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Due Process of Euthanasia: The Living Will, A Proposal

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COMMENTS

DUE PROCESS OF EUTHANASIA: THE LIVING WILL, A PROPOSAL

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"She asked me to do it," explained Robert Waskin, a young college student, after he had fatally shot his cancer-striken mother while she lay in her hospital room. The Grand Jury of Cook County, Illinois, dispassionately returned an indictment of murder in the first degree.[1] The story became headline news, and euthanasia became the subject of editorial comment on radio and television talk shows.

> After a trial of one week, Robert Waskin was freed by a jury that deliberated only forty minutes before determining that he was temporarily insane when he shot his mother three times. The jury further found that he was no longer insane. The foreman of the jury commented: 'He knew he shot his mother. That was not disputed, but the prosecution failed to show he was of sound mind when he did it.' Robert Waskin is quoted as he prepared to pick up the threads of a nearly shattered life: 'The moral issue of euthanasia . . . was not taken up at the trial, and it should have been faced squarely. Some day it will have to be.'[2]

This case illustrates a dilemma in the criminal law. The underlying values of our society and the Constitution assert the right to life. The protection of life is basic to any legal order. Indeed, as Thomas Hobbs affirmed, the protection of human life is the prime justification for the existence of a state and the accompanying legal machinery. However, when one individual observes another who is suffering from the pain of an incurable disease or a genetic deformation and, motivated by compassion, ends his life, the question arises as to whether he should be regarded as a murderer. One so acting takes the life of another, an act forbidden by law; but his actions are not motivated by malice or personal

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1. Letter from Patrick A. Truite, State's Attorney's Office, Criminal Division, Cook County, Illinois. The State also charged that the defendant previously had tried to administer sleeping pills. Chicago Sun-Times, Aug. 18, 1967.
2. Chicago Daily News, Jan. 25, 1969.

profit, rather they are motivated by the very human desire to end suffering.

Mercy killing raises a myriad of philosophical and theological considerations. However, this paper wll confine itself to a consideration of the issue from the perspective of law and individual rights. This paper will first consider the present state of the law, examine proposed solutions, and suggest an approach to the problem.

THE PRESENT STATE OF THE LAW

The common law does not recognize motive as an element of homicide. If the proved facts establish that the defendant in fact did the killing wilfully, that is, with intent to kill, and as the result of premeditation and deliberation, there is murder in the first degree regardless of motive.[3] Motive is relevant evidence only to establish the degree of murder or homicide (premeditation).[4] Conceptually, if the elements of wilful premeditation exist, the perpetrator of the act stands equally condemned regardless of the fact that he may have acted from an impulse of mercy.[5]

The law in this area, however, cannot be confined to a consideration of statutory language and appellate court reports. An observation of what takes place at the trial level indicates that the law in practice deals differently with mercy killing than does the theory and letter of the law. "The Law In Action is as malleable as the Law On The Books is uncompromising."[6] There is a high incidence of failure to indict, acquittals, suspended sentences and reprieves where the killer had mercy as his motive.[7]

An illustration of one trial court's approach to mercy killing was

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3. P.J.T. CALLAHAN & J. CALLAHAN, THE LAW OF MEDICINE 58-59 (1950); State v. Ehlers, 98 N.J.L. 236, 119 A. 15 (1922); Annot., 25 A.L.R. 1007 (1923).

> The word 'euthanasia' has a Greek origin and is made up of two component parts, namely *eu* and *thanatos*. The best translation for *eu* is: easy, happy, pleasant, painless, while *thanatos* means death. