted, such compromises have produced "new laws [which] simply make the whole process much more complicated and ambiguous."\textsuperscript{295} In fact, many new laws may be a step backward in the movement to secure and enhance the rights of patients to control fateful treatment choices.

V. EVALUATION AND RECOMMENDATION

A. Advance Planning for Health Care Purposes

Advance planning for health care purposes, including the desire to control to what extent, if any, life-prolonging treatment will be utilized, has been the subject of increased attention as a result of both the aging of the American population and the AIDS epidemic. This national focus of attention creates a very practical need for flexible legal mechanisms that will enable an ever-increasing portion of the American population to make treatment decisions in advance or to set standards for and authorize the appointment of trusted friends or family members to act as surrogate health-care decision-makers.\textsuperscript{296}

Along with the ever-growing accumulation of experience relative to decision-making concerning the abatement of life-sustaining treatment, something of a consensus has emerged on a number of the issues that have impeded efforts to enact flexible and practical natural death laws. Although disagreement will inevitably exist on some issues, most medical

\textsuperscript{294} Id.

\textsuperscript{295} Id. Oklahoma's 1985 Natural Death Act was identified as illustrative of legislation that complicated the decision-making process. Id.

\textsuperscript{296} Special Report, Preferences of Homosexual Men with AIDS for Life-Sustaining Treatment, supra note 2, at 457.
ethicists, physicians, and courts which have addressed right-to-die questions concur on these important points:

(1) No difference exists, analytically, between artificially supplied sustenance and any other medical treatment.\(^{297}\)

(2) A constitutional privacy right allows control of fundamental medical decisions affecting one's body, including the right to refuse life-extending treatment, and this right should prevail in the absence of a sufficiently compelling governmental interest in forcing treatment on a patient.\(^{298}\)

(3) The constitutional right to refuse life-sustaining treatment, which is also supported by the patient's common law right of self-determination and, in some jurisdictions, a state constitutional right of privacy, extends to patients who no longer have decisional capacity as long as there is clear and convincing evidence that the patient, if competent, would decline treatment.\(^{299}\)

(4) Under appropriate circumstances, the family or guardian may order the abatement of life-extending treatment, including artificial nourishment, on behalf of a patient who lacks capacity to make medical decisions.\(^{300}\)

(5) When the physician's perceived duty to sustain life conflicts with the decision of the patient or that patient's surrogate decision-maker to decline medical treatment, the choice of the patient or the substitute decision-maker should prevail.\(^{301}\)

Since the approval of the URTIA in August of 1985, the most important factors leading to this consensus have been (1) the issuance of the March 15, 1986, Opinion of the AMA Council on Ethical and Judicial Affairs on Withholding or Withdrawing Life Prolonging Medical Treatment; (2) the ever-increasing number of federal and state court decisions recognizing a constitutional privacy right to die and determining that the artificial administration of nutrition and hydra-

\(^{297}\) Annas, supra note 63, at 685.

\(^{298}\) Id.


\(^{300}\) Annas, Fashion and Freedom, supra note 63, at 685; Areen, The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment, 258 J. AM. MED. ASSN. 229 (1987).

\(^{301}\) AMA Opinion, supra note 191, at para. 1.
tion is not legally different from any other medical treatment that may be declined; and (3) the 1987 publication of Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying by the Hastings Center. Greater media attention and increased public education regarding the difficult ethical, medical, and legal issues posed by the right-to-die cases also have likely contributed to the emergence of this consensus.

On balance, the judiciary has done a far superior job of protecting the right of patients to refuse medical treatment than have the state legislatures. Yet the courts continue to implore the legislative branch to formulate laws addressing the many complex issues involving medical decision-making for the terminally ill and the permanently unconscious. Unfortunately, in view of the compromising nature of most natural death statutes adopted between 1983 and 1988, a greater need than ever before exists for a comprehensive, well-crafted uniform law on this subject.

The Uniform Rights of the Terminally Ill Act, as the title of this article suggests, clearly is "too little, too late" to convince state legislators to push for its adoption. The goals of the drafters of the Uniform Act were too modest, and even so, the ULC failed to completely achieve all their stated objectives.

B. Success of the URTIA Relative to Goals of the Drafters

The three stated purposes of the ULC in promulgating the URTIA were to (1) draft an act which is "simple, effective, and acceptable" both to persons desiring to execute a declaration and to health-care professionals and providers; (2) provide for the effectiveness of a living will "in states other than the state in which it is executed through uniformity of

scope and procedure”; and (3) “avoid the inconsistency in approach” which had characterized existing state living will laws. The extent to which the ULC fulfilled these objectives is best assessed by examining each goal separately.

