The Living Will Revisited

In *Ethics and Medics* in 1986, (Oct. & Dec.), I authored a two-part article on living wills. Legislative and legal development in this area — which have been rapid — and additional, updated information which came to my attention has led me to reconsider this issue and reevaluate some of the conclusions I came to in the previous article. I wish to take a second look at the living will in this article in light of this new information.

In the previous article, I stated that the living will's "acceptability hinges on the care with which its language safeguards the dignity and right to life of the terminally ill patient." The approach in the last few years of some who were initially concerned about living will laws being a step to the full legalization of euthanasia has been to try to secure "protective" living will laws, with supposedly tight, restrictive, pro-life-sounding language. As Msgr. William Smith, a leading American Catholic moral theologian, contends, however, such laws have done little more than provide "pro-life language shrouding basic right-to-die assumptions." (Quoted in Marker, Rita L., "Euthanasia: The New Family Planning," Pt. I, *International Review of Natural Family Planning*, Spring 1987, p. 28.) We can see what he means below.

The following are examples of typical living will-type directives (the second is language taken from an actual living will document):

1. If I am in the final stages of a terminal condition and my death is imminent, I direct my attending physician to withhold all artificial life-sustaining procedures so that I may die a natural death. (Source: Marker, *ibid.*, Pt. II, Summer 1987, p. 97 - emphasis in the article.)

and

2. If the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes and directions... If at such a time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or heroic measures... I want the wishes and directions here expressed carried out to the extent permitted by law. (Emphasis added by this writer.)

The emphasized language is considered "protective" of human dignity and the right to life, but is it? The drafter or signer of a living will may understand or think he understands the key words to mean one thing, but they may be interpreted in an entirely different way in legislative provisions or by a physician or judge when the time comes to put them into effect.

**Ambiguity of Language**

Let us first take the term "final stages" in example #1 above. A person may figure that this means the last few days of life, but it is seldom defined in living will legislation. In a proposed bill in Minnesota, "final stages" was defined to mean that death was expected to occur in a "relatively short period of time." (Marker, Pt. II, pp. 97-98, quoting the proposed bill.) We see a similar ambiguity in the term "terminal condition" in example #1 and

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the phrase "my recovery from extreme physical and mental disability" in example #2. One readily assumes that a "terminal condition" is one which, with a high degree of certainty, is going to lead to death. The signer of the living will, then, believes the will's provisions apply only when death is just about upon him (i.e., he is in the "final stages" of a life-ending, hopeless disease, such as cancer). This is not necessarily what "terminal condition" means in law, however. In some states' living will statutes, such as Maine's and Montana's, it is defined as "an incurable or irreversible condition that, without the administration of life-sustaining procedures, will in the opinion of the attending physician, result in death in a relatively short time." This definition would include diabetes, as well as other diseases which are incurable and irreversible, but can be controlled so the afflicted person can have a normal life span. (Without the administration of life-sustaining procedures — i.e., providing insulin in the case of diabetes — such a person will die "in a relatively short time.") (Marker, Pt. II, p. 98, quoting the state statutes.) The phrase "extreme physical or mental disability" in #2 above is even broader and less clear. It is not even limited to a terminal condition, not even to a terminal condition which is controllable.

What has just been said enables one also to see the problem with the phrase "death is imminent" in example #1. As with "final stages of a terminal condition," one assumes that it means death will come in hours or perhaps days. Again, not necessarily so: a 1986 Virginia court decision (Hazelton v. Powhatan Nursing Home) interpreted this phrase in the state's living will statute to mean that death might be even months away. (Discussed in Marker, Pt. II, pp. 98-99.) Actually, the term "imminent" may be inherently vague since medical science lacks the capability of predicting the time of death with precision (which fact, by itself, may indicate the infeasibility of living wills).

Artificial Life-Sustaining Procedures

The phrases "artificial life-sustaining procedures" in #1 and "medications, artificial means or 'heroic measures'" in #2 are also unsettlingly ambiguous. Artificial and heroic measures are not necessarily limited by this language to respirators or complex technological procedures, nor is there any differentiation between those procedures which may be necessary for the remainder of the patient's life and those which may be needed temporarily. During the debate on the "Uniform Rights of the Terminally Ill Act" at the 1985 meeting of the National Conference of Commissioners on Uniform State Laws (the act is a model living will statute, proposed in the hope of bringing about uniformity in state legislation on the subject), it was contended that "artificial life-sustaining treatment" could include such common medications as insulin and antibiotics and such basic care as assisted feeding. (Marker, Pt. II, p. 100, citing the transcript of the debate.) One article, defending the 1985 New Jersey court decision in the Claire C. Conroy case, suggested that under certain circumstances a spoon could be considered a means of "artificial feeding." (Marmonestein, Jerome D., M.D., "Could the New Jersey Decision Apply to Alzheimer's?" Medical Tribune (Wed., Mar. 27, 1985), p. 85. In the Conroy case, by the way, the court permitted a nursing home, at the request of a nephew, to remove a feeding tube from the elderly Miss Conroy, even though she was neither comatose nor terminally ill. As it turned out, she died before the final determination of the case.) As far as specifying that one not be kept alive by "medications" is concerned, it is worth noting that no living will statute in any jurisdiction excludes from this medications a patient was previously receiving (before a life-threatening situation developed). Again, insulin for the diabetic could be withheld.

Potentiality for Abuse

The other emphasized words in the sample living wills above are also ambiguous and can easily open the way to abuse. For example, the use of the term "attending physician" in #1 should not make the signer feel confident that he will be in the sure hands of his own doctor. In some hospitals, a patient may have several attending physicians in a day. The term is broad enough to mean whichever physician is on duty at any particular time. (Marker, Pt. II, p. 99.) Finally, referring to #2 above, we must ask who is going to decide when a person "can no longer take part in decisions" about himself, and what criteria is to be used in coming to this conclusion? Does it refer to the person's being temporarily in a state of being unable to decide and not just permanently? What does it mean to say that one wants his wishes "carried out to the extent permitted by law"? Exactly what the law will permit, as this discussion makes apparent, is unclear; this will be decided by physicians or a hospital or, if there is a controversy about it, by a judge. To paraphrase the comment of a Nebraska state legislator speaking about this: if a provision of a living will statute or a term in a living will can be interpreted in a certain way, even in a seemingly ludicrous way, it will be — by someone.

The above analysis has sought to illustrate that there is probably no way to escape the ambiguity of the language of living wills and living will statutes. It is probably an inherent problem, at least in an era of philosophical, moral, and legal disorder in which there is sometimes radical disagreement about the meaning of common terms.

Protective Statutes

A few other facts about current living will statutes — including so-called "protective" ones — are worth noting: none requires that a conscious patient be informed that his will is being put into effect; none requires that an attending physician who determines a patient is incompetent inform him of that decision; none prevents the withholding of medications the patient was dependent on before an even unrelated life-threatening situation developed. (Marker, Pt. I, p. 7.) None of these problems may be resolvable because of the language dilemma. Moreover, the very notion of the living will, a declaration made in the abstract (possibly) years before a life-threatening condition, suggests impracticality and unreliability.
It seems that even the “Christian Affirmation of Life”, an alternative to living wills used by Catholic health facilities to permit people to forego ethically extraordinary treatment, has been a casualty of recent legal developments. It is likely now that this document, not originally designed to be legally binding, would be held to be such by courts in at least some states. State living will statutes generally do not specify that a particular form be used, so the Affirmation document could be treated as living will by both judges and health care professionals. It would then face all the problems of misinterpretation that have been discussed above.

Thus, the commonly promulgated description of the living will as a document a person can sign to insure that if he finds himself suffering hopelessly and terminally he will not be kept alive by artificial or “heroic” means is simply incorrect. In light of what has been said about the invitation to help another way, be coupled to describe an act which today so many advocate without a blush of shame?

It would seem, therefore, from recent judicial actions that living wills do not really protect that which the Church’s teaching permits in the area of ethically extraordinary or disproportionate means of sustaining life. There may be other legal avenues by which this objective can be accomplished.

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**Death For The Relief Of Pain**

What an oxymoron! *Mercy killing*, a term which at one time was universally regarded as pejorative has in recent years become increasingly acceptable to more people. Mercy is such a sweet, gentle word. One thinks of forgiveness, of succor to a person in need, of extending a helping hand to one bereft of adequate clothing, food or shelter. However, that other word, killing, is so violent, so destructive, so contrary to the basic tendency of all life. In the act of killing, another’s life is snatched from him, usually in opposition to the individual’s fundamental desires. So, how can these two words, so much in opposition to each other, be coupled to describe an act which today so many advocate without a blush of shame?

**Debbie’s Death**

A physician who requested his or her name be withheld, sent a contribution to a regular column, “A Piece of My Mind” of the *Journal of the American Medical Association* (JAMA). The tone of the very brief article, “It’s Over, Debbie” was that of one who felt that what he did was morally right. The physician did what he considered best for the 20 year old patient dying of ovarian cancer who had not responded to chemotherapy. The young resident described his middle-of-the-night response in the following words:

I grabbed the chart from the nurses station on my way to the patient’s room, and the nurse gave me some hurried details: a 20-year-old girl named Debbie was dying of ovarian cancer. She was having unrelenting vomiting apparently as the result of an alcohol drip administered for sedation. Hmmm, I thought. Very sad. As I approached the room I could hear loud, labored breathing. I entered and saw an emaciated, dark-haired woman who appeared much older than 20. She was receiving nasal oxygen, had an IV, and was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at 80 pounds. A second woman, also dark-haired but of middle age, stood at her right, holding her hand. Both looked up as I entered. The room seemed filled with the patient’s desperate effort to survive. Her eyes were hollow, and she had suprasternal and intercostal retractions with her rapid inspirations. She had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, “Let’s get this over with” (JAMA, January 3, 1988, p. 272).

After a quick assessment, the physician “. . . told the two women I was going to give Debbie something that would let her rest and to say good-bye” (ibid). He then intravenously injected 20 mg of morphine sulfate, which generally — depending on her medication history — would be considered a lethal dose. Within a few minutes, her breathing slowed and finally ceased. He notes that the older woman “seemed relieved.” His concluding words were, “It’s over, Debbie.” But was it over for the physician who apparently decided on his or her own initiative even with the seeming consent of the patient who had simply stated, “Let’s get (continued from page 2)