

Death With Dignity: Proposed Amendments To The California Natural Death Act

TABLE OF CONTENTS

I.	INTRODUCTION	783
II.	COMMON LAW AND CONSTITUTIONAL DEVELOPMENT OF THE RIGHT TO DIE	786
III.	THE RIGHT TO DIE FOR INCOMPETENT PATIENTS	787
	A. In re Quinlan	787
	B. Superintendent of Belchertown State School v. Saikewicz	789
IV.	THE RIGHT TO DIE FOR COMPETENT PATIENTS: <i>Satz v. Perlmutter</i>	791
V.	THE CALIFORNIA NATURAL DEATH ACT	792
VI.	COMPARATIVE ANALYSIS OF THE CALIFORNIA NATURAL DEATH ACT	795
VII.	CALIFORNIA CASES AFTER PASSAGE OF THE NATURAL DEATH ACT	803
	A. Barber v. Superior Court	803
	B. Drabick v. Drabick	804
	C. Bartling v. Superior Court	806
	D. Bouvia v. Superior Court	808
VIII.	TWO PROPOSALS TO EXPAND THE NATURAL DEATH ACT	810
	A. <i>The Dignified Death Act</i>	810
	B. <i>The Humane and Dignified Death Act Initiative</i>	811
	C. <i>Opposition to the Resolution and the Initiative</i>	813
	D. <i>The Netherlands Approach</i>	815
IX.	PROPOSED AMENDMENTS TO THE NATURAL DEATH ACT	815
	A. <i>Amendments Which Clarify or Expand Existing Provisions in the Act.</i>	815
	1. <i>The Directive Should Be Able To Be Executed and Be Binding Before a Patient Is Certified as Terminal, as well as After Such a Certification</i>	817
	2. <i>The Provision Which Requires a Fourteen-Day Period After Diagnosis of Terminal Illness Before a Patient can Initiate a Directive Should Be Revoked</i>	818
	3. <i>The Natural Death Act Should Provide an Opportunity for Permanently Unconscious, as well as Terminally Ill Patients, to Withhold or Withdraw Life-Support Equipment</i>	818
	4. <i>The Natural Death Act Should Provide that the Decision to Termi-</i>	
		781

	<i>nate Life Support Can Be Made by a Surrogate for an Incompetent Terminal or Nonterminal Patient Who Has Not Executed a Directive and Who Has Not Authorized a Durable Power of Attorney . . .</i>	819
5.	<i>The Provision that a Directive Must Be Reexecuted Every Five Years in Order To Be Effective Should Be Revoked</i>	820
6.	<i>The Term "Imminent" Included in the Natural Death Act's Definition of Life-Sustaining Procedure Should Be Dropped</i>	820
7.	<i>The Pregnancy Clause Should Be Restated as an Optional Clause</i>	821
8.	<i>The Mandate that the Directive Must Be Followed Directly Should Be Revoked</i>	821
9.	<i>Minors Should Not Be Excluded from the Provisions of the Act . .</i>	822
10.	<i>The Natural Death Act Should Specify Under Section 7187(c) that Nutrition and Fluids Can Be Withdrawn</i>	822
11.	<i>The Natural Death Act Should Provide for Oral or Nonwritten Directives</i>	822
12.	<i>The Natural Death Act Should Define Clearly what Procedures Are Considered Life-Sustaining</i>	822
X.	PROPOSAL WHICH EXPANDS THE NATURAL DEATH ACT TO INCLUDE PHYSICIAN AID-IN-DYING	823
XI.	ARGUMENTS AGAINST AID-IN-DYING	824
XII.	PROPOSED MODIFICATIONS TO THE INITIATIVE	826
XIII.	CONCLUSION	827

Death With Dignity: Proposed Amendments To The California Natural Death Act

Most laws passed by the state legislature affect our lives, but at least one, the California Natural Death Act, affects our death. For the most part today, gone is the ability to take that last breath before death in a warm, quiet bed at home surrounded by loved ones; that scene has been replaced by hospital rooms or long-term care facilities in which tubes, wires and electronic equipment of medical wizardry help prolong lives with icy indifference. In an attempt to lend more humanity and dignity to the dying process, this Comment advocates that the California Legislature amend the Natural Death Act to clarify ambiguous language and to allow non-terminal, as well as terminal, patients to benefit from the statute. In addition, this Comment proposes that the legislature broaden the Act to permit physician aid-in-dying under certain limited conditions and upon patient request.

Now . . . we are on the threshold of new terrain - the penumbra where death begins but life, in some form, continues. We have been led to it by the medical miracles which now compel us to distinguish between 'death,' as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not.¹

I. INTRODUCTION

Death is inevitable. Although modern medical technology is able to forestall death with "stunning virtuosity," it is not always able to alleviate patients' suffering.² Thus, "the quality of the additional life so skillfully sought can range from marginally tolerable to positively

1. *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1344 (Del. 1980).

2. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH: DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 15 (1983) [hereinafter PRESIDENT'S COMM'N]; UNIVERSITY OF CALIFORNIA AT SAN DIEGO, Panel Debate, *Long Term Care: When Is Enough Enough?* (Oct. 14, 1987), quote by Larry Schneiderman, M.D. [hereinafter UCSD Panel].

miserable.”³ This conflict has led to fears that dying will become a prolonged, undignified and agonizing process for thousands of patients.⁴ As a result, the right to “pull the plug” — withdraw artificial life-support equipment⁵ or withhold life-sustaining procedures⁶—has been litigated in courts throughout the country.⁷

Legislative provisions such as the California Natural Death Act (the Act)⁸ attempt to establish a statutory right for terminally ill patients to refuse treatment by use of a living will.⁹ The California Natural Death Act, the first such statute in the country, has been

3. Ruark, Raffin and Stanford Univ. Medical Center Comm’n on Ethics, *Initiating and Withdrawing Life Support*, 318 NEW ENG. J. MED. 25, 25 (1988).

4. A 1983 presidential commission estimated that at any one time, there are approximately 5,000 permanently unconscious patients in the United States. Life-support treatment is withdrawn from many of those patients. PRESIDENT’S COMM’N, *supra* note 2, at 176-77 n.15.

Since Dr. Elisabeth Kubler-Ross’s pioneering work on dying in a society with modern medicine (see E. KUBLER-ROSS, *ON DEATH & DYING* (1969)), other commentators have reexamined traditional American attitudes toward life and death. See, e.g., D. HUMPHRY & A. WICKETT, *THE RIGHT TO DIE* (1986); R. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* (1976); J. ROBERTSON, *THE RIGHTS OF THE CRITICALLY ILL* (1983); A. DOUDERA & J. PETERS, *LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS* (1982).

As examples of the public’s awareness of this issue, the author notes the following. After a “Dear Abby” column on living wills ran in the nation’s newspapers in 1983, the Society for the Right to Die received over 110,000 requests for copies of the document. Leflar, *Liberty and Death: Advance Health Care Directives and the Law of Arkansas*, 39 ARK. L. REV. 375, 408 (1986). In addition, a 1986 Roper Poll of 1,998 Americans found that 62% believed doctors should be legally permitted to end a patient’s life if there is no hope of recovery and the patient requests it. R. RISLEY, *A HUMANE AND DIGNIFIED DEATH: A NEW LAW PERMITTING PHYSICIAN AID-IN-DYING* 36 (1987) [hereinafter *INITIATIVE HANDBOOK*]. FURTHER, THE RIGHT TO DIE ISSUE HAS BEEN THE SUBJECT OF TWO RECENT MOVIES: “WHOSE LIFE IS IT ANYWAY?” WITH RICHARD DREYFUS (1981), AND THE TELEVISION MOVIE, “RIGHT TO DIE” WITH RAQUEL WELCH, WHICH AIRED ON OCT. 12, 1987, AND WAS BASED ON A TRUE STORY OF AN AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG’S DISEASE) VICTIM.

5. Artificial life-support equipment can include respirators, dialysis, and intravenous feeding. See Note, *The California Natural Death Act: An Empirical Study of Physicians’ Practices*, 31 STAN. L. REV. 913, 932 (1979) [hereinafter *Stanford Study*].

6. Life-sustaining treatment has been defined in various ways. The California Natural Death Act defines it as any medical procedure which uses mechanical means to sustain or supplant a vital function, but does not include medication or any medical procedure to alleviate pain. Thus, life-sustaining equipment could include respirators, dialysis and intravenous feeding. See CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1987). See also PRESIDENT’S COMM’N, *supra* note 2, at 3.

7. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

8. CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1987) [hereinafter *Natural Death Act*].

9. In a living will, a concept proposed by Luis Kutner in 1950, patients still in control of their faculties indicate in a written document the extent to which they would or would not consent to treatment. Kutner, *Due Process of Euthanasian: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969). See also PRESIDENT’S COMM’N, *supra* note 2, at 139-41. A living will is also known as a written directive.

criticized as being constitutionally defective,¹⁰ problematic,¹¹ and cumbersome;¹² yet, it has not been amended since its passage twelve years ago. However, a bill amending the Natural Death Act was introduced in the state legislature.¹³ Also, both a proposed State Bar Conference of Delegates Resolution¹⁴ and a similar but more expansive initiative,¹⁵ which was targeted for the 1988 November ballot, amend the Natural Death Act to permit a physician to administer aid-in-dying under certain limited conditions to patients who request it.¹⁶

This Comment will discuss, first, the development of the right to die based on a constitutional right to privacy and the common law informed consent doctrine. Second, this Comment will compare the California Natural Death Act to other such statutes which have been enacted by state legislatures nationwide. A comparison will show that, although California led the way in enacting a right to die statute, other states have since enacted legislation which is broader, less confusing, and less ambiguous, thus allowing greater numbers of patients to die with dignity. Third, this Comment will address how California appellate courts have expanded the provisions of the Natural Death Act. Finally, this Comment will analyze the proposed Resolution and Initiative.

10. See Comment, *Give Me Liberty & Give Me Death: The Right to the California Natural Death Act*, 20 SANTA CLARA L. REV. 971, 988-90 (1980). The author suggests the Natural Death Act is underinclusive and that the large amount of discretion given to the physician concerning when to withhold or withdraw life support restricts the patient's exercise of the right to die.

11. See Comment, *A Proposed Amendment to the California Natural Death Act to Assure the Statutory Right to Control Life Sustaining Treatment Decisions*, 17 U.S.F. L. REV. 579, 600-05 (1983). The author indicates five patient situations which the Natural Death Act would not cover. For example, a directive executed prior to 14 days after diagnosis of a terminal illness is not covered under the Act, nor is a directive which does not exactly follow the statutory form. See *infra* notes 89-94 and accompanying text.

12. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983). (The Natural Death Act's procedural requirements are "so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires.")

13. S. 1808, authored by Sen. Barry Keene (D-Vallejo). The bill passed the state legislature on August 25, 1988, but was vetoed by Gov. Deukmejian on September 28, 1988. See *infra* note 79 and accompanying text.

14. Res. 3-4-87, sponsored by the California State Bar's Conference of Delegates on Sept. 20, 1987, and called the Dignified Death Act (on file with the San Diego Law Review) [hereinafter Resolution].

15. The Humane & Dignified Death Act Initiative, proposed by Americans Against Human Suffering, Inc. [hereinafter Initiative] (on file with the San Diego Law Review).

16. See *infra* notes 161-81 and accompanying text.

This Comment will conclude that the California Natural Death Act should be amended to clarify ambiguous provisions in the statute and to broaden the category of terminal as well as non-terminal patients who could benefit from the statute. Additionally, the Act should be expanded to permit physician aid-in-dying under certain limited conditions and upon patient request. Procedures should be instituted that will safeguard the right of patients to decide whether to "struggle for yet another morning or slip gently into the night."¹⁷

II. COMMON LAW AND CONSTITUTIONAL DEVELOPMENT OF THE RIGHT TO DIE

The legally recognized right to die, which stems from the basic principle of self-determination over one's body,¹⁸ is derived from two sources — judicial interpretation of the United States Constitution and the common law informed consent doctrine.¹⁹ Although the Constitution does not explicitly enunciate a right to privacy,²⁰ the United States Supreme Court found such a right in *Griswold v. Connecticut*,²¹ in the "penumbra" of rights guaranteed in the Bill of Rights which create "zones of privacy."²² The Court did not define the scope of this constitutional right to privacy, but left its boundaries to be determined on a case-by-case basis.²³ The Court extended the right to privacy in *Roe v. Wade*²⁴ by holding that personal privacy includes a woman's decision to have an abortion.²⁵ While the Court has yet to determine whether an individual has a constitu-

17. Riga, *Privacy and the Right to Die*, 26 CATH. LAW. 89, 126 (1981).

18. John Stuart Mill recognized this right in 1873: "Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest." J.S. MILL, *On Liberty*, in PREFACES TO LIBERTY - SELECTED WRITINGS OF JOHN STUART MILL 254 (B. Wishy ed. 1959).

19. The informed consent doctrine — whereby the patient must authorize treatment after being informed about his or her condition, the nature of the treatment, the substantial risks involved and alternative therapies — is based on a person's right of bodily integrity. The doctrine was first enunciated by Judge Cardozo in *Schloendorff v. Society of N.Y. Hosps.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body."). *Accord*, *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

20. The right to privacy received early judicial recognition in the dissenting opinion in *Olmstead v. United States*, 277 U.S. 438 (1928), in which Justice Brandeis referred to a "right to be let alone." *Id.* at 478. Brandeis referred to this right as the "most comprehensive of rights and the right most valued by civilized men." *Id.*

21. 381 U.S. 479 (1965) (the right of a married couple to use contraceptives without state interference).

22. *Id.* at 484 (Douglas, J.)

23. *Id.* at 497.

24. 410 U.S. 113 (1973).

