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DISCONTINUING TREATMENT OF COMATOSE PATIENTS WHO HAVE NOT EXECUTED LIVING WILLS

I. INTRODUCTION

Since the 1976 New Jersey Supreme Court decision, *In re Quinlan*,¹ many courts have faced life and death decisions involving people who are not legally brain dead,² but are in irreversible vegetative comas.³ These courts have been asked to decide whether life-supporting medical treatment should be discontinued once such a coma has been diagnosed and further treatment has become futile. Although the courts have indicated that the legislature is the proper branch of government to set guidelines in this area,⁴ the courts have been compelled to hear these cases because of legislative inaction.

Most courts have tried to determine what the patient would want if he or she were competent to make the life or death decision.⁵ These courts recognized the right of the patient to refuse medical treatment.⁶ Many legislatures have also recognized this right by enacting Natural Death Acts.⁷ These statutory schemes allow patients to decide whether

1. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

2. *See infra* notes 9-14 and accompanying text.

3. *See infra* notes 15-17 and accompanying text.

4. *See, e.g.*, *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1014, 195 Cal. Rptr. 484, 488-89 (1983); *In re Storar*, 52 N.Y.2d 363, 382-83, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276, *cert. denied*, 454 U.S. 858 (1981); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1346 (Del. 1980); *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980).

5. *Barber*, 147 Cal. App. 3d at 1021, 195 Cal. Rptr. at 493. *See also* *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 750-52, 370 N.E.2d 417, 430-31 (1977), discussed *infra* note 27.

6. This right has been found in both the common law, *Barber*, 147 Cal. App. 3d at 1015, 195 Cal. Rptr. at 489, and the constitutional right to privacy. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663. *See infra* text accompanying notes 20-26 for discussion.

7. California was the first state to enact a Natural Death Act in 1976. CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Supp. 1985), discussed *infra* at notes 144-58 and accompanying text. Since then, 16 other states and the District of Columbia have passed Natural Death Acts. ALA. CODE §§ 22-8A-1 to 22-8A-10 (1984); ARK. STAT. ANN. §§ 82-3801 to 82-3804 (Supp. 1983); DEL. CODE ANN. tit. 16 §§ 2501 to 2508 (1983); D.C. CODE ANN. §§ 6-2421 to 6-2430 (Supp. 1985); IDAHO CODE §§ 39-4501 to 39-4508 (Supp. 1984); ILL. REV. STAT. ch. 110-1/2 ¶¶ 701 to 710 (Supp. 1984); KAN. STAT. ANN. §§ 65-18,101 to 65-28,109 (1980); LA. REV. STAT. ANN. §§ 40:1299.58.1 to 40:1299.58.10 (West Supp. 1985); NEV. REV. STAT. §§ 449.540 to 449.690 (1981); N.M. STAT. ANN. §§ 24-7-2 to 24-7-10 (SUPP. 1984); N.C. GEN. STAT. §§ 90-320 to 90-322 (1981 & Supp. 1983); OR. REV. STAT. §§ 97.050 to 97.090 (1983); TEX. STAT. ANN. art. 4590h §§ 1 to 11 (Vernon Supp. 1985); VT. STAT. ANN. tit. 18 §§ 5251 to 5262 (Supp. 1984); VA. CODE §§ 54-325.8:1 to 54-325.8:12 (Supp. 1984);

or not to refuse treatment before their condition deteriorates to the point where further treatment may be futile.

This Comment discusses the attempts that have been made to provide practical solutions to the problem of withdrawing treatment from patients in irreversible vegetative comas.⁸ It also discusses the limitations inherent in most of these solutions, both the judicial and statutory law. Finally, it discusses the North Carolina Natural Death Act, the most comprehensive statute to date, and advocates that similar statutes be enacted by each state.

A. Brain Death

A diagnosis of brain death is a declaration that the person is legally dead. The Ad Hoc Committee of the Harvard Medical School has adopted a variety of standards to determine when brain death has occurred. These include: absence of response to pain or other stimuli; absence of pupillary reflexes; absence of corneal, pharyngeal and other reflexes; absence of blood pressure; absence of spontaneous respiration; and an isoelectric ("flat") electroencephalogram.⁹ These tests must be repeated at least twenty-four hours after the first readings with no change before the patient may be declared brain dead.¹⁰

Kansas adopted the first brain death statute in 1970.¹¹ Since then, thirty-four other states and the District of Columbia have adopted statutes defining brain death.¹² Generally, these statutes fall into three cate-

WASH. REV. CODE ANN. §§ 70.122.010 to 70.122.905 (Supp. 1985); W. VA. CODE §§ 16-30-1 to 16-30-10 (Supp. 1984).

8. A similar problem is presented by patients with terminal illnesses who are mentally incompetent and thereby cannot make such decisions for themselves. This Comment takes no position on dealing with these patients. However, because many of the legal principles involved in dealing with mentally incompetent patients are the same as the principles of dealing with patients in irreversible vegetative comas, cases dealing with both types of patients will be cited.

Additionally, the North Carolina Natural Death Act, discussed *infra* at notes 166-202 and accompanying text, includes a provision covering mentally incompetent patients with terminal illnesses. N.C. GEN. STAT. § 90-322(a) (1981). This statute could be easily modified to exclude such a provision. See *infra* note 168.

9. *In re Quinlan*, 70 N.J. 10, 27, 355 A.2d 647, 656 (citing *A Definition of Irreversible Coma*, 205 J.A.M.A. 337, 339 (1968)), *cert. denied* 429 U.S. 922 (1976).

10. *Id.* (citing *A Definition of Irreversible Coma*, 205 J.A.M.A. 337, 339 (1968)).

11. D.W. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 4:7 (1981). The original Kansas statute, § 77-202, was repealed in 1984 and replaced by KAN. STAT. ANN. § 77-205.

12. These statutes are: ALA. CODE § 22-31-1 (Supp. 1981); ALASKA STAT. § 09.65.120 (1983); ARK. STAT. ANN. §§ 82-537 to 82-538 (Supp. 1983); CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1985); COLO. REV. STAT. § 12-36-136 (Supp. 1984); CONN. GEN. STAT. § 19A-278(b) (Rev. 1985); D.C. CODE ANN. § 6-2401 (Supp. 1984); FLA. STAT. § 382.085

gories: (1) those which provide two alternate definitions of death, one based on respiratory and cardiac functions and the other based on the absence of brain function; (2) those which allow absence of brain function as a definition of death where physical signs cannot be determined because they are being artificially maintained; and (3) those which require total, irreversible cessation of brain function, with no mention of the traditional, physical methods of determining death.¹³ The California statute falls into the first category, and provides that: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."¹⁴

B. Irreversible Vegetative Coma

In contrast to brain death, an irreversible vegative coma (also known as a chronic persistent vegetative state) has been defined as a condition in which the patient remains capable of "maintain[ing] the vegetative parts of neurological function but who . . . no longer has any cognitive function."¹⁵ Since the vegetative portion of the brain, which controls the automatic functions such as heart rate and breathing, continues to live, the patient is not brain dead. However, the cognitive portion of the brain, which controls the higher functions such as speech and

(Supp. 1985); GA. CODE ANN. § 31-10-16 (1985); HAWAII REV. STAT. § 327C-1(b) (Supp. 1984); IDAHO CODE § 54-1819 (Supp. 1985); ILL. REV. STAT. ch. 110-1/2 ¶ 302 (1983); IOWA CODE § 702.8 (1979); KAN. STAT. ANN. § 77-205 (1984); LA. REV. STAT. ANN. § 9:111 (West Supp. 1985); ME. REV. STAT. ANN. tit. 22, § 2811 to 2813 (Supp. 1984); MD. PUB. HEALTH CODE ANN. § 5-202 (Supp. 1984); MICH. COMP. LAWS ANN. § 333.1021 (West 1980); MISS. CODE ANN. § 41-36-3 (1981); MO. REV. STAT. § 194.005 (Supp. 1984); MONT. CODE ANN. § 50-22-101 (1983); NEV. REV. STAT. § 451.007 (1983); N.M. STAT. ANN. § 12-2-4 (1978); N.C. GEN. STAT. § 90-323 (1981); OHIO REV. CODE ANN. § 2108.30 (Page Supp. 1984); OR. REV. STAT. § 146.001 (1983); PA. STAT. ANN. tit. 35 § 10201 to 10203 (Purdon Supp. 1984); R.I. GEN. LAWS § 23-4-16 (Supp. 1984); S.C. CODE ANN. § 44-43-460 (Law. Co-op. 1985); TENN. CODE ANN. § 68-3-501 (1983); TEX. STAT. ANN. art. 4447t §§ 1 to 3 (Vernon Supp. 1985); VT. STAT. ANN. tit. 18 § 5218 (Supp. 1984); VA. CODE § 54-325.7 (1982); W. VA. CODE § 16-10-2 (Supp. 1984); WIS. STAT. ANN. § 146.71 (West Supp. 1984); WYO. STAT. § 35-19-101 (Supp. 1985).

13. D.W. MEYERS, *supra* note 11, at § 4:7.

14. CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1985). As originally enacted in 1974, the California statute fell into the third category. D.W. MEYERS, *supra* note 11, at § 4:7. In 1982, however, the California Legislature repealed that statute and passed the current version, which is consistent with the Uniform Brain Death Act, 12 U.L.A. 187 (Supp. 1981). D.W. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 4:7 (Supp. 1984).

15. *In re Quinlan*, 70 N.J. 10, 24, 355 A.2d 647, 654 (quoting the testimony of Dr. Fred Plum, one of the expert witnesses), *cert. denied*, 429 U.S. 922 (1976).

sight, is dead.¹⁶ The patient thus continues to "live," but loses all contact with the outside environment.¹⁷

In dealing with patients in irreversible vegetative comas, there are two ways treatment can be discontinued—it may be withdrawn or it may be withheld. Withdrawing treatment occurs when the patient is removed from life-support apparatus to which he or she is already attached.¹⁸ Treatment is withheld, however, when the patient is not attached to any additional apparatus, or when additional forms of treatment are simply foregone. Such a case frequently arises from "Do Not Resuscitate" (DNR) codes (also called "no-code" or "no code blue" orders). DNR codes are placed on a patient's chart to indicate that no effort to resuscitate the patient should be made in the event of cardiac or respiratory arrest.¹⁹ Whether withdrawing or withholding treatment is contemplated, the problem arises as to who should make the decision. This problem led to the use of the substituted judgment model.

II. SUBSTITUTED JUDGMENT MODEL

The common law right to refuse medical treatment is well established. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"²⁰ The only case to rely on this common law principle in the context of patients in irreversible vegetative comas, however, is *Barber v. Superior Court*.²¹ "[W]here a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this princi-

16. *Id.*, 355 A.2d at 654. See also *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1337 (Del. 1980).

17. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1020, 195 Cal. Rptr. 484, 492 (1983). See also *Quinlan*, 70 N.J. at 24, 355 A.2d at 654-55; *Eichner v. Dillon*, 73 A.D.2d 431, 443-44, 426 N.Y.S.2d 517, 529 (1980), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *Severns*, 421 A.2d at 1336-37; *In re Dinnerstein*, 6 Mass. App. Ct. 466, 467, 380 N.E.2d 134, 135 (1978).

18. See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (patient attached to a respirator, which father, as guardian, sought to remove), *cert. denied*, 429 U.S. 922 (1976); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (family sought to remove nasogastric tube attached to patient).

19. See, e.g., *Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (family of patient in irreversible vegetative coma sought to place DNR code on patient's chart). Only Massachusetts has treated withdrawing treatment differently from withholding treatment. Massachusetts requires court permission to withdraw treatment, *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), but not to withhold treatment. *Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978). See *infra* note 41 for a discussion of these cases.

20. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *quoted with approval in Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

21. 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983).

ple is that a competent adult patient has the legal right to refuse medical treatment."²²

All other cases have decided this issue on the basis of the constitutional right to privacy.²³ This right, of course, must be balanced against the interest of the state in preserving life.²⁴ However, the state's interest weakens as the degree of bodily invasion increases and the prognosis for full recovery dims.²⁵ With respect to a patient in an irreversible vegetative coma with no chance of recovery, the state's interest is secondary to the individual's right to privacy.²⁶

A person in a coma obviously cannot assert his or her own rights. Courts that have addressed the problem of patients in irreversible vegetative comas have developed an analysis commonly referred to as the substituted judgment model.²⁷ Under this model, a surrogate for the patient makes the actual decision as to the cessation or continuation of treat-

22. *Id.*

23. *See, e.g.,* *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 8-9, 426 N.E.2d 809, 814 (1980) ("Each court that has been faced with the question [of withdrawing treatment] has used the same constitutional right to privacy as the legal basis for its decision."); *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663 ("[T]he unwritten constitutional right of privacy . . . exist[s] in the penumbra of specific guarantees of the Bill of Rights . . ." (citing *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965))), *cert. denied*, 429 U.S. 922 (1976). "Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." *Id.*, 355 A.2d at 663 (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

24. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663.

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

26. *Id.* *See also* *Leach*, 68 Ohio Misc. at 9-10, 426 N.E.2d at 814-15; *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 740-41, 370 N.E.2d 417, 424-25 (1977); *In re Colyer*, 99 Wash. 2d 114, 119-21, 660 P.2d 738, 741-42 (1983), *subsequently modified on other grounds*, *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

27. *See, e.g.,* *Saikewicz*, 373 Mass. at 750-52, 370 N.E.2d at 431. The first use of the substituted judgment model was in 1816 in England, and involved the administration of an incompetent person's estate. *Ex parte Whitbread*, 35 Eng. Rep. 878 (1816). In that case, the court acted as a substitute for an incompetent person in order to validate a gift from the incompetent's estate to a person to whom the incompetent owed no duty of support. The court, as surrogate, authorized the gift, based on the motives and considerations that the court believed would have motivated the incompetent.