1. Simplicity, Effectiveness, and Acceptability of the URTIA

The first objective focuses upon the simplicity, effectiveness, and acceptability of the URTIA both to individuals who wish to execute advance directives and to the affected health-care providers. The URTIA should be quite acceptable to physicians and health-care facilities. Like the state living will laws which precede it, the Uniform Act confers immunity from civil and criminal liability and from unprofessional conduct actions upon persons who carry out valid patient declarations.

Even though the URTIA imposes sanctions upon a physician who willfully fails to record the determination of terminal condition or who willfully fails to transfer a patient when the attending physician is unwilling to implement the declaration, no penalties are imposed upon physicians and other health-care providers who refuse to comply with a patient’s declaration when acting “in accord with reasonable medical standards.” Furthermore, another section of the Uniform Act expressly confers immunity from criminal or civil liability or professional disciplinary actions upon health-care providers whose actions are in accord with reasonable medical standards.

The “reasonable medical standards” qualifier is obviously beneficial to physicians. However, the qualifier also creates a potential escape hatch which may prove disconcerting to patients seeking to execute binding advance declarations. This problem, coupled with the narrow scope of the URTIA and its failure to authorize proxy directives, may actually

305. URTIA, supra note 3, at Preamble.
306. Id. at Preamble, para. 2.
307. Id. § 8 & comment.
308. Id. § 10(f).
309. Id. § 8(b).
310. Annas & Glantz, supra note 237, at 143-44.
make the Uniform Act *less* effective and acceptable to most patients.

As discussed in Part III of this article, the URTIA is an improvement from the patient’s point of view over many state living will laws. The Uniform Act simplifies procedures for executing a living will and loosens other restrictions found in some state statutes. On the other hand, short-comings of the Act include:

(1) The definition of “life-sustaining treatment” is unduly restrictive. The qualifier, “will only serve to prolong the dying process,” if read literally, would never be applied because physicians should not administer unnecessary or inappropriate treatment.\(^{311}\) A more practical definition is provided by the Hastings Center’s Guidelines: “Life-sustaining treatment is any medical intervention, technology, procedure, or medication that is administered to a patient in order to forestall the moment of death, whether or not the treatment is intended to affect the underlying life-threatening disease(s) or biologic processes.”\(^{312}\)

(2) In view of the consensus that artificially supplied nutrition and hydration are no different, analytically, from any other medical treatment, the Uniform Act should explicitly state in the definition of life-sustaining treatment that artificial sustenance is a medical procedure that may be withheld or withdrawn.\(^{313}\)

(3) The Uniform Act should expressly require the provision of palliative care to the patient. Palliative care includes medical, surgical, and other procedures used to alleviate suffering and discomfort. Patients who decline a particular medical treatment or procedure should not be deprived of medical or nursing care for the relief of pain or the easing of discomfort.

(4) While the definition of “terminal condition” represents an improvement over a number of existing statutes, it is still much too narrow. Minimally, the Uniform Act should

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311. *Id.* at 142-43.
313. See, e.g., Appendix 2, Right to Refuse Treatment Act, Annas & Glantz, *supra* note 237, at 156, § 1 (listing artificial feeding as one example of treatment that may be withheld).
extend to all patients who no longer have decision-making capacity and who have previously expressed their wishes, in a clear and convincing manner, to decline treatment and let nature take its course.

(5) The revocation section should be modified by deleting the language "without regard to [the declarant's] mental ... condition." To recognize the revocation of a directive by a declarant who lacks decisional capacity and, therefore, does not appreciate such action, "negates the very essence of what the act seeks to promote: self determination." 314

(6) The pregnancy provision should be redrafted to clearly state that it only suspends the operative effect of a pregnant patient's declaration when there is a reasonable probability of the development of the fetus to the point of live birth if the mother receives continued medical treatment.

(7) Language should be added to the "transfer of patients" section delineating the course of action to be followed in the event the "unwilling" attending physician or other health-care provider, after taking "all reasonable steps," is unable to transfer the patient to someone who will honor the patient's wishes. 315 On the infrequent occasions when this situation arises, the patient's right to decline treatment should prevail over the views of the physician or other health-care provider who disagrees with the treatment abatement decision. 316

(8) The Uniform Act should require that institutions, including nursing homes, which mandate certain treatments or limit the right of patients to forgo treatment, must notify patients and their surrogate decision-makers of these policies upon admission. 317

(9) The reasonable medical standards qualifier should be redrafted to more carefully circumscribe physician discretion. 318

314. Id. at 143.
315. Id.
316. Id.
317. See Hastings Center Guidelines, supra note 302, at 33 (stating that the institution should publicize its policies, including notifying patients and surrogates as early as possible upon admission).
318. Annas & Glantz, supra note 237, at 144; Marzen, supra note 232, at 475.
The penalties section should be expanded to impose a sanction against a physician or other health-care provider who fails to comply with the declaration of a qualified patient or, in the alternative, effectuate transfer. In addition, a more meaningful and administratively efficient sanction than the current misdemeanor penalty should be prescribed for willful failure to transfer or record the determination of terminal condition.

In sum, the Uniform Act contains a number of significant shortcomings which undermine its utility to individuals seeking mechanisms for securing and enhancing their right to decline life-extending medical treatment. While the first objective of the ULC may have been fulfilled with regard to health-care providers, this goal has been only partially achieved relative to the needs and desires of patients.

2. Extraterritorial Effectiveness of Living Wills

The second objective of the ULC, that of providing for the effectiveness of a living will in states other than the jurisdiction in which it was executed through uniformity of scope and procedure, is arguably achieved through the very drafting and approval of the Uniform Act. In addition, the URTIA provides that a declaration executed in compliance with the laws of another state is to be treated as validly executed in the enacting state. However, recognition of a declaration may not be assumed because, as the comment explains, its operation in the enacting state is subject to that state's substantive policies. Finally, if the improvements offered by the Uniform Act are not sufficiently compelling to convince state legislators to adopt the URTIA or to amend existing state living will laws to conform more closely to it, the second goal cannot be fulfilled.

319. Annas & Glantz, supra note 237, at 143-44.

320. One appropriate penalty is that imposed in Alaska, where a physician failing to comply with a declaration or make a transfer is denied part of the fee for medical services. The physician may also be liable for a civil penalty. See supra note 266 (quoting ALASKA STAT. § 18.12.070(a)).

321. URTIA, supra note 3, at Preamble.

322. Id. § 12.

323. Id. § 12 & comment.
3. Avoidance of Inconsistent Approaches in Existing Laws

The third purpose of the URTIA is to avoid the inconsistent approaches of the early living will statutes.324 While by definition the URTIA provides a uniform approach to the preparation and implementation of terminally ill patients' advance treatment directives, actual consistency and conformity will depend upon the extent to which the commissioners are able to convince state legislators of the need for and utility of enacting it.

C. The Need for a More Comprehensive Uniform Act

The most significant shortcomings of the URTIA are: (1) the failure to provide a mechanism for the appointment of a proxy decision-maker for health-care purposes; (2) the lack of procedures governing non-terminal, permanently unconscious patients; and (3) the failure to establish a decision-making process for the abatement of medical treatment on behalf of the patient who lacks decisional capacity and who has neither executed a valid treatment directive nor appointed a health-care proxy.325 Unfortunately, nothing exists to fill the sizable void left by the Uniform Act with regard to these three broad categories. Accordingly, the URTIA may be considered more remarkable for those patients it excludes than for those it includes.

1. The Need for a Mechanism for the Appointment of a Health-Care Proxy

As discussed previously, the value of a personally appointed surrogate decision-maker has been recognized by several right-to-die authorities.326 The natural death statutes of thirteen states327 now provide mechanisms for the designation of a proxy or surrogate health-care decision-maker. Americans who are concerned about the inflexibility or rigidity of

324. Id. at Preamble.
325. Annas & Glantz, supra note 237, at 142-43. Moreover, the Model Health Care Consent Act of 1982 clearly does not fill the void left by URTIA.
326. See supra notes 246, 273 and accompanying text.
treatment directives should have the clearly established option of appointing a proxy for health-care decision-making. They should not have to leave to chance or to litigation the question of whether a form treatment directive can be modified to designate a proxy in states not insistent upon precise conformance with a statutory form. Nor should they have to leave unresolved the question of whether a state's durable power-of-attorney law encompasses the appointment of a health-care proxy. The failure of the URTIA to expressly authorize the execution of a health-care proxy directive was extremely shortsighted.

328. Approximately half of the state natural death statutes, as well as the Uniform Act, allow a declarant to modify the directions set forth in the declaration. See Gelbard, The First Decade, supra note 17, at 753 & nn.63, 64. In those jurisdictions, it may be possible to vary the declaration to include the appointment of a medical decision-making agent. Id. at 795. See also Cohen, Appointing a Proxy for Health-Care Decisions, Society for the Right to Die, 6 (Monograph) (September, 1986) (stating that thirty-six of the thirty-nine jurisdictions with living will statutes do not require a specific form be followed, and thus may permit proxy appointments).