25. The court warned, though, that the right to privacy was not absolute and could be outweighed by compelling state interests, such as viability of the fetus and maternal health. *Id.* at 114. *See also infra* notes 102-03 and accompanying text.

tional right to die, a number of state courts have found such a right to exist based on the informed consent doctrine and the right to privacy.²⁶

III. THE RIGHT TO DIE FOR INCOMPETENT PATIENTS

A. In re Quinlan

Most of the first cases dealing with a refusal to consent to life-sustaining treatment involved blood transfusions. In these cases, usually brought by Jehovah's Witnesses, the common law doctrine of informed consent and the First Amendment's fundamental right of religious freedom are interrelated. In *In re President and Directors of Georgetown College*,²⁷ a Jehovah's Witness refused a blood transfusion for a bleeding ulcer. Since receiving blood is against the religious beliefs of Jehovah's Witnesses, the patient refused to consent to a blood transfusion which was needed to save her life. The Court of Appeals for the District of Columbia ordered the transfusion, notwithstanding the patient's fundamental right to exercise her religious beliefs, because of the state's compelling interest in preserving the life of a patient whose death was imminent, and also because the woman had a seven-month old child who might potentially have become a ward of the state upon the patient's death.²⁸

In the *In re Quinlan* case,²⁹ which was the first and the most pub-

26. See, e.g., *Severns*, 421 A.2d 1334; *Satz*, 379 So. 2d 359; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; *Quinlan*, 70 N.J. 10, 355 A.2d 647. See *infra* notes 29-55 and accompanying text. *Satz* was the only case where the patient was competent to assert his rights. In the others, the patient was unable to consent or refuse treatment and a guardian asserted the patient's right to privacy.

27. 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964).

28. Courts have consistently found such compelling state purposes. However, exceptions to this trend include *In re Osborne*, 294 A.2d 372 (D.C. Civ. 1972), and *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965). In *Osborne*, the court denied a request for the appointment of a guardian to consent to the administration of blood transfusions to a male Jehovah's Witness. Although the patient was the father of two minor children, the court reasoned that because of the close family relationship which existed, the children would be well cared for. *Osborne*, 294 A.2d at 374. In *Brooks*, the Illinois Supreme Court held that the state could not force a Jehovah's Witness, who was mentally competent, without minor children, and who had released the hospital from liability, to submit to a blood transfusion. *Brooks*, 32 Ill. 2d at 372, 205 N.E.2d at 442. The court based its decision on the constitutional right to be let alone, a form of the right to privacy. *Id.* at 373, 205 N.E.2d at 442.

29. 70 N.J. 10, 355 A.2d 647 (1976). For in-depth reading about the Quinlan case, see B. COLEN, KAREN ANN QUINLAN: DYING IN THE AGE OF ETERNAL LIFE (1976).

licized³⁰ decision directly to address the legal issues concerning the withholding or withdrawal of life-sustaining procedures from a terminal patient, the New Jersey Supreme Court distinguished the blood transfusion cases from the situation of Karen Quinlan. In the blood transfusion cases, the prognoses for the patients' recoveries were good, thus the state's interest in preserving life superseded the patients' right to privacy.³¹ In contrast, the bodily invasion from artificial life support was great and the prognosis extremely poor for Quinlan.³² Therefore, Quinlan's right of privacy outweighed the state's interest in preserving life.³³

On April 15, 1975, Karen Ann Quinlan, twenty-one, suffered irreversible brain damage resulting from two fifteen-minute periods during which she stopped breathing after taking drugs and alcohol. In the hospital, her breathing was regulated by a respirator and she was fed through a nasogastric tube. Five months after Karen became unconscious, her father, Joseph Quinlan, petitioned the New Jersey Superior Court, Chancery Division, to be appointed Karen's guardian and to have her removed from the respirator.³⁴ The superior court refused the request. The Quinlans appealed to the New Jersey Supreme Court and in March 1976, the state high court reversed and held that a respirator could be withdrawn from a patient in an irreversibly comatose condition,³⁵ without criminal or civil liability for any participant.³⁶

30. The extent of publicity is illustrated by the extensive newspaper coverage in the N.Y. Times. Articles on Quinlan ran on 55 days between Sept. 14, 1975 and Dec. 22, 1975. See 1975 N.Y. TIMES INDEX 2041. In 1976, Quinlan's case made the news on 52 days. See 1976 N.Y. TIMES INDEX 1406.

31. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

32. *Id.*, 355 A.2d at 664.

33. *Id.*, 355 A.2d at 664.

34. See Marsh, *Living Will Legislation in Colorado: An Analysis of the Colorado Medical Treatment Decision Act in Relation to Similar Developments in Other Jurisdictions*, 64 DEN. U.L. REV. 5, 7-8 (1987) (quoting from J. QUINLAN, J. QUINLAN & P. BATTLE, *KAREN ANN, THE QUINLANS TELL THEIR STORY* 142 (1977)).

35. Several medical terms are used to describe the various levels of brain injury:

A patient in a persistent vegetative state is awake but unaware and may have spontaneous but involuntary movement. Most patients are respiratory dependent only temporarily and the brain is able to maintain subsistence functions such as digestion, kidney elimination and blood circulation, but no thinking functions. The brain damage is irreversible. These patients are also known by the term "permanently unconscious."

The term coma or comatose is often used to reflect different levels of unconsciousness.

A patient who exhibits no movements or breathing and whose eyes are closed is usually considered brain dead. Brain death is the irreversible loss of all functions of the brain. Medical treatment includes total respiratory support. Brain death in most states is a proper means of diagnosing death. PRESIDENT'S COMM'N, *supra* note 2, at 174-76; A. DOUDERA & J. PETERS, *supra* note 4, at 63-66; D. MEYERS, *MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING* 27-28 (1981).

Under California law, brain death is defined as "irreversible cessation of all functions of the entire brain, including the brain stem . . ." CAL. HEALTH & SAFETY CODE § 7180(a)(2) (West Supp. 1984).

36. *Quinlan*, 70 N.J. at 55, 355 A.2d at 672.

The state supreme court stated that the constitutional right to privacy also encompassed a patient's decision to decline medical treatment under certain circumstances.³⁷ The court held that the individual's right to privacy outweighed the state's interest in the preservation of life;³⁸ the state interest in protecting life diminishes as the magnitude of the bodily invasion from artificial life-support systems increases and the prognosis becomes worse. Finding Quinlan's prognosis "extremely poor" since she would never resume cognitive life, and the bodily invasion great since she required 24-hour intensive nursing care, a respirator, a catheter and a feeding tube, the court held that her right of privacy outweighed the state's interest in preserving life.³⁹

The court found Karen's right to privacy would allow her to refuse respirator treatment if she were competent to do so. No evidence of sufficient probative weight was admitted to inform the court as to what Karen's actual wishes would be concerning further treatment. The court concluded that such a right could not be disregarded because she was unable to decide for herself. Therefore, the court decided the only way to protect Karen's right of privacy would be to allow that right to be asserted in her behalf by her family as surrogate decisionmakers.⁴⁰ The court then established a new standard which provided, with the concurrence of Karen's family, that life support could be withdrawn if the attending physicians and a hospital ethics committee agreed there was no reasonable chance of Karen returning to a cognitive, sapient state.⁴¹

B. Superintendent of Belchertown State School v. Saikewicz

The Massachusetts Supreme Judicial Court adopted a similar approach in *Superintendent of Belchertown State School v.*

37. *Id.* at 39, 355 A.2d at 663. The court recognized that the right to privacy discussed in *Griswold* and *Roe* was broad enough to encompass a patient's decision to decline medical treatment in much the same way it was broad enough to encompass a woman's right to terminate pregnancy.

38. *Id.* at 40, 355 A.2d at 663. "We have no hesitancy in deciding . . . that no external compelling interest of the state could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life." *Id.*, 355 A.2d at 663.

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

40. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664. This is considered the substituted judgment rule. *See infra* note 87.

41. *Id.* at 55, 355 A.2d at 671-72. Quinlan was successfully weaned from the respirator but remained in a persistent vegetative state for another 10 years. She died on June 11, 1985. *See Marsh, supra* note 34, at 8.

Saikewicz.⁴² Joseph Saikewicz, a sixty-seven-year-old severely retarded man who had been institutionalized for most of his life, suffered from acute myeloblastic leukemia. Chemotherapy treatment would have caused a thirty to fifty percent chance of remission for between two to thirteen months, but would have also caused drug-related side effects, the reasons for which would have been beyond Saikewicz's understanding. The attending physicians and guardian ad litem recommended that chemotherapy be withheld, and a probate judge agreed.⁴³ Two months later, on September 14, 1976, Saikewicz died from pneumonia, a complication of the leukemia. Thereafter, the Massachusetts Supreme Judicial Court issued its opinion on November 28, 1977.⁴⁴

The court held that all persons, whether competent or incompetent, have a right to refuse medical treatment because "the value of human dignity extends to both."⁴⁵ The court's reasoning was based on balancing the patient's interest in bodily integrity and privacy with four state interests: preservation of life, protection of innocent third parties (especially patients' minor children), prevention of suicide, and preservation of the ethical integrity of the medical profession.⁴⁶ The only state interest the court found applicable was that of preserving life, but it deemed such an interest of little weight given the hopelessness of Saikewicz's prognosis.⁴⁷

The court also held that the state's suicide interest is the prevention of irrational self-destruction. A decision to refuse treatment when death is inevitable and the treatment offers no hope of cure, as in this case, did not constitute suicide because the patient did not set into motion the natural processes that ultimately cause death.⁴⁸

The *Saikewicz* court further held that the courts are the appropriate forums to decide questions concerning discontinuing treatment, unlike the New Jersey court in *Quinlan*, which adopted the approach of entrusting the decision to the patient's guardian, family members, attending doctors and a hospital ethics committee.⁴⁹ However, the court's opinion did not address what type of patients were to be in-

42. 373 Mass. 728, 370 N.E.2d 417 (1977).

43. See D. MEYERS, *supra* note 35, at 359-60.

44. No explanation was given for the delay. *Id.* at 360 n.36.

45. *Saikewicz*, 373 Mass. at 745, 754-55, 370 N.E.2d at 427, 432.

46. *Id.* at 741, 370 N.E.2d at 425.

47. The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the state interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual life may be briefly extended.

Id. at 742, 370 N.E.2d at 425-26.

48. *Id.* at 743 n.11, 370 N.E.2d at 426 n.11.

49. *Id.* at 747, 370 N.E.2d at 434-35.

cluded in judicial review.⁵⁰

IV. THE RIGHT TO DIE FOR COMPETENT PATIENTS: *Satz v. Perlmutter*

One of the first cases in which a court applied the *Quinlan/Saikewicz* balancing analysis to a *competent* patient's request to die was in *Satz v. Perlmutter*.⁵¹ Abe Perlmutter, seventy-three, was suffering from Lou Gehrig's disease. He was incapable of movement, unable to breathe without a respirator and unable to speak without extreme effort. He decided he no longer wanted to be connected to a respirator and filed suit requesting permission to refuse further medical treatment.⁵² The trial court and the Florida District Court of Appeal granted Perlmutter's request.⁵³ The decision was affirmed by the Florida Supreme Court in 1980, after Perlmutter had already been removed from the respirator and had died a year before.⁵⁴ The state supreme court analyzed the four state interests mentioned in *Saikewicz*, found none of them compelling, and held that, based upon his constitutional right to privacy, Perlmutter had the right to discontinue use of the respirator.⁵⁵

Quinlan, *Saikewicz*, and *Perlmutter* demonstrate the evolution of

50. For example, did death have to be imminent or did the *Saikewicz* holding require court review in all cases involving the proposed withdrawal of life support treatment from incompetent patients, no matter how futile such treatment might be? Many commentators felt that such an interpretation of the decision led to an unwarranted intrusion by the law into the last stages of a dying patient's life, making cases lengthy and expensive and needlessly prolonging the suffering of the patient's family. See D. MEYERS, *supra* note 35, at 363-64, and Riga, *supra* note 17, at 105.

These questions were later answered by the Massachusetts appellate courts in *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978) (Court approval for incompetent patient is needed only when treatment is considered lifesaving or life prolonging), and *Brophy v. New Eng. Sinai Hosp., Inc.* 398 Mass. 417, 497 N.E.2d 626 (1986) (Court permitted the guardian of a persistently vegetative patient to direct the cessation of life-support measures without addressing the need for judicial approval).

51. 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

52. 362 So. 2d at 161.

53. It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determination.

Id. at 164.

54. *Perlmutter*, 379 So. 2d 359 (Fla. 1980).

55. *Id.* at 162. See also text accompanying note 46.

judicial interpretation of right to die issues in various jurisdictions.⁵⁶ Courts generally have upheld terminal or non-terminal competent and incompetent patients' constitutional right to refuse medical care. Moreover, courts have held that there need not be judicial review of right to die cases for incompetent patients in the absence of legislation unless there is a dispute among a patient's family, guardian or physicians. This view, however, has been debated by those who believe an incompetent patient's right to die should not be invoked by a surrogate.⁵⁷ Case law evolution has been accompanied in the majority of states by legislative assistance through right to die statutes.

V. THE CALIFORNIA NATURAL DEATH ACT

In 1976, several months after the New Jersey Supreme Court's *Quinlan* decision,⁵⁸ California became the first state to legislate a right to die.⁵⁹ The Natural Death Act's legislative findings state that

56. See also *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); *Brophy*, 398 Mass. 417, 497 N.E.2d 626 (1986); *Eichner v. Dillon* 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980); and *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

57. See, e.g., Pescetta, *A Matter of Life and Death: Who Should Have the Power to Choose on the Right to Die?*, L.A. Daily J., Apr. 8, 1988, §1 (Open Forum), at 4, col. 1.

The critical substantive flaw in the *Quinlan* decision and its progeny is the assumption that the right of competent choice, which is necessary to a personal decision to embrace death, can actually be exercised by someone else on an incompetent's behalf. We may be willing to indulge the fiction that a surrogate's choice is the incompetent's when the choice to be made is whether the incompetent should undergo some minor surgical procedure or should be cared for in one hospital or another. But when the choice is whether the incompetent's life should be extinguished, the pretense that the surrogate can act on the incompetent's behalf is too dangerous to accept. Is it not wholly presumptuous of anyone — whether relative or friend, doctor or court — to draw the line at which another person would decide to accept death rather than continue living? . . .

To say that an individual's life can be taken on the basis of a deduction from his "world view" that he "would have wanted" to be dead is a burlesque of due process.

Id.

