There has been a trend in state legislatures in the past decade to enact so-called "living will" legislation. California, often a pacesetter in legal change, enacted the first statute in 1976 in the wake of the national publicity given to the case of Karen Ann Quinlan. As of the end of 1985, 35 states and the District of Columbia had passed "living will" legislation (see Ann Helm, Nursing 85, Nov. 1985, pp 40-41). The idea appears to have had its genesis in 1967, when legal scholar and former judge, Louis Kutner, proposed it at a meeting of the Euthanasia Society of America. He later elaborated on it in a 1969 law review article (see Indiana Law Journal, Vol. 44, 1969, p. 539).

The living will is a document a person may sign saying that in circumstances with no reasonable expectation of recovering from extreme mental or physical disability he does not wish to have his life prolonged by medications, artificial means, or heroic measures. Depending on how terms such as these are defined in "living will" legislation (e.g., whether or not "artificial means" includes ethically obligatory nourishment), there may be no conflict, in theory, with Catholic moral teaching (see Donald McCarthy and Edward Bayer, Handbook on Critical Life Issues, Pope John Center, Braintree, MA 02184, 1982, p. 167). People are free to draft such wills even without such legislation; the purpose of the statutes supposedly is to insure that their wishes will be followed.

**Typical Statutory Provisions**

Most of the "living will" statutes that have been enacted impose the following requirements that:

1. The person making the will must be an adult (usually age 18)
2. He must be of sound mind when making it
3. Two persons must be present to witness the attaching of his signature to the will and that the witnesses cannot include his attending physician or nurse, potential heirs, or anyone who might gain something as a result of his death
4. He must be terminally ill before the provisions of the will may be carried out or executed
5. He must be competent in order to revoke the will
6. A revocation of the will must be in writing
7. The patient must notify his attending physician of the existence of the will
8. There be a confirming consultation and/or written certification of the existence of a terminal condition
9. The attending physician comply with the will’s directive, if the terminal condition is confirmed, or transfer the patient to another physician (although they generally fail to provide any penalties for not complying)
10. Health care professionals have immunity from civil and criminal liability if they comply with the will.

Only three states — Arkansas, Louisiana, and New Mexico — permit a will to be drawn up and executed for a minor by a parent or guardian. Arkansas permits execution of the will for an incompetent person by a relative (see Richard Sherlock, Brigham Young University Law Review, 1982, 588-9).

(continued on page 2)
The Document

The document typically takes the following form. It begins by affirming that the person making the will is of sound mind and is acting "willfully and voluntarily." Then it states that if it is determined that a terminal condition exists — following the requirements of the state’s statute for confirming this — the person directs that where "death is imminent whether or not life-sustaining procedures are utilized" the procedures be withheld and he "be permitted to die naturally." It next states that if he is unable to give such directions, he intends that these wishes "shall be honored by my family and physician(s)." It also indicates whether a terminal condition has been diagnosed or not, it may set an expiration time for the will if the provisions are not put into effect (a few states require this), and affirms the competence of the person to make the will.

The second section of the document is for the witnesses. The various qualifications of the law that the patient must satisfy are listed (see above) and they attest with their signatures that these are met. The formal statutory provisions governing the witnesses and the rights of the maker of the will to revoke it are spelled out in detail.

Arguments For and Against the Living Will

Supporters of the living will say that it offers the advantage of permitting a person rationally to contemplate a future, unforeseeable illness and plan for it. It makes him secure, they suggest, in the knowledge that his wishes will be carried out when the time comes. They also contend that they afford immunity from liability for attending physicians for not providing extraordinary treatment to a patient who does not specifically refuse it (see Dennis Horan and Thomas Marzen, Journal of Legislation, Vol 5, 1978).

Opponents have argued that they are unnecessary and create many problems. For instance, they contend that most patients are unlikely ever to execute a living will (see McCarthy and Bayer, op.cit., p. 192). They also say that such documents do not provide any new substantive rights for the patient nor, contrary to the above, immunities from legal liability for the physician. In the absence of such legislation, the physician, they argue, is under no obligation to initiate or continue ethically extraordinary or useless treatment. It is normal practice for physicians, with the family’s consent, to withhold such treatment. Moreover, they do so without acting contrary to the ethical norms of either the community or the medical profession. A legal consensus has emerged that the physician who withdraws treatment — meaning specifically medical care, not food and water — from the terminally ill patient facing imminent death should not be held either criminally or civilly liable. Also, as far as the patient is concerned, there already exists, at least for Catholic health care facilities, a document that can serve as an alternative to the living will. The "Christian Affirmation of Life: A Statement on Terminal Illness" does not have the legally binding force of the living will. (although the failure to provide penalties raises questions about how binding the living will truly is) but it does enable people to record their disposition to forego ethically extraordinary means of prolonging life.

Critics of the living will have also pointed out other problems and difficulties. Legal experts Dennis J. Horan and Thomas J. Marzen tell us that "living will" legislation "increases rather than decreases the decision-making burden upon the physician." They state that in (supposedly) clarifying that there is no liability for withholding heroic or useless treatment, the living will implies that there is liability in the absence of a directive or when the directive is invalid. It also causes the physician to become burdened with questions and controversies that are outside his competence, such as 1) whether the patient was of a sound mind when the will was executed, 2) whether the will had ever been revoked, and 3) whether the patient met the requirements at the time of the execution. Under the California statute, the model for many of the others, he would have to seek a determination of the third point from legal counsel and the hospital’s ethics committee. If it is determined that the patient did meet the requirements, the physician must then weigh the will together with the "totality of circumstances" surrounding the execution in order to justify carrying out the directive. Then, the physician must determine whether the directive complies with the law. In the end, he must make a decision about present competence and, if the patient is competent, disregard the document and obtain the usual consent to terminate treatment. The most serious problem, say Horan and Marzen, is that "living will" legislation tends to subtract this area of medical practice from the usual legal principles by which physician conduct is controlled and blocks the development of standards of medical practice in it and also "attempts the impossible task of particularizing medical decision-making." (To be continued in a subsequent issue)

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