329. An excellent student note identified three "potential infirmities" in the authority of an agent to make health-care decisions for an incapacitated patient pursuant to a durable power-of-attorney law: (1) whether the making of health-care decisions is a "nondelegable act" under the law of agency; (2) whether a durable power-of-attorney can be used in a medical decision-making context; and (3) whether the use of a durable power-of-attorney might conflict with existing guardianship laws. See Note, Appointing an Agent to Make Medical Treatment Choices, 84 COLUM. L. REV. 985, 1009 (1984). In an incisive analysis of these potential problems, the author concluded that while "the laws provide no effective mechanism whereby the patient can ensure that his choice of treatment will be respected," the arguments against the use of durable powers-of-attorney are unconvincing. Id. at 1031. Therefore, "[a]gency is a simple, workable mechanism that could bring greater certainty to the law while furthering the traditional freedom of patients to make their own decisions regarding the course of their medical care. Id.

The President's Commission also thought that the language of existing durable power-of-attorney statutes could accommodate the appointment of a surrogate for health-care decision-making on behalf of patients who had lost capacity. PRESIDENT'S COMMISSION REPORT, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, supra note 46, at 147. Certainly, nothing in the durable power-of-attorney statutes expressly precludes such modifications. More importantly, as the President's Commission noted, the utilization of durable power-of-attorney statutes for health-care decision-making on behalf of incapacitated patients presents the "possibility for abuse inherent in the statutes." Because durable power-of-attorney laws were designed for small estates to obviate the expense of full guardianship or conservatorship proceedings, greater procedural safeguards may be needed for medical decision-making purposes. Id.

For an in-depth examination of the use of state durable power-of-attorney statutes for health-care decision-making, see Cohen, supra note 328, at 2-6.
2. The Need for Decision-Making Mechanisms that Encompass the Permanently Unconscious

Eleven states have living will statutes that address decision-making on behalf of permanently unconscious patients who are not terminally ill. In view of the number of landmark cases involving the permanently unconscious and the judicial affirmation of the right of a surrogate to make a treatment abatement decision on behalf of such an individual, a clear need exists for extending the scope of living will laws to include these patients.

3. The Need for Decision-Making Mechanisms for Patients Who Lack Capacity or Who Do Not Have a Directive

Because most Americans never execute property wills, there is little reason to expect any significant difference with respect to the use of living wills. In addition, in most states minors and patients who have always lacked decisional capacity cannot execute valid treatment or proxy directives. Although medical decisions on behalf of these individuals have traditionally been made informally by the patients' families and physicians, this process typically breaks down when the family and the physicians disagree about the use of a particular procedure. Thus, there is a need for a legal mechanism for decision-making on behalf of those who lack capacity and who have never executed a directive of any kind. Only eleven states currently have natural death statutes which encompass these patients.

330. The states are Arkansas, North Carolina, Florida, Louisiana, Virginia, New Mexico, Oregon, Connecticut, Iowa, Utah, and Texas.
332. Professors Scoles and Halbach have observed that "[d]espite the reasons for disposing of one's property by will or even by trust, most Americans die intestate." E. Scoles & E. Halbach, Jr., Problems & Materials on Decedents' Estates & Trusts 13 (3rd ed., 1981).
333. Areen, supra note 300.
334. The states are Arkansas, North Carolina, Florida, Louisiana, Virginia, New Mexico, Oregon, Connecticut, Iowa, Utah, and Texas.
VI. CONCLUSION

The limited influence of the Uniform Rights of the Terminally Ill Act during the biennium that began in January, 1987, suggests very little potential for widespread acceptance of the Act. Most of the twenty-five legislatures that have enacted laws since 1983 simply will not be anxious to again engage in battles so recently fought. As long as the improvements over existing laws are modest in scope and applicable to only a small portion of the American population, little enthusiasm to push for the adoption of the URTIA is likely to ensue. Moreover, the twelve states still without living will legislation are the ones that most successfully resisted right-to-die legislation before the Uniform Act was approved. In order to be adopted, the Uniform Act will have to overcome residual objection in those states.

Finally, patients in situations not covered by the URTIA have been the focus of most of the landmark state appellate court decisions. By deciding to draft a narrow uniform law, the Uniform Law Commissioners missed an important opportunity to provide leadership in this area.

Just as the Commissioners returned to the drafting table to prepare a better "brain death" act, they should begin anew to draft a URTIA that truly accomplishes what the title of the act suggests—coverage of much broader categories of dying patients. They should prepare a completely new uniform act that will transcend the modest improvements of the URTIA and the superficial approach of its forerunner, the Model Health Care Consent Act.

Ultimately, the success of the Uniform Law Commissioners will require drafting a comprehensive act that is consonant with the ethical, medical, and judicial consensus that has emerged on the most important issues affecting dying patients. As this article has endeavored to point out, the need is great and the time is right.

335. See supra notes 93-96 and accompanying text.