Pescetta also argues that relatives may have "powerful" reasons to favor death: the ruinous cost of medical care and the emotional distress caused by the incompetent's illness. Physicians also may favor death because long-term care of comatose patients is of little medical interest and absorbs scarce time, money and other resources. *Id.*

58. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). See *supra* notes 29-41 and accompanying text. *Quinlan* was decided in March 1976; the California Assembly passed the Natural Death Act in June 1976. For a discussion of the connection, see, *Right to Die Bill Passed by Assembly*, San Francisco Chron., June 6, 1976, at 1.

59. Natural Death Act, §§ 7185-95, was sponsored by Assemblyman Barry Keene, now a member of the Senate (D-Vallejo). Support for the bill at that time included the California Medical Ass'n, the California Nurses Ass'n, the Comm'n on Aging, and the Nat'l Council of Senior Citizens. See A. 3060, ASSEMBLY OFFICE OF RESEARCH, CALIFORNIA LEGISLATIVE STATE ASSEMBLY ANALYSIS, ASSEMBLY 3D READING,

artificial prolongation of life by modern medical technology may cause "loss of patient dignity and unnecessary pain and suffering."⁶⁰ The Natural Death Act therefore provides that a qualified adult patient can direct his or her physician to withhold or withdraw life-sustaining medical care in the event of a terminal condition by use of a written directive, or living will.⁶¹ The Natural Death Act includes definitions of the terms "life-sustaining procedure," "qualified patient" and "terminal condition."⁶² No physician, health facility or licensed health professional acting under the direction of a physician who participates in the withholding or withdrawing of life-sustaining procedures under the Act is subject to civil or criminal liability.⁶³

In order for the directive to take effect, a patient must be qualified — diagnosed and certified in writing by two physicians, one of which must be the attending physician, as suffering from a terminal condition.⁶⁴ Also, the directive must be initiated at least fourteen days after diagnosis of a terminal condition.⁶⁵ The directive is considered non-binding on a physician if it is initiated prior to fourteen days following diagnosis, but may be used by the physician as evidence of the patient's wishes regarding the withholding or withdrawal of life-sustaining measures.⁶⁶ A physician is liable for unprofessional conduct for failure to follow a binding directive if the physician does not transfer the patient to another doctor who will follow the patient's wishes.⁶⁷

at 2, Comments (1976).

60. Natural Death Act, § 7186. For further background information, see *Assembly Comm. on Health, Interim Hearing on Rights of Terminally Ill*, Oct. 8, 1974.

61. Natural Death Act, § 7187; see generally Kutner, *supra* note 9.

62. "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain. *Id.* § 7187(c).

"Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient. *Id.* § 7187(e).

"Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient. *Id.* § 7187(f).

63. *Id.* § 7190.

64. *Id.* § 7187(e).

65. *Id.* § 7191(b).

66. *Id.* § 7191(c).

67. *Id.* § 7191(b). According to the Natural Death Act's sponsor, Barry Keene,

The directive must be signed by two witnesses not related to the patient by blood or marriage, who would not be entitled to the patient's estate, and who are not the attending physicians.⁶⁸ The patient may revoke the directive at any time either in writing, verbally to the attending physician, or by destroying the directive.⁶⁹ The directive is effective for five years, after which time it must be re-executed to remain effective.⁷⁰ If a directive was executed before the patient was deemed terminal, the directive must be re-executed at least fourteen days after the patient becomes qualified in order to take effect.⁷¹ The directive must be in the form stipulated by the statute.⁷²

more severe sanctions were politically unacceptable. *See Stanford Study, supra* note 5, at 923 n.56.

68. Natural Death Act, § 7188.

69. *Id.* § 7189.

70. *Id.* § 7189.5.

71. *Id.* § 7191(c).

72. *Id.* § 7188. The directive in the Natural Death Act states:

DIRECTIVE TO PHYSICIANS

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

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

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

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

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

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

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

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

Signed

City, County and State of Residence

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

Witness _____

Witness _____

The Natural Death Act does not apply to patients in a skilled nursing facility,⁷³ to pregnant women, or to terminally ill children.⁷⁴ The Natural Death Act also states that withholding or withdrawing life-sustaining procedures from a qualified patient does not constitute a suicide,⁷⁵ does not invalidate a life insurance policy for an insured qualified patient,⁷⁶ and cannot be construed to condone mercy killing or to permit any deliberate act to end life other than by the natural process of dying.⁷⁷

VI. COMPARATIVE ANALYSIS OF THE CALIFORNIA NATURAL DEATH ACT

Despite the Natural Death Act's passage as a response to the need for such a statute, commentators have criticized the Act as too restrictive and ambiguous.⁷⁸ The Natural Death Act's original author, Senator Barry Keene, proposed Senate Bill 1808, which advocated several major changes to the 1976 Natural Death Act.⁷⁹

73. Unless one of the two witnesses to the directive is a state-designated patient advocate or ombudsman. *Id.* § 7188.5. The intent is to "recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive." *Id.*

74. *Id.* § 7188.

75. *Id.* § 7192(a). Section 401 of the California Penal Code makes assisting another to commit suicide a criminal offense. "Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony." CAL. PENAL CODE § 401 (West 1970).

76. Natural Death Act, § 7192(b).

77. *Id.* § 7195.

78. See Meyers, *The California Natural Death Act: A Critical Appraisal*, CAL. ST. B.J. 326 (1977); Comment, *supra* note 11, at 597-98; *Stanford Study*, *supra* note 5, at 940-45.

79. The proposed changes made by S.1808, as revised on March 7, 1988, included: (1) adding permanently unconscious to the definition of qualified patient, (2) eliminating the 14-day waiting period after a terminal diagnosis before execution of a directive, (3) adding misdemeanor penalties for those physicians who disregard a patient's directive and (4) deleting the requirement that death be "imminent" before life support may be withheld or withdrawn, instead providing that without life-sustaining treatment, a terminal condition will result in death within one year. Other amendments, made on June 27, 1988, included: (1) allowing any two witnesses to sign the directive, even if related to the patient, (2) permitting the directive to be valid until revoked, and (3) not requiring the directive to be followed exactly in form.

S.1808 had the support of the California Council of Churches, the California Medical Ass'n, the American Ass'n of Retired Persons, the California Catholic Conference, the State Bar, and the California Senior Legislature. Planned Parenthood and the American Civil Liberties Union specifically oppose the Natural Death Act's pregnancy provision, which denies pregnant patients the right to die if it is probable the fetus could develop to the point of live birth with continued application of life-sustaining treatment. See *supra* notes 101-105 and accompanying text. Interview with Paul Donahue, Aide to Senator

To date, thirty-nine state legislatures have enacted living will statutes⁸⁰ which vary widely in the breadth of their applications. The

Keene (Aug. 9, 1988).

In his veto message, Deukmejian said, "I am concerned that this bill compromises the checks and balances in existing law relative to the withdrawal of life-sustaining services." Deukmejian Vetoes Bill to Extend State 'Right to Die' Law, *The Los Angeles Daily J.*, Sept. 29, 1988, at 1, col. 4. Deukmejian objected to the elimination of the Act's provision which provides that directives are effective for five years because the measure would have made "it impossible for the declaration to be revoked if the declarant is unable to communicate his or her desire to revoke." *Id.* The governor also criticized the elimination of the "imminent" requirement because it would have granted "wide descretion to terminate life on as estimate of death within one year, rather than an estimate of imminent death." *Id.* But Donahue said Deukmejian ignored the broad support for the bill & instead buckled under pressure from fundamentalists such as the Committee on Moral Concerns and the California Pro-Life Council. In response to the governor's concerns, Donahue argues that the proposed bill would have made revocation easier by permitting it in any form instead of just in writing. Donahue also notes that the proposed bill provides that declarations are executed only when life-sustaining treatment prolongs the dying process, not immediately upon diagnosis of a terminal condition. *Id.*

Keene first proposed new legislation eight years ago to supplant the Natural Death Act. The proposed statute, S.700, entitled the "Self-Determination in Medicine Act," was introduced but not acted upon in the 1979-80 legislative session. Some of the proposed changes included allowing a terminally ill minor to refuse medical care if approved by a court, allowing the execution of a binding directive before a patient becomes terminally ill, allowing refusal of medical care by oral or written communication, and not requiring the directive to follow the specified form. Self-Determination in Medicine Act, Cal. S.700, 1979-80 Sess. (1980).

In addition to S.1808, A.2549, sponsored by Elihu Harris (D-Oakland), proposed that the Act conform to the Uniform Rights of the Terminally Ill Act. *Id.* See *infra* note 82. The bill died in committee.

80. ALA. CODE §§ 22-8A-1 to -10 (1984); ALASKA STAT. §§ 18.12.010 to -.100 (Supp. 1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); 1987 ARK. ACTS 713; CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1987); COLO. REV. STAT. §§ 15-18-101 to -113 (Supp. 1986); CONN. GEN. STAT. §§ 19a-570 to -575 (1987); DEL. CODE ANN. tit. 16, §§ 2501-09 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1986); FLA. STAT. ANN. §§ 765.01 to -.15 (West 1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1986), amended 1987 Ga. Laws 488; HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1986); IDAHO CODE §§ 39-4501 to -4508 (1985 & Supp. 1987); ILL. ANN. STAT. ch. 110 ½ §§ 701-710 (Smith-Hurd Supp. 1986); IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1987); IOWA CODE ANN. §§ 144A.1 to .11 (West Supp. 1986), amended H.F. 360, 1987 session, 72nd Iowa General Assembly; KAN. STAT. ANN. §§ 65-28, 101 to -28, 109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to -.10 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22, §§ 2921-31 (Supp. 1987); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1986); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1986); MO. ANN. STAT. §§ 459.010 to -.055 (Vernon Supp. 1987); MONT. CODE ANN. §§ 50-9-101 to -104, -111, -201 to -206 (1985); NEV. REV. STAT. §§ 449.540 to -.690 (1986); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (Supp. 1986); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-11 (West Supp. 1987); OR. REV. STAT. §§ 97.050 to -.90 (1985); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1986); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h §§ 1-11 (Vernon Supp. 1987); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251-62 (1987); VA. CODE §§ 54-325.8:1 to -:13 (Supp. 1987); WASH. REV. CODE ANN. §§ 70.122.010 to -.905 (Supp. 1987); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01 to -.15 (West Supp. 1987); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1986).

For key provisions in natural death statutes, see SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS (1984 ed. & 1987 ed.) [hereinafter SOCIETY FOR

years 1985 and 1986 saw an acceleration in living will legislation. Enactment of the first twenty-three statutes spanned eight years (ten between 1976 and 1980, and thirteen between 1981 and 1984). An additional sixteen were adopted within sixteen months between March 1985 and June 1986.⁸¹ Many of the new laws incorporate some or all of the Uniform Rights of the Terminally Ill Act.⁸² A number of states followed California's lead by enacting similar legislation,⁸³ but other states since have enacted statutes more liberal and, thus, more conducive to patients who wish to withhold or withdraw artificial life support.⁸⁴

The Natural Death Act provides relief from artificial life support only for competent patients who are certified as terminal and who then initiate a directive at least fourteen days after diagnosis. The Natural Death Act does not provide a procedure for terminating treatment in the case of competent, incompetent or permanently unconscious non-terminal patients. Thus, the Natural Death Act would not have helped Abe Perlmutter, who was competent but not terminal, nor Karen Ann Quinlan, who was incompetent and also not con-

THE RIGHT TO DIE HANDBOOK].

81. SOCIETY FOR THE RIGHT TO DIE HANDBOOK, *supra* note 80, at 5. New Jersey, the national leader in addressing the legal and ethical dilemmas in the right to die issue, has yet to enact a single, substantive piece of legislation in this area. Several pieces of legislation have been introduced but not enacted; for example, in 1985, S-875, S-935, S-1050, A-182, A-269, A-524, A-1165 were introduced. In 1986, three bills were introduced: S-33, a Natural Death Act; S-846, a Death With Dignity Act; and A-564, a Right to Die Act. 202d Legis., 1st Sess. (1986). Instead, the New Jersey Legislature established the Commission On Legal and Ethical Problems in Delivery of Health Care to monitor non-treatment court decisions and report to the legislature. N.J. STAT. ANN. § 52:9Y (West 1986).

82. This Act was drafted by the 95-year-old National Conference of Commissioners on Uniform State Laws and approved in 1985. SOCIETY FOR THE RIGHT TO DIE HANDBOOK, *supra* note 80, at 13-14. See Uniform Rights of the Terminally Ill Act, §§ 1-18 9B U.L.A. 609 (Supp. 1987) [hereinafter Uniform Act].

The Uniform Act's directive provides for a declarant's additional instructions; does not limit who may witness the signing; does not require diagnosis of a terminal condition by more than one physician; provides that nutrition and hydration may be withdrawn if not necessary for the patient's comfort or for alleviation of pain; recognizes a directive executed in another state; and penalizes physicians who do not comply with the Act. Not included in the Uniform Act are provisions for a proxy or surrogate or procedures for decisionmaking on behalf of incompetent patients who have not made a prior declaration. *Id.*

83. For example, the Texas Natural Death Act, enacted in 1977, closely followed the California statute. See Comment, *The Recent Amendments to the Texas Natural Death Act: Implications for Health Care Providers*, 17 ST. MARY'S L.J. 1003, 1020-23 (1986).

84. For example, the Texas legislature significantly amended its Natural Death Act in 1979 and 1985. One change was to eliminate the 14-day waiting period. See also *infra* notes 88, 90, 97, 111, 113, 114 and accompanying text for other changes.

sidered terminal.⁸⁵

By contrast, four states have provided that a directive is binding if the patient is diagnosed as either terminally ill or permanently unconscious,⁸⁶ thereby increasing the number of patients who have the opportunity to withhold or withdraw life support and making it possible for those who are incompetent as well as competent to determine their medical treatment.

The Natural Death Act contains no provision for family or a legal guardian to act on behalf of an incompetent patient who has not executed a directive,⁸⁷ thereby forcing the family to resort to time-consuming and expensive litigation for approval to terminate life support systems. Many other state statutes specifically recognize the authority of a proxy, agent or attorney-in-fact who can act for the incompetent patient.⁸⁸

The Natural Death Act also does not consider directives executed

85. "The only patients covered by this statute are those who are on the edge of death despite the doctor's efforts. The very people for whom the greatest concern is expressed about a prolonged and undignified dying process are unaffected by the statute because their deaths are not imminent." Capron, *The Development of Law On Human Death*, 315 ANNALS N.Y. ACAD. SCI. 45, 55 (1978).