The United States Supreme Court approved use of the substituted judgment model in *City Bank Farmers Trust Co. v. McGowan*, 323 U.S. 594, 599 (1945) ("[T]he court is to substitute itself as nearly as may be for the incompetent, and to act upon the same motives and considerations as would have moved her," and any action taken by the court "is, in legal effect, her act and the motive is hers."). More recently, the model has been used to approve removal of a kidney from an incompetent to transplant to the incompetent's brother. *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. Ct. App. 1969). Of all the family members, only the incompetent was compatible as a donor. *Id.* at 146. The court decided that based on the close relationship, and the benefit the incompetent would derive from his brother's continued life, the incompetent would have approved the transplant. *Id.* at 146, 149.

ment, guided by the preference of the patient, if known or ascertainable.²⁸ Use of a surrogate assures that the patient's right to privacy will not be destroyed.²⁹ The courts have used two basic variations of the substituted judgment model to make their decisions.

A. *The Guardian as the Surrogate*

The first variation of the model requires the court to appoint a guardian who is allowed to act as the surrogate and decide whether or not to withdraw treatment. The court limits its involvement to evaluating the qualifications of the prospective guardian. The leading case using this procedure is *In re Quinlan*.³⁰

In *Quinlan*, the father of a patient in an irreversible vegetative coma sought appointment as her guardian so that he could "authorize the discontinuance of all extraordinary medical procedures."³¹ The court held that the character and motivations of the prospective guardian should be

28. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983) (citing *Saikewicz*, 373 Mass. at 750-52, 370 N.E.2d at 431).

A recent decision of the New Jersey Supreme Court, *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), interpreted the substituted judgment model as containing three separate tests. *Id.* at 360-67, 486 A.2d at 1229-32. Under any of these tests, if the patient has expressed a desire to have treatment continued, regardless of the circumstances, treatment should never be withdrawn or withheld. *Id.* at 366-67, 486 A.2d at 1232.

The first test is the subjective test. *Id.* at 360-61, 486 A.2d at 1229. This test is used when the patient has expressed a strong desire to have life-prolonging treatment withheld or withdrawn if the situation ever arose. Casual remarks should not be taken into account. *Id.* at 360-64, 486 A.2d at 1229-31.

The second test is the limited-objective test. *Id.* at 365, 486 A.2d at 1232. Under this test the net benefit to the patient from continued treatment should be examined, along with any indications (even casual remarks) that the patient would want treatment discontinued. As the benefit decreases and the patient's prior expression to have treatment discontinued increases, the surrogate should give greater weight to the option of discontinuing treatment. *Id.* at 365-66, 486 A.2d at 1232.

The last test is the pure objective test. *Id.* at 366, 486 A.2d at 1232. This test should be used when there has been no indication of the patient's preference. This test uses a high burden, allowing treatment to be withdrawn or withheld only if there is virtually no benefit to the patient. *Id.* at 366-67, 486 A.2d at 1232.

29. See *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 ("The only practical way to prevent destruction of the right is to permit the guardian and family . . . to render their best judgment . . . as to whether the [patient] would exercise it in these circumstances."), *cert. denied*, 429 U.S. 922 (1976). Thus, the guardian may "vicariously assert the constitutional right of a comatose ward to accept medical care or to refuse it." *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1347 (Del. 1980). *Accord In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980) (family may assert rights of incompetent in court, but only the court may make decision to withdraw treatment).

30. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

31. *Id.* at 18, 355 A.2d at 651.

evaluated in all respects.³² Absent a finding of unsuitability, the court should appoint the father as guardian pursuant to the statutory preference for the next of kin.³³ The guardian could then assert any right of the patient, including her right to refuse treatment.³⁴ Finally, the court held that the guardian did not have to obtain the court's permission in order to withdraw treatment.³⁵

32. One of the factors that impressed the court was the religious beliefs of the patient's father, Joseph Quinlan. *Id.* at 30, 355 A.2d at 658. Although the court recognized that it is unusual for religious dogma and concepts to enter into a civil trial, it held that they were properly considered here as evidence of Mr. Quinlan's character, since these matters bore upon his decision. *Id.* at 30, 355 A.2d at 658. The court emphasized that no religious views could serve as precedent for future cases, but noted that any religious view, if it bears at all on the guardian's beliefs and judgments, may be considered to the extent that it bears upon the guardian's decision. *Id.* at 33-34, 355 A.2d at 660.

In the present case, since Mr. Quinlan was Catholic, the Catholic Church's point of view on withdrawal of treatment could be considered. *Id.* at 30, 355 A.2d at 658. Pope Pius XII, in a 1957 "allocutio" (address), stated that to the extent that the use of a respirator goes

"beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them or . . . to give the doctor permission to use them There is not involved here a case of direct disposal of life of the patient; nor of euthanasia in any way; this would never be licit. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life."

Eichner v. Dillon, 73 A.D.2d 431, 439 n.3, 426 N.Y.S.2d 517, 526 n.3 (1980) (quoting The Prolongation of Life, Address of Pope Pius XII to an International Congress of Anesthesiologists, November 24, 1957 AAS XXXXIX (1957)), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981). The Church filed an amicus brief in *Quinlan* which stated that "'the decision of Joseph Quinlan to request the discontinuance of this treatment is, according to the teachings of the Catholic Church, a morally correct decision.'" *Quinlan*, 70 N.J. at 32, 355 A.2d at 659 (quoting the statement of Bishop Lawrence B. Casey, as reproduced in the amicus brief) (emphasis in original). This statement of position coincided with the advice that was given to Mr. Quinlan when he consulted with his parish priest. *Id.* at 30, 355 A.2d at 658. The evidence also showed that had the Church's viewpoint been to the contrary, Mr. Quinlan would not have sought to discontinue treatment for his daughter. *Id.* The court indicated that this evidence demonstrated Mr. Quinlan's desire to make a moral choice and his suitability to serve as guardian. *Id.* at 32, 355 A.2d at 660.

33. *Quinlan*, 70 N.J. at 53, 355 A.2d at 670-71. See N.J. STAT. ANN. 3B:12-25 (1983) (court should appoint as guardian the person's spouse, heirs, or any other proper person, in that order). Implicit in this decision is that a prospective guardian's express intention to withdraw treatment is not, by itself, sufficient to make a prospective guardian unsuitable.

34. *Id.* at 41-42, 355 A.2d at 664. See *supra* note 29.

35. *Id.* at 50-51, 355 A.2d at 669. See *infra* note 51 and accompanying text. The court did, however, set out a procedure that must be followed in order to discontinue treatment. See *infra* note 162.

Soon after the court's March 31, 1976 decision, treatment was withdrawn from Karen Ann Quinlan. She continued to live until June 11, 1985, however, when she died of pneumonia. L.A. Times, June 12, 1985, § 1, at 4, col. 1. Although the cases of *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) and *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), allowing withdrawal of nasogastric tubes, were decided during this time, Ms. Quinlan's family never had such treatment withdrawn from her. Jacobs, *Don't Pull Feeding Tubes From Dying, State Advises*, L.A. Times, June 28, 1985, § 1, at 1, 24, col. 1.

B. The Court as the Surrogate

The second variation of the model requires the court to determine whether or not to continue life-support treatment after a full hearing. In effect, the court acts as the surrogate.³⁶ This approach is exemplified by the Massachusetts case, *In re Spring*.³⁷ *Spring* involved an incompetent patient suffering from end-stage kidney disease.³⁸ The patient's son was appointed guardian and, together with the patient's wife, requested that life-prolonging treatment be discontinued.³⁹ The Appeals Court of Massachusetts granted the wife and son, together with the attending physician, the power to make the decision to withdraw treatment.⁴⁰

The Massachusetts Supreme Court expressly rejected this procedure, noting that "the ultimate decision making responsibility [should not be shifted] away from the duly established courts of proper jurisdiction."⁴¹ The court reasoned that private medical decisions must be made

36. This variation comes closer to the historical use of the substituted judgment model than does the variation used in *Quinlan*. See *supra* note 27.

37. 380 Mass. 629, 405 N.E.2d 115 (1980).

38. *Id.* at 632, 405 N.E.2d at 118.

39. *Id.* at 631, 405 N.E.2d at 117.

40. *Id.*, 405 N.E.2d at 118. The lower court used the first variation of the substituted judgment model. Instead of appointing one surrogate, as the court in *Quinlan* had, the court appointed three surrogates, all of whom needed to approve the final decision. 8 Mass. App. Ct. 831, 399 N.E.2d 493 (1979), *rev'd* 380 Mass. 629, 405 N.E.2d 115 (1980).

41. 380 Mass. at 636, 405 N.E.2d at 120. The court was faced with the apparently conflicting decisions of *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), and *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978). In *Saikewicz*, the court required that a guardian ad litem be appointed to oppose the person seeking to withdraw treatment. The guardian was to conduct an investigation and to submit "all reasonable arguments in favor of administering treatment to prolong the life of the individual involved." 373 Mass. at 757, 370 N.E.2d at 433. The judge should then decide whether or not to allow treatment to be withdrawn. *Id.*, 370 N.E.2d at 434. The court specifically rejected the *Quinlan* court's approach of allowing the guardian to make the decision. *Id.* at 758-59, 370 N.E.2d at 434-35.

In *Dinnerstein*, however, the court allowed the family and physician of a patient in an irreversible vegetative coma to decide to withhold treatment and not to resuscitate the patient in the event of cardiac or respiratory arrest. 6 Mass. App. Ct. at 475-76, 380 N.E.2d at 139. The court indicated that the *Saikewicz* decision did not intend to force resuscitation of a terminally ill patient during natural death. *Id.* at 471, 380 N.E.2d at 137. "[S]ince it is obvious on reflection that cardiac or respiratory arrest will signal the arrival of death for the overwhelming majority of persons whose lives are terminated by illness or old age," *id.* at 470, 380 N.E.2d at 136, a strict reading of *Saikewicz* "would require attempts to resuscitate dying patients in most cases, without exercise of medical judgment, even when that course of action could aptly be characterized as a pointless, even cruel, prolongation of the act of dying." *Id.* at 471, 380 N.E.2d 137 (footnote omitted).

The *Spring* court, while not specifically approving the *Dinnerstein* decision in its entirety, did agree that the result was consistent with *Saikewicz*. 380 Mass. at 635, 405 N.E.2d at 120. The court reaffirmed the procedure outlined in *Saikewicz*, requiring the use of a guardian ad litem in all cases involving the withdrawal of treatment. *Id.* In addition to the findings of the

responsibly, subject to judicial scrutiny in order to insure that good faith and due care are observed.⁴² Accordingly, this variation of the substituted judgment model requires the court, as surrogate, to determine what the patient would have decided if he or she were capable of making the decision.⁴³ The court should achieve a balance between the putative desires of the ward and the possible countervailing state interests.⁴⁴

The use of the judiciary under either of these variations, however, has a number of drawbacks. Chief among these is that it is "impossibly cumbersome."⁴⁵ Court proceedings consume such a tremendous amount of time, including the inevitable appeals,⁴⁶ that the patient often dies before final judicial resolution.⁴⁷ Next, the financial burden placed on the patient's family by legal expenses, added to the expenditures for medical care, can overwhelm the typical family budget. Thirdly, "[t]he methodology and the techniques from our classic adversary system are not best suited to the resolution of the issues presented."⁴⁸ Fourthly, there is evidence that for many years patients' families and physicians

guardian, the court could also consider the findings of medical ethics committees, the testimony of the attending physician, and the testimony of other medical experts. *Id.* Accordingly, in Massachusetts, treatment may be withheld without prior court approval, but cannot be withdrawn unless such approval is received.

42. 380 Mass. at 639, 405 N.E.2d at 122.

43. *Id.* at 640, 405 N.E.2d at 122. See also *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1349-50 (Del. 1980) (the problems presented are factual in a very significant way and require resolution of a number of questions about what constitutes a life-sustaining system in each case).

44. 380 Mass. at 640-41, 405 N.E.2d at 123.

45. *In re Quinlan*, 70 N.J. 10, 50, 355 A.2d 647, 669, *cert. denied*, 429 U.S. 922 (1976).

46. *In re Storar*, 52 N.Y.2d 363, 385, 420 N.E.2d 64, 75, 438 N.Y.S.2d 266, 277 (Jones, J., dissenting in part) ("The lapse of time consumed in appellate review before there can be final judicial determination will almost always be unacceptable and makes recourse to judicial proceedings impracticable."), *cert. denied*, 454 U.S. 858 (1981).

47. See, e.g., *In re Conroy*, 98 N.J. 321, 341, 486 A.2d 1209, 1219 (1985); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 189, 209 Cal. Rptr. 220, 221 (1984); *Eichner v. Dillon*, 73 A.D.2d 431, 434, 426 N.Y.S.2d 517, 523 (1980), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *In re Storar*, 52 N.Y.2d 363, 369 & n.1, 420 N.E.2d 64, 66 & n.1, 438 N.Y.S.2d 266, 268 & n.1, *cert. denied*, 454 U.S. 858 (1981); *In re Spring*, 380 Mass. 629, 631-32 n.1, 405 N.E.2d 115, 118 n.1 (1980).

48. *In re Storar*, 52 N.Y.2d 363, 385, 420 N.E.2d 64, 75, 438 N.Y.S.2d 266, 277 (Jones, J., dissenting in part) ("The courts can claim no particular competence to reach the difficult ultimate decision, depending as it must not only on medical data, but on theological tenets and perceptions of human values which defy classification and calibration."), *cert. denied*, 454 U.S. 858 (1981); *In re Quinlan*, 70 N.J. 10, 50, 355 A.2d 647, 669 (Court confirmation of these decisions would be a "gratuitous encroachment on the medical profession's field of competence [These decisions] should obviously include at some stage the feelings of the family . . . [and thus] should be controlled primarily within the patient-doctor-family relationship"), *cert. denied*, 429 U.S. 922 (1976). The courts have also indicated that the legislature is the proper branch of government to set guidelines in this area. See *infra* note 127.

have made decisions to withdraw or withhold treatment, often after consulting with religious counselors.⁴⁹ Finally, the decision of the family is usually followed by the courts anyway.⁵⁰ Accordingly, most courts have concluded that it is not necessary in all cases to obtain prior court approval in order to disconnect life-support apparatus from patients in irreversible vegetative comas.⁵¹

The only potential benefit to the use of the court system is that it protects the person who actually disconnects the patient, usually the attending physician, from civil or criminal liability.⁵² Any physician who

49. *Storar*, 52 N.Y.2d at 385-86 & n.3, 420 N.E.2d at 75-76 & n.3, 438 N.Y.S.2d at 277-78 & n.3 (Jones, J., dissenting in part) ("[T]he austere American Medical Association [has] formally adopted the following policy statement: 'The cessation of the employment of extraordinary means to prolong the life of the body where there is irrefutable evidence that biological death is imminent is the decision of the patient and-or his immediate family . . .'" This provided doctors with a sanction for what many had been doing for some time, since the practice of turning off machines, for example, to allow death to come to a patient whom only the machine is keeping alive is a fairly common practice for hospitals.'" (quoting Kutner, *Euthanasia: Due Process For Death With Dignity; The Living Will*, 54 IND. L.J. 201, 223 (1979))). See also *Quinlan*, 70 N.J. at 33, 355 A.2d at 660 (Authorization of withdrawal of treatment may merely require that courts "recognize the present standards and practices of many people engaged in medical care who have been doing what the parents of Karen Ann Quinlan are requesting.'" (quoting position statement of Bishop Casey, spokesman for the N.J. Catholic Conference)).

