The Living Will: Preservation of the Right-to-Die Demands Clarity and Consistency

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The Living Will: Preservation of the Right-to-Die Demands Clarity and Consistency

There is no way that there can be a set of rules to govern this circumstance. Guidelines perhaps are possible, but not rules. I can think of no more tragic circumstance to come on the practice of medicine and no more tragic circumstances for a future patient to face than to have a legal decision made by someone in the field of jurisprudence who has not lived through these circumstances, and who could not in a lifetime of testimony understand what the problems are and how they should be handled. His training, experience and his emotions have not been intimately involved with similar circumstances in the past where his decision and his decision alone is the one that must answer all the questions, no matter how inadequately.¹

I. Introduction

Life may be artificially prolonged to extreme lengths through the use of medical technology.² Despite these medical achievements, many people wish to avoid being kept alive through artificial means and prefer to die naturally. As the likelihood of death increases,

1. Armstrong & Colen, From Quinlan to Jobes: The Courts and the PVS Patient, Hastings Center Rep., Feb.-Mar. 1988, at 37, 40 quoting C. Everett Koop, former Surgeon General of the United States. This admonition was issued shortly after the New Jersey Supreme Court's decision in In Re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), to terminate Miss Quinlan's life-support apparatus following the onset of a persistent vegetative state. See infra note 22. Due to the reasons Mr. Koop gave, the living will should be perfected or at least modified to clarify ambiguity in order to avoid the judicial system.

2. Almost 80% of all deaths occur in institutions such as hospitals, which provide medical treatment to save or artificially sustain life. President's Comm'n for the Study of Ethical, Medical and Legal Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions, 17 (Mar. 1983) [hereinafter President's Comm'n Report]. Moreover, an estimated 5,000 to 10,000 Americans presently exist in a persistent vegetative state because no medical directives were made to provide for future medical decisions. N.Y. Times, Dec. 3, 1989, § 6 (Magazine), at 38, 40.

Although many people protect their financial assets and relatives by preparing a standard will, few plan for the inability to make future medical decisions. Special Comm. on Aging, U.S. Senate, A Matter of Choice: Planning Ahead for Health Care Decisions, 1987, cited in Hoffman, Planning for Medical Decision Making: Living Wills and Durable Powers of Attorney, 38(2) Md. Med. J. 154, 154 n.1 (Feb. 1989). A 1986 SRI Gallup/Hospitals poll revealed that only 9% of Americans have executed living wills even though over 70% are willing to forego life-sustaining treatment. At the same time, over 48% of Americans have executed a standard will. Steiber, Right to die: Public Balks at Deciding for Others, 61 Hosps., Mar. 5, 1987, at 72.
ple frequently become more concerned with the quality rather than the quantity of life remaining. A living will provides a way for patients to clearly state their own desires in the event that they become terminally ill and unable to make medical decisions.

A living will, also called an advanced directive, documents a person's treatment preferences when, after certain triggering conditions have occurred, that person is unable to communicate these preferences. When all hope of recovery is gone and a patient is no longer competent to make treatment decisions, the living will becomes effective. The right to execute a living will stems from an extension of the fundamental right of self-determination. Life and death decisions are not at issue; the decision is between a natural death and an unnaturally postponed death.

Increasingly, Americans are entrusting their future medical decision-making power to living wills. Living wills have been endorsed by medical and public interest groups and nearly every state. When first proposed, living wills appeared to be the solution to a long recognized dilemma. Unfortunately, inherent flaws in living wills make them less than authoritative.

Living wills confront significant problems that impede their effectiveness. State statutes are not uniform; instead they are plagued by vague, narrow terminology and statutory definitions that tend to create overly restrictive requirements. Moreover, the lack of legal precedent tends to cripple the enforceability of the statutes. For these reasons, the benefits sought by statutory recognition of the liv-

4. Id. Specifically, while still competent and capable of conveying his or her thoughts, a patient states in a living will that if his or her condition becomes incurable and his or her bodily state vegetative, with no hope of recovery, consent to further treatment would be terminated. Kutner, Due Process of Euthanasia: The Living Will, a Proposal, 44 Ind. L.J. 539, 551 (1969).
5. This right allows an individual to refuse to permit a physician to treat him or her, even if such treatment would prolong his or her life. This right, however, does not allow an individual to direct another to commit euthanasia. Kutner, supra note 4, at 550.
7. Id.
8. See infra note 28.
9. See infra notes 64-101 and accompanying text.
10. See infra notes 44-64 and accompanying text.
11. See infra notes 64-101 and accompanying text.
12. Patients place their future decision-making power in living wills expecting the living will to be honored. The living will may prove to be inadequate at a time when the executor is already past the state of competency to make revisions. Therefore, legislative changes must be made to avoid the harm that would result if a living will's directions are not honored because of vagueness.
ing will have fallen short of state legislative goals. The time has come for a clear and effective declaration. Only through an understanding of the moral concepts, reasoning, and principles involved in this delicate area can legislators attempt to incorporate these ideas into living will legislation. The focus of legislation will then be directed toward the physical and mental condition of the patient rather than specific medical treatments, which in turn will create fewer interpretive problems. A living will, properly executed according to clear statutory language, will then dispense with judicial intervention because it will allow the executor to declare, without ambiguity, when life is no longer meaningful. Because courts lack the expertise to make value judgments involving the meaning of human life, reliance upon the judicial system should be avoided.

This Comment addresses the inherent inadequacies of present living will directives. Part II traces the development of the living will, its vague terminology, and the dilemmas legislators face in drafting a clear, effective declaration. Part III of this Comment discusses the unfortunate results of some ambiguous living wills. These tragic outcomes demonstrate a need for legislative revision in order to avoid judicial intervention. Parts IV and V explore potentially effective declarations, specific areas that should be addressed, and suggestions for both long-term and immediate modifications. Finally, Part VI suggests that immediate action be taken before the courts are required to make any further decisions on an issue they are ill-equipped to handle.

II. Historical Background

A. The Origin of the Living Will

Luis Kutner, an Illinois attorney, first proposed the living will in 1969. The living will is premised on the belief that every person possesses the ultimate right to decide what is to be done to his or her body — including the right to decide whether he or she should be

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13. See Kutner, supra note 4, at 551-52.
14. See infra notes 103-15 and accompanying text.
15. Living wills attempt to protect the sanctity of life. Dying in an unnatural manner, sustained by life-prolonging treatment, destroys the sense of dignity accompanying life itself. Living wills provide the means to possess the ultimate control over one's life. This control rightly belongs to a person and should not be lost simply because legislators fail to adequately provide for the importance of this right when drafting living will legislation.
16. See infra notes 44-64 and accompanying text.
17. See infra notes 142-53 and accompanying text.
18. See supra note 1 and accompanying text.
19. See Kutner, supra note 4 at 539.
permitted to die. The issues surrounding the use of living wills, however, were not fully recognized and addressed until 1976 when significant statutory and judicial declarations were made. In that year, the California Legislature enacted the "Natural Death Act" and the New Jersey Supreme Court decided the case of In re Quinlan. To date, over 9% of Americans have executed a living will, and according to one study, 89.7% of the physicians surveyed supported the legal authority of living wills.

The living will can take one of two forms. The first form is statutory and necessarily follows the state's living will statute.

20. Kutner, supra note 4, at 550. In essence, a doctor is acting as a trustee of a patient's body resulting from a patient's consent or nonconsent to treatment written in a living will. A patient may not be forced to accept treatment contrary to his wishes and may at any time revoke the living will, thereby removing the trust. Id. at 552.


22. 70 N.J. 10, 355 A.2d 647 (1976). In Quinlan, the court faced the issue of a terminally ill patient's right to refuse life-sustaining treatment. Despite the lack of a living will or a statute validating a living will, the court held that the patient's right to privacy must be balanced against the state's interests in preserving life. The court recognized that as the degree of bodily invasion increased, the state's interests decreased while the right to privacy grew; the court therefore held that the life-support apparatus should be terminated. Id. at 27, 355 A.2d at 664.


24. Shapiro, Tavill, Rivkin & Gruchow, Living Will in Wisconsin, 85 Wis. MED. J., Oct. 1986, at 17, 20. Additionally, over 90% of the physicians surveyed agreed with the idea of withholding or withdrawing life-sustaining treatment when a patient is terminally ill. Id. at 19-20. See generally Rosoff, supra note 3, at 10.

25. Rosoff, supra note 3, at 11.

26. An example of a statutory living will is as follows:

MY LIVING WILL AND DIRECTIVE TO MY PHYSICIANS

Directive made this ____ day of ________, 19__. I, residing in the County of ______________, State of ______________, 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 and 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 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 physicians(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
THE LIVING WILL

Since 1976, following California's Natural Death Act, twenty-seven states and the District of Columbia have enacted living will statutes. In general, statutory living wills are straightforward documents that are relatively simple to prepare and execute. One must simply fill in the spaces provided. Most statutory living will forms also provide a space for "other instructions." In this space, the pa-

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. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.
Dated: __________________________, 19
Principal __________________________
This declarant has been personally known to me and I believe him to be of sound mind.

Residing __________________________ at __________________________

______________________________
Residing __________________________ at __________________________

27. See supra note 21.
29. These areas are described as non-statutory because there is no set format, only a blank section to be filled in by the executor or executrix. See infra note 32.
tient must specifically describe any treatment desired or not desired, the circumstances under which the will should become effective, and interpretive guidelines.\textsuperscript{30} This writing personalizes the living will for each executor. Unfortunately, specific and clear guidelines are not easy to formulate and the result is often judicial action because of ambiguous language.\textsuperscript{31}

The second form of living will is nonstatutory.\textsuperscript{32} The failure of a state to adopt a living will statute does not preclude a resident of that state from drafting a living will. Legislation merely serves as an example for executors of living wills to follow. The right to execute a living will stems ultimately from a person's constitutional\textsuperscript{33} and common law\textsuperscript{34} right to informed consent before receiving medical treatment.\textsuperscript{35} Indeed, the “other instructions” sections of statutory forms are derived from these same principles.\textsuperscript{36}

Several criteria are recognized by right-to-die proponents as authoritative with regard to nonstatutory living wills and sections described as nonstatutory.\textsuperscript{37} These criteria are: 1) absent emergency situations, medical personnel may be civilly liable if they provide health-care treatment without a patient’s informed consent;\textsuperscript{38} 2) the common law and constitutional right to refuse health-care treatment offered to competent patients who are capable of making decisions is not lost when the person becomes incompetent;\textsuperscript{39} and 3) oral or writ-

\textsuperscript{30} Rosoff, supra note 3, at 12.
\textsuperscript{31} See infra note 40 and accompanying text.
\textsuperscript{32} Rosoff, supra note 3, at 11. This format is found in states without living will statutes and in states with statutes that leave out specific components and provide space for other instructions. Id.
\textsuperscript{33} Patients have a constitutional right to refuse medical treatment. See Harnish v. Children's Hosp. Medical Center, 387 Mass. 152, 439 N.E.2d 240 (1982). This right must be exercised while the patient is still competent. Therefore, the living will derives its constitutionality from the constitutional right to refuse medical treatment. Kornreich, \textit{Who Will Decide Whether to Withhold or Withdraw Extraordinary Medical Treatment? The Constitutional Right to a "Living Will"}, 6 PROB. L.J. 33, 37 (1984). See also infra notes 35 and 81.
\textsuperscript{35} Cohen, \textit{State-by-State Summary of Legal Authority for Living Wills}, 5 THE COMPLETE LAW., Fall 1988, at 15. The right to refuse medical treatment is not absolute. A state's interests may override this right. Such state interests include: preserving life, protecting innocent third parties and incompetent patients, and maintaining the integrity of the medical profession. Kornreich, supra note 33, at 37. See generally \textit{In re Farrell}, 108 N.J. 335, 529 A.2d 404 (1987); \textit{In re Quinlan}, 70 N.J. 10, 355 A.2d 647 (1976); \textit{President's Comm'n Report}, supra note 2, at 31-32.
\textsuperscript{36} Rosoff, supra note 3, at 12.
\textsuperscript{37} Cohen, supra note 35, at 16.
\textsuperscript{38} Informed consent encompasses the duty of a physician to disclose to a patient, in the exercise of reasonable care, any risks of injury that might be incurred from a proposed course of treatment, so that the patient may exercise reasonable judgment in accepting or declining to accept the proposed course of treatment. \textit{BLACK'S LAW DICTIONARY} 701 (5th ed. 1979).
\textsuperscript{39} A person is competent when he or she has the capacity to understand and appreciate
ten directives, if specific enough, will be recognized as a refusal of consent. Unfortunately, few guidelines exist to help determine what "specific enough" means. This creates problems with both statutory and nonstatutory living wills.

The technology of life-support systems is so new that little clear and settled language exists concerning life-prolonging procedures and their application. The medical and legal professions must strive to provide precise and consistent terminology so that society can enjoy the benefits of living wills and guard against the possibility of an undignified death. The lack of definite technical language raises the issue of whether a living will adequately protects the rights of the terminally ill on paper as well as in practice.

B. Legislative Dilemmas

Legislatures have encountered great difficulty in drafting an effective declaration that allows persons to exercise the right to decide which types of health-care treatment should be used if they become incompetent during terminal illness. In attempting to avoid the judicial system, these statutory declarations have only complicated the decision-making process by being too narrowly drafted or inadequately worded. Changes must be made to avoid problems of interpretation so that the living will may become an authoritative document. For example, particular and specific instructions, present in both statutory and nonstatutory living wills, should be made clear. In drafting the living will, certain terms, such as "terminally ill," "heroic measures," and "life prolonging procedures," must be avoided so as not to contradict the statutory form itself or, in nonstatutory forms, so as not to create more confusion rather than clarity.

the nature and consequences of a medical decision, including risks, benefits, and alternatives to treatment. Rosoff, supra note 3, at 11. The person must also have the capacity to communicate a decision. Id.

40. Cohen, supra note 35, at 16. States disagree on the amount of specificity sufficient to be recognized as an oral or written refusal of consent. Some have held that oral statements attested to by family members may be enough. See Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986). Others have held that non-statutory written directives were necessary. See John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984). Bludworth accepts the "substituted judgment" doctrine. Under the doctrine of substituted judgment, close family members or legal guardians substitute their judgment for what they believe the terminally ill incompetent person, if competent, would have done under the circumstances. Bludworth, 452 So. 2d at 921. If the terminally ill incompetent person, while competent, had executed a living will, that will is persuasive evidence of the incompetent person's intention and should be given great weight by those persons who substitute their judgment on behalf of the terminally ill incompetent person.

41. See infra notes 64-81, 85-92, 93-99 and accompanying text.

42. See infra notes 51-64 and accompanying text.

43. See infra notes 44-64 and accompanying text.
Two areas of terminological vagueness exist that invite interpretation problems. One area concerns the language describing a patient’s condition. The other area concerns the types of medical treatment, or a patient’s desire to avoid certain medical treatment. Examples of the former include phrases such as “terminally ill” and “no reasonable expectation of recovery.” “Heroic measures,” and “life-prolonging procedures” are examples of the latter. Both types of terminology have produced multiple interpretations in the medical community. When faced with such phrases, doctors frequently remain unsure of the patient’s directives and consequently take no action for fear that their interpretation will not be honored by the state. Moreover, state statutory schemes define these terms inconsistently, when defined at all.

The purpose of refusing or terminating life-sustaining treatment is to allow a natural death or to prevent prolonging life by artificial means. Dying with dignity is the goal. Thus, a patient’s condition must be terminal before a living will becomes effective. The determination of when a patient’s condition is terminal, however, is not as clear as many believe.

C. Defining Vague Terminology

State directives as to when a living will should become effective differ, but it appears that most states have decided that when a person’s medical condition becomes terminal, advance directives should become effective. Unfortunately, a precise definition of “terminal

45. Carey, supra note 6.
46. Id.
47. Id.
48. See, e.g., infra note 51.
49. Living wills are activated when only extraordinary procedures will sustain a patient’s life. Extraordinary or life-sustaining procedures are only used when a patient’s condition is terminal. Therefore, living wills become effective when a patient’s condition becomes terminal. Kornreich, supra note 33, at 35.
50. In one sense, everyone has a terminal condition. See D. Clifford, supra note 26, at 6:13.
condition” does not exist. A terminal condition has been defined as an “incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.”\(^2\) The question then arises: should “terminal condition” mean that death will result with or without the use of treatment?\(^3\) Perhaps terminal condition can be defined in relation to “life-prolonging” procedures; that is, a terminal condition has resulted when life-prolonging procedures become necessary.\(^4\) What are “life-prolonging” procedures?\(^5\) What about those illnesses that are terminal, but might not result in death for a number of years? Despite the ambiguity surrounding the phrase “terminal condition,” twenty-three jurisdictions\(^6\) still require interpretations.


54. Life-prolonging procedures become necessary when a patient suffers from an incurable condition and medical treatment serves only to postpone the patient’s inevitable death. Kornreich, supra note 33, at 34 n.6.

55. The American Medical Association defines “[l]ife-prolonging treatment as including: medication and artificially or technologically supplied respiration, nutrition and hydration.” AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, WITHHOLDING OR WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT (Mar. 15, 1986) cited in Francis, The Evanescence of Living Wills, 14 J. CONTEMP. L. 27, 33 (1988). There is no absolute definition, however, of “life-prolonging procedures.”

A large number of states exclude nutrition and hydration from the types of life-sustaining treatment that may be refused in a living will. See, e.g., ARIZ. REV. STAT. ANN. §§ 36-3201 - 3210 (1986); COLO. REV. STAT. §§ 15-18-101 - 15-18-113 (1987); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1990). Simply because a type of procedure has been omitted from a living will does not necessarily suggest a refusal of such treatment. Since there are a variety of ways to define life-sustaining treatment, it is best to state explicitly what treatment is or is not necessary.

the attending physician to certify that the patient's condition is terminal before a living will can become effective. Clearly, the problems that legislators face in enacting living will legislation are difficult to resolve. Because problems exist in many areas, however, the interpretation of terminal condition is not the only area that requires consistency.

Living wills contain a variety of vague terms used to describe the condition a patient must be in before life-support systems can be terminated. The term "irreversible coma" has met with a plethora of interpretations by the medical profession. At one time, this phrase was used interchangeably with the term "brain dead." Twenty years ago, neurological experts used the term to describe patients in a persistent vegetative state. At present, it is also used as a general term describing permanently unconscious patients. The phrase "chronically and irreversibly comatose" causes even greater confusion and should be abandoned.

petent, the living will would speak for the patient's further consent. Kutner, supra note 4, at 550-51.

57. Arkansas is one state that does not require that a patient's illness be terminal. Ark. Stat. Ann. §§ 20-17-201 to -218 (Supp. 1987). Instead, a living will may be activated if two physicians sign a statement which declares that extraordinary means are necessary to prolong life. Id. Comment, Comparison of the Living Will Statutes of the Fifty States, 14 J. of Contemp. L. 105, 111 n.43 (1988).


61. Cranford, supra note 59, at 28. A patient in a "persistent vegetative state" experiences a coma that may last from a few days to a few weeks. The patient will then exist in a condition of eyes-open unconsciousness, called the persistent vegetative state. Id. This condition differs from "brain death" in that, in the persistent vegetative state, the brain stem remains in working condition carrying out higher cerebral functions, such as respiration and reflexes. With brain death, all brain stem functions cease except for those that are semi-autonomous, such as the heartbeat. Id. at 27.


63. No present statute uses this term. However, the term has been used frequently in the past by the medical community. See Cranford, supra note 59, at 27.

64. A comatose patient will remain in a comatose state for weeks or months, but not for years. Chronic, by definition, means "of long duration." The American Heritage Dictionary of the English Language 240 (New College ed. 1978). Therefore, the characterization of chronically comatose is inaccurate. A patient cannot have both a chronic condition and be
Unfortunately, no magical words exist to define when a living will should become operative. Legislators must work with language already in existence and strive to avoid the use of ambiguous language.

III. Judicial Intervention

A. Ambiguity Compels Judicial Intervention

In a situation in which a patient is not competent to make medical decisions and the patient’s living will is ambiguous, decisions regarding the patient’s treatment may be made by a designated proxy. The patient may appoint a medical surrogate decision-maker or an attorney-in-fact with a medical durable power of attorney granted by the patient while still competent. Absent this type of prior designation, or in the case of disputes concerning future treatment, decisions will have to ultimately be resolved by the judicial system. Unfortunately, it is difficult to foresee the problems that may arise. The following cases represent some of the problems present in today’s living will.

Estelle Browning, a Florida resident, executed her living will in November of 1985. The document directed that if she ever became terminally ill, life-prolonging procedures should be withheld or withdrawn. Specifically, she wrote in the “other instructions” section of Florida’s statutory form, “I do not desire that nutrition and hydration (food and water) be provided by gastric tube or intravenously if necessary.” Mrs. Browning’s living will, however, is still creating controversy in the Florida court system, despite her death on July 16, 1989. She died before the court could interpret the directives she thought were unambiguous. She received the specific treatment she did not want because she included the ambiguous phrase “when death is imminent” in her living will.

Mrs. Browning suffered a massive stroke on November 9, 1986. The stroke caused permanent and irreversible brain damage. She remained unresponsive except with a slight reaction to deep pain. On November 20, 1986, a gastronomy was performed to allow food and water to flow directly into her stomach through an opening in her abdominal wall. In 1988, the tube dislodged and a nasogastric tube, providing her only nourishment, fed her until her death. In re Browning, 543 So. 2d 258, 261-62 (Fla. Dist. Ct. App. 1989). The Florida Supreme Court handed down its decision on September 13, 1990. See infra note 83.

70. Browning, 543 So. 2d at 275.
Mrs. Browning's living will directed physicians to refrain from applying life-sustaining procedures "when death is imminent" and those procedures "serve only to artificially prolong the dying process." Doris Herbert, Browning's appointed legal guardian, took the position that Browning's condition had reached the terminal stage. On September 2, 1988, Mrs. Herbert filed a petition, based on Browning's living will, to terminate artificial support. The trial court denied this petition based solely upon statutory interpretation. The statutory issues presented were 1) whether the nasogastric tube was a life-prolonging procedure; and 2) whether Mrs. Browning was suffering from a terminal illness. Both were answered in the negative. The court ruled that Mrs. Browning's imminence of death must be measured under conditions in which sustenance is provided. The State argued that death was not imminent because the nasogastric tube allowed Mrs. Browning to live indefinitely, even though without the tube she would have died within nine days. Therefore, because Mrs. Browning's condition was not terminal as that word is defined in the Florida Code, and because the nasogastric tube was not a statutory life-prolonging procedure, no remedy existed.

On appeal, the Florida District Court of Appeal had to decide whether Mrs. Browning had any existing rights through the common law or constitutional law that would authorize the remedy requested. The court found that a right to refuse treatment existed

71. Id.
72. See Carey, supra note 6, at 63.
73. The trial court held that under the Life-Prolonging Procedure Act of Florida, FLA. STAT. ANN. §§ 765.01-.15 (West 1986), no remedy existed. Browning, 543 So. 2d at 261. Specifically, the court found that the language Mrs. Browning selected by placing an "X" in a box designating that "nutrition and hydration" not be provided is not the standard statutory language. Id. at 262. This language is within the same paragraph as the standard language, "when death is imminent," and was therefore ambiguous. Id.
74. The nasogastric tube allows food and liquid to be introduced into the body through the nasal cavity. It then passes into the stomach. In re Browning, 543 So.2d 258, 261 (Fla. Dist. Ct. App. 1989).
75. Id. at 264. "The term 'life-prolonging procedure' does not include the provision of sustenance or the administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain." See FLA. STAT. ANN. § 765.03(3) (1986).
76. Browning, 543 So. 2d at 264. The living will would become effective under the Florida statute if death remained imminent even with the use of the nasogastric tube.
77. Id. at 262. The guardian argued that Mrs. Browning's condition was terminal because her death would be imminent if the nasogastric tube were removed. "Imminent" is not defined under the Florida Act. Moreover, the definition of "terminal condition" in section 765.03(6) does not indicate the conditions under which death is imminent. See FLA. STAT. ANN. § 765.03(6) (1986).
78. Browning, 543 So. 2d at 264.
THE LIVING WILL

based upon an individual's right to self-determination under the common law. Further, case law had established that an incompetent patient also has a constitutional right to refuse medical treatment. Relying on these two rights, the appellate court concluded that Mrs. Browning's right to die existed and life-prolonging procedures should be terminated. The remedy provided by the court and the subsequent procedures suggested by the court to protect that remedy are all derived from a patient's right to make personal and private decisions. The Florida Supreme Court affirmed and adopted the reasoning of the District Court of Appeal.

Mrs. Browning, in executing her living will, thought she had taken care of her future. She even executed a more recent will to be certain that her earlier one would remain enforceable. Unfortunately, the ambiguity of a few seemingly clear words destroyed her efforts. Mrs. Browning's desire to avoid the use of life-prolonging treatment when her death became imminent was not fulfilled by her previously executed living will; her relief came from her common law and her constitutional right to self-determination. Mrs. Browning's wishes were fulfilled long after they could have been had her living the trial court's decision that termination of treatment was not permitted by the statute. The district court, however, held that Mrs. Browning was entitled to relief under the state constitution, which expressly recognized every citizen's basic right of privacy. See also Corbett v. D'Alessandro, 487 So.2d 368, 379 (Fla. Dist. Ct. App. 1986), review denied, 492 So. 2d 1331 (Fla. 1986).


81. Browning, 543 So. 2d at 267. See In re Peter, 108 N.J. 365, 529 A.2d 419 (1987); In re Westchester County Medical Center, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988); In re Grant, 109 Wash.2d 543, 757 P.2d 534 (1987). This right still exists when a person becomes incompetent, but it must be delegated to a surrogate decision-maker or proxy. See also supra note 33; infra note 94 and accompanying text.

82. The district court then authorized the guardian to make the decision in accordance with procedures established in the opinion. Browning, 543 So. 2d at 271-73.

83. In re Browning, No. 88-02887 (Fla. Sept. 13, 1990) (LEXIS, States library, Fla. file). The Florida Supreme Court decided that the guardian of an incompetent patient who suffers from an incurable but not terminal condition may exercise the patient's right of self-determination to forego sustenance provided artificially by a nasogastric tube. Specifically, the supreme court agreed with the district court's assertion that Mrs. Browning's right of self-determination, or right of privacy, controlled the case. Id. Further, the court held that there was no basis for drawing a constitutional line between the protections afforded to competent and incompetent persons. Both have the constitutional right to accept or reject medical treatment. The individual's right to chart his or her own course of medical treatment in the event of later incapacity must be safeguarded. In this case, all of the conditions established by Mrs. Browning in her declaration were satisfied. Therefore, Mrs. Browning's guardian was correct in instructing the health-care providers to discontinue all life-sustaining procedures in accordance with Mrs. Browning's wishes. Id.

84. Browning, 543 So. 2d at 262. Mrs. Browning even provided a copy of her living will to her doctor. Id.
will not been ambiguous.

A situation similar to that in *Browning* was addressed in the case of *Evans v. Bellevue Hospital*. In *Evans*, the petitioner brought an action to enjoin the patient's medical treatment pursuant to the patient's nonstatutory living will. Despite the petitioner's attempts to comply with the patient's living will, the hospital began life-sustaining treatment. The hospital felt that the phrase, "meaningful quality of life" was ambiguous. This ambiguity precluded the court from allowing the patient's living will to create a basis upon which to grant relief. Further, the court declined to accept petitioner as the proper person to interpret the ambiguous phrase. For the petitioner to prevail, he had to demonstrate with clear and convincing evidence that 1) the patient was incompetent and 2) there was no hope of recovery from the present danger, the stupor, or the overall disease itself. These requirements were not met. The petitioner did not find it necessary to appeal the court's decision.

An important legal issue arose from *Evans* that has yet to be resolved. *Evans* questioned whether a person, appointed on the patient's behalf as a proxy for medical decision-making, may interpret ambiguities in a living will and then subsequently reject life-sustaining treatment. In *Evans*, if the answer to this question had

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86. Id. The patient, Tom Wirth, had been suffering from AIDS-related-complex and brain lesions, and subsequently fell into a stupor. Previously, he had given the petitioner, John Evans, a power of attorney. Evans brought this action pursuant to the power of attorney to decline medical treatment on behalf of the patient. Id.
87. Id. Mr. Wirth's living will was executed on April 13, 1987 and stated: "life-sustaining procedures should be withheld or withdrawn if I have illness, disease or injury or experience extreme mental deterioration, such that there is no reasonable expectation of recovering or regaining a meaningful quality of life." Id.
88. Id. The living will did not apply initially because of the ambiguity. The court refused to grant relief based on mere speculation. Specifically, the hospital asserted that, given the treatment being administered, the patient would recover within two weeks. In fact, two physicians testified to this. Id.
89. Id. The court refused to accept Evans's assertion that the patient already considered his condition not "a meaningful quality of life." Id.
91. Contrary to the hospital's earlier prognosis and soon after this decision, it became apparent that the patient would not recover. After a month of life-sustaining treatment while remaining in a continuing stupor, health-care treatment ceased. The living will was honored because there was now no hope of recovery. Tom Wirth died a week later. *Society for the Right to Die, Right to Die Court Decisions* Vol. II, at NY 8 (Oct. 1988).
92. The New Jersey Supreme Court concluded that a proxy could make such a decision.
been yes, the life of the patient would not have been unnecessarily and unwillingly prolonged. If the patient's living will had not raised a question of interpretation at the outset, the appointment of a proxy would not have been necessary. Therefore, until the proxy issue is resolved, care should be taken to make directives for each case specific and unambiguous.

An advance directive will not be enforced unless the language employed applies to the circumstances at issue. Because the language in living wills can be ambiguous without appearing so facially, it is sometimes difficult to establish the exact desire of the patient at the time the living will was executed, and in which circumstances this desire should be applied. In re Kerr, 93 exemplifies this problem. The patient in Kerr had requested in her nonstatutory living will that she be allowed to "die with dignity," avoiding life-prolonging procedures. 94 The court held that dying from gangrene was not "dying with dignity." 95 Therefore, the hospital was given the authorization to surgically amputate the patient's gangrenous limb to sustain her life. 96 The living will was never effectuated. Moreover, the patient's niece, who opposed this decision, failed to establish with clear and convincing evidence that the patient wanted to die in the manner in which she would have had the decision to authorize the surgery not been granted. 97 Clear and convincing evidence of a patient's wishes may preserve them. 98 The patient's living will, which was executed to avoid a medically prolonged life, proved to be worded inadequately, and the patient's apparent wishes were not honored by the court. 99

The preceding cases demonstrate the importance of specificity and precision when drafting living wills. The right to self-determina-


93. No. 21748/86 (N.Y. Sup. Ct. Dec. 17, 1986). In this case, Joan Essner, an 87 year-old patient, was paralyzed from a stroke and dying of gangrene. The hospital requested surgical procedures to amputate her right leg above the knee and perform an anal circlage. The patient's prognosis remained uncertain even if surgery was performed; it remained clear, however, that if surgery was not performed, the patient would die within weeks. The death would be painful. The patient's niece argued that surgery would not be her aunt's wish. Id.
96. Id.
97. Id. See also supra note 89 and accompanying text.
98. See generally In re Peter, 108 N.J. 365, 529 A.2d 419 (1987) (when a patient has left clear and convincing evidence that he or she would not want to be sustained by life-support, judicial review of a patient's preferences is unnecessary).
99. The author understands the unusual circumstances under which the court had to make a decision. In effect, dying from gangrene is not a dignified death. It would seem, however, that there must have been a more compassionate method in which to decide this case. The patient died while in surgery.
tion should not be lost simply because the patient's noncognitive or vegetative condition prevents a competent choice to refuse life-prolonging treatment. But this right will be lost unless care is taken when drafting living will legislation. It is not always easy to anticipate future circumstances, including one's future medical condition. Even with foresight, problems of how or when to apply a living will arise. Even though living wills too narrowly drawn or too generally worded cannot always be completely avoided, care must be taken to draft them as specifically as possible.

B. Avoiding the Judicial System

Judicial intervention in construing living wills because they include ambiguous language must be avoided. Avoidance can only be achieved by modifying the present requirements for a living will. It is clear that an unambiguous living will has not yet been created. The time to perfect the living will is now.

All words contain some ambiguity. However, some words and phrases are more ambiguous than others. Legislators must be selective and strive to make the wording in living will statutes just broad or narrow enough to encompass the rights of individuals who are confronting death. Rapidly advancing medical technology necessitates this transformation; changes must be made immediately. Without change, unsuspecting executors of living wills may find their

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100. "Even though millions of people have signed some kind of living will, almost no one has fallen under a category that the statutes address." Blodgett, New "living wills", A.B.A. J., Sept. 1, 1986, at 24 (quoting George Annas, of the Boston University School of Medicine).

101. One proposal states, "I request that no ethically extraordinary means be used to prolong my life, but that pain be alleviated if it becomes unbearable." "Extraordinary," in this context, means "no reasonable hope of benefit or without increasing expense or grave burden." CATHOLIC HEALTH ASS'N: CHRISTIAN AFFIRMATION OF LIFE, A STATEMENT OF TERMINAL ILLNESS (1982), cited in Laukfer, Living Wills and Durable Power Authorizing Medical Treatment Decisions, 64 Mich. B.J. 684, 686 (1985). See also infra note 103.

102. See supra note 45 and accompanying text.

103. Specific treatments that are or are not wanted should be listed. For example:

I do not want any treatment that merely prolongs my life if my attending physician, based on reasonable medical judgment, determines that I am suffering from an irreversible disease, illness, or injury that prevents me from communicating and thinking. The treatments I do not want include (but are not limited to): antibiotics, artificial feeding, blood transfusions, chemotherapy, dialysis, resuscitation, hospitalization, medication (specify), respiratory support, [and] surgery. The medical circumstances in which I would not want my life artificially prolonged include, but are not limited to: irreversible dementia, severe brain damage, and permanent unconsciousness (including irreversible coma and vegetative state.)

Rosoff, supra note 3, at 12. Further, one may ask for treatments in some circumstances, but not in others. For example: "If I am severely demented, I want artificial feeding, but not a respirator. If I am permanently unconscious, I do not want either artificial feeding or a respirator." Id.
cases entering the realm of judicial interpretation. The court may not support the living will, and executors may find their right to self-determination grounded in the common law or in constitutional law. The executor's right of self-determination may not always be based on the intentions expressed in the living will. This result defeats the goal of the living will.

IV. Time for Change

A. Proposed Uniform Law

The best solution to the judicial and legislative morass is to compile the most favorable aspects of current state living will statutes and draft a uniform law. The National Conference of Commissioners on Uniform State Laws (Commissioners) attempted this when they proposed the "Uniform Rights of the Terminally Ill Act" presented in August 1985. Purported to present a simple method to enact a declaration, provide for effectiveness of declarations in states other than the one in which the declaration was executed, and avoid inconsistencies in approach, the Act has met with limited success. Although the Act has some shortcomings, it also has a

104. See supra note 80 and accompanying text.
105. See supra note 81 and accompanying text.
106. To remedy this problem some non-statutory documents specifically include a severability statement that claims, "My directions are also based on my constitutional and common law right to control my medical treatment. If any provisions of this document are held to be invalid, it will not affect the validity of the rest of the document." Rosoff, supra note 3, at 12.

In drafting legislation, it must be remembered that uniformity is important as a practical matter. No guarantee exists that a declaration declining life-support systems signed in one state will be honored in another, though many are. Reaves, Living Wills, Uniform Law Proposal, A.B.A. J., Dec. 1984 at 29. See generally Saunders v. State, 1299 Misc.2d 45, 492 N.Y.S.2d 510 (Sup. Ct. Nassau County 1985).

107. UNIFORM RIGHTS OF THE Terminally Ill ACT, §§ 1-18 9B U.L.A. 609 (1989). The Act's provisions apply to adults alone, and only to treatment that is life-prolonging. Living wills follow the standard set forth by the Uniform Probate Code. The Code states that any competent person 18 years or older may make a will. UNIFORM PROB. CODE § 2-501 (1975). Only those patients whose terminal conditions are incurable and/or irreversible, whose death will soon occur, and who are unable to participate in treatment decisions are affected. Blodgett, supra note 100, at 24.

108. UNIFORM RIGHTS OF THE Terminally Ill ACT, supra note 107. See generally Reaves, supra note 107, at 29.

109. Forty states and the District of Columbia have enacted living will legislation, but only seven states have adopted the Uniform Act in its entirety. These seven states are: ALASKA STAT. §§ 18.12.010-.100 (1986); ARK. STAT. ANN. §§ 20-17-201 to 218 (Supp. 1989); IOWA CODE ANN. §§ 144A.1-11 (West 1989); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1989); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1990); MONT. CODE ANN. §§ 50-9-101 - 50-9-104, 111, 201-206 (1989); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1990). Jurisdictions have adopted portions of the Uniform Act, but have also departed substantially from the Act. Added material could not be clearly distinguished from the Act itself. See, e.g., CONN. GEN. STAT. §§ 19a - 570 - 575 (Supp. 1989); FLA. STAT. ANN. §§ 765.01 -.15 (West 1986).
number of promising points. The Commissioners recognized the problems surrounding the statutory terms “life-sustaining” and “terminal condition.” “Terminal condition” was defined in terms of “life-sustaining” and vice-versa. Neither term conveys a concrete meaning, and hence cannot be distinguished. These terms require the physician to determine whether medical treatment is merely postponing death before the living will becomes effective. This results in considerable delay because the physician is faced with a formidable task.

To remedy this confusion, the Commissioners attempted to clarify certain phrases that are essential to preparing a proper declaration. The Act reads:

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain. The word “condition” contemplates a state that could be caused by an accident as well as by an illness that will lead to death. Further, the Act separates this definition from that of “life-sustaining treatment” by stating that death will occur in a “relatively short time” simply from the “condition.” In this way, in determining a terminal

110. A critique of the Act reveals that the commissioners confused the meaning of “terminal condition” by using the word “or” between the words “incurable” and “irreversible” in the definition section of the Act. UNIFORM RIGHTS OF THE TERMINALLY ILL ACT, supra note 107, at 612. Perhaps the word “and” would be a better choice since it would not limit the interpretation of the Act to specific treatments. Both words, “incurable” and “irreversible,” need not be present as they convey the same meaning.

Further, in using the term “irreversible,” the Act contradicts its purpose and the idea that because of new technology prolonging life, living will legislation was enacted. In short, any treatment that would keep a patient alive may not be withheld or withdrawn according to the Act unless the patient would die within a “relatively short time.” This then only allows the Act to apply to life-sustaining treatment, not to all medical treatment. Marzen, The "Uniform Rights of the Terminally Ill Act": A Critical Analysis, 1 ISSUES IN LAW & MED. 444 (1986).

Additionally, the phrase “relatively short time” remains as ambiguous as the word “imminent” in this context. Physicians are uncertain about the exact length of time the phrase purports to depict, and as a result they avoid it. Id.

111. See infra notes 113-14 and accompanying text.

112. “Terminal condition” sometimes means death must occur or be imminent regardless of “life-sustaining treatment.” Further, “life-sustaining treatment[s]” are those that may prolong dying or conversely fail to prevent death. This latter phrase suggests death is imminent even with the use of such treatment. One must then ask: Why discontinue the treatment in the first place? Rizzo, The Living Will: Does it Protect the Rights of the Terminally Ill?, N.Y.S. J. OF MED., at 72, 74 (1989). See also supra note 47 and accompanying text.

113. UNIFORM RIGHTS OF THE TERMINALLY ILL ACT, supra note 107, § 2, at 614.
condition, the use of medical procedures is not an issue. The Act best clarifies the problems surrounding the phrase "death is imminent." Even though the use of the phrase "relatively short time" answers some questions concerning the use of the word "imminent," it is still not the best phrase. Although the Act appears to be the best solution to ambiguous phrases at present, any benefits the Act may facially appear to provide in clearing up the ambiguity in these phrases are still outweighed by its shortcomings.

B. Allowing the Patient to Decide

Another suggestion, proposed by Linda L. Emanuel and Ezekial J. Emanuel, attempts to create an ideal living will declaration and is entitled The Medical Directive. The directive is divided into five sections: 1) an introduction; 2) a section containing four paradigmatic scenarios of illness in which preferences for medical care are given; 3) a section for the designation of a proxy decision maker; 4) a section for organ donation; and 5) a section for a personal statement.

In an attempt to eliminate linguistic vagueness, section two of the directive addresses a patient's positive requests for treatment. In this section, patients consider actual illness situations, evaluate common types of life-sustaining health-care treatment, and designate their own treatment preferences. The four scenarios presented allow the physician or counselor to educate the patient on life-sustaining terminology, thereby enabling the patient to make informed decisions. Specifically, the patient's options include the refusal of

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114. Rizzo, supra note 112, at 75.
115. Id.
116. See supra note 110.
117. This directive seeks to remedy the vagueness, inflexibility, and poor communication present in advanced care directives. See Emanuel & Emanuel, supra note 44. It is also intended to enable such directives to be used more widely in clinical practice. Id.
118. Id. at 3289.
119. See infra notes 122-25 and accompanying text.
120. See infra note 127 and accompanying text.
121. The personal statement section simply allows patients to reiterate more accurately their personal values and goals of treatment. Emanuel & Emanuel, supra note 44, at 3291.
122. Id. This section provides a context for a patient's wishes to be explored in addition to an evaluation of the patient's view of life.
123. The four scenarios are as follows:

[When the patient is in an irreversible coma or a persistent vegetative state, but with no terminal illness (situation A); when the patient is in a coma with a small and uncertain chance of recovery (situation B); when the patient has some brain damage causing mental incompetence and is terminally ill (situation C); and when the patient has some brain damage causing mental incompetence without any terminal illness (situation D).]
care and the chance to affirm requests to intervene in twelve common treatment categories.\textsuperscript{124} These categories cover various areas of mental incompetence and address the concerns that have led to judicial intervention.\textsuperscript{125} \textit{The Medical Directive} demonstrates significant improvements in declarations regarding incompetent patients' preferences in life-sustaining treatments. Because the directive limits terminological vagueness, provides strong evidence of patients' wishes, and simplifies terminology, it makes great strides in the drafting of living wills. Unfortunately, a facial analysis fails to indicate how the directive will fare in actual implementation. Its success can only be evaluated through its application.

C. \textit{Proxy Decision Making}

Perhaps the trouble with the living will lies within its four corners. That is, the living will contains certain limitations that prevent it from being applied efficiently in contemporary medicine.\textsuperscript{126} These limitations coupled with vague terminology create a declaration whose application may be very limited. To compensate for the deficiency, the current trend appears to be the incorporation into the living will of an option for durable power of attorney decision-making.\textsuperscript{127}

Traditionally, physicians looked to family members to make decisions for incompetent patients.\textsuperscript{128} Many patients, however, prefer an option to appoint a proxy. The durable power of attorney provides this option and is more flexible than the appointment of a proxy by

\textit{Id.} at 3291.

\textsuperscript{124} The categories listed are: cardiopulmonary resuscitation, mechanical breathing, artificial nutrition and hydration, major surgery, kidney dialysis, chemotherapy, minor surgery, invasive diagnostic tests, blood or blood products, antibiotics, simple diagnostic tests, and pain medications, even if they dull consciousness and indirectly shorten the life. \textit{Id.} at 3290.


\textsuperscript{126} The living will is limited because it: 1) is addressed specifically to physicians, which excludes allowing others to make health-care decisions; 2) is only binding once the patient's condition becomes terminal; and 3) applies only to the use of life-support systems, not to other health-care treatments. \textit{See} D. \textit{CLIFFORD}, \textit{supra} note 26, at 6:15. \textit{See also} Blodgett, \textit{supra} note 100, at 24.

\textsuperscript{127} The durable power of attorney enables a patient to appoint someone else to serve as a proxy (sometimes called a medical surrogate, decision-maker agent, health-care agent or attorney in fact). The proxy makes treatment decisions based on the patient's wishes, or if these are not known, in the patient's best interests. Rosoff, \textit{supra} note 3, at 16. \textit{See also} Rasmussen v. Fleming, 154 Ariz. 207, 222, 741 P.2d 674, 689 (1987).

someone other than the patient. The durable power of attorney acts and durable power of attorney acts provide the legal authority for health-care proxies. Some commentators and legislators support the durable power of attorney law alone. But the living will remains necessary as both a guide and as a precaution to ensure that the proxy is following the patient's wishes. The best method is to incorporate the durable power of attorney into the living will. Further, to maximize protection, the same person should be appointed as proxy in all directives regarding health-care treatment. The use of durable power of attorney is still in its infancy. There are no legal precedents establishing durable power of attorney authority for terminating life-support systems. The New Jersey Supreme Court fleetingly addressed the issue in In re Peter. It is interesting to note that the court interpreted New Jersey's durable power of attorney statute to authorize a proxy appointment, even though the statute does not expressly authorize proxy medical

129. The durable power of attorney should be given to someone the patient trusts and who is cognizant of the patient's treatment preferences. An alternative proxy should be appointed in case the primary proxy becomes unavailable. Rosoff, supra note 3, at 13.


133. The living will is also necessary to guard against possible drawbacks when the durable power of attorney exists by itself. These drawbacks include: the chance of death or incapacity of the proxy; the proxy's refusal to act; and the possibility of an inadequately drafted declaration. Moses, The Last Rights, 2 Prob. Pract. Rep. 1, 3 (1990).

134. Rosoff, supra note 3, at 14.

135. D. Clifford, supra note 26, at 6:16.

136. 108 N.J. 365, 529 A.2d 419 (1987). The court stated that the best proof of a patient's intent is a living will. However, it "would have been better" had Ms. Peter, the executrix, specifically provided that Mr. Johanning, her proxy, had the authority to terminate life-sustaining treatment. Id. at 371, 529 A.2d at 426.
decisions.\textsuperscript{137}

Several guidelines have been proposed by the Society for the Right to Die to ensure the enforceability of a durable power of attorney in the state in which it is executed as well as in any state in which such power might have to be implemented.\textsuperscript{138} If a person chooses to execute both documents, the documents must be carefully prepared so that each one remains consistent with the other.\textsuperscript{139}

V. Focusing on the Real Issue

Present living will statutes and declarations concentrate solely on the effects of medical treatment\textsuperscript{140} without adequately focusing on the mental and physical condition of the patient. Moral concepts, principles, and reasoning\textsuperscript{141} about the use of a living will should play a larger role in the drafting process. Perhaps only two areas have to be changed to better enable legislatures to effectively draft guidelines for the living will.

A. The Time Element

The first area legislators should address is the restrictive language that is used in living wills. One of the most troublesome features of state statutes is the language that restricts the application of the directive.\textsuperscript{142} The statutes need detailed and precise terminology. Specifically, the terms that dictate a time element, such as “death is imminent” or “relatively short time,” should be redrafted or eliminated because they impose severe problems of interpretation.\textsuperscript{143} The wide-spread use of the living will is hampered by the problems involved in interpreting these terms. The phrases are unclear and alien, even to a physician’s vocabulary.\textsuperscript{144} As a result, most declarations

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{137} Id.
\item \textsuperscript{138} The Society recommends that the patient formulate his or her wishes regarding medical treatment. Next, the patient should execute a living will (if no attorney will be taking over) and/or a durable power of attorney (to guide the proxy in making health-care decisions). Further, the patient should discuss his or her wishes with those who will be involved in making medical treatment decisions for the patient. Each document should be updated periodically. Finally, if the patient travels frequently to one area, steps should be taken to conform the documents to the laws of that area so that the document is honored. Laukfer, supra note 101, at 689.
\item \textsuperscript{139} D. Clifford, supra note 26, at 6:16. See generally Francis, supra note 55.
\item \textsuperscript{140} Most statutory living wills define a terminal condition as if death is imminent with or without the use of life-sustaining treatment. If death is imminent, the living will becomes effective. See supra note 53.
\item \textsuperscript{141} See supra note 16.
\item \textsuperscript{142} See infra notes 149-50 and accompanying text.
\item \textsuperscript{143} See infra notes 146-48 and accompanying text.
\item \textsuperscript{144} Rizzo, supra note 112, at 76.
\end{enumerate}
\end{footnotesize}
under state acts experience problems in this area due to vague lan-
guage. The lack of a definite interpretation coupled with a variety of
phrases defined within various state statutes impedes the usefulness
of the living will.

Perhaps the time element reference should be left out of the
declaration altogether. This would eliminate the difficulty of as-
signing a time period and would allow the decision-maker to focus on
the real issue, which is whether the life-sustaining treatment is a
benefit or a burden to the patient. Effective terminology could be
drafted so that life-sustaining procedures would not be used solely to
“prolong artificially the dying process.” A phrase similar to this
would be beneficial in a situation in which a patient is irreversibly
comatose, but may survive for more than a year. Under the ex-
isting time element system, that patient could fail to qualify as ter-

definal, even though that patient’s condition is, in all aspects, termi-
nal. If the effect of all life-sustaining treatment becomes the focal
point, rather than the treatment itself, the real issue of whether life-
sustaining treatment substantially benefits the patient will become a
major factor.