The original version of the Natural Death Act did not distinguish between a directive made by a terminally ill patient and one made by a non-terminal patient. The end result was a compromise. See Cal. A.3060, 1975-76 Session (1976); *Stanford Study*, *supra* note 5, at 922 n.44.

86. 1987 ARK. ACTS. 713, § 1(7); COLO. REV. STAT. § 15-18-104; N.M. STAT. ANN. 5; LA. REV. STAT. ANN. § 1299.58.2(8). These states also provide that the directive may be initiated at any time, including before certification of a terminal illness or a permanently unconscious state.

87. California's Durable Power of Attorney Statute for Health Care (CAL. CIV. CODE § 2500 (West 1988)) permits a competent individual to designate a surrogate to make medical treatment decisions, including the right to terminate or withhold any medical procedure, in the event of the patient's incompetency. It is valid for seven years and can be used in conjunction with the directive authorized by the Natural Death Act. However, a person must designate a durable power of attorney; otherwise, there is no legislative guidance as to guardianship requirements once a patient becomes incompetent).

Under California case law (*see Barber v. Superior Court*, 147 Cal. App. 3d, 195 Cal Rptr. 484 (1983), *infra* notes 116-128 and accompanying text), an incompetent non-terminal patient's family can request the removal of life-support equipment without prior court approval.

Under case law elsewhere, in the absence of a directive, two tests are used to guide guardians or surrogates. One is the substituted judgment test, in which the patient's family makes the argument that the patient would or would not have wanted continuing medical treatment based on reliable evidence of those views. *See Quinlan*, 70 N.J. at 41, 355 A.2d at 664. *See also* PRESIDENT'S COMM'N, *supra* note 2, at 132-34. The second is the best interests test. Under this standard, used when patients have never been competent or their wishes are not known with any certainty, the family seeks to implement what is in the patient's best interests. Factors taken into account include the relief of suffering, the preservation or restoration of bodily functioning and the quality as well as the extent of life. *See* PRESIDENT'S COMM'N, *supra* note 2, at 134-36.

88. *See, e.g.*, 1987 ARK. ACTS 713, § 14; DEL. CODE ANN. tit. 16, § 2505(b); CONN. GEN. STAT. § 2; IOWA CODE ANN. § 144A.7; TEX. REV. CIV. STAT. ANN. art. 4590(h), § 4C; UTAH CODE ANN. §§ 75-2-1105(2), 75-2-1107.

before certification of a terminal illness to be binding on the physician.⁸⁹ This eliminates prior planning by a healthy individual for a future time when he or she may become terminally ill and/or incompetent, thus unable at that time to effectuate a directive. Additionally, the Act encourages prior planning which could eliminate confusion and uncertainty on the part of the family, as well as physicians, as to the patient's wishes for medical treatment. The distinction in the Natural Death Act between directives made subsequent to the fourteen-day period and those made prior to the fourteen days also could involve the courts in reevaluating treatment decisions already made by the patients.

Many other states allow directives to be executed at any time by competent individuals.⁹⁰ Further, only California and Oklahoma specifically require re-execution of a directive after diagnosis of a terminal illness in order for the directive to be binding.⁹¹ Often, a patient's illness precludes him or her from re-executing the directive, thus leaving the patient with no binding evidence of his or her wishes, even though the patient had previously executed a directive.

In addition, the Natural Death Act's arbitrary fourteen-day waiting period after diagnosis of terminal illness limits the number of patients who can benefit from the Act.⁹² A Stanford University study indicates that, although the legislature included the fourteen-day waiting period in the Natural Death Act to ensure that patients would have time to reflect on their treatment decision, about one-half of all terminally ill patients die or become unable to sign a directive during those two weeks.⁹³ Thus, the Natural Death Act is of no benefit to at least one-half of the terminally ill patients who could potentially take advantage of it. No other state except Colorado⁹⁴ requires an arbitrary time period to pass before a patient, after being certified as terminal, can effectuate a directive.

The Natural Death Act also requires a directive to be re-executed every five years to remain valid.⁹⁵ Since patients can revoke their

89. CAL. HEALTH & SAFETY CODE § 7191(c).

90. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4590(h), § 3(a); UTAH CODE ANN. § 75-2-1104; TENN. CODE ANN. § 32-11-104; MONT. CODE ANN. § 50-9-103(1).

91. CAL. HEALTH & SAFETY CODE 7191(b); OKLA. STAT. ANN. tit. 63, § 3107(c).

92. The Natural Death Act as originally drafted only required a three-day waiting period. The 14-day period was the result of a political compromise with the Pro-Life Council. *Stanford Study*, *supra* note 5, at 923 n.50.

93. *Id.* at 928.

94. COLO. REV. STAT. § 15-18-104. Period of time is 48 consecutive hours.

95. Natural Death Act, § 7189.5.

directives at any time,⁹⁶ the requirement seems redundant and burdensome. The majority of states provide that a directive remains in effect until revoked.⁹⁷

Another problem with the Natural Death Act is that death must be "imminent"⁹⁸ before life-support measures may be stopped. Thus, a patient may be qualified under the Natural Death Act to make a directive (i.e., fourteen days have passed since the patient was certified as terminal), but life-support equipment cannot be withdrawn until the doctor proclaims the patient's death to be imminent. Although "imminent" is not defined in the statute, the Stanford University study indicates that over eighty percent of physicians believe death is imminent only when it will occur within one week, and forty-six percent believe it is imminent only when it will occur within twenty-four hours.⁹⁹ Therefore, if the doctor's diagnosis of imminence is correct, most patients are spared at best a few days of artificial life-support. Accordingly, many qualified terminal patients may die before effecting a binding directive. Various other states define life-sustaining treatment without requiring death to be imminent.¹⁰⁰

The Natural Death Act prohibits the use of a directive to withhold or withdraw life-sustaining medical care in the event of a terminal condition if the patient is pregnant.¹⁰¹ This restriction raises constitutional questions pertaining to the right of privacy. In *Roe v. Wade*, the United States Supreme Court held that the fundamental right to personal privacy, found in the penumbra of the fourteenth amendment's due process clause, includes a woman's decision whether to

96. *Id.* § 7189.

97. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4590(h), § 5; TENN. CODE ANN. § 32-11-107.

98. *See supra* note 62 (definition of life-sustaining treatment whereby death must be imminent). "Imminent" is not defined, but an article quoted by Keene defined imminent as death that will occur in two weeks. *Stanford Study, supra* note 5, at 921 n.38 (quoting Rabkin, Gillerman & Rice, *Orders Not to Resuscitate*, 295 NEW ENG. J. MED. 364, 365 (1976)). Keene also has suggested a statutory definition of imminent as 90 days for terminally ill patients and 180 days for patients in a vegetative state. *Id.* at 942 n.128.

99. *Stanford Study, supra* note 5, at 933. The study was conducted a year after the Natural Death Act went into effect. A questionnaire was mailed to 920 doctors, of whom 284 responded. *Id.* at 925.

100. *See, e.g.*, ALASKA STAT. § 18.12.100(4); 1987 Ark. Acts 713, § 1(4); MD. HEALTH-GEN. CODE ANN. § 5-601(E); MONT. CODE ANN. § 50-9-102(4).

101. Natural Death Act, § 7188. The pregnancy prohibition was a collateral ethical issue legislators "simply did not want to get involved in." *California's Natural Death Act*, 128 W.J. MED. 318, 322 (1978) (quoting Sen. Keene). The clause also was the result of a political compromise with the Pro-Life Council and the California Conference of Catholic Health Facilities. Other compromises included tightening the definitions of "life-sustaining procedures" and "terminal condition," and not fully binding a physician to a directive if the directive was not signed or reexecuted after the patient was declared terminally ill. Cartabruno, *First Step to Euthanasia? Giving the "right to die" to California's terminally ill*, CAL. J. 217, 218 (July 1976).

terminate her pregnancy.¹⁰² The Court based its decision on a balancing of both the woman's and state's interests. The Court held that during the first trimester, the state cannot regulate an abortion; during the second trimester, the state can regulate abortion if reasonably related to maternal health; and during the third trimester, the state's interest in preserving the life of the fetus becomes compelling and the state can regulate or prohibit an abortion.¹⁰³

It would logically follow from *Roe* that a competent, terminally ill, pregnant woman could terminate her pregnancy at the same time she would effectuate her directive during the first six months. Instead, the Natural Death Act requires two medical procedures — the abortion followed by the withdrawal of life support — rather than the one procedure of withdrawing life support from the mother.¹⁰⁴ Thus, the exemption forces a pregnant woman to remain on life support for six months against her will. Because of the questionable constitutionality of a pregnancy clause, twelve other states either have deleted or excluded such a provision from their statutes.¹⁰⁵

The Natural Death Act also mandates that the patient's directive precisely follow the prescribed form in the Act.¹⁰⁶ The Natural Death Act does not stipulate what should happen if a person from another state or even a resident has a similar, but not identical directive. Should the physician consider such a document binding or only as evidence of the patient's wishes? This provision requires patients'

102. 410 U.S. at 113, 153 (1973).

103. *Id.* at 164-65.

104. See D. MEYERS, *supra* note 35, at 255-56; Note, *Statutory Recognition of the Right to Die: The California Natural Death Act*, 57 B.U.L. REV. 148, 165-67 (1977).

Other than to raise the potential unconstitutionality of the pregnancy clause, the broader issue of pregnant, terminally ill women is beyond the scope of this Comment, although it is becoming a highly controversial issue nationwide. For example, in June 1987, a terminally ill Washington D.C. patient, identified only as Angie, was forced by a three-judge appellate panel to undergo a Caesarean section against her will. The baby girl, delivered in the 26th week of pregnancy, died a few hours after surgery. Angie died two days later. The American Civil Liberties Union in December 1987 asked the Court of Appeals for the District of Columbia to rehear the case, fearing it could set a precedent for courts to make decisions over the objections of pregnant terminally ill women. See *Drama in the Womb: A Matter of Life and Death Winds Up in Court*, L.A. Times, Dec. 25, 1987, Part V-A, at 5, col. 1.

105. D.C. CODE ANN. §§ 6-2421 to -2430; IDAHO CODE §§ 39-4501 to -4508; IND. CODE ANN. §§ 16-8-11-1 to -22; LA. REV. STAT. ANN. §§ 40:1299.58.1 to -.10; ME. REV. STAT. ANN. tit. 22, §§ 2921-31; N.M. STAT. ANN. §§ 24-7-1 to -11; N.C. GEN. STAT. ANN. §§ 90-320 to -322; OR. REV. STAT. §§ 97-050 to -.090; TENN. CODE ANN. §§ 32-11-101 to -110; VT. STAT. ANN. tit. 18, §§ 5251-63; W. VA. CODE §§ 16-30-1 to -10 (1985); VA. CODE §§ 54-325.8:1 to -.13.

106. Natural Death Act, § 7188; see *supra* note 72.

families to go to court for a ruling on the integrity of the document. Only three other states require strict adherence to the form of the directive specified in the statute;¹⁰⁷ the rest recognize living wills executed out-of-state and/or permit personalized instructions to be attached to the directive.¹⁰⁸

The Natural Death Act excludes minors under age eighteen.¹⁰⁹ This exclusion is not consistent with court decisions in the abortion area, where minors, under certain circumstances, are solely responsible for the decision to abort.¹¹⁰ Statutes in Arkansas, Louisiana, New Mexico and Texas give statutory authority for execution of a directive on behalf of a terminally ill minor.¹¹¹

The Natural Death Act does not specify whether tube-feeding is included under its definition of life-sustaining procedure, although it is included under case law.¹¹² This is confusing to individuals or patients who may consult the Natural Death Act but who may be unfamiliar with California case law. Eighteen other states statutorily permit the withholding or withdrawal of artificial feeding and hydration,¹¹³ thereby making it easier for those reading the statute to understand exactly what is considered a life-sustaining procedure.

Four states recognize oral or non-written directives,¹¹⁴ whereas California recognizes only a written directive.¹¹⁵ Recognizing only a written directive cuts off those competent patients unable to sign a directive or execute one.

107. IDAHO CODE § 39-4504 (1985 & Supp. 1986); OR. REV. STAT. § 97.055; WIS. STAT. ANN. § 154.03(2).

108. See, e.g., ALASKA STAT. § 18.12.090; ARIZ. REV. STAT. ANN. § 36-3202(c); HAW. REV. STAT. § 327D-25; ME. REV. STAT. ANN. tit. 22, § 2930; MONT. CODE ANN. § 50-9-111.

109. Natural Death Act, § 7188.

110. In a series of cases, the United States Supreme Court has refused to grant parents anything resembling a veto power over the child's decision to abort. See *Bellotti v. Baird*, 443 U.S. 622 (1979).

111. 1987 ARK. ACTS 713 § 14 § 20-17-214; LA. REV. STAT. ANN. § 40:1299.58.6 (West Supp. 1987); N.M. STAT. ANN. § 24-7-4; TEX. REV. CIV. STAT. ANN. art. 459h § 4(d) (Vernon Supp. 1988).

112. Natural Death Act § 7187(c). See *Barber*, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490. The court of appeal held that for the purpose of enforcing the Natural Death Act, there is no legal difference between the withdrawal of feeding tubes from a patient and the withdrawal of a respirator. See *infra* notes 116-28 and accompanying text.

113. See, e.g., ALASKA STAT. § 18.12.010(c); DEL. CODE ANN. titl. 16, 2501(d); TENN. CODE ANN. § 32-11-103(5); TEX. REV. CIV. STAT. ANN. art. 4590h 2(4); LA. REV. STAT. ANN. § 40:1299.58.2(4) (West Supp. 1987); MONT. CODE ANN. § 50-9-102(4).

114. FLA. STAT. ANN. § 765.03(2)(b); LA. REV. STAT. ANN. § 40:1299.58.3 (West Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h § 3(b); VA. CODE § 54-325.8:3.