50. See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (decision of father to withdraw life-sustaining apparatus allowed), cert. denied, 429 U.S. 922 (1976); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980) (decision of wife and son to withdraw hemodialysis treatment approved); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980) (petition of husband to discontinue treatment granted); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980) (leader of religious order allowed to withdraw treatment from one of its members), modified sub nom., *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978) (family and physician of patient allowed to withhold treatment via DNR code). But see *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (decision of mother to withdraw treatment overruled), cert. denied, 454 U.S. 858 (1981).

51. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 493 (1983) ("[W]e agree with those [courts] which have held that requiring judicial intervention in all cases is unnecessary and may be unwise."); *Storar*, 52 N.Y.2d at 382-83, 420 N.E.2d at 74, 438 N.Y.S.2d at 276 ("Neither the common law nor existing statutes require persons generally to seek prior court assessment . . ."); *In re Colyer*, 99 Wash. 2d 114, 127-28, 660 P.2d 738, 745-46 (1983) ("[W]e choose a course similar to that in *Quinlan* and hold that judicial intervention in every decision to withdraw life sustaining treatment is not required."), subsequently modified on other grounds, *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984). But see *In re Spring*, 380 Mass. 629, 636, 405 N.E.2d 115, 120 (1980) ("Again we disapprove shifting of the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction.").

52. See, e.g., *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1349 n.12 (Del. 1980) ("[A] criminal prosecution may be enjoined if it infringes upon some constitutional right, provided that the party seeking such relief demonstrates that failure to enjoin will cause irreparable harm." (citing *Younger v. Harris*, 401 U.S. 37 (1971))); *In re Storar*, 52 N.Y.2d 363, 382, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 ("[R]esponsible parties who wish to com-

is acting under the direction of the court, either directly or through a court appointed guardian, cannot later be held liable for the decision if it is challenged.⁵³ It has been suggested that even without a court order, a physician who acts on a good faith judgment that is not previously unreasonable by medical standards will at least be protected from criminal liability.⁵⁴ Following accepted medical standards,⁵⁵ however, did not

ply with the law, in cases where the legal consequences of the contemplated action is uncertain, need not act at their peril."), *cert. denied*, 454 U.S. 858 (1981). *But see In re Quinlan*, 70 N.J. 10, 52, 355 A.2d 647, 670 ("[E]xercise of a constitutional right . . . is protected from criminal prosecution. . . . [Such protection] extends to third parties whose action is necessary to effectuate the exercise of that right" (citations omitted)), *cert. denied*, 429 U.S. 922 (1976).

53. A physician might still be liable if (1) the original diagnosis of an irreversible vegetative coma was made negligently, and it was upon this erroneous diagnosis that the court based its decision to discontinue treatment, or (2) if the discontinuation was negligently carried out. *See, e.g., In re Spring*, 380 Mass. 629, 639, 405 N.E.2d 115, 122 (1980) ("[C]ourt approval may serve the useful purpose of resolving a doubtful or disputed question of law or fact, but it does not eliminate all risk of liability.").

54. *Id.* at 637, 405 N.E.2d at 121 (citing *Commonwealth v. Edelin*, 371 Mass. 497, 544, 359 N.E.2d 4, 28-29 (1976) (Hennessey, C.J., dissenting)).

55. The Los Angeles Bar Association, together with the Los Angeles Medical Society, has developed the following guidelines for withdrawing treatment from a patient:

A. The general principles which should govern decision making are:

1. It is the right of a person capable of giving informed consent to make his or her own decision regarding medical care after having been fully informed about the benefits, risks and consequences of available treatment, even when such a decision might foreseeably result in shortening the individual's life.
2. Persons who are unable to give informed consent have the same rights as do persons who can give such consent. Decisions made on behalf of persons who cannot give their own informed consent should, to the extent possible, be the decisions which those persons would have made for themselves had they been able to do so. . . . [T]he conservator of an adult patient[] must consent to the decision. Family members of adult patients should always be consulted, although they have no legal standing under present California Law to make decisions on behalf of the patient.
3. A physician may discontinue use of a cardiopulmonary life-support system (i.e. a mechanical respirator or ventilator), and is not required to continue its use indefinitely solely because such support was initiated at an earlier time.

....

B. Three sets of circumstances in which decisions to discontinue the use of cardiopulmonary life-support systems can be made without the necessity of prior approval by the courts are:

....

3. Irreversible Coma

Cardiopulmonary life-support systems may be discontinued if all of the following conditions are present:

- a. The medical record contains a written diagnosis of irreversible coma, confirmed by a physician who by training or experience is qualified to assist in making such decisions. The medical record must include adequate medical evidence to support the diagnosis;
- b. The medical record indicates that there has been no expressed intention on the part of the patient that life-support systems be initiated or maintained in such circumstance; and

protect two physicians from prosecution in a recent California case.

III. PROPORTIONATE/DISPROPORTIONATE ANALYSIS

In *Barber v. Superior Court*,⁵⁶ the California Court of Appeal held that two physicians' omission to treat a patient in an irreversible vegetative coma was not a wrongful failure to perform a legal duty.⁵⁷ Because the court found that there was no legal duty to provide medical care, a decision not to act could not lead to criminal liability.⁵⁸ Thus, even though the physicians acted intentionally and with the knowledge that the patient would die, their conduct did not amount to murder.⁵⁹ The court therefore issued a peremptory writ dismissing the murder charges against the two physicians.⁶⁰

A. Barber v. Superior Court

The facts of *Barber* are as follows:

On August 26, 1981, Dr. Neil Barber, an internist, and Dr. Robert Nejd, a surgeon, operated on Clarence Herbert. Following the successful completion of the surgery, Mr. Herbert went into cardiorespiratory arrest. Although he was quickly revived and placed on life-support equipment, Mr. Herbert suffered severe brain damage that left him in an irreversible vegetative coma.⁶¹ Three days later, after being fully informed of the prognosis, Mr. Herbert's family authorized the removal of all life-support equipment.⁶² As a result, either directly by or through the orders of the doctors, the respirator and certain other life-support

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- c. The medical record indicates that the patient's family or guardian or conservator concurs in the decision to discontinue such support.

D.A. ROBBINS, LEGAL AND ETHICAL ISSUES IN CANCER CARE IN THE UNITED STATES, 11-13 (1983). All of the conditions described above were met by the physicians in *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). See *infra* notes 193-99 and accompanying text. Although these guidelines only mention cardiopulmonary life-support apparatus, other authorities have stated that it is also justifiable to withhold or withdraw artificial nutrition and hydration supplied by a nasogastric tube, as was the case in *Barber*. Siegel, *Medical Quandary: Bioethics Seeks Rules for Dying*, L.A. Times, Jan. 6, 1985, § 1, at 1, 30, col. 2 (citing NEW ENG. J. MED. and HASTINGS CENTER REP.); *In re Conroy*, 98 N.J. 321, 374, 486 A.2d 1209, 1236-37 (1985).

56. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

57. *Id.* at 1022, 195 Cal. Rptr. at 493.

58. *Id.* at 1017, 105 Cal. Rptr. at 490 (citing 1 WITKIN, CAL. CRIMES § 67 (1963)).

59. *Id.* at 1022, 195 Cal. Rptr. at 493.

60. *Id.* at 1010, 1022, 195 Cal. Rptr. at 486, 494.

61. See *supra* notes 15-17 and accompanying text. This diagnosis was made by Drs. Barber and Nejd, and was confirmed by two specialists, a cardiologist and a neurologist. *Id.* at 1010, 195 Cal. Rptr. at 486; CHA INSIGHT Vol. 8, No. 13, p. 1, April 3, 1984.

62. The family sent a written request to the hospital that they wanted "all machines taken off that are sustaining life." 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486. All

equipment were removed. Mr. Herbert continued to breathe, however, but showed no signs of improvement.⁶³ On August 31, the family requested the removal of the nasogastric and intravenous tubes which had been providing nourishment and hydration. These were removed, and Mr. Herbert died on September 6, 1981.⁶⁴

Acting on the report of a nurse,⁶⁵ the Los Angeles County District Attorney filed charges of murder and conspiracy to commit murder against Drs. Barber and Nejd. At the close of the preliminary hearing, the municipal court magistrate dismissed all charges. A superior court judge, on the motion of the district attorney, ordered the charges reinstated, and the two physicians filed for writs of prohibition. Subsequently, the court of appeal issued an alternate writ pending a full hearing of the case.⁶⁶

In explaining its decision to issue the peremptory writ, the court of appeal drew two important distinctions from existing case law. The court first modified the test for determining when life-sustaining measures may be withdrawn or withheld.⁶⁷ Secondly, the court eliminated the differentiation between the various types of mechanical life-support apparatus.⁶⁸

In the past, courts have characterized life-sustaining measures as being either "ordinary" or "extraordinary." In making its first distinction, the *Barber* court noted that the use of the terms ordinary and extraordinary to describe the medical procedures only "begs the question."⁶⁹ Although there may have been a duty to start life-support treatment at some point, a physician has no duty to continue ineffective or futile treatment,⁷⁰ and may discontinue such treatment without fear of civil or criminal liability.⁷¹ Treatment is futile when it cannot and does not improve the prognosis for recovery.⁷² The court found that using the terms "proportionate" and "disproportionate" better describes the balancing

decisions were made unanimously by Mr. Herbert's wife and eight of their children. *Id.* at 1021, 195 Cal. Rptr. at 493; *CHA INSIGHT*, *supra* note 61, at 1.

63. 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

64. *Id.* at 1011, 195 Cal. Rptr. at 486; *CHA INSIGHT*, *supra* note 61, at 1-2.

65. *CHA INSIGHT*, *supra* note 61, at 2.

66. 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

67. *Id.* at 1018-19, 195 Cal. Rptr. at 491.

68. *Id.* at 1016-17, 195 Cal. Rptr. at 490.

69. *Id.* at 1018, 195 Cal. Rptr. at 491.

70. *Id.* at 1017-18, 195 Cal. Rptr. at 491.

71. *Id.* at 1018, 195 Cal. Rptr. at 491 (quoting Horan, *Euthanasia and Brain Death: Ethical and Legal Considerations*, 315 ANNALS N.Y. ACAD. SCI. 363, 367 (1978)).

72. *Id.* (quoting Horan, *Euthanasia and Brain Death: Ethical and Legal Considerations*, 315 ANNALS N.Y. ACAD. SCI. 363, 367 (1978)).

test of benefits gained versus burdens caused by life-sustaining equipment.⁷³ "[P]roportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment."⁷⁴

The difference in a proportionate/disproportionate analysis is not in its ultimate focus,⁷⁵ but in its approach. Whereas an ordinary/extraordinary analysis examines the equipment being used,⁷⁶ a proportionate/disproportionate analysis emphasizes the *net* benefit to the patient. Thus, a treatment may be disproportionate if it has a small burden but an even smaller benefit, or if it has a large benefit but an even larger burden.⁷⁷ The following discussion exemplifies how a proportionate/disproportionate analysis would be applied in various treatment situations.

The first type of treatment is one that is only minimally intrusive, such as a blood transfusion. In the New York case of *In re Storar*,⁷⁸ the mother of an incompetent patient with terminal cancer sought to stop blood transfusions since the cancer would kill the patient within six months even with continued treatment.⁷⁹ The court decided that the transfusions should have been continued.⁸⁰ Although the treatment

73. *Id.* at 1018-19, 195 Cal. Rptr. at 491.

[E]ven if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.

Id. at 1019, 195 Cal. Rptr. at 491.

74. *Id.*

75. "[T]he focal point of the decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of . . . biological vegetative existence . . ." *Id.*, 195 Cal. Rptr. at 492 (quoting *Quinlan*, 70 N.J. 10, 50, 355 A.2d 647, 669, *cert. denied*, 429 U.S. 922 (1976)). See also *In re Dinnerstein*, 6 Mass. App. Ct. 466, 472-73, 380 N.E.2d 134, 138 (1978) (" 'Prolongation of life' . . . does not mean a mere suspension of the act of dying, but contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence. ").

76. "[O]ne would have to think that the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient." 147 Cal. App. 3d at 1019, 195 Cal. Rptr. at 491-92 (quoting *Quinlan*, 70 N.J. at 48, 355 A.2d at 668).

77. *Id.*, 195 Cal. Rptr. at 491.

78. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

79. *Id.* at 374, 420 N.E.2d at 69, 438 N.Y.S.2d at 271.

80. *Id.* at 381-82, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. The patient died while the case was on appeal, even though treatment was continued. *Id.* at 369 & n.1, 420 N.E.2d at 66 & n.1, 438 N.Y.S.2d at 268 & n.1. The court decided that, despite the mootness of the particular controversy, the issues underlying the case were of public importance and had not previously been discussed by the court. *Id.* at 369-70, 420 N.E.2d at 66-67, 438 N.Y.S.2d at 268-69.

could not cure the cancer, it would have maintained the patient's mental and physical abilities "at the usual level" for that patient.⁸¹ The treatment generated great benefits which outweighed the small burden; thus, the treatment was proportional.