B. The Total Condition of the Patient

The phrase “life-sustaining treatment” must also be better un-
derstood. The phrase as it now stands is too limiting. When re-
drafting this term, the main focus should be on the benefits and bur-
dens of all medical treatment on the patient, not merely those
treatments that sustain life. One suggested definition comes from
the Legal Advisory Committee of the Concern for Dying, which
reads:

Medical procedure or treatment shall mean any action

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145. See supra note 140. The patient’s life should be the central concern rather than the
treatment itself because it is the patient’s life that is most precious. The care of the patient
must remain paramount. Living will directives will not be ambiguous if the patient’s well-being
is kept in mind. Legislators will begin to understand the decisions that courts may have to
make and will then understand why judicial intervention should be avoided whenever possible.
146. See supra note 145.
147. See supra notes 63-64 and accompanying text.
148. The executor of a living will may want all medical treatment terminated, not
merely treatment considered life-sustaining, once a certain condition has occurred. For exam-
ple, some statutes do not include nutrition and hydration within the scope of the term “life-
sustaining.” See supra note 55. An executor, however, may not want to authorize these treat-
ments despite their failure to be classified as life-sustaining. Therefore, the focal point when
redrafting the term “life-sustaining” should be on the mental and physical condition of the
patient, not on the treatment itself.
149. Frances, supra note 55.
taken by a physician or health care provider designed to diagnose, assess, or treat a disease, illness or injury. These include, but are not limited to, surgery, drugs, transfusion, mechanical ventilation, dialysis, resuscitation, artificial feeding, and any other medical act designed for diagnosis, assessment or treatment.  

This definition meets the objective of focusing on both the benefits and burdens of all medical treatment by avoiding the term "life-sustaining." In this way, treatment is withheld or withdrawn depending upon a balance of the benefits of providing treatment and the burdens of prolonging death with such treatment. This balance is determined by considering the total condition of the patient, including his or her wishes. Again, the focus should be on the patient, as it should be when redrafting the time element definition, not on the treatment itself. If prolonging treatment negates any benefits, then the treatment should be withheld or withdrawn. Once states adopt living will statutes that include these two changes, individuals will be better able to exercise their right to die by executing an effective living will.

C. The Medical Profession Must Play a Role

Statutory declarations and court rulings codify the law in the area of the right-to-die. They cannot, however, facilitate the decisions of those intimately involved in these situations. Patients and families face difficult dilemmas when deciding whether to terminate treatment. They must weigh ethical, financial, medical, and legal considerations to come to a decision. Not surprisingly, doctors also weigh these same considerations when deciding whether to let the patient die or to take steps to prolong life.

For the medical profession, life and death decisions are an everyday occurrence. At the same time, they are always difficult. Doctors learn through experience. Many hospitals have now appointed some of their doctors to ethics committees within the hospital itself to advise other doctors on difficult moral issues. After years of boasting about medical technology, doctors now realize that technology often unnaturally prolongs the inevitable.

Medical terminology also requires clarity and consistency.

150. Rizzo, supra note 112, at 77.
151. Living will directives could terminate medical treatment by avoiding the term "life-sustaining." This would create a less limiting definition and perhaps suit the needs of a larger group of people. Further, if all treatments may be terminated, no ambiguity will exist regarding specific treatments.
152. See supra note 143.
153. See supra note 145.
Those who work most closely with the patient and life-prolonging treatment should lay the groundwork for state legislatures to act. Physicians and other medical personnel have the power to educate the public about the persistent vegetative state and life-prolonging treatment. Physicians, more so than legislators, are aware of which terms are more accurate and create the least ambiguity. The medical community should lay the groundwork by educating legislators about terminal diseases and creating guidelines for the appropriate treatments. Only through an understanding of the medical reality associated with this area can everyone involved, including families, medical personnel, and especially the judicial system, make informed and caring decisions about living wills.

D. Immediate Changes are Necessary

Until legislative changes become a reality, some measures do exist that can be taken when executing a living will to better ensure its enforceability. The Society for the Right to Die and Concern for Dying, suggest the following guidelines: 1) discuss with your doctor your wishes and make sure the doctor understands them and places the living will in your medical file; 2) aim to be as specific as possible when describing treatments desired or not desired and at what point they are no longer desired; 3) designate a person familiar with your personal philosophy and feelings about terminal care to make health-care decisions for you; 4) sign the living will before two witnesses and a notary; 5) give copies of the living will to next of kin, clergyman, lawyer, and all others who may take part in the decision-making process; 6) store the living will where your family can easily find it; and 7) sign and date the document before a notary every two to three years, and before witnesses every five years. If these recommendations are followed, legal complications will decrease while legislatures work on long-term modifications. The ultimate goal of creating a trouble-free living will, however, can only be realized through nation-wide adoption of the proposed legislative changes set forth in this Comment and other scholarly works.

155. The Society for the Right to Die is a nonprofit organization located at 250 West 57th Street, New York, New York, 10107.

156. Concern for Dying is a nonprofit organization located at 250 West 57th Street, New York, New York, 10107.

VI. Conclusion

The living will provides the means through which the rights of the terminally ill are protected. The potential of the living will, however, will not be fully realized until it is drafted with precision. Presently, no such form exists. Accordingly, state statutes need legislative revision. The most effective living will directive should be brief and clear, without the use of ambiguous terminology. Further, it should provide an area where executors give specific instructions concerning treatments and conditions, and at what time to apply these instructions. In addition, the ultimate living will directive should include an option to appoint a proxy to make medical decisions on behalf of the executor carrying out the intentions of the patient. The proxy and the living will should exist cohesively.\textsuperscript{158} This theoretical declaration has the ability to become reality if state legislatures recognize the problems inherent in present statutory directives. Legislators should revise those statutes immediately, before any further right-to-die decisions have to be made by the judicial system. Only legislatures have the power to validate a living will and to formulate "clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients."\textsuperscript{159} Legislators should strive for uniformity and avoid restrictions that can be narrowly interpreted. The focus should be shifted to a comprehensive consideration of the condition of the patient, rather than a narrow look at the available medical treatments. Effective living will legislation can only be achieved once legislators understand the goals of the living will itself and concentrate on those goals while drafting such legislation. Once this is done, the judicial system will no longer have to interpret right-to-die cases involving ambiguous living wills. Courts are not equipped to handle these decisions involving tragic circumstances,\textsuperscript{160} and should not be required to do so. At a time when the fear of lingering before death outweighs the fear of death itself, the right to die in a dignified manner must be preserved.

Susan J. Nanovic

\textsuperscript{158} D. Clifford, \textit{supra} note 26, at 6:16.
\textsuperscript{159} See Saunders v. State, 129 Misc.2d 45, 51, 492 N.Y.S.2d 510, 515 (N.Y. Sup. Ct. 1985). Clearly, it is the legislature, not the judicial system, that must overcome problems of interpretation in the living will.
\textsuperscript{160} See \textit{supra} note 1 and accompanying text.