115. Natural Death Act, § 7188.

VII. CALIFORNIA CASES AFTER PASSAGE OF THE NATURAL
DEATH ACTA. Barber v. Superior Court¹¹⁶

Clarence Herbert suffered a cardio-respiratory arrest after surgery for closure of an ileostomy.¹¹⁷ As a result, he suffered severe brain damage and was expected to permanently remain in a vegetative state.¹¹⁸

Herbert's family drafted a written request to the hospital stating they wanted life-sustaining machines terminated. Drs. Robert Nejdil and Neil Barber complied. Herbert continued to breathe without the equipment but showed no signs of improvement. The doctors, after consulting with the family, then removed the intravenous tubes providing fluid and nourishment. From then until his death, Herbert received nursing care which provided a clean and hygienic environment. The doctors were charged by the state with murder and conspiracy to commit murder.¹¹⁹

When the case was preliminarily reviewed in the municipal court, it was dismissed, only to be reversed by the superior court, which reinstated the murder charges.¹²⁰ However, the Second District Court of Appeal reversed the superior court, noting that since Clarence Herbert had not previously executed a written directive and was not considered terminal, the Natural Death Act did not apply. However, the court stated that the Natural Death Act did not purport to be the exclusive means for terminating life-support equipment in the state. The court, thus held that an incompetent non-terminal patient who has not executed a living will can be taken off life-support equipment at the request of the family.¹²¹

116. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

117. An ileostomy is a surgical procedure that creates a passage through the abdominal wall into the ileum, which is part of the small intestine. *STEDMAN'S MEDICAL DICTIONARY* (22d ed. 1972).

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

119. *Id.* at 1010-11, 195 Cal. Rptr. at 486. The case represented the first time murder charges were filed against doctors responsible for withdrawing intravenous nutrients.

120. *Id.* at 1011-12, 195 Cal. Rptr. at 486-87.

121. *Id.* at 1015-16, 195 Cal. Rptr. at 489-90.

The court quoted Natural Death Act § 7193, which provides, "Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative." The court also stated that the legislature "has gone part-way, but only part-way, in dealing with this troublesome issue." *Id.*, 195 Cal. Rptr. at 489-90.

The appellate court relied on the concept of proportionality as the criterion to be used in deciding whether to withdraw life support. “[P]roportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment.”¹²² The *Barber* court then stated that the “focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from . . . biological vegetative existence.”¹²³

The court also concluded that intravenous feeding and hydration is the same as use of a respirator or other life-support equipment.¹²⁴ Therefore, the removal of life-support equipment was an omission of further treatment rather than an affirmative act.¹²⁵ Further, the court determined that Drs. Nejdil and Barber could not be found criminally liable for failure to act since there is no duty to continue treatment “once it has proved to be ineffective.”¹²⁶ The court concluded that Herbert’s wife was a proper surrogate decision-maker. There was evidence that Herbert had, prior to his incompetency, expressed to his wife that he would not want to be kept alive by machines or “become another Karen Ann Quinlan.”¹²⁷ In the absence of legislative guidance, the court held that prior judicial approval is not required before making decisions to withdraw treatment.¹²⁸

B. *Drabick v. Drabick*¹²⁹

William J. Drabick III has been in a persistent vegetative state since 1983 after receiving severe head injuries in a car accident. He is in a nursing home and is fed through a nasogastric tube.¹³⁰

One of Drabick’s four brothers, David Drabick, was appointed conservator of the person of William in September 1985; in December, the conservator petitioned the Santa Clara County superior court for removal of the feeding tube.¹³¹ In July 1986, the superior

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

123. *Id.*, 195 Cal. Rptr. at 492 (quoting *Quinlan*, 70 N.J. at 45, 355 A.2d at 669).

124. *Id.* at 1016, 195 Cal. Rptr. at 490. “Medical nutrition and hydration may not always provide net benefits to patients . . . Their benefits and burdens ought to be evaluated in the same manner as any other medical procedure.” *Id.* at 1016-17, 195 Cal. Rptr. at 490.

125. *Id.* at 1017, 195 Cal. Rptr. at 490.

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

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

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

129. 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988).

130. *Id.* at 190, 245 Cal. Rptr. at 842.

131. *Id.* at 191, 245 Cal. Rptr. at 842. The conservator testified in Superior Court he was the beneficiary of a \$40,000 life insurance policy covering William. The appellate court stated that a financial interest need not disqualify a conservator since immediate family members, those most likely chosen as conservators, may often have some benefi-

court denied the petition, holding that "continued feeding is in the best interest of a patient who is not brain dead. . . ." ¹³² The Sixth District Court of Appeal reversed, basing its decision on *Barber*, and held that a surrogate may make treatment decisions concerning an incompetent patient. ¹³³

William Drabick did not provide either a written directive under the Natural Death Act or a durable power of attorney; ¹³⁴ however, there was substantial evidence that William would not have wanted to be kept alive by artificial means. ¹³⁵ The court stated that William's prior statements about medical care were one factor in considering whether the decision to forego treatment would be consistent with his best interests. ¹³⁶

The court also held that even though the conservator chose to file a petition and seek the court's approval, ¹³⁷ such approval is not required for medical treatment decisions. ¹³⁸ "[F]aced with a persist-

cial interest and an inflexible rule would eliminate qualified conservators. *Id.* at 217 n.36, 245 Cal. Rptr. at 861 n. 38.

132. *Id.* at 193, 245 Cal. Rptr. at 844.

133. *Id.* at 195, 245 Cal. Rptr. at 845-46.

Allowing persons to determine their own medical treatment is an important way in which society respects persons as individuals. Moreover, the respect due to persons as individuals does not diminish simply because they have become incapable of participating in treatment decisions. While William's coma precludes his participation, it is still possible for others to make a decision that reflects his interests more closely than would a purely technological decision to do whatever is possible. Lacking the ability to decide, he has a right to a decision that takes his interests into account.

Id. at 208, 245 Cal. Rptr. at 854-55.

134. *Id.* 214, 245 Cal. Rptr. at 858-59. William was not a qualified patient under the Natural Death Act because he was not considered terminal by his physician and because he became incompetent immediately after the accident and could not execute a binding directive. He also could not execute a durable power of attorney since that act did not become effective until January 1984, almost a year after the accident. *Id.* at 214-15, 245 Cal. Rptr. at 859.

135. *Id.* at 210, 245 Cal. Rptr. at 856. Jeannine C. Gonzalez lived with William for twelve years and testified that he repeatedly stated he would never want to be kept alive by artificial means as was his father, a victim of liver cancer. *Id.* at 192, 245 Cal. Rptr. at 843.

136. *Id.* at 218, 245 Cal. Rptr. at 861.

137. *Id.* at 191, 245 Cal. Rptr. at 842. The conservator filed an unopposed petition under CAL. PROBATE CODE, § 2355 (a). *Id.*, 245 Cal. Rptr. at 843.

138. *Id.* at 202, 245 Cal. Rptr. at 850.

[W]hen a conservator has authority under [Probate Code] section 2355 for medical treatment decisions, there is no need for judicial approval absent a disagreement among the interested persons. When an interested person does not seek the court's approval, the court's role is limited to determining whether the conservator has made a good faith decision based upon medical advice.

Id. at 204, 245 Cal. Rptr. at 852.

ently vegetative patient and a diagnosis establishing that further treatment offers no reasonable hope of returning the patient to cognitive life, the decision whether to continue noncurative treatment is an ethical one for the physicians and family members"¹³⁹

C. *Bartling v. Superior Court (Glendale Adventist Medical Center)*¹⁴⁰

William Bartling, seventy, suffered from emphysema, chronic respiratory failure, arteriosclerosis, an abdominal aneurysm and a malignant lung tumor. He also had a history of chronic acute anxiety depression and alcoholism. He had entered Glendale Adventist Medical Center on April 8, 1984 for treatment of his depression. A routine physical examination and chest x-ray revealed a tumor on his lung. A biopsy of the tumor was performed by inserting a needle in the lung, which caused the lung to collapse. Tubes were then inserted in his chest and throat to reinflate his lung. However, because of his emphysema, the hole made by the biopsy needle did not heal properly and the lung would not reinflate. A tracheotomy was performed and he was placed on a ventilator. Despite repeated requests from both Bartling and his wife, Glendale Adventist and the treating physicians refused to remove the ventilator.¹⁴¹

Bartling had executed a living will and a durable power of attorney,¹⁴² but the trial court dismissed the applicability of the Natural Death Act because the Act provides that the patient must be terminally ill. Bartling's physicians testified his illness was not terminal and that he could live for at least a year if he were weaned from the ventilator, although previous efforts to wean him from the machine had been unsuccessful.¹⁴³

139. *Id.*, 245 Cal. Rptr. at 852.

140. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

141. *Bartling v. Superior Court*, 163 Cal. App. 3d at 190, 209 Cal. Rptr. at 221.

142. Bartling also executed a declaration, which stated in part:

While I have no wish to die, I find intolerable the living conditions forced upon me by my deteriorating lungs, heart and blood vessel systems, and find intolerable my being continuously connected to this ventilator, which sustains my every breath and my life for the past six and one-half (6 ½) weeks. Therefore, I wish this Court to order that the sustaining of my respiration by this mechanical device violates my constitutional right, is contrary to my every wish, and constitutes a battery upon my person. I fully understand that my request to have the ventilator removed and discontinued, which I have frequently made to my wife and to my doctors, will very likely cause respiratory failure and ultimately lead to my death. I am willing to accept that risk rather than to continue the burden of this artificial existence which I find unbearable, degrading and dehumanizing. I also suffer a great deal of pain and discomfort because of being confined to bed, being on this ventilator, and from other problems which are occurring.

Id. at 191, 209 Cal. Rptr. at 222.

143. *Id.* at 193, 209 Cal. Rptr. at 223.

The trial court held that the right to have life-support equipment disconnected was limited to comatose, terminally ill patients, or representatives acting on their behalf. The Second District Court of Appeal reversed and determined that the right to have life-support equipment disconnected extends to competent patients with serious illnesses which are incurable but not terminal.¹⁴⁴

The appellate court focused on the legally recognized right to control one's own medical treatment asserted in a long line of California cases, starting with *Cobbs v. Grant*.¹⁴⁵ The court stated that this privacy right is specifically guaranteed by the California Constitution, and is also found to exist in the penumbra of rights guaranteed by the Bill of Rights of the United States Constitution.¹⁴⁶ The court also relied on the Natural Death Act, which provides in part that adult persons have the fundamental right to control the decisions related to their own medical care.¹⁴⁷

The court then applied a balancing test to determine whether Bartling's right to refuse unwanted treatment as a competent adult was outweighed by state interests in preserving life, maintaining the ethical integrity of the medical profession, and preventing suicide. The court concluded that the right of a competent patient to refuse treatment is a constitutionally guaranteed right which must not be abridged.¹⁴⁸ Disconnecting Bartling's ventilator was not tantamount

144. *Id.* 209 Cal. Rptr. at 223. The day before the appellate court's decision, William Bartling, after lapsing into a coma, died of complications suffered due to kidney failure. The court decided to render an opinion in the case despite its mootness in order to formulate guidelines for similar situations in the future. *Id.* at 189, 209 Cal. Rptr. at 221.

145. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (In California, "a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment.").

146. *Bartling*, 163 Cal. App. 3d at 194-95, 209 Cal. Rptr. at 224-25.

"All people are by nature free and independent and have inalienable rights. Among these are enjoying and . . . pursuing and obtaining . . . privacy." CAL. CONST., art. 1, at 1.

147. Natural Death Act, § 7186. However, the court agreed with the court in *Barber*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, that the Natural Death Act applies to only a limited number of terminally ill patients and that the procedural requirements of the act are "so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desire." *Id.* at 1015, 195 Cal. Rptr. at 489.

148. *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225.

The most significant of these [state] interests is the preservation of life. This is of prime concern to Glendale Adventist Medical Center which submitted a declaration to the effect that it is a Christian, pro-life oriented hospital, the majority of whose doctors would view disconnecting a life-support system in a case such as this one as inconsistent with the healing orientation of physicians

to aiding a suicide, but merely hastened his inevitable death by natural causes. The court made a distinction between the self-infliction of deadly harm by unnatural causes, which is suicide, and a self-determination to withhold or withdraw artificial life-support, which is not.¹⁴⁹

D. Bouvia v. Superior Court¹⁵⁰

Elizabeth Bouvia suffers from severe cerebral palsy and as a result, is quadriplegic and completely bedridden. At age twenty-eight, she became a patient at a public hospital in Los Angeles County.¹⁵¹ Except for mobility in a few fingers on one hand and slight head and facial movements, she was totally immobile, physically helpless, and totally dependent upon others for all of her needs, including feeding, washing, toileting and turning. She could not stand or sit upright in bed or in a wheelchair. After the medical and dietary staff at the hospital determined Bouvia was not consuming sufficient nutrients, she was force-fed through a nasogastric tube.¹⁵² Bouvia filed a petition for a temporary restraining order and preliminary and permanent injunctions, requesting the court to enjoin the hospital from force-feeding her. The trial court declined to issue an injunction and considered Bouvia's motives to be an attempt to commit suicide with the state's help.¹⁵³ Bouvia appealed.

The Second District Court of Appeal issued a peremptory writ of mandate ordering the trial court to immediately grant Bouvia's request for removal of the nasogastric tube.¹⁵⁴ The appellate court found that the "trial court [had] mistakenly attached undue importance to the *amount of time* available to [Bouvia] . . ." rather than "the *quality* of that life"¹⁵⁵ The court also disagreed with the

. . . . However, if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors.

Id., 209 Cal. Rptr. at 225.

149. *Id.* at 196, 209 Cal. Rptr. at 225-26.

150. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

151. High Desert Hospital in Lancaster, California.

152. *Bouvia*, 179 Cal. App. 3d at 1135-36, 225 Cal. Rptr. at 299-300. The hospital noted that Bouvia was not terminal, nor comatose nor in a vegetative state — all conditions which have justified the termination of life-support equipment in other cases — and that she could continue to live for another fifteen to twenty years with sufficient nourishment. *Id.* at 1142, 225 Cal. Rptr. at 304.

153. *Id.* at 1134-35, 225 Cal. Rptr. at 298-99.

154. *Id.* at 1146, 225 Cal. Rptr. at 307.

155. *Id.* at 1142, 225 Cal. Rptr. at 304 (emphasis in original). The court states: We do not believe it is the policy of this state that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure, for '15 to 20 years.' We cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone.

trial court's conclusion that Bouvia wanted to commit suicide. The appellate court reasoned that since Bouvia's condition had worsened to the point where she could no longer eat independently, her decision to withdraw from the nasogastric feedings should be construed merely as a choice of an earlier death without force-feeding, not as a suicide.¹⁵⁶

The court further disagreed with the trial court's determination that the state-supported hospital would be assisting suicide by adhering to Bouvia's request to stop force-feeding her. The court clarified that there is a distinction between aiding and abetting suicide and merely being present during the exercise of a patient's constitutional right to refuse medical treatment.¹⁵⁷ The court concluded that no criminal or civil liability would attach to a doctor or hospital by honoring the refusal of medical treatment by a competent patient.¹⁵⁸

Like the court in *Bartling*, the *Bouvia* court extended the right to die beyond the mandate of the Natural Death Act by holding that even a competent patient who is not terminally ill has the right to refuse any medical treatment, even that which may save or prolong life, including nourishment and hydration.¹⁵⁹

Barber, *Drabick*, *Bartling* and *Bouvia* indicate the Natural Death Act may be drawn too narrowly to be practically applied to cases in which patients are not terminally ill, but whose grave and irreversible medical condition seriously impairs their quality of life. Within twelve years of the Natural Death Act's passage, appellate courts in four major cases have expanded the right to die beyond the limited competent terminal patient requirement in the Act. Under case law, competent non-terminal patients, as well as incompetent non-terminal patients (by way of a surrogate), can refuse life-sustaining treatment, including food and water.

Id. at 1143-44, 225 Cal. Rptr. at 305.

156. *Id.* at 1144-45, 225 Cal. Rptr. at 306. Furthermore, the court stated that the trial court erred in basing its decision on the motive behind Bouvia's decision. "If a right exists, it matters not what 'motivates' its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's *motives* meet someone else's approval. *Id.* 225 Cal. Rptr. at 306 (emphasis in original).

Elizabeth Bouvia, now 30, is still alive and eating and living in an isolation room at County-University of Southern California Medical Center. She watches television, sees friends weekly, but gave up reading because she doesn't have the strength to hold books. *Controlling the End: Right-to-Die Laws Take on New Life*, L.A. Times, May 23, 1988, Part I, at 14, col. 1. "The thought of being here another 10 years, I just can't fathom. I just take it one day at a time. . . I would rather be dead than lie here." *Id.*

157. *Bouvia*, 179 Cal. App. 3d at 1145, 225 Cal. Rptr. at 308.

158. *Id.* 225 Cal. Rptr. at 308.

159. *Id.* at 1127, 225 Cal. Rptr. at 297.

Apart from expanding the Natural Death Act to cover non-terminal patients, some proponents believe the Act should be expanded to permit a physician, under certain stringent circumstances and at the request of a patient, to aid a terminal patient in dying.¹⁶⁰

VIII. TWO PROPOSALS TO EXPAND THE NATURAL DEATH ACT

A. *The Dignified Death Act*

On September 20, 1987, the California State Bar's Conference of Delegates narrowly adopted Resolution 3-4-87 (Resolution),¹⁶¹ which advocates giving doctors permission to help terminally ill patients, upon their request, end their lives.¹⁶²

The Resolution advocates changing the Natural Death Act to the Dignified Death Act and permits patients to seek a doctor's help in dying if: (1) two physicians, one of which is the attending physician, certify the patient is terminal and will die within six months, absent life-sustaining procedures;¹⁶³ (2) a psychiatrist determines the patient is competent and is voluntarily making such a decision for the purpose of ending physical pain and suffering resulting from the terminal condition;¹⁶⁴ (3) the patient makes the request in writing, following exactly the request form contained in the Resolution;¹⁶⁵ and (4) the patient waits ten days and then orally requests aid-in-dying.¹⁶⁶

The Resolution gives the physician the right to administer aid-in-dying, at the patient's request, by lethal dosage of a prescription drug.¹⁶⁷ The Resolution also eliminates criminal penalties for physicians who render such aid;¹⁶⁸ however, an attending physician may refuse to administer aid-in-dying to a qualified patient, but must

160. See *infra* notes 161-81 and accompanying text.

161. Resolution, *supra* note 14.

162. 'Right-to-Die' Resolution Okd by Bar Group, L.A. Times, Sept. 21, 1987, Part I, at 3, col. 4. The vote was 282-239. The resolution was sponsored by the Beverly Hills Bar Ass'n. The 19,000-member Los Angeles County Bar Ass'n., among others, opposed the Resolution.

163. Resolution, *supra* note 14 § 7195 (a). The Resolution amends CAL. HEALTH & SAFETY CODE §§ 7185-87 and 7195, and adds §§ 7195.1, 7195.2 and 7195.3. The rest of the present Natural Death Act would remain the same and would be incorporated into the Dignified Death Act.

Under the Resolution, the patient must remain conscious and, thus, be able to revoke the request up to the day aid is given. The objective is to insure that patients have carefully considered their options and are acting voluntarily to end uncontrollable physical pain and not in response to mental depression or from fear of being a burden to others. Resolution, *supra* note 14, Statement of Reasons.

164. Resolution at § 7195 (c).

165. *Id.* at § 7195 (d).

166. *Id.* at § 7195, Request to Physician for Aid in Dying.

167. *Id.*

168. *Id.* at § 7195.2.

promptly notify the patient of the refusal.¹⁶⁹ The Resolution also states that an aid-in-dying request by a qualified patient will not constitute a suicide.¹⁷⁰

B. The Humane and Dignified Death Act Initiative

The Humane and Dignified Death Act Initiative (Initiative) is sponsored by Americans Against Human Suffering, Inc.¹⁷¹ and is similar to the Resolution. Both permit a terminally ill patient, who is certified by two physicians that death is likely within six months, to request physician aid-in-dying. Both exonerate physicians from all criminal liability. Both permit aid-in-dying by a physician only, and both exclude children or pregnant women. Both provide that a directive has no force if the patient is in a nursing home or similar facility unless one of the two witnesses to the directive is a state-designated patient advocate or ombudsman. Both provide that the making of a directive will not affect the terms of an existing life insurance policy or the procurement of such a policy. Neither requires a physician to administer aid-in-dying if he or she is morally or ethically opposed.¹⁷²

There are differences, however. The Resolution requires an examination of the terminal patient by a psychiatrist to ensure the patient's competency, while the Initiative requires a declaration of disinterested witnesses¹⁷³ that the patient is of sound mind and is not acting under duress. Under the Resolution, the request form expires six months from the date of execution; the directive in the Initiative expires after seven years. The Resolution's request form is signed after the patient is certified as terminal; the patient must then wait

169. *Id.* at § 7195.1.

170. *Id.* at § 7195.3.

171. Americans Against Human Suffering, Inc., is a non-profit organization, headquartered in Glendale, Cal., and was established on July 18, 1986 to change state laws to permit physician aid-in-dying for the terminally ill. The organization had hoped to place the Humane and Dignified Death Act Initiative (Initiative), two years in the works, on the November 1988 ballot but fell short of the required number of signatures. The group will try again on the 1990 ballot (Initiative on file with the San Diego Law Review). *See, supra* note 4, at vii, INITIATIVE HANDBOOK (on file with the San Diego Law Review).

172. *See* the Humane & Dignified Death Act Initiative leaflet, which compares the two. The leaflet was prepared by Robert L. Risley, president of the Americans Against Human Suffering, Inc., and author of the Initiative, *supra* note 15, and the INITIATIVE HANDBOOK, *supra* note 4. *See also* Initiative, *supra* note 15, and Resolution, *supra* note 14.

173. Disinterested witnesses are two individuals not related to the patient by blood or marriage, not entitled to any portion of the patient's estate, and not an attending physician. Initiative, *supra* note 15, at § 2525.3.

ten days before a physician administers aid-in-dying. The Initiative's directive can be signed in advance of the terminal illness by a competent person who is not yet qualified to receive a physician's aid-in-dying.¹⁷⁴

The Resolution mandates that only a competent patient may request aid-in-dying; the Initiative permits an attorney-in-fact to initiate the request if the patient becomes incompetent, as long as the patient has so provided in the directive.¹⁷⁵ The Initiative also permits a separate page for special instructions by the declarant to be attached to the directive.¹⁷⁶

174. *Id.* at § 2526.5.

175. *Id.* at § 2525.2 (i). This surrogate provision is a carryover of the Durable Power of Attorney for Health Care and thereby combines the California Natural Death Act and the Durable Power of Attorney into one law. In addition, the surrogate's decision must be reviewed by a three-member ethics committee. INITIATIVE HANDBOOK, *supra* note 4, at 16, 18, 19.

176. *Id.* at Directive to Physicians, Instructions. This provision enables patients to, for example, specify a certain drug they prefer used, a specific time to die or those persons they desire present. Interview with Michael H. White, member of Americans Against Human Suffering (Dec. 29, 1987) [hereinafter White Interview].

The Initiative's Instructions within the Directive to Physicians, which must be followed exactly, are as follows:

I, _____ being of sound mind, willfully and voluntarily make known my desire

(a) _____ That my life shall not be artificially prolonged and

(b) _____ That my life shall be ended with the aid of a physician under the circumstances set forth below, and do hereby declare: (You must initial (a) or (b), or both).

1. If at any time I should have a terminal condition or illness certified to be terminal by two physicians, and they determine that my death will occur within six months,

(a) _____ I direct that life-sustaining procedures be withheld or withdrawn, and

(b) _____ I direct that my physician administer aid-in-dying in a humane and dignified manner. (You must initial (a) or (b) or both).

(c) _____ I have attached Special Instructions on a separate page to the directive. (Initial if you have attached a separate page.) The action taken under this paragraph shall be at the time of my own choosing if I am competent.

2. In the absence of my ability to give directions regarding the termination of my life, it is my intention that this directive shall be honored by my family, agent (described in paragraph 5), and physician(s) as the final expression of my legal right to

(a) _____ Refuse medical or surgical treatment, and

(b) _____ To choose to die in a humane and dignified manner. (You must initial (a) or (b), or both and you must initial one box below.)

_____ If I am unable to give directions, I *do not* want my attorney-in-fact to request aid-in-dying.

_____ If I am unable to give directions, I *do* want my attorney-in-fact to ask my physician for aid-in-dying.

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

4. I understand that a terminal condition is one in which I am not likely to live for more than six months.

5. a. I, _____, do hereby designate and appoint _____ as my attorney-in-fact (agent) to make health-

C. Opposition to the Resolution and the Initiative

If either the Resolution or the Initiative are enacted, it would be the first time any country in the world has advocated physician aid-

care decisions for me if I am in a coma or otherwise unable to decide for myself as authorized in this document. For the purpose of this document, "health-care decision" means consent, refusal to consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose, or treat an individual's physical or mental condition, or to administer aid-in-dying.

b. By this document I intend to create a durable power of attorney for health care under the Humane and Dignified Death Act and sections 2430 to 2443, inclusive, of the Civil Code. This power of attorney shall not be affected by my subsequent incapacity, except by revocation.

c. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health-care decisions for me to the same extent that I could make these decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health-care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining, refusing, or withdrawing life-prolonging care, treatment, services and procedures, and administration of aid-in-dying.

c. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health-care decisions for me to the same extent that I could make these decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health-care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining, refusing, or withdrawing life-prolonging care, treatment, services and procedures, and administration of aid-in-dying.

6. This directive shall have no force or effect seven years from the date filled in above, unless I am incompetent to act on my own behalf and then it shall remain valid until my competency is restored.

7. I recognize that a physician's judgment is not always certain, and that medical science continues to make progress in extending life, but in spite of these facts, I nevertheless wish aid-in-dying rather than letting my terminal condition take its natural course.

8. My family has been informed of my request to die, their opinions have been taken into consideration, but the final decision remains mine, so long as I am competent.

9. The exact time of my death will be determined by me and my physician with my desire or my attorney-in-fact's instructions paramount.

I have given full consideration and understand the full import of this directive, and I am emotionally and mentally competent to make this directive. I accept the moral and legal responsibility for receiving aid-in-dying.

This directive will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature. The witnesses must not be related to you by blood, marriage, or adoption; they must not be entitled to any part of your estate; and they must not include a physician or other person responsible for, or employed by anyone responsible for, your health care. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this power of attorney.

Signed: _____

in-dying through legislation.¹⁷⁷ The initiators of both measures are aware of the sizable opposition to such measures.¹⁷⁸ The objections include the potential for abuse and the "slippery slope" argument. For example, potential for abuse centers around the possibility of fraud, coercion or duress in requests for aid-in-dying.¹⁷⁹ The "slippery slope" argument cautions against taking a first step that ethically may be justified but which might lead to subsequent unjustified actions.¹⁸⁰ These objections have been somewhat surmounted in the

City, County, and State of Residency

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of satisfactory evidence) to be the declarant of this directive; that he or she signed and acknowledged this directive in my presence; that he or she appears to be of sound mind and under no duress, fraud, or undue influence; that I am not a health-care provider, an employee of a health-care provider, the operator of a community-care facility, nor an employee or an operator of a community-care facility.

Date: _____

Witness's Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Witness's Signature: _____

Print Name: _____

Residence Address: _____

177. White Interview, *supra* note 176. Physician aid-in-dying is another term for "euthanasia," which is defined as "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy." BLACK'S LAW DICTIONARY 497 (5th ed. 1979).

178. Interview with Barry E. Shanley, author of Res. 3-4-87 and member of the Beverly Hills Bar Ass'n (May 29, 1988). It was not likely the State Bar Board of Governors would support the controversial Resolution because of the political climate, and although legislators' interest was solicited, a sponsor was not asked to introduce the Resolution during the 1987-88 session. The Beverly Hills Bar Ass'n expects to reintroduce the issue next session.

The Initiative was sent to the Attorney General's Office, and a title and summary prepared. To qualify for the ballot, 372,000 signatures were needed by May 11, 1988, but only 150,000 were gathered. White Interview. See also *'Humane, Dignified Death Act' May Be Headed for June Ballot*, L.A. Daily Journal, Nov. 20, 1987, Part 1, at 2, col. 1; *Bringing Euthanasia Issue to the Ballot Box*, L.A. Times, Apr. 10, 1987, Part V, at 1, col. 1. Various groups have already signaled opposition to physician aid-in-dying: the California Medical Ass'n, the American Medical Ass'n, the Hastings Center, right-to-life groups, the Catholic Church, and the President's Comm'n. See materials distributed by Inyo-Mono County Bar Associations to Conference of Delegates (on file with the San Diego Law Review).

179. INITIATIVE HANDBOOK, *supra* note 4, acknowledges the specter of a malevolent, greedy relative encouraging a patient to end his or her life. However, Risley points to the safeguards in the Initiative: only physicians will be permitted to aid patients in dying, witnesses to the directive cannot be heirs or beneficiaries, and the directive can be revoked at any time. See INITIATIVE HANDBOOK, *supra* note 4, at 15.

180. PRESIDENT'S COMM'N, *supra* note 2, at 28-30. For example, some fear that euthanasia eventually will lead to the killing of the severely disabled or the incapacitated elderly, as during the Nazi regime fifty years ago. See Alexander, *Medical Science*

Netherlands.¹⁸¹

D. *The Netherlands Approach*

Physician-assisted suicide is an international controversy. It is illegal in Western Europe but unofficially condoned in the Netherlands. The government of the Netherlands is considering formally legalizing the practice by legislation.¹⁸²

Dutch doctors are not punished for giving a lethal injection to a dying person who has requested death. Rather than legalize mercy killing through Parliament, the Dutch have, in a series of judicial steps since 1973, permitted doctors to go unpunished.¹⁸³ An estimated 2,000 Dutch doctors (out of 17,000) practice various degrees of euthanasia, but the handful of cases (thirty-six) that have come to official notice indicates that most doctors keep their actions secret.¹⁸⁴ Government polls suggest that more than three-quarters of the Dutch population supports euthanasia and that an estimated 7,000 people die by euthanasia each year.¹⁸⁵

One factor in explaining why the Netherlands has made such advances in accepting aid-in-dying, as compared to the relative inactivity in other Western countries, is that no single church plays a dominant role in the country. In fact, twenty-seven percent of the Dutch population claims no religious denomination.¹⁸⁶

IX. PROPOSED AMENDMENTS TO THE NATURAL DEATH ACT

A. *Amendments Which Clarify or Expand Existing Provisions in the Act*

The legislature should reevaluate the Natural Death Act with an eye toward broadening its provisions. One commentator¹⁸⁷ has sug-

Under Dictatorship, 241 NEW ENG. J. MED 39 (1949); D. HUMPHRY & A. WICKETT, *supra* note 4, at 20-32. On the other hand, "[a]ll social policy requires the drawing of lines . . . Prohibitions have to be established and distinctions made even where human affairs are uncertain and hard to classify." S. BOK, DEATH & DYING: EUTHANASIA & SUSTAINING LIFE, ETHICAL VIEWS, in 1 ENCYCLOPEDIA OF BIOETHICS 268, 277 (1978).

181. See *infra* notes 182-86 and accompanying text.

182. See L.A. Times, *supra* note 178, at 1.

183. D. HUMPHRY & A. WICKETT, *supra* note 4, at 170.

184. *Id.* at 176.

185. *Id.* at 179.

186. *Id.* at 180.

187. Shulman, *Death with Dignity: The Courts Enforce Public Policy*, BEVERLY HILLS B.J. 236-39 (Fall 1984).

gested that modifications in the Natural Death Act are not necessary in order for the purposes of that Act to be fulfilled because *Barber*¹⁸⁸ and *Bartling*¹⁸⁹ have filled in the gaps; thus, the developing case law upholding the patient's right to death with dignity and providing freedom from liability for physicians is adequately solving the problems.¹⁹⁰ Another commentator said the Natural Death Act may have been "the first in the world, but it was a mess. It was savaged by opponents and it came out a dog's breakfast."¹⁹¹

Among the reasons cited for enactment of the statute was the concern that although common law precedent did exist that allowed an individual to exercise choice over what medical treatment he or she would consent to, such authority was sparse and limited to the facts of a given case.¹⁹² The result has been uncertainty by physicians¹⁹³ and attorneys as to the application of the common law precedent. Courts are ill-equipped to provide rules, procedures, forms, guidance, penalties and sanctions for abuse. Rules for witnessing, revocation, appointment of attorneys-in-fact and immunizing physicians from liability need to be drawn by the legislature.¹⁹⁴ The legislature also embodies the public will and possesses the resources to investigate proposed laws.¹⁹⁵

The principle of the Natural Death Act — that individuals have the fundamental right to control decisions concerning their own medical care — has been upheld by the courts.¹⁹⁶ But the Natural Death Act limits itself to a narrow range of patients who are competent

188. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); see *supra* notes 116-28 and accompanying text.

189. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); see *supra* notes 140-49 and accompanying text.

190. Shulman, *supra* note 187, at 238.

191. L.A. Times, *supra* note 156, at 14. (quoting Derek Humphry, founder and Executive Director of the Hemlock Society).

192. See Natural Death Act, § 7186. "The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures . . ." *Id.*

193. In a survey conducted by the California Medical Education and Research Foundation of the California Medical Ass'n one year after passage of the Natural Death Act, physicians noted they had difficulty in interpreting sections of the Act; 17 percent thought the Natural Death Act's language should be clarified. A questionnaire was mailed to 168 physicians in 1977; 112 replies were received, or a response rate of 68 percent. 128 W.J. MED. 329-330 (1978).

194. See INITIATIVE HANDBOOK, *supra* note 4, at 11-12.

As Judge Compton said in *Barber*:

[T]he only long-term solution to this problem is necessarily legislative in nature. It is that body which must address the moral, social, ethical, medical and legal issues raised by cases such as the one at bench. [T]his court cannot attempt to reunite the statutory definition of death or set forth guidelines covering all possible future cases.

Barber, 147 Cal. App. 3d at 1014, 195 Cal. Rptr. at 488.

195. Riga, *supra* note 17, at 107.

196. See, e.g., *Bouvia*, 179 Cal. App. 3d at 1132, 225 Cal. Rptr. at 301.

and terminally ill. It is only these patients who can end their suffering by terminating life-support systems. The Natural Death Act suffers from ambiguous language which makes its provisions unclear and confusing. For example, it is not clear from the Act when death is "imminent," and so qualified patients may be spared only a few days of artificial life support.¹⁹⁷

The Natural Death Act has not been flexible enough to keep up with case law. Physicians, hospital and nursing home administrators and personnel, and attorneys are now required to assimilate a wide spectrum of case law which has interpreted and fleshed out the Natural Death Act in order to get an accurate picture of the state of the right to die law. Such assimilation poses an unfair burden on any party, especially the average person on the street interested in learning how to apply the Act.

At the very least, the Natural Death Act should be amended to make it current with case law. Such amendments would include providing that any medical treatment, including life support and intravenous fluid and nourishment, may be removed for (1) non-terminal incompetent or permanently unconscious patients at the request of family or other surrogate, or (2) non-terminal competent patients. The following amendments are suggested in order to increase the number of patients who can take advantage of the Act, and to clear up ambiguous language.

1. The Directive Should Be Able To Be Executed and Be Binding Before a Patient Is Certified as Terminal, as well as After Such a Certification.

An individual is capable of more rational thought before a terminal diagnosis. A person who executes a directive while still healthy has probably put much serious thought into the decision before the advent of traumatic illness. On the other hand, a newly diagnosed terminal patient may be overwhelmed by the diagnosis and confused. Pain-killing drugs may impair reasoning. Also, a directive executed before a patient becomes terminal indicates to the family the patient's wishes in case he or she becomes incompetent before the directive is executed. Since a directive can be revoked at any time, a patient could still change his or her mind after being diagnosed as terminal. Therefore, the definition of a qualified patient¹⁹⁸ should be

197. See *supra* notes 98-100 and accompanying text.

198. See *supra* note 62.

changed in the Natural Death Act to include an individual who has previously executed a directive, as well as a patient who has been diagnosed as terminal.

2. The Provision Which Requires a Fourteen-Day Period After Diagnosis of Terminal Illness Before a Patient Can Initiate a Directive Should Be Revoked.

The rationale of the legislature for including the fourteen-day requirement¹⁹⁹ was the belief that once diagnosis of a terminal condition was made, the patient needed that time to make an objective decision about treatment.²⁰⁰ However, if a person has objectively executed a directive while still healthy and competent, there is no need for a two-week waiting period, especially since a directive can be revoked at any time. Even for those patients who have not previously executed a directive, such a provision is not beneficial. If a significant number of terminal patients die during those fourteen days or are unable to sign a directive, the Natural Death Act becomes useless and they are not able to choose to terminate life support. Also, some physicians may delay telling patients of a terminal condition, thus preventing patients from executing binding directives which could save them at least some time of suffering while on life-support equipment.

If a directive previously has been executed, it should be binding on the physician as soon as the patient is diagnosed as terminal. If a patient is diagnosed as terminal and then executes a directive, the directive should be binding immediately. Thus, a patient is able to withhold or withdraw life support at once and is spared needless further suffering.

*3. The Natural Death Act Should Provide an Opportunity for Permanently Unconscious, as well as Terminally Ill Patients, to Withhold or Withdraw Life-Support Equipment.*²⁰¹

Often, permanently unconscious patients, though they may not be terminal, have the same dismal prognosis for recovery as terminally ill patients. "Permanently unconscious" could be defined as an incurable condition caused by injury or disease in which thought, feeling and awareness of performance and environment are absent.²⁰² The Natural Death Act should explicitly state, following *Bartling* and *Bouvia*, that those competent patients with incurable, but not termi-

199. See *supra* text accompanying notes 92-94.

200. See Comment, *supra* note 11, at 599.

201. See *supra* notes 85-86 and accompanying text.

202. See, e.g., 1987 ARK. ACTS 713, § 1(11).

nal, diseases, have the right to withhold or withdraw life-support equipment.²⁰³ Therefore, a "qualified patient" would need to be redefined in the Natural Death Act to include those diagnosed as permanently unconscious as well as terminal.

4. *The Natural Death Act Should Provide that the Decision to Terminate Life Support Can Be Made by a Surrogate for an Incompetent Terminal or Non-Terminal Patient Who Has Not Executed a Directive and Who Has Not Authorized a Durable Power of Attorney.*²⁰⁴

Even though *Barber* and *Drabick* held that an incompetent non-terminal patient's family could request the removal of life-support equipment, this specific provision should be incorporated into the Natural Death Act to make it less susceptible to varied judicial interpretation. Guardianship requirements should be explicitly stated in the Act so that interested individuals or patients know exactly what may occur if they become incompetent. Substituted consent could eliminate the need for costly and time-consuming litigation in an attempt to have life-support systems removed, and would, therefore, reduce the likelihood of a patient's prolonged suffering. Substituted consent would also decrease a physician's fear of liability. Under a surrogate proposal, even if a directive does not exist, a physician cannot be charged with criminal homicide after removing life-support systems if the decision to do so was made jointly by the physician, the patient's family, and/or a hospital ethics committee.

Such a guardianship provision could allow the attending physician and family of the patient to make a treatment decision based on knowledge of what the patient would desire, if known, or what would be the patient's best interest.²⁰⁵ A treatment decision could be made by one or more of the following, in order of priority: the patient's spouse, a majority of the adult children, the patient's parents, the nearest relative. The court's intervention should only be resorted to when the family members cannot agree on a treatment decision, when there is no family, or when the patient has never been competent and there is no legal guardian. Then a court hearing and appointment of a guardian is necessary. Thus, "incompetent" could be

203. See *supra* notes 140-49 and 150-58 and accompanying text.

204. See *supra* notes 86-88 and accompanying text.

205. See *supra* note 87.

defined to include the permanently unconscious. For those who have appointed a durable power of attorney or legal guardian, it should be stated in the Natural Death Act that such surrogates can effect the wishes of the incompetent patient.

5. The Provision That a Directive Must Be Re-executed Every Five Years in Order To Be Effective²⁰⁶ Should Be Revoked.

This provision is especially burdensome to young adults who execute a directive and then must remember to re-execute it every five years for the rest of their lives. Such a requirement will undoubtedly lead to litigation concerning previous directives. Also, a patient's illness or injury may prevent him or her from re-executing the directive, thereby leaving the patient with no binding evidence of his or her wishes. Directives should remain valid until revoked. For individuals who execute a directive and then become competent terminal or non-terminal patients, a change of heart or a past intent to revoke not acted upon can be rectified by simply revoking the directive. In circumstances where individuals executed directives and then intended to revoke them but did not (i.e. due to forgetfulness or procrastination) before becoming incompetent, the surrogate provision proposed above should provide protection as long as the patient had expressed the change of heart to family members.

6. The Term "Imminent" Included in the Natural Death Act's Definition of Life-Sustaining Procedure Should Be Dropped.²⁰⁷

The lack of definition of "imminent" in the statute only leads to confusion. The term offers no guidance for those patients whose physicians believe imminent means twenty-four hours, or at most a few days, until death. Defining "imminent" as a certain time period, such as six months, would also be ineffective for two reasons. First, most physicians would feel uncomfortable diagnosing a patient's death that far in advance.²⁰⁸ Second, most patients certified as terminal, and on life-support equipment, have a very limited time to live. A patient (or surrogate) should be able to terminate life support as soon as he or she effects a directive or is certified as terminal or permanently unconscious, thus getting the maximum benefit out of the statute. The time sequence from execution of a directive through withdrawal of treatment should be clearly stated in the Natural

206. See *supra* notes 95-97 and accompanying text.

207. See *supra* notes 98-100 and accompanying text.

208. *Stanford Study*, *supra* note 5, at 942 n.130.

Death Act, rather than determined by piecing together the various definitions in the Act. Life-sustaining procedure can be defined in the Natural Death Act without requiring death to be imminent.²⁰⁹ For example, a life-sustaining procedure could be "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process or to maintain the patient in a condition of permanent unconsciousness."²¹⁰

7. *The Pregnancy Clause Should Be Restated as an Optional Clause.*

Since the pregnancy clause²¹¹ is of questionable constitutionality, restating it as an optional clause would protect the state from claims of violation of substantive due process. If a patient wants to mandate that life-support systems should not be terminated if she is pregnant, she could include that clause in the directive. If not, the clause can be excluded. Alternatively, the Natural Death Act could be amended to prohibit only the withholding or withdrawal of life support from a pregnant woman in the last trimester.

8. *The Mandate That the Directive Must be Followed Directly Should be Revoked.*²¹²

Individuals should be able to include special individualized instructions,²¹³ such as who they want to appoint as surrogate decisionmaker if they become incompetent, and also to exclude clauses not desired. Although in some cases there may be a need for judicial determination of the integrity of a non-standard directive, a non-standard option would be in keeping with the legislature's intent that individuals have the right to control their own medical care decisions. The Natural Death Act's standardized form may minimize interpretation difficulties, but it also creates inconvenience for patients who wish to express their desires in more detail. A non-standard form creates more flexibility as to treatment choice. A provision should also be included in the Natural Death Act to honor out-of-state patients' directives which comply with laws in other jurisdictions.

209. See *supra* note 62 (current definition).

210. See, e.g., 1987 ARK. ACTS 713, § 1(4).

211. See *supra* notes 101-105 and accompanying text.

212. See *supra* notes 106-13 and accompanying text.

213. See *supra* note 108 and accompanying text.

9. *Minors Should Not Be Excluded from the Provisions of the Act.*²¹⁴

Minors should also have the opportunity to alleviate suffering on life-support equipment. Surrogates should be able to act on the behalf of either incompetent terminal minors, including the permanently unconscious, who either have or have not executed a directive, or competent terminal minors who have executed a directive. Surrogates could be designated as either a minor's spouse over eighteen, a parent or a legal guardian. If a minor has no family, a legal guardian could be appointed to represent the minor and an evidentiary court hearing could be held to certify that the directive was executed in good faith.

10. *The Natural Death Act Should Specify Under Section 7187(c) That Nutrition and Fluids Can Be Withdrawn.*²¹⁵

This specification would be in keeping with the California appellate court's decision in *Barber*.²¹⁶ Alternatively, the Natural Death Act could provide in the directive an optional nutrition/fluid clause which patients or individuals could choose to include.

11. *The Natural Death Act Should Provide for Oral or Non-Written Directives.*²¹⁷

Oral directives should be allowed for those competent, qualified patients unable to sign a directive or make a written one. Non-written directives would include blinking eyes or a shake of the head in answer to certain questions, or even a video directive. Such directives could be executed in front of an attending physician and two witnesses with the same qualifications as those required for witnessing a written directive. Physicians can then make a note in the patient's chart and the directive becomes as binding as a written one. An oral or non-written directive could also be revoked at any time.

12. *The Natural Death Act Should Define Clearly What Procedures Are Considered Life-Sustaining.*

Life-sustaining procedures should be defined so physicians can apply them uniformly, and so interested persons know exactly what may be withheld or withdrawn. For example, under the Natural Death Act section 7187(c), does a "mechanical or other artificial

214. See *supra* notes 109-11 and accompanying text.

215. See *supra* notes 112-13 and accompanying text.

216. See *Barber*, 147 Cal. App. 1006, 195 Cal. Rptr. 484.

217. See *supra* notes 114-15 and accompanying text.

means” of life-sustaining procedure include resuscitation, respirators and intravenous hydration and feeding?

X. PROPOSAL WHICH EXPANDS THE NATURAL DEATH ACT TO INCLUDE PHYSICIAN AID-IN-DYING

This Comment supports the Humane and Dignified Death Act Initiative²¹⁸ with some revision. The Natural Death Act should be expanded to include physician aid-in-dying by lethal injection if requested by a competent, terminal (certified to die within six months) patient, by a competent person who had executed a directive prior to terminal illness, or by a now incompetent terminal patient who has previously executed a directive while competent and who provided for a surrogate. In addition, the Natural Death Act should guarantee that physicians will not be criminally liable for assisting a patient to die at the patient’s request.²¹⁹

Proponents of physician aid-in-dying — or the right to reject the continuation of life that is supported only by artificial life support devices or made bearable from the pain of incurable illness by drugs — submit that such aid is a constitutional right that exists within the “penumbras” of the fundamental right to privacy.²²⁰ Privacy has been viewed by the United States Supreme Court as a fundamental aspect of personal liberty.²²¹ Liberty, or freedom, not only is freedom from restraint but also is the ability to choose a destiny and to have that decision respected by others.²²² The right to be left alone²²³ should include this “right” of a terminal patient to decide when to end life. That right should include the ability to request assistance from the medical profession to end life quickly and painlessly.²²⁴ The

218. See *supra* notes 171-80 and accompanying text.

The initiative does not provide for non-terminal competent or incompetent patients to request aid-in-dying. The reason, according to Michael H. White, was a matter of line drawing due to sensitivity to the current political and public climate. White Interview, *supra* note 176.

219. This would mean invalidating section 401 of the California Penal Code which makes assisting another to commit suicide a criminal offense. See *supra* note 74 and accompanying text.

220. See *supra* notes 20-22 and accompanying text.

221. Note, *The Legal Aspects of the Right to Die: Before and After the Quinlan Decision*, 65 Ky. L.J. 823, 867-68 (1977); see also notes 18-26 and accompanying text.

222. Riga, *supra* note 17, at 107.

223. See *supra* note 20.

224. In a concurring opinion in *Bouvia*, 179 Cal. App. 3d 1127, 1146-48, 225 Cal. Rptr. 297, 307-308 (see *supra* notes 150-59 and accompanying text), Justice Compton eloquently argued:

state should not interfere as long as the rights of others are not affected and there is no threat to the public welfare.²²⁵ A competent patient who has made such a decision should be immune from state interference, even though the decision might be considered by others to be immoral or unwise.

XI. ARGUMENTS AGAINST AID-IN-DYING

There are many arguments against aid-in-dying. One is the rare possibility of a mistaken terminal diagnosis. A caution is included in the Initiative's Directive to Physicians.²²⁶ Most patients are aware that medical science is not perfect and that there is always the possibility of a miracle cure.

Another argument is that if one of the purposes of the Initiative is to alleviate unnecessary pain and suffering,²²⁷ medical technology now can provide the patient with drugs which eliminate pain. Therefore, if the patient is in no physical pain, he or she does not need to end life. However, in some terminal cases drugs may alleviate pain, but also may leave the patient in a nearly comatose state, which can hardly be considered "life." It ethically is acceptable to sedate a patient into unconsciousness to control pain, even if the sedation hastens death.²²⁸ In other words, hastening death by medication is ethical as long as the intent to cause death is absent. Such so-called ethical behavior sits on an extremely fine line, and one worth crossing in order to humanely aid a patient in dying.

A third argument is that if aid-in-dying is permitted, physicians

[I] feel compelled to write separately and reflect on what I consider to be one of the real tragedies of this case, which is that Elizabeth Bouvia has had to go to such ends to obtain relief from her suffering.

Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe she has an absolute right to effectuate that decision. This state and the medical profession, instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

If there is ever a time when we ought to be able to get the "government off our backs" it is when we face death - either by choice or otherwise.

225. Comment, *A Right to Choose Death*, 13 CUMB. L. REV. 117, 133 (1982).

226. See *supra* note 176, para. 7.

227. Initiative, *supra* note 15, at § 2525.1.

228. One of the guidelines recommended by the Hastings Center for deciding when to withhold or withdraw life support. See *Terminal Care Experts Stress Patients' Rights*, N.Y. Times, Sept. 11, 1987, at 7, col. 1.

eventually will be asked to administer lethal injections to patients recently diagnosed with incurable diseases who cannot face the pain and suffering that lies ahead. Aid-in-dying should not be available to the patient who merely anticipates pain and suffering. Therefore, for example, early AIDS patients could not take advantage of aid-in-dying after they are first diagnosed, even though it is nearly certain they are terminal. The focus of an aid-in-dying statute is on patients who are in such a weakened condition that they must ask for assistance from physicians in order to die.

There is also an argument against allowing surrogates to effectuate an aid-in-dying directive. Some fear that surrogates may coerce patients to consent to aid-in-dying, or such aid may be fraudulently given. However, the Initiative includes safeguards. The directive can be revoked at any time by the declarant.²²⁹ Also, the decision of a surrogate to request a physician to administer aid-in-dying can be reviewed by a hospital ethics committee to assure the integrity of the directive.²³⁰ These safeguards eliminate the greatest risks of potential fraud. Patients should have the option to appoint a surrogate to carry out their aid-in-dying wishes should they become incompetent. Once a patient becomes incompetent, he or she should not automatically lose the right to affect medical treatment decisions, including the right to request aid-in-dying.

Another argument is that the six-month limit is arbitrary and doctors may feel uncomfortable diagnosing death that far in advance.²³¹ However, without the six-month limit, or any time limit, the period during which a patient could request aid-in-dying could be interpreted to be broad. It would then be necessary to determine, for instance, how much pain and suffering is needed before a patient's request for aid is granted or to perhaps define "terminal" for each medical disease. Under such a broad statute, many physicians would probably argue that patients are not terminal from the disease itself but from complications of the disease, for example, from infections such as pneumonia. Therefore, physicians might not diagnose patients as terminal until death is imminent, which would in many cases be less than six months.

229. Initiative, *supra* note 15, at § 2525.5.

230. *Id.* at § 2525.10.

231. *See supra* note 208.

XII. PROPOSED MODIFICATIONS TO THE INITIATIVE

Unlike the Initiative, this Comment proposes that another focus of an aid-in-dying statute should be on competent non-terminal patients who experience pain and/or suffering from incurable diseases. This focus is also based on an individual's Constitutional right to privacy and the right to control one's destiny, as discussed throughout this Comment. It is acknowledged that there are patients suffering some amount of pain which can be alleviated by drugs. However, suffering, both mental and physical, may contribute, along with pain, to a request for aid-in-dying. For example, patients with incurable diseases such as multiple sclerosis,²³² Parkinson's Syndrome,²³³ Lou Gehrig's,²³⁴ or AIDS²³⁵ and other similar illnesses where the mind is housed in a body which no longer functions, can suffer greatly as they lose control of bodily movement and become gradually more dependent on others for all bodily processes. Such suffering encompasses not only a loss of dignity but also in many cases a desire to end suffering before the disease finally runs its course and death occurs.

Further, Alzheimer's²³⁶ or Huntington's Chorea²³⁷ patients usually are not in pain per se during the entire course of the illness, but still may be suffering greatly from the debilitating effects of the disease — a useless brain in a body that can function for years. Patients with such diseases should be able to take advantage of aid-in-dying if they have executed a directive and if they experience the pain and/or suffering associated with these diseases.

For all such diseases, the six-month terminal provision should not be required. Under the Initiative, such patients would have to suffer for years before being diagnosed as terminal.

232. Multiple sclerosis is "[o]ne of the most common and dreaded" disorders of the central nervous system, which can lead to total motor disability. The disease progresses for many years punctuated by relapses and remissions. The end stage is often characterized by blindness and a "tragic degree of utter helplessness." S. ROBBINS & R. COTRAN, *PATHOLOGIC BASIS OF DISEASES* 1578-79 (2d ed. 1979) [hereinafter *Pathologic Diseases*].

233. "These poor patients present the tragedy of a responsive mind trapped within an unresponsive body." The disease is characterized by slowness of voluntary movement, stooped posture, hand tremors, and an expressionless face. *Id.* at 1585.

234. Also known as amyotrophic lateral sclerosis or ALS. Characterized by degeneration of the motor system where muscles atrophy. The course is progressive and fatal, usually within two to six years. *Id.* at 1587-88.

235. Acquired immunodeficiency syndrome. The body loses ability to fight certain diseases. *UNDERSTANDING AIDS, UNITED STATES DEP'T OF HEALTH & HUMAN SERVICES, Publication No. HHS-88-8404* (1988).

236. Characterized by progressive atrophy of the entire brain over five to ten years. The end stage is severe dementia. Death is often associated with dehydration or respiratory infection. *PATHOLOGIC DISEASES, supra* note 232, at 1582.

237. Progressive dementia in which patients manifest delusions, paranoia, neurosis and abnormal eye movements. The average course of the disease is 15 years. *Id.* at 1584.

As further modifications of the Initiative, two clauses should be eliminated. The Initiative includes a pregnancy clause which states that the directive is ineffective if the patient is pregnant.²³⁸ Because of its questionable constitutionality,²³⁹ such a clause should not be included in an aid-in-dying statute, but could be offered on an optional basis.

The Initiative also provides that a directive is effective for seven years, unless revoked.²⁴⁰ An aid-in-dying directive should be effective until revoked. Since a directive can be revoked at any time, there is no need for a time limit. A person who has executed a directive should not be inconvenienced to remember to re-execute the directive. If he or she has a change of heart, the directive can be revoked.

XIII. CONCLUSION

The Natural Death Act should be amended by the legislature to incorporate recent case law in order to allow more definitive and standardized treatment, to clarify vague terms, and to offer patients more flexibility. Compared with other states' more progressive right-to-die statutes, California has fallen behind.

The Natural Death Act should be broadened to include coverage for non-terminal competent and incompetent or permanently unconscious patients, in addition to coverage now provided for competent terminal patients. The Natural Death Act should also be broadened to permit guardians to act on behalf of an incompetent patient who has not executed a directive or a durable power of attorney; to revoke the arbitrary fourteen-day waiting period after diagnosis of a terminal illness so more patients can benefit from the Act; to eliminate the term "imminent" in order to allow a patient to terminate life support immediately after effecting a directive or immediately after certification as terminal or permanently unconscious; to restate the pregnancy clause as an option or only prohibit termination of life support during the last trimester; and to permit patients to include individualized instructions within the directive.

The Natural Death Act also should be expanded to incorporate physician aid-in-dying upon a competent terminal patient's request, or by a surrogate for an incompetent patient who has previously executed a directive. Further, physician aid-in-dying should be available

238. See *supra* note 176, at para. 3.

239. See *supra* notes 101-05 and accompanying text.

240. Initiative, *supra* note 15, at § 2525.6(a).

for competent non-terminal patients who experience pain and/or suffer from incurable diseases. The Natural Death Act also should guarantee that physicians will not be criminally liable for assisting a patient to die.

The right of a terminally ill, permanently unconscious or non-terminal patient to choose his or her own course of treatment, whether it be the withholding or withdrawing of life-support equipment or a request for help in ending life, legally should be upheld without state interference. In the end, it is the patient who ultimately must decide whether it is worth hoping for a new dawn.

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