In a case such as *Barber*, however, treatment by blood transfusion would be disproportionate (assuming that transfusions were necessary in addition to the other treatments). A transfusion would not return the patient to anywhere near his "usual level," even coupled with the other treatment. It would only maintain the patient's coma, and prolong the process of death. The treatment would thus not provide any significant improvement in condition.⁸² Since there would be virtually no benefit to a patient such as Mr. Herbert, the treatment would be disproportionate despite its relatively small burden.

The second type of treatment is one that imposes a great burden on the patient, such as chemotherapy. In the Massachusetts case of *Superintendent of Belchertown v. Saikewicz*,⁸³ the court dealt with an incompetent patient suffering from leukemia.⁸⁴ If treated with chemotherapy, there was a thirty to forty percent chance of remission, but the remission would last for only two to thirteen months, with no chance of a total cure.⁸⁵ The burden placed on the patient, however, would be extensive. The toxic nature of the chemicals involved would have caused " 'pain and discomfort, depressed bone marrow, pronounced anemia, increased chance of infection, possible bladder irritation, and possible loss of hair.' " ⁸⁶ The court determined that the great burden placed on the patient outweighed the minimal benefit.⁸⁷ Accordingly, the treatment could be discontinued as disproportionate.

If, on the other hand, there was a great benefit, such as a ninety percent chance of full remission, then the treatment would be propor-

81. *Id.* at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275 (emphasis added). It should be noted that the quality of life determination is made with respect to the patient's pre-illness condition. John Storar could never have had the same quality of life as an average person, since he had never been, and never would be, competent. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274-75. However, "a court should not . . . allow an incompetent patient to . . . [die] because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease." *Id.* at 382, 420 N.E.2d at 73, 438 N.Y.S.2d at 275-76.

82. *Barber*, 147 Cal. App. 3d at 1019, 195 Cal. Rptr. at 491.

83. 373 Mass. 728, 370 N.E.2d 417 (1977).

84. *Id.* at 729, 370 N.E.2d at 419.

85. *Id.* at 734, 370 N.E.2d at 421 (quoting the findings of the lower court). Both of Mr. Saikewicz's attending physicians recommended against the chemotherapy. *Id.* at 730, 370 N.E.2d at 419.

86. *Id.* at 734, 370 N.E.2d at 421 (quoting the findings of the lower court).

87. *Id.* at 759, 370 N.E.2d at 435.

tionate. There would be an excellent chance of "significant improvement in the patient's condition,"⁸⁸ namely, a return to the patient's "usual level" of mental and physical ability.⁸⁹ This great benefit would outweigh the large burden, making the treatment proportionate; therefore, it could not be withdrawn.

The second distinction recognized by the *Barber* court was that there is no rational difference between the use of mechanical breathing devices such as respirators, and mechanical feeding devices such as intravenous tubes.⁹⁰ The court emphasized that medical nutrition and hydration do not always provide a net benefit to the patient and are more similar to other medical procedures than to typical human methods of nutrition and hydration.⁹¹ Thus, the benefits and burdens of such devices "ought to be evaluated in the same manner as any other medical procedure."⁹²

Once it has been determined that further treatment is useless, respirators, medical nutrition and hydration, and similar procedures which do not address the pathology,⁹³ become futile and merely prolong the act of

88. *Barber*, 147 Cal. App. 3d at 1019, 195 Cal. Rptr. at 491.

89. *In re Storar*, 52 N.Y.2d 363, 381, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275, cert. denied, 454 U.S. 858 (1981).

90. *Barber*, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490. The court noted that the distinction urged by the prosecutor was based "on the emotional symbolism of providing food and water to those incapable of providing for themselves." *Id.* However, on closer examination, it is clear that medical nutrition and hydration provides aid which is no different in kind than is provided by a machine such as a respirator, without which the patient cannot breathe. Both procedures amount to forced sustenance of life by medical equipment. *Id.* at 1016-17, 195 Cal. Rptr. at 490. Also, neither a respirator nor medical nutrition and hydration directly cure or even address the pathological condition; they merely sustain the biological function while other processes address the pathology. *Id.* at 1017, 195 Cal. Rptr. at 490.

Despite this decision, a recent New Jersey decision, *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), and at least two reports by prominent physicians that artificial nutrition and hydration and antibiotics could be withheld or withdrawn from patients in irreversible vegetative comas, Siegel, *Medical Quandary: Bioethics Seeks Rules for Dying*, L.A. Times, Jan. 6, 1985, § 1, at 1, 30, col. 2 (citing NEW ENG. J. MED. and HASTINGS CENTER REP.), the evidence indicates that only 5% of all physicians would agree to withdraw nasogastric tubes, and only 15% to 20% would withdraw antibiotics. Siegel, *Medical Quandary: Bioethics Seeks Rules for Dying*, L.A. Times, Jan. 6, 1985, § 1, at 1, 30, col. 2 (citing estimates of Arthur Caplan, a philosopher at the Hastings Center). Additionally, the California Department of Aging has started recommending that nursing homes not withdraw nasogastric tubes from unconscious dying patients despite the *Barber* decision. Jacobs, *Don't Pull Feeding Tubes From Dying, State Advises*, L.A. Times, June 28, 1985, § 1, at 1, col. 1.

91. *Barber*, 147 Cal. App. 3d at 1016-17, 195 Cal. Rptr. at 490.

92. *Id.* at 1017, 195 Cal. Rptr. at 490. More recently, the New Jersey Supreme Court reached a similar conclusion about medical nutrition and hydration. *In re Conroy*, 98 N.J. 321, 374, 486 A.2d 1209, 1236-37 (1985).

93. *Barber*, 147 Cal. App. 3d at 1017, 195 Cal. Rptr. at 490. See *supra* note 90.

dying. Therefore, they are disproportionate and may be discontinued.⁹⁴ In *Barber*, the court concluded that the evidence showed that Mr. Herbert's condition had deteriorated to the point where continued treatment no longer provided a net benefit to Mr. Herbert.⁹⁵

A physician has no duty to continue treatment if further efforts would be futile.⁹⁶ Using the proportionate/disproportionate analysis, the continued treatment of Mr. Herbert was clearly futile. According to the experts who testified at the preliminary hearing, Mr. Herbert's chances for unimpaired or full recovery were miniscule.⁹⁷ These opinions coincided with the diagnosis of the four physicians who had examined Mr. Herbert.⁹⁸ Since there was virtually no chance that Mr. Herbert would fully recover, the treatments being used (including the intravenous tubes) served no further purpose. Therefore, they were disproportionate to the burdens that they were causing, even though they carried fairly minor burdens in absolute terms.

The court thus concluded that the physicians' conduct was not murder.⁹⁹ The court noted that "[m]urder is the *unlawful* killing of a human being, . . . with malice aforethought."¹⁰⁰ Whereas the superior court found that the physicians' conduct was unlawful as a matter of law since it shortened Mr. Herbert's life,¹⁰¹ the appellate court determined that their conduct was an omission, not an affirmative act.¹⁰² There can be no

94. *Barber*, 147 Cal. App. 3d at 1020, 195 Cal. Rptr. at 492. "Although there may be a duty to provide life-sustaining machinery in the *immediate* aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel." *Id.* at 1017-18, 195 Cal. Rptr. at 491 (emphasis in original).

95. *Id.* at 1020, 195 Cal. Rptr. at 492.

96. *Id.* at 1017-18, 195 Cal. Rptr. at 491.

97. *Id.* at 1020, 195 Cal. Rptr. at 492. The most optimistic prognosis provided that Mr. Herbert had an excellent chance of "recovery," but defined "recovery" as a spectrum running from an irreversible vegetative coma to full recovery. This expert could not predict where on this spectrum Mr. Herbert would end up, but the studies he relied upon indicated the chances for full recovery were miniscule. *Id.*

98. *Id.*

99. *Id.* at 1022, 195 Cal. Rptr. at 493.

100. *Id.* at 1011, 195 Cal. Rptr. at 486 (emphasis in original) (citing CAL. PENAL CODE § 187 (West 1984)).

101. *Id.* at 1011-12, 195 Cal. Rptr. at 487.

102. *Id.* at 1017, 195 Cal. Rptr. at 490. "[C]essation of 'heroic' life support measures is not an affirmative act but rather a withdrawal or omission of further treatment." *Id.* at 1016, 195 Cal. Rptr. at 490.

Even though these life support devices are, to a degree, "self-propelled," each pulsation of the respirator or each drop of fluid introduced into the patient's body by intravenous feeding devices is comparable to a manually administered injection or item of medication. Hence, "disconnecting" of the mechanical devices is comparable to withholding the manually administered injection or medication, *id.*, 195 Cal. Rptr. at 490, and thus is equivalent to an omission, not an affirmative act.

criminal liability from an omission to act unless there is a duty to act which has been violated.¹⁰³ Since the court found that the physicians had no further duty to continue treatment under the proportionate/disproportionate model, any omission on their part was not unlawful.¹⁰⁴

Lastly, the court addressed the question of who was the proper person to act as surrogate and decide if treatment should be withdrawn.¹⁰⁵ The court first noted that there is nothing in the California Natural Death Act to indicate that the statutory procedure is the exclusive method of discontinuing life-support treatment.¹⁰⁶ The court then decided that there should first be a diagnosis by the attending and consulting physicians that further treatment would be useless.¹⁰⁷ Then, if at all possible, the patient should make the decision himself.¹⁰⁸ If, as in this case, the patient is unable to make the decision, a surrogate should be chosen. The surrogate should be guided by the wishes of the patient, if ascertainable. If those desires are not ascertainable, the surrogate should objectively consider the patient's best interests.¹⁰⁹

103. *Id.* at 1017, 195 Cal. Rptr. at 490 (citing 1 WITKIN, CAL. CRIMES § 67 (1963)).

104. *Id.* at 1020, 195 Cal. Rptr. at 492.

105. For all practical purposes, the *Barber* court adopted the *Quinlan* variation of the substituted judgment model. See *infra* notes 117-39 and accompanying text.

106. *Id.* at 1016, 195 Cal. Rptr. at 490. CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1985) provides in part: "Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner." However, CAL. HEALTH & SAFETY CODE § 7195 (West Supp. 1985) provides: "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter."

Although the court never discussed § 7195, inherent in its decision is that Mr. Herbert died a "natural death," and so was not the victim of "mercy killing" such that § 7195 would be invoked. The court specifically quoted the legislative findings contained in § 7186 that recognize the futility of medical treatment in some cases, and the patient's fundamental right to have such procedures withdrawn or withheld. *Barber*, 147 Cal. App. 3d at 1015-16, 195 Cal. Rptr. at 489 (quoting CAL. HEALTH & SAFETY CODE § 7186 (West 1984)). When the court found that the procedures in *Barber* were futile and disproportionate, *id.* at 1020, 195 Cal. Rptr. at 492, it implicitly held that Mr. Herbert's fundamental right to have treatment withdrawn under §§ 7186 and 7193 could be exercised. When the patient is unable to exercise this right himself, a surrogate may exercise it for him. *Id.* at 1021, 195 Cal. Rptr. at 493. See *supra* notes 27-29 and accompanying text. For a more complete discussion of the California Natural Death Act, see *infra* notes 144-59 and accompanying text.

107. 147 Cal. App. 3d at 1020, 195 Cal. Rptr. at 492 ("Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice . . .").

108. *Id.*

109. *Id.* at 1021, 195 Cal. Rptr. at 493. The court indicated that the factors the surrogate should consider include, but are not limited to, relief of suffering, preservation or restoration of normal functions, the quality and extent of life sustained, and the impact upon the patient's loved ones. *Id.*

Ultimately, the court decided that the proper person to act as Mr. Herbert's surrogate was his wife.¹¹⁰ She was not only familiar with her husband's wishes,¹¹¹ but was also motivated only by love and concern for her husband.¹¹² The court noted that there is no legal requirement that the surrogate be a court appointed guardian,¹¹³ but if the court had been petitioned to appoint a guardian, the patient's wife would have qualified as such under existing California law.¹¹⁴ Thus, she had full legal authority to authorize the physicians to discontinue treatment,¹¹⁵ since there is no legal requirement that the surrogate seek court permission prior to taking such an action.¹¹⁶

B. Analysis of the Court

The *Barber* court effectively adopted the *Quinlan* variation of the substituted judgment model.¹¹⁷ The only differences between *Barber* and *Quinlan* are: (1) *Quinlan* requires consultation with a hospital "Ethics Committee" before the life-sustaining treatment may be withdrawn,¹¹⁸ whereas *Barber* only requires that consulting physicians concur in the diagnosis and prognosis;¹¹⁹ (2) *Barber* allows the surrogate to be someone other than a court appointed guardian;¹²⁰ and (3) *Quinlan* extends greater protection from liability to participants in the decision.¹²¹ Only the third difference is significant.

The first difference merely involves who should be consulted. Both *Barber* and *Quinlan* seek to ensure that the proper diagnosis has been made, requiring the attending physician(s) to consult with others. Under *Quinlan*, an Ethics Committee should concur with this diagnosis.¹²² The *Quinlan* court indicated that use of these committees would diffuse the professional responsibility for the decision, and would protect patients by screening out cases which might be contaminated by less than worthy

110. *Id.*

111. Mr. Herbert had indicated to his wife that he would not want to be kept alive by machines or to "become another Karen Ann Quinlan." *Id.*

112. *Id.*

113. *Id.* at 1020-21, 195 Cal. Rptr. at 492-93.

114. *Id.* at 1021, 195 Cal. Rptr. at 493. See CAL. PROBATE CODE § 1812 (West 1981).

115. *Barber*, 147 Cal. App. 3d at 1021, 195 Cal. Rptr. at 493.

116. *Id.* ("[I]n the absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made."). See *infra* note 140 and accompanying text.

117. See *supra* notes 29-35 and accompanying text.

118. *In re Quinlan*, 70 N.J. 10, 54, 355 A.2d 647, 671, cert. denied, 429 U.S. 922 (1976).

119. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1020, 195 Cal. Rptr. 482, 492 (1983).

120. *Id.* at 1020-21, 195 Cal. Rptr. at 492-93.

121. *Quinlan*, 70 N.J. at 54-55, 355 A.2d at 671-72.

122. *Id.*

motivations of family or physician.¹²³ Although *Barber* does not specifically state a reason for requiring a consulting physician to concur in the diagnosis, the general trend of the decision seems to be consistent with *Quinlan*'s reasoning. At various points in its decision the *Barber* court refers to the opinions of the testifying experts who agreed with the prognosis of the physicians,¹²⁴ the preference for the patient to be the ultimate decision-maker,¹²⁵ the family's "love and concern" as motivation for the decision,¹²⁶ and the physicians' deference to the feelings of the family.¹²⁷ All of these facts indicate that the court was concerned with what was best for the patient. The consultation requirement can thus be seen as a protective measure, designed to ensure that the correct diagnosis has been made.

The second difference between *Barber* and *Quinlan* seems to be limited to the facts of *Barber*. Not only was there complete unanimity of opinion among Mr. Herbert's close relatives (including Mrs. Herbert) that treatment should be withdrawn, but if they had gone to court Mrs. Herbert would have been appointed guardian.¹²⁸ Also, the physicians were merely trying to implement the family's wishes, and would have continued treatment if the family so desired.¹²⁹ Had there been any dissension among the family or the physicians, the case would have ended up in court, as the dissenting party would have sought an injunction to prevent the withdrawal of treatment. Since the *Barber* court did not exclude guardianship procedures in future cases,¹³⁰ presumably if petitioned for an injunction in the future the court would evaluate the situation and appoint a guardian. This would be the same procedure as outlined in *Quinlan*. Thus, only if the interested parties completely agree in the decision, as in *Barber*, is there any difference from *Quinlan*.

The third difference between the cases is the scope of protection from civil and criminal liability. The *Quinlan* court, after setting out a specific procedure,¹³¹ provided that any participant in the withdrawal, including the guardian, physician or hospital, would be protected from civil or criminal liability if he, she or it followed this procedure.¹³² The

123. *Id.* at 50, 355 A.2d at 669.

124. *Barber*, 147 Cal. App. 3d at 1020, 195 Cal. Rptr. at 492.

125. *Id.*

126. *Id.* at 1021, 195 Cal. Rptr. at 493.

127. *Id.* at 1020, 195 Cal. Rptr. at 492.

128. *Id.* at 1021, 195 Cal. Rptr. at 493.

129. *Id.* at 1020, 195 Cal. Rptr. at 492.

130. *Id.* at 1020-21, 195 Cal. Rptr. at 492-93.

131. See *infra* note 162.

132. *Quinlan*, 70 N.J. at 54-55, 355 A.2d at 671-72. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), modifies and limits *Quinlan*'s protection from liability in cases involving patients

Barber court, on the other hand, did not expressly grant protection from liability. Since the court protected the physicians in *Barber* from liability based on the particular facts of the case,¹³³ physicians in similar cases in the future should be protected. Other physicians, however, will have to rely on the proportionate/disproportionate test, which is subject to second-guessing by the courts.¹³⁴ The *Quinlan* decision thus provides much greater protection to physicians than does *Barber*.¹³⁵

In addition to adopting the *Quinlan* variation of the substituted judgment model, the *Barber* court also effectively adopted the California Natural Death Act's definition of "life-sustaining procedure" for use in the proportionate/disproportionate test.¹³⁶ Under the California Natural Death Act, a life-sustaining procedure which may be withheld is defined as a procedure which artificially maintains a vital function of the patient and which "serve[s] only to artificially prolong the moment of death."¹³⁷

As the *Barber* court noted, respirators and medical nutrition and hydration do not address the pathology; rather, they merely sustain biological functions while other processes address the pathology.¹³⁸ When other treatment becomes futile, these processes can be discontinued as disproportionate.¹³⁹ Implicit in this part of the court's decision is that, at this point in the treatment, procedures which do not address the pathology are only artificially prolonging the moment of death. Thus the court has effectively extended section 7187(c) so that it covers patients in irreversible vegetative comas who have not executed a living will.

IV. STATUTORY SOLUTIONS

Although the California Court of Appeal was able to provide some guidance for physicians by its decision in *Barber*, the question of liability is still unsettled. The courts have consistently stated that the legislature is the proper branch of government to set guidelines in this area.¹⁴⁰

in nursing homes. In those cases the participants are free from liability only if there is no bad faith. *Id.* at 385, 486 A.2d at 1242.

133. *Barber*, 147 Cal. App. 3d at 1022, 195 Cal. Rptr. at 493.

134. *See infra* note 161 and accompanying text.

135. *See infra* note 163.

136. *Barber*, 147 Cal. App. 3d at 1017-18, 195 Cal. Rptr. at 491.

137. CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1985). The North Carolina Natural Death Act has a comparable definition of "extraordinary means." N.C. GEN. STAT. § 90-321(a)(2) (Supp. 1983).

138. *Barber*, 147 Cal. App. 3d at 1017, 195 Cal. Rptr. at 490.

139. *Id.* at 1019, 195 Cal. Rptr. at 491.

140. *See, e.g., Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983):

[T]he only long term solution to this problem is necessarily legislative in nature. It is that body which much address the moral, social, ethical, medical and legal issues

However, most legislatures have not acted, except for enacting statutes authorizing living wills.¹⁴¹ California was the first state to pass such legislation in 1976, and since then a number of states have followed.¹⁴² A review of the California Natural Death Act will reveal the weaknesses of such a restrictive statute.¹⁴³

A. *The California Natural Death Act*

In passing the Natural Death Act,¹⁴⁴ the California Legislature spe-

raised by cases such as the one at bench. Manifestly, this court cannot attempt to rewrite the statutory definition of death or set forth guidelines covering all possible future cases.

Id. at 1014, 195 Cal. Rptr. at 488; *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981):

It should be emphasized though, that any guidance we may provide for future cases is necessarily limited. Unlike the Legislature, the courts are neither equipped nor empowered to prescribe substantive or procedural rules for all, most, or even the more common contingencies. Our role, especially in matters as sensitive as these, is limited to resolving the issues raised by facts presented in particular cases.

Id. at 370, 420 N.E.2d at 67, 438 N.Y.S.2d at 269 (footnote omitted); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980):

Given the community values at stake, specific action by the General Assembly is most desirable. . . . [W]e earnestly invite the prompt attention of the General Assembly to them, with the hope that it will enact a comprehensive State policy governing these matters, which are, in the words of *Quinlan*, "of transcendent importance."

Id. at 1346 (citation omitted); *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980):

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

Id. at 360. *See also supra* notes 45-51 and accompanying text.

141. Seventeen states and the District of Columbia have passed living will legislation, *see supra* note 7, yet only Louisiana, New Mexico, North Carolina, Oregon and Virginia have adopted provisions covering patients in irreversible vegetative comas who have not executed living wills. North Carolina was the first to adopt such a statute in 1977, and the others followed in 1983 and 1984. *See infra* notes 166-202 and accompanying text for a discussion of the North Carolina Act and a comparison to the other four acts.

The National Conference of Commissioners on Uniform State Laws has recently undertaken to draft a uniform living will statute. Reaves, *Living Wills*, A.B.A. J., Dec. 1984, at 29.

142. *See supra* note 7.

143. The weaknesses of the California Act were apparent at the time it was proposed, which prompted a number of people to urge Governor Edmund G. Brown, Jr. not to sign the legislation. Rosoff, *Living Wills and Natural Death Acts*, in *LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS* (A.E. Douder and J.D. Peters eds. 1982).

144. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985). *See* Appendix A (full text of the Act).

cifically recognized that adults have the fundamental right¹⁴⁵ to decide to have life-sustaining procedures withdrawn in the event of terminal illness, especially since the treatment for such an illness often causes unnecessary pain and suffering without providing any medical benefit.¹⁴⁶ However, in many cases the patient is unable to give his or her consent at the time that further treatment becomes futile, because the patient is comatose or has become otherwise incapacitated. Accordingly, the patient is allowed to give his or her consent in advance by executing a living will.¹⁴⁷ Then, when the patient is diagnosed as having a terminal condition¹⁴⁸ by two physicians, one of whom is the attending physician,¹⁴⁹ the attending physician may rely on the patient's prior informed consent (the living will) to discontinue treatment. The physician is specifically exempted from civil or criminal liability when acting in accordance with a valid living will.¹⁵⁰

There are, however, significant limitations in the California Act. A living will is not binding unless executed at least fourteen days after diagnosis of the terminal condition.¹⁵¹ It remains binding for only five years, after which it must be reexecuted.¹⁵² Lastly, a binding living will cannot be executed by a patient in a nursing home, unless one of the witnesses is a patient advocate designated by the California Department of Aging at the nursing home.¹⁵³

The California Natural Death Act therefore excludes a large

145. "[T]he theoretical basis of the California Act is couched in terms of the right to privacy." Comment, *North Carolina's Natural Death Act: Confronting Death With Dignity*, 14 WAKE FOREST L. REV. 771, 782 (1978).

146. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1985).

147. CAL. HEALTH & SAFETY CODE § 7188 contains the form that must be used in a valid living will, as well as the procedure necessary to effectuate it. The document must be signed by the declarant in the presence of two witnesses who are not blood relatives, are not entitled to any portion of the declarant's estate, and who are not an attending physician or an employee thereof.

148. A terminal condition is defined in CAL. HEALTH & SAFETY CODE § 7187(f) (West Supp. 1985).

149. CAL. HEALTH & SAFETY CODE § 7187(e) (West Supp. 1985).

150. CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1985).

151. CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1985). A living will which was executed prior to this time is, if not reexecuted, only advisory, and the physician may or may not implement it, whichever he determines to be the best course of action. CAL. HEALTH & SAFETY CODE § 7191(c) (West Supp. 1985). A physician who implements an "advisory" living will remains exempt from criminal or civil liability. CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1985).

152. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1985). A living will may be revoked by the patient at any time, without regard to the patient's mental competency at the time. CAL. HEALTH & SAFETY CODE § 7189 (West Supp. 1985).

153. CAL. HEALTH & SAFETY CODE § 7188.5 (West Supp. 1985).

number of patients. Firstly, it excludes all patients who are unable to remain conscious for fourteen days after the diagnosis of the terminal condition. This category is made up mostly of patients who enter a coma quickly, and it is only the advent of the coma that indicates that the patient's condition is terminal.¹⁵⁴ It also excludes patients who are not competent at the time the diagnosis is made.¹⁵⁵ Secondly, the statute excludes patients who live for more than five years after the initial diagnosis, but are no longer competent at the end of that time, and therefore cannot legally reexecute a living will.¹⁵⁶ Even if these patients had executed a living will after the original diagnosis, it would no longer be binding.¹⁵⁷ Finally, the statute excludes all patients who never execute a living will at all.¹⁵⁸

154. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (healthy man suffered cardiorespiratory arrest after routine operation and entered a coma); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980) (man in good health suffered cardiac arrest during surgery, resulting in irreversible vegetative coma), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (previously unimpaired woman stopped breathing for fifteen minutes, was comatose by the time she reached the hospital), *cert. denied*, 429 U.S. 922 (1976).

155. See, e.g., *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978) (woman diagnosed as having Alzheimer's disease subsequently entered irreversible vegetative coma due to massive stroke).

156. See, e.g., *Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134. Although Mrs. Dinnerstein was not diagnosed as having Alzheimer's disease until 1975, symptoms were observed as early as 1972. *Id.* at 467, 380 N.E.2d at 135. Assuming the diagnosis had been made at that time, Mrs. Dinnerstein could have executed a living will under the California Act. Since Alzheimer's disease causes progressive degeneration of mental and physical capabilities, *id.* at 466-67, 380 N.E.2d at 134-35, when the living will had to be reexecuted in 1977 to remain binding, she was no longer competent. *Id.* at 467, 380 N.E.2d at 135. Thus, she could not reexecute the living will and, in 1978 when she entered the coma, the 1972 living will would no longer have been binding. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1985).

157. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1985). If a living will is binding at the advent of a coma, however, it remains binding for the duration of the coma. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1985).

158. A living will can be executed by anyone, even though it is not binding unless all of the conditions of the Act are met. If all of the conditions are not met, then the living will is merely evidence of the patient's intent, and should be considered as part of the "totality of circumstances known to the attending physician" in deciding whether or not to withdraw treatment. CAL. HEALTH & SAFETY CODE § 7191(c) (West Supp. 1985). However, there is evidence that most people are unwilling to execute living wills, even if a living will is consistent with their feelings. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983) (patient did not execute a living will despite his express intent not to be kept alive by machines or to "become another Karen Ann Quinlan"); *Eichner v. Dillon*, 73 A.D.2d 431, 440, 426 N.Y.S.2d 517, 526 (1980) (patient had indicated he "would not want any of this extraordinary business . . . to be done for him" and that he "want[ed] to go," but did not execute a living will), *modified sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

Since there is no established procedure for dealing with patients in irreversible vegetative comas who have not executed binding living wills, these cases are effectively forced into the court system. The courts have reluctantly accepted such cases, but only by default.¹⁵⁹ Although some courts have indicated that prior court approval is not necessary in order to deal with patients in irreversible vegetative comas,¹⁶⁰ as a practical matter, there is no way that physicians who withdraw treatment from patients in irreversible vegetative comas can be sure that they will not later be subject to liability unless they obtain prior court permission. The ordinary/extraordinary and proportionate/disproportionate tests are highly subjective, and diagnosis under them is susceptible to second-guessing.¹⁶¹ Only *Quinlan* has set forth any specific guidelines¹⁶² and offered immunity to physicians acting under them.¹⁶³ Despite *Barber's*

159. See *supra* note 140.

160. See *supra* note 51.

161. No rational person would intentionally subject himself to criminal liability needlessly. Therefore, it is clear that the physicians in *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983), thought they had a patient who satisfied one of the two tests. If they were uncertain, they could have refused to follow the family's request, forcing the matter into the courts, which would have protected them from liability. See *supra* notes 52-53 and accompanying text. Despite the physicians' certainty, they were second-guessed and charged with murder. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

162. There must be a diagnosis by the attending physician of "no reasonable possibility" of returning to a cognitive, sapient state; a decision by the family and guardian to disconnect; and concurrence in the diagnosis by a hospital Ethics Committee. *In re Quinlan*, 70 N.J. 10, 54-55, 355 A.2d 647, 671-72, *cert. denied*, 429 U.S. 922 (1976). Other cases have refused to endorse the *Quinlan* methodology, holding that such a procedure, if necessary, should be established by the legislature. See, e.g., *Barber*, 147 Cal. App. 3d at 1018, 195 Cal. Rptr. at 491 (compared to *Quinlan*, *supra* text accompanying notes 117-35); *In re Storar*, 52 N.Y.2d 363, 382-83, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276, *cert. denied*, 454 U.S. 858 (1981). See also *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 758-59, 370 N.E.2d 417, 434 (1977) (rejecting the *Quinlan* methodology and requiring court approval).

The New Jersey Supreme Court recently refused to extend *Quinlan* to comatose patients in nursing homes. *In re Conroy*, 98 N.J. 321, 342 n.1, 486 A.2d 1209, 1219 n.1 (1985). Because of the differences between hospitals and nursing homes, the *Conroy* procedure requires the guardian to report his intention to withdraw treatment to the Office of the Ombudsman, who must treat the proposal as an "abuse," obtain confirmation of the diagnosis and prognosis from two physicians (other than the treating physician), and make a report to the appropriate regulatory agency. *Id.* at 383-84, 486 A.2d at 1241-42. If the subjective test, see *supra* note 28, is being used, then the guardian needs only the concurrence of the attending physician. 98 N.J. at 384, 486 A.2d at 1242. If either the limited-objective or pure-objective test, see *supra* note 28, is being used, then the family should also concur. 98 N.J. at 384-85, 486 A.2d at 1242.

163. *Quinlan*, 70 N.J. at 54-55, 355 A.2d at 671-72. Although other cases have indicated that court approval is not necessary in all cases, see *supra* note 51, none of these cases have expressly granted physicians protection from liability. Impliedly, these cases have granted immunity to physicians who withdraw treatment from a patient who satisfies the test established by the courts of their jurisdiction (either ordinary/extraordinary or proportionate/disproportionate). However, these tests are subjective, and are limited in their scope. See, e.g., *Barber*, 147 Cal. App. 3d at 1022, 195 Cal. Rptr. at 493 ("[W]e conclude that the petitioners' omission

attempt to provide some guidelines for physicians in the absence of legislation,¹⁶⁴ the very fact that there was an attempt to prosecute any physician will probably make physicians in future cases wary of withdrawing treatment without prior court approval, especially since *Barber* extended only limited protection to physicians.¹⁶⁵

B. *The North Carolina Natural Death Act*

The first statute passed that expressly sets forth a procedure to cover all comatose patients was the North Carolina Natural Death Act.¹⁶⁶ The Act provides for a living will on substantially the same grounds as the California Natural Death Act.¹⁶⁷ The major differences between the two acts are: (1) the North Carolina Act makes all living wills valid, not just those living wills executed fourteen days after diagnosis of the terminal condition; (2) the North Carolina Act places no restrictions on living wills executed in nursing homes; and (3) the North Carolina Act requires that the living will be notarized. However, the North Carolina Act also provides for comatose patients in the absence of a living will.¹⁶⁸ This is

to continue treatment *under the circumstances* . . . was not an unlawful failure to perform a legal duty." (emphasis added)). Only *Quinlan* has extended protection to physicians in a quantifiable manner that can be determined in advance, even if the particular facts differ from prior cases. 70 N.J. at 54-55, 355 A.2d at 671-72 (If the procedures described are followed, there can be no civil or criminal liability for "any participant, whether guardian, physician, hospital or others.").

164. *Barber*, 147 Cal. App. 3d at 1018, 195 Cal. Rptr. at 491. See *supra* note 116.

165. *Barber*, 147 Cal. App. 3d at 1022, 195 Cal. Rptr. at 493. See *supra* notes 116 and 163.

166. N.C. GEN. STAT. §§ 90-320 to 90-322 (1981 & Supp. 1983). See Appendix B (full text of the Act). The statute was originally enacted in 1977. Since that time four other states have added similar provisions. In 1983 Oregon added § 97.083 to its Natural Death Act and Virginia enacted a Natural Death Act which included § 54-325.8:6. In 1984 Louisiana enacted a Natural Death Act which included § 40:1299.58.5 and New Mexico added § 24-7-8.1 to its Right to Die Act. The differences between these statutes and the North Carolina Act will be discussed as the latter is analyzed.

Additionally, five states have enacted medical consent statutes which delineate who may authorize medical treatment. GA. CODE ANN. §§ 31-9-1 to 31-9-7 (1985); IDAHO CODE §§ 39-4301 to 39-4306 (1985); MD. PUB. HEALTH CODE ANN. § 20-102 (1982); MISS. CODE ANN. §§ 41-41-3 to 41-41-11 (1981 & Supp. 1984); UTAH CODE ANN. § 78-14-5 (1977). Implicit in these statutes is the power to authorize no medical treatment—to refuse it. This type of statute is inferior to the North Carolina type of statute because it does not indicate the circumstances under which treatment can be legally withdrawn or withheld.

167. N.C. GEN. STAT. § 90-321 (1981 & Supp. 1983).

168. N.C. GEN. STAT. § 90-322 (Supp. 1983). If the phrase "or is mentally incapacitated" is removed from N.C. GEN. STAT. § 90-322(a), then the Act would be limited to patients in irreversible vegetative comas. With that language included, the Act also covers incompetent patients with terminal illnesses. See *supra* note 8. Louisiana and Oregon restrict their statutes to comatose patients, LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1985); OR. REV. STAT. § 97.083 (1983), while the laws of New Mexico and Virginia are similar to that of North Carolina. N.M. STAT. ANN. § 24-7-8.1 (Supp. 1984); VA. CODE § 54-325.8:6 (Supp. 1984).

an improvement over all other acts since it covers a class of people ignored by the other acts.¹⁶⁹

The North Carolina Act is also superior to the *Quinlan* procedure because it is more specific.¹⁷⁰ As discussed above, *Quinlan* requires the use of an Ethics Committee that must confirm the diagnosis before treatment can be withdrawn,¹⁷¹ but it does not delineate the composition of such a committee. Presumably it should contain at least one physician in order to confirm the diagnosis of the attending physician,¹⁷² but there is no requirement that a physician be one of the members.¹⁷³ One wonders if a confirmation of a diagnosis of irreversible vegetative coma made by an Ethics Committee without a physician as one of its members would be valid, or if the decision would withstand subsequent review.¹⁷⁴ Another problem arises if the Committee's decision is less than unanimous. Presumably, a majority of the Committee would be sufficient to constitute a confirmation of the decision to withdraw treatment, but again *Quinlan* is silent on the issue.¹⁷⁵ Section 90-322 of the North Carolina Act solves these problems by specifying that the confirmation must

169. See *supra* notes 154-58 and accompanying text.

170. The problems brought on by lack of specificity were recognized by the Delaware Supreme Court in *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (1980):

If there is a disagreement among the persons involved who are competent to make a responsible judgment in the matter, how is that to be resolved? Should any decision be unanimous? If not, whose vote controls? In what way are hospital administrative or ethics committees involved in the problem and how are they affected by a decision? What are the prevailing medical/hospital ethics which are relevant to the issue? Is there a consensus as to such ethics?

Id. at 1349-50.

171. *In re Quinlan*, 70 N.J. 10, 54-55, 355 A.2d 647, 671-72, *cert. denied*, 429 U.S. 922 (1976).

172. *Quinlan* only requires the attending physician(s) to make the diagnosis; it does not require any confirmation of the diagnosis except by the Ethics Committee. *Id.*

173. The *Quinlan* court seems to presume that a physician will be one of the members of the committee, since it refers to existing "Ethics Committee[s] composed of physicians, social workers, attorneys, and theologians." *Id.* at 49, 355 A.2d at 668 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What The Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975)). The court does not make a physician's membership on the committee mandatory, however. See *infra* note 177.

174. The ability of the decision to withstand judicial review is particularly important, since judicial review may be necessary if a person who disagrees with the decision decides to file a wrongful death suit.

175. Unless a majority of the committee were physicians, it is conceivable that no physician would be in the majority voting to allow withdrawal. Again, the validity of such a decision would be uncertain. Perhaps the *Quinlan* court was trying to give latitude to each hospital to set its own standards, but this could lead to conflicting rules (it is not hard to imagine that some hospitals may be so strict that treatment could never be withheld, while other hospitals are so lax that any decision could be confirmed), as well as uncertainty over the legality of the action (it is axiomatic that the less specific the guidelines, the greater the risk of being second-guessed, see *supra* note 161 and accompanying text).

be made in writing by a physician other than the attending physician.¹⁷⁶

Section 90-322 also improves on *Quinlan* by specifying who the surrogate decision-maker should be. *Quinlan* only refers to "the concurrence of the guardian and family" of the patient, and the amorphous "Ethics Committee."¹⁷⁷ Again, it is not clear whether this means a unanimous decision of guardian and family, a decision by the guardian after consultation with the family, or an action by the guardian as the agent of the family. The North Carolina Act specifically designates the decision-maker as the patient's spouse, guardian, or a majority of relatives of the first degree, in that order, if available.¹⁷⁸ This definitive statement leaves no doubt about the legality of the decision—either the statutory procedure was observed or it was not.

Besides covering a class of patients excluded by other statutes, the

176. N.C. GEN. STAT. § 90-322(a)(2) (Supp. 1983).

177. *Quinlan*, 70 N.J. at 55, 355 A.2d at 671. *Quinlan* also does not define what viewpoints should be represented on the Ethics Committee, which must confirm any decision. The only indication in *Quinlan* of the composition of the committee is the reference to some existing committees. *Id.* at 49-50, 355 A.2d at 668-69 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What The Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975)). See *supra* note 173. The membership of the committee is one of the largest problems with the *Quinlan* procedure. If a physician is to be one of the members, should he or she be an outside consultant, or someone from within the hospital such as the Chief of Staff? Should the physician's spot be filled by a specialist, such as a neurologist, or are a number of specialists necessary? Should a majority of the committee be physicians? See *supra* note 175. If one member is to be a community representative, how can one person be chosen who represents the views of the entire community? Should a number of such positions be created and be filled in proportion to the ideological breakdown of the community? If one member is to represent a religious point of view, which religion should he or she represent? Should this position be rotated depending upon the religion of the patient involved? What about agnostics and atheists? Should a lawyer be on the committee to give advice on the legality of the proposed action? The debate as to who should be represented on the committee and how the decision should be made could conceivably deadlock a committee.

178. N.C. GEN. STAT. § 90-322(b) (Supp. 1983). This is the only area where there is any real difference in the Louisiana, New Mexico, North Carolina, Oregon and Virginia statutes. New Mexico provides that treatment can only be withdrawn or withheld upon the concurrence of "all family members who can be contacted through reasonable diligence." N.M. STAT. ANN. § 24-7-8.1(A) (Supp. 1984). Louisiana, Oregon and Virginia, on the other hand, are similar to North Carolina in providing a list of people.

Louisiana requires the attending physician to consult with the tutor or curator of the patient (if one has been appointed), the spouse, adult child, parents, or other ascendants or descended, in that order. If there is more than one person in the applicable class then the decision must be made by everyone in that class who is reasonably available. LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1985). Oregon requires the physician to consult with the spouse, guardian, majority of adult children, or either parent, in that order. OR. REV. STAT. § 97.083(2) (1983). Virginia requires consultation with the judicially appointed guardian (if one previously had been appointed), the person(s) designated by the patient in writing, the spouse, an adult child or a majority of the adult children if there are more than one, the parents, or the nearest living relative, in that order. VA. CODE § 54-325.8:6 (Supp. 1984).

North Carolina Act has a number of other advantages. First, the patient is offered significant protection. A physician must first diagnose the patient's condition as terminal, incurable *and* irreversible before treatment may be withdrawn.¹⁷⁹ By requiring that all three conditions be met, the statute virtually assures that no patient who could potentially recover will be disconnected from life-support apparatus. The statute provides additional assurance that the diagnosis has been made correctly by requiring that the diagnosis be confirmed in writing by a physician other than the attending physician.¹⁸⁰

Additionally, treatment can be withdrawn only under the supervision of the attending physician,¹⁸¹ so the physician can refuse to comply if there are some doubts about the family's motives. If the family tries to bring in a new physician who is willing to comply with their decision, the supplanted physician can report the conduct. This would require the family to prove in court that they are acting in the patient's best interest.¹⁸²

179. N.C. GEN. STAT. § 90-322(a)(1) (Supp. 1983). The Louisiana, New Mexico, Oregon and Virginia statutes are similar, even though they use different terms to describe the condition. See LA. REV. STAT. ANN. § 40:1299.58.2(8) (West Supp. 1985); N.M. STAT. ANN. § 24-7-8.1(A) (Supp. 1984); OR. REV. STAT. § 97.083(a) (1983); VA. CODE § 54-325.8:6 (Supp. 1984).

180. N.C. GEN. STAT. § 90-322(a)(2) (Supp. 1983).

181. N.C. GEN. STAT. § 90-322(b) (Supp. 1983).

182. As for the prospect of collusion to kill a patient in the absence of judicial review, such collusion, at a minimum, would require the cooperation of the entire family, the attending and consulting physicians, and all of the medical staff involved, since each of these people would, presumably, be fully aware of the status of the patient. If any one person suspected foul play, he or she could report the actions to the proper authorities. It should be remembered that it was the report of a nurse that led to the arrests of the two physicians in *Barber*. See *supra* note 64 and accompanying text.

Accordingly, if the case reached the courts through reported misdeeds, no treatment could be withdrawn until a court was satisfied that the action was in the patient's best interest. Although there is no requirement in the North Carolina Natural Death Act that a court be consulted, there is no prohibition against the use of the court system either. In fact, the Act could be amended to require the use of the courts, if the legislature decided that to be the best course. Presumably, the state's interest in preserving life would allow intervention. See, e.g., *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980) (a balance should be achieved between "the individual interest against countervailing State interests, particularly the State interest in the preservation of life"); *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 ("ultimately there comes a point at which the individual's rights overcome the State interest" in preserving life, which implies that there are cases where the state's interest overrides the individual's interests), *cert. denied*, 429 U.S. 922 (1976); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) ("[t]here can be no doubt that the State *does* have an interest in preserving life" (emphasis in original)), *aff'd*, 379 So. 2d 359 (Fla. 1980). If treatment had already been withdrawn, the principals involved could be prosecuted for murder. N.C. GEN. STAT. § 90-320(b) (1981) ("Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."); N.C. GEN. STAT. § 90-322(d) (Supp. 1983) ("Any person, institution or facility

Second, the family is spared many burdens. They do not have to bear the expense of protracted medical care for a hopeless patient,¹⁸³ nor must they incur the expense of a legal battle to withdraw treatment.¹⁸⁴ The family is also spared the psychological and emotional burden of watching a loved one, possibly in pain,¹⁸⁵ slowly wither away.¹⁸⁶ After being assured that there is no chance for recovery,¹⁸⁷ the family can decide what is best for the patient and implement that decision quickly.¹⁸⁸

against whom criminal or civil liability is asserted because of *conduct in compliance with this section* may interpose this section as a defense." (emphasis added). The obvious corollary to this is that a person who does not follow the procedures and restrictions of the Act will not be protected by this section.). The fear of prosecution alone should deter physicians from colluding, since it involves a very serious risk, and they have very little to gain (as opposed to someone who may be entitled to a portion of the estate).

If all of these people were colluding, they could also collude to fool a court in a system that requires court approval. Thus, the danger of improper withdrawal of treatment is no greater under the North Carolina Act than under any other system.

183. For example, in one case the cost of a respirator and dialysis for a comatose patient was \$2,000 a day. Siegel, *Medical Quandary: Bioethics Seeks Rules for Dying*, L.A. Times, Jan. 6, 1985, § 1, at 1, 32, col. 1. Even if a patient is stable enough to be cared for outside of a hospital, care can still be expensive. At one hospice the average cost is \$22,000 a year per patient. Siegel, *Physician and Policy-Maker: Hospice Doctor Torn by Dilemma*, L.A. Times, Jan. 6, 1985, § 1, at 32, 33, col. 2.

184. See *supra* notes 46-50 and accompanying text.

185. See, e.g., *In re Quinlan*, 70 N.J. 10, 25, 355 A.2d 647, 655 ("the quality of [Ms. Quinlan's] feeling impulses is unknown"), *cert. denied*, 429 U.S. 922 (1976); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021 n.2, 195 Cal. Rptr. 484, 493 n.2 (1983) (the family was "concerned for [Mr. Herbert's] comfort"); *Eichner v. Dillon*, 73 A.D.2d 431, 442, 426 N.Y.S.2d 517, 528 (1980) (Brother Fox "'has convulsive episodes' . . . and sensory response to stimuli" (quoting testimony of Dr. Kelley, the attending physician)), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

186. The *Quinlan* court's description of Ms. Quinlan's physical state aptly demonstrates the source of this burden:

Karen is described as emaciated, having suffered a weight loss of at least 40 pounds, and undergoing a continuing deteriorative process. Her posture is described as fetal-like and grotesque; there is extreme flexion-rigidity of the arms, legs and related muscles and her joints are severely rigid and deformed.

. . . .

She is debilitated and moribund

Quinlan, 70 N.J. at 26, 355 A.2d at 655.

187. See *supra* notes 179-80 and accompanying text.

188. "[W]e . . . perceive the judicial process as an unresponsive and cumbersome mechanism for decisions of this nature. This fact is borne out by a number of the leading cases in which arguments were heard . . . long after the patient had died." *In re Colyer*, 99 Wash. 2d 114, 127, 660 P.2d 738, 746 (1983), *subsequently modified on other grounds*, *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984). See also *supra* note 47 and accompanying text. See also the following cases in which the parenthetically indicated time periods passed between the advent of the coma and final judicial action: *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976) (one year, seven months); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981) (two years); *In re Colyer*, 99

Since most courts follow the decision of the family in any event,¹⁸⁹ the statutory procedure saves a lot of wasted time and effort.

Third, physicians are protected from liability.¹⁹⁰ The statute specifically exempts from civil or criminal liability any person acting under the statute and in accordance with its provisions.¹⁹¹ Although the statute does not expressly protect physicians from liability for an incorrect diagnosis of a terminal, incurable and irreversible condition,¹⁹² it does in fact provide some protection in such a situation. By requiring that the diagnosis be confirmed in writing by an independent physician,¹⁹³ the statute not only makes an incorrect diagnosis less likely,¹⁹⁴ but also makes it more difficult to prove. Any person who challenges the diagnosis has the additional burden of proving that both physicians, who had reached their decisions independently, were incorrect.¹⁹⁵ Since the concurring physi-

Wash. 2d 114, 660 P.2d 738 (one year); *Leach v. Akron Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1981) (six months).

189. See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (decision of father to withdraw treatment approved), *cert. denied*, 429 U.S. 922 (1976); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980) (court approved decision of wife and son to withdraw treatment); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980) (petition of husband to discontinue treatment granted); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980) (leader of religious order allowed to withdraw treatment from one of the order's members), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981). But see *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (decision of mother to discontinue treatment overruled), *cert. denied*, 454 U.S. 858 (1981).

190. See *supra* notes 131-35, 161-65 and accompanying text.

191. N.C. GEN. STAT. § 90-322(d) (Supp. 1983). The protection from civil liability would include not only malpractice, but also charges of unprofessional conduct, and tort liability such as wrongful death.

Section 90-321(h) contains exactly the same language, thus extending protection to physicians acting pursuant to living wills. Interestingly, California provides even more protection since it not only protects physicians acting pursuant to living wills, CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1985), but also physicians who refuse to follow a living will. CAL. HEALTH & SAFETY CODE § 7191(b)-(c) (West Supp. 1985). If a physician refuses to implement a binding living will, however, he or she must make arrangements for the transfer of the patient to a physician who will implement it, or else face charges of unprofessional conduct. CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1985).

192. See *supra* note 53 and accompanying text.

193. N.C. GEN. STAT. § 90-322(a)(2) (Supp. 1983).

194. See *supra* notes 179-80 and accompanying text.

195. In the absence of a statutory provision to the contrary, not only would the challenger have to prove that the diagnosis was incorrect, but also that it was negligently made. As noted in *Barber*:

"A physician, surgeon or dentist must exercise that degree of skill or care *usual* in the profession in the place in which he practices; i.e. the standard is set by doctors of good standing practicing in that locality. [Citations.] It follows that 'mere error of judgment, in the absence of a want of reasonable care and skill in the application of his medical learning to the case presented, will not render a doctor responsible for untoward consequences in the treatment of the patient' [Citation.]"

cian's diagnosis must be in writing,¹⁹⁶ there should be an exact record of the factors that were considered in making the diagnosis. Such a record could serve as persuasive proof of what actually happened, thus minimizing the possibility that the physician's diagnosis will be second-guessed.¹⁹⁷

Finally, judicial economy is promoted by removing these cases from the court system. The judicial system is already overcrowded, and these cases only add to the congestion by requiring both a hearing and subsequent appeals.¹⁹⁸ Additionally, the court system is "ill-suited" to handle cases of this sort.¹⁹⁹ The North Carolina Act resolves this problem by removing the court system from the decision, leaving the choice in the hands of the family.²⁰⁰ The courts, however, are still able to act as a "fail-safe" mechanism in the system in case someone suspects that the action is illegal.²⁰¹ The courts would thus have to hear only a few cases where their protection is needed, rather than every case, including the routine ones, as they must do under the present system.²⁰²

C. Application to Barber

As yet, no cases have been decided under the North Carolina Natural Death Act,²⁰³ but the facts of *Barber* provide an excellent vehicle to illustrate how the Act would function. The analysis under the Act has two steps: (1) determining if the patient is a qualified patient under the Act; and (2) implementing the procedure set forth in the Act.

The initial finding required by the statute is that the patient is coma-

Barber, 147 Cal. App. 3d 1006, 1017, 195 Cal. Rptr. 484, 490 (1983) (quoting 4 WITKIN, SUMMARY OF CALIFORNIA LAW Torts § 514, at 2778 (8th ed. 1974)).

196. N.C. GEN. STAT. § 90-322(a)(2) (Supp. 1983).

197. This assumes that the physician puts all factors considered in the diagnosis in the written confirmation. If the writing merely contains conclusory language (i.e. "I, _____, determine _____'s condition to be terminal, incurable and irreversible. s/_____"), then the only protection provided is the fact that another physician agrees with the diagnosis.

198. *In re Storar*, 52 N.Y.2d 363, 385, 420 N.E.2d 64, 75, 438 N.Y.S.2d 266, 277 (Jones, J., dissenting in part), *cert. denied*, 454 U.S. 858 (1981). See *supra* note 46.

199. See *supra* note 48.

200. N.C. GEN. STAT. § 90-322(b) (Supp. 1983).

201. See *supra* note 182.

202. Although the physicians in *Barber* were not held liable even though they acted without prior court approval, the lack of protection and guidance for future cases may bring even more cases into the courts. See *supra* notes 133-34, 161-65 and accompanying text.

203. To date, the statute has been cited in only one case, in which it was decided that the Act had no application to a homicide case and did not extend protection to criminal assailants. *State v. Holsclaw*, 42 N.C. App. 696, 699, 257 S.E.2d 650, 652 (1979). No cases have cited the Louisiana, New Mexico, Oregon or Virginia statutes.

tose with no reasonable possibility of returning to a cognitive, sapient state,²⁰⁴ and that the condition is terminal, incurable and irreversible.²⁰⁵ In *Barber*, such a diagnosis was made by Drs. Barber and Nejdil within three days of the advent of the coma.²⁰⁶ Next, the Act requires that the condition be confirmed in writing by a physician other than the attending physician.²⁰⁷ Mr. Herbert's condition was confirmed by two other physicians, a cardiologist and a neurologist,²⁰⁸ thus satisfying this requirement. Finally, the Act requires that a vital function of the person is being sustained, or could be restored, by extraordinary means.²⁰⁹ This requirement was also met since Mr. Herbert was being kept alive only by means of the intravenous tubes to which he was connected.²¹⁰ Accordingly, Mr. Herbert would have qualified as a candidate for natural death under the North Carolina Natural Death Act.

The first procedural step under the Act, set forth in section 90-322, is that a patient's condition must meet the requirements of subsection (a), and that no living will has been executed.²¹¹ Mr. Herbert's condition met these requirements,²¹² and he had not executed a living will.²¹³ The

204. N.C. GEN. STAT. § 90-322(a) (Supp. 1983).

205. N.C. GEN. STAT. § 90-322(a)(1) (Supp. 1983).

206. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1010, 195 Cal. Rptr. 484, 486 (1983). Although the physicians did not use the terms "terminal, incurable and irreversible," this was the substantive content of their finding of "a deeply comatose state from which [Mr. Herbert] was not likely to recover. . . . Mr. Herbert had suffered severe brain damage, leaving him in a vegetative state, which was likely to be permanent." *Id.* at 1010, 195 Cal. Rptr. at 486.

207. N.C. GEN. STAT. § 90-322(a)(2) (Supp. 1983).

208. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486; CHA INSIGHT, *supra* note 61, at 1. The evidence does not indicate whether or not these confirmations were in writing, but there is no evidence that they would not have been in writing had that been the law.

209. N.C. GEN. STAT. § 90-322(a)(3) (Supp. 1983). This provision addresses both withdrawing and withholding treatment. *See supra* notes 18-19 and accompanying text.

210. *Barber*, 147 Cal. App. 3d at 1011, 1018-20, 195 Cal. Rptr. at 486, 491-92. *See supra* notes 90-92 and accompanying text. The court used the term "disproportionate" instead of "extraordinary." *Barber*, 147 Cal. App. 3d at 1018-19, 195 Cal. Rptr. at 491. *See supra* notes 93-95 and accompanying text.

211. N.C. GEN. STAT. § 90-322(b) (Supp. 1983). If a living will has been executed, then treatment may be withdrawn under § 90-321(b), and no further analysis is needed. Section 90-321(b) contains virtually the same diagnostic requirements as § 90-322(a). *See supra* at notes 204-10 and accompanying text for a description of these requirements. The differences are that § 90-321(b) requires that the condition be diagnosed as terminal and incurable, instead of terminal, incurable and irreversible, as § 90-322(a) does. Also, § 90-321(b) does not apply to mentally incompetent patients with terminal illnesses, *see supra* note 8, since the patient has to be competent in order to execute a living will. N.C. GEN. STAT. § 90-321(c) (1981).

212. Mr. Herbert was in a terminal, incurable and irreversible coma, with no reasonable possibility of returning to a cognitive, sapient state. *See supra* notes 203-10 and accompanying text.

213. *Barber*, 147 Cal. App. 3d at 1014, 195 Cal. Rptr. at 489. Even if Mr. Herbert had executed a living will, it would not have been binding under California law since he was not

next step is to consult with the patient's spouse, guardian, or relatives of the first degree, in that order, if available.²¹⁴ After receiving consent, the extraordinary means of support may be withheld or withdrawn.²¹⁵ In *Barber*, Drs. Barber and Nejdil informed Mrs. Herbert of the diagnosis and prognosis, and she and her children decided to have the treatment withdrawn.²¹⁶ Thus, the treatment could have been withdrawn from Mr. Herbert in compliance with the North Carolina Act upon the direction and under the supervision of the attending physician.²¹⁷

Since all of the conditions of section 90-322(a) were met and all of the procedures of section 90-322(b) were followed, the physicians in *Barber* would have been protected from both civil and criminal liability.²¹⁸ Thus, if the North Carolina Act had been applicable, the physicians could not have been charged with murder and conspiracy to commit murder, as they actually were.²¹⁹ Since the result reached by the court system after the case was presented to a municipal court magistrate, a superior court judge, and the court of appeal²²⁰ was the same result which would have been achieved under the North Carolina Act, there was no gain to the patient or his family by requiring the courts to hear this case, and a lot of time, money and effort was wasted.

V. CONCLUSION

The procedure used by the California Court of Appeal in its final decision in *Barber* was almost identical to the procedure outlined by the North Carolina Natural Death Act.²²¹ It is also very similar to the procedure which was used in *Quinlan*.²²² The advantage that the North Carolina Act has over the procedures outlined in *Quinlan* and *Barber* is

conscious 14 days after the diagnosis, and so could not reexecute it. CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1985). See *supra* notes 151, 154 and accompanying text.

214. N.C. GEN. STAT. § 90-322(b) (Supp. 1983).

215. N.C. GEN. STAT. § 90-322(b) (Supp. 1983).

216. *Barber*, 147 Cal. App. 3d at 1010-11, 195 Cal. Rptr. at 486. Only Mrs. Herbert's permission would be required under the Act, however. N.C. GEN. STAT. § 90-322(b) (Supp. 1983).

217. N.C. GEN. STAT. § 90-322(b) (Supp. 1983).

218. N.C. GEN. STAT. § 90-322(d) (Supp. 1983).

219. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

220. *Id.*

221. See *supra* notes 203-20 and accompanying text.

222. See *supra* notes 117-35 and accompanying text. A variation of the *Quinlan* procedure was also used by the lower court in *Eichner v. Dillon*, 73 A.D.2d 431, 476-77, 426 N.Y.S.2d 517, 550 (1980), but this approach was rejected on appeal. *In re Storar*, 52 N.Y.2d 363, 383, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 ("[A] mandatory procedure [for dealing with patients in irreversible vegetative comas] . . . should come from the Legislature."), *cert. denied*, 454 U.S. 858 (1981).

that it is more specific²²³ and more flexible. A statute may be amended to provide for incompetent patients with terminal illnesses,²²⁴ to provide for the use of a guardian,²²⁵ or to provide for the use of an Ethics Committee along the lines of *Quinlan*.²²⁶ Although the withdrawal of nasogastric tubes has been found to be legal in two cases,²²⁷ and approved by some commentators,²²⁸ the fact that few physicians would follow such a procedure²²⁹ indicates that there is still a substantial difference of opinion on this issue. A state could, when adopting the legislation, define extraordinary (disproportionate) treatment so as not to include nasogastric tubes, if that is the consensus of that particular community. Each state could thus adapt the legislation to its particular needs.

Additionally, by adopting the substituted judgment model via statute, each state would provide much needed relief to the dilemma physicians now face. A specific procedure, with the guarantee of protection from liability for following the procedure, would allow physicians to act with certainty.²³⁰ They could thus concentrate on the course of treatment that would be best for the patient, not the course of action that protects them from liability, since the two courses would be the same.

The North Carolina Natural Death Act, or a variation thereof, thus provides the best solution to the problem. As medical technology progresses, more of these cases will arise. Without a definitive law, these cases will undoubtedly end up in the courts. As they do, the courts may use *Barber's* proportionate/disproportionate test to resolve them, since it

223. See *supra* notes 170-78 and accompanying text.

224. See *supra* note 168.

225. This could be done by changing § 90-322(b) to read: "the extraordinary means to prolong life may be withheld or discontinued upon the direction and under the supervision of the attending physician with the concurrence of the legal guardian of the person." This would allow the courts to evaluate the qualifications of the person seeking to withdraw treatment, if that is what the legislature decides is best. This would also be consistent with the Massachusetts courts' disapproval of removing these cases from the courts. See *supra* notes 41-44 and accompanying text.

226. A legislative statement would eliminate the problem of lack of specificity in the membership of such a committee, see *supra* notes 171-75 and accompanying text, since the composition would be listed in the statute.

227. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1016-17, 195 Cal. Rptr. 484, 490 (1983); *In re Conroy*, 98 N.J. 321, 374, 486 A.2d 1209, 1236-37 (1985).

228. In the last year, two teams of prominent physicians have published articles supporting withdrawal of nasogastric tubes in some cases. Siegel, *Medical Quandary: Bioethics Seeks Rules for Dying*, L.A. Times, Jan. 6, 1985, § I, at 1, 30, col. 2.

229. Arthur Caplan, a philosopher at the Hastings Center, estimates that only five percent of all physicians would withdraw nasogastric tubes. Siegel, *Medical Quandary: Bioethics Seeks Rules for Dying*, L.A. Times, Jan. 6, 1985, § I, at 1, 30, col. 2 (citing NEW ENG. J. MED. and HASTINGS CENTER REP.).

230. See *supra* notes 161-63 and accompanying text.

is an improvement over the traditional ordinary/extraordinary test.²³¹ This is not a satisfactory solution, however, because the courts will still be required to address each case as it arises.²³² Until the legislatures adopt legislation along the lines of the North Carolina Natural Death Act, there will be no settled procedure for dealing with patients in irreversible vegetative comas. Since the Act provides safeguards for patients,²³³ offers greater protection for physicians,²³⁴ and is more efficient in terms of time, money and effort expended than the current method of handling these cases,²³⁵ similar, uniform statutes should be adopted by each state.

Matthew G. Ainley

231. See *supra* notes 69-77 and accompanying text.

232. See, e.g., *In re Storar*, 52 N.Y.2d 363, 383, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 (court refused to adopt a set procedure for dealing with patients in irreversible vegetative comas, holding that the legislature is the body that should establish any such procedure), *cert. denied*, 454 U.S. 858 (1981). See also *supra* note 140.

233. See *supra* notes 179-82 and accompanying text.

234. See *supra* notes 190-97 and accompanying text.

235. See *supra* notes 183-89, 218-20 and accompanying text.

APPENDIX A: CALIFORNIA NATURAL DEATH ACT²³⁶

§ 7185

This act shall be known and may be cited as the Natural Death Act.

§ 7186

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

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

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

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

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

§ 7187

The following definitions shall govern the construction of this chapter:

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

(b) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section 7188. The directive, or a copy of the directive, shall be made part of the patient's medical records.

(c) "Life-sustaining procedure" means any medical procedure or

236. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985).

intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(d) "Physician" means a physician and surgeon licensed by the Board of Medical Quality Assurance or the Board of Osteopathic Examiners.

(e) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

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

§ 7188

Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year).

I _____, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially

prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

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

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, M.D., whose address is _____, and whose telephone number is _____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

5. This directive shall have no force or effect five years from the date filled in above.

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

Signed _____

City, County and State of residence _____

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

Witness _____

Witness _____

§ 7188.5

A directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section 1250 at the time the directive is executed unless one of the two witnesses to the directive is a patient advocate or ombudsman as may be designated by the State Department of Aging for this purpose pursuant to any other applicable provision of law. The patient advocate or ombudsman shall have the same qualifications as a witness under Section 7188.

The intent of this section is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, as to require special

assurance that they are capable of willfully and voluntarily executing a directive.

§ 7189

(a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

(1) By being cancelled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction.

(2) By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. Such a revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he received notification of the written revocation.

(3) By a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

§ 7189.5

A directive shall be effective for five years from the date of execution thereof unless sooner revoked in a manner prescribed in Section 7189. Nothing in this chapter shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 7188, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

§ 7190

No physician or health facility which, acting in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

§ 7191

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with Section 7188, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient.

(b) If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision. A failure by a physician to effectuate the directive of a qualified patient pursuant to this division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.

(c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justify effectuating the directive. No physician, and no licensed health professional acting under the direction of a

physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision.

§ 7192

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide.

(b) The making of a directive pursuant to Section 7188 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

§ 7193

Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

§ 7194

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a misdemeanor. Any person who, except where justified or excused by law, falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 7189, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide as provided in Chapter 1 (commencing with Section 187) of Title 8 of Part 1 of the Penal Code.

§ 7195

Nothing in this chapter shall be construed to condone, authorize, or

approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.

APPENDIX B: NORTH CAROLINA NATURAL DEATH ACT²³⁷

§ 90-320

(a) The General Assembly recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or his representative has the fundamental right to control the decisions relating to the rendering of his own medical care, including the decision to have extraordinary means withheld or withdrawn in instances of a terminal condition. This Article is to establish an optional and nonexclusive procedure by which a patient or his representative may exercise these rights.

(b) Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying. Nothing in this Article shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this Article are cumulative.

§ 90-321

(a) As used in this Article the term:

- (1) "Declarant" means a person who has signed a declaration in accordance with subsection (c);
- (2) "Extraordinary means" is defined as any medical procedure or intervention which in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function;
- (3) "Physician" means any person licensed to practice medicine under Article 1 of Chapter 90 of the laws of the State of North Carolina.

(b) If a person has declared, in accordance with subsection (c) below, a desire that his life not be prolonged by extraordinary means; and the declaration has not been revoked in accordance with subsection (e); and

- (1) It is determined by the attending physician that the declarant's present condition is
 - a. Terminal; and
 - b. Incurable; and
- (2) There is confirmation of the declarant's present condition

237. N.C. GEN. STAT. §§ 90-320 to 90-322 (1981 & Supp. 1983).

as set out above in subdivision (b)(1) by a physician other than the attending physician;

then extraordinary means may be withheld or discontinued upon the direction and under the supervision of the attending physician.

(c) The attending physician may rely upon a signed, witnessed, dated and proved declaration:

- (1) Which expresses a desire of the declarant that no extraordinary means be used to prolong his life if his condition is determined to be terminal and incurable; and
- (2) Which states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means; and
- (3) Which has been signed by the declarant in the presence of two witnesses who believe the declarant to be of sound mind and who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse, (ii) do not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon his death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it then provides, (iii) are not the attending physician, or an employee of the attending physician, or an employee of a health facility in which the declarant is a patient, or an employee of a nursing home or any group-care home in which the declarant resides, and (iv) do not have a claim against any portion of the estate of the declarant at the time of the declaration; and
- (4) Which has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d) below.

(d) The following form is specifically determined to meet the requirements above:

"Declaration Of A Desire For A Natural Death"

"I, _____, being of sound mind, desire that my life not be prolonged by extraordinary means if my condition is determined to be terminal and incurable. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means.

"This the _____ day of _____
Signature _____

"I hereby state that the declarant, _____, being of sound mind

signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act if the declarant died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

Witness _____
Witness _____”

The clerk or assistant clerk, or a notary public may, upon proper proof, certify the declaration as follows:

“Certificate”

“I, _____, Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for _____ County hereby certify that _____, the declarant, appeared before me and swore to me and to the witnesses in my presence that this instrument is his Declaration Of A Desire For A Natural Death, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.

“I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____, declarant, sign the attached declaration, believing him to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (iii) they were not a physician attending the declarant or any employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

“This the _____ day of _____
Clerk (Assistant Clerk) of Superior Court or

Notary Public (circle one as appropriate) for
the County of _____”

The above declaration may be proved by the clerk or the assistant clerk, or a notary public in the following manner:

- (1) Upon the testimony of the two witnesses; or
- (2) If the testimony of only one witness is available, then
 - a. Upon the testimony of such witness, and
 - b. Upon proof of the handwriting of the witness who is dead or whose testimony is otherwise unavailable, and
 - c. Upon proof of the handwriting of the declarant, unless he signed by his mark; or upon proof of such other circumstances as will satisfy the clerk or assistant clerk of the superior court, or a notary public as to the genuineness and due execution of the declaration.
- (3) If the testimony of none of the witnesses is available, such declaration may be proved by the clerk or assistant clerk, or a notary public
 - a. Upon proof of the handwriting of the two witnesses whose testimony is unavailable, and
 - b. Upon compliance with paragraph c of subdivision (2) above.

Due execution may be established, where the evidence required above is unavoidably lacking or inadequate, by testimony of other competent witnesses as to the requisite facts.

The testimony of a witness is unavailable within the meaning of this subsection when the witness is dead, out of the State, not to be found within the State, insane or otherwise incompetent, physically unable to testify or refuses to testify.

If the testimony of one or both of the witnesses is not available the clerk or the assistant clerk, or a notary public or superior court may, upon proper proof, certify the declaration as follows:

“Certificate”

“I _____, Clerk (Assistant Clerk) of Court of the Superior Court or Notary Public (circle one as appropriate) of _____ County hereby certify that based upon the evidence before me I am satisfied as to the genuineness and due execution of the attached declaration by _____, declarant, and that the declarant’s signature was witnessed by _____, and

_____, who at the time of the declaration met the qualifications of G.S. 90-321(c)(3).

"This the _____ day of _____

Clerk (Assistant Clerk) of Superior Court or
Notary Public (circle one as appropriate) for
_____ County."

(e) The above declaration may be revoked by the declarant, in any manner by which he is able to communicate his intent to revoke, without regard to his mental or physical condition. Such revocation shall become effective only upon communication to the attending physician by the declarant or by an individual acting on behalf of the declarant.

(f) The execution and consummation of declarations made in accordance with subsection (c) shall not constitute suicide for any purpose.

(g) No person shall be required to sign a declaration in accordance with subsection (c) as a condition for becoming insured under any insurance contract or for receiving any medical treatment.

(h) The withholding or discontinuance of extraordinary means in accordance with this section shall not be considered the cause of death for any civil or criminal purposes nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense.

(i) Any certificate in the form provided by this section prior to July 1, 1979 shall continue to be valid.

§ 90-322

(a) If a person is comatose and there is no reasonable possibility that he will return to a cognitive sapient state or is mentally incapacitated, and:

- (1) It is determined by the attending physician that the person's present condition is:
 - a. Terminal; and
 - b. Incurable; and
 - c. Irreversible; and
- (2) There is confirmation of the person's present condition as set out above in this subsection, in writing by a physician other than the attending physician; and
- (3) A vital function of the person could be restored by extraordinary means or a vital function of the person if being sustained by extraordinary means;

then, extraordinary means may be withheld or discontinued in accordance with subsection (b).

(b) If a person's condition has been determined to meet the conditions set forth in subsection (a) and no instrument has been executed as provided in G.S. 90-321 the extraordinary means to prolong life may be withheld or discontinued upon the direction and under the supervision of the attending physician with the concurrence (i) of the person's spouse, or (ii) of a guardian of the person, or (iii) of a majority of the relatives of the first degree, in that order. If none of the above is available then at the discretion of the attending physician the extraordinary means may be withheld or discontinued upon the direction and under the supervision of the attending physician.

(c) Repealed by Session Laws 1979 c. 715 s. 2.

(d) The withholding or discontinuance of such extraordinary means shall not be considered the cause of death for any civil or criminal purpose nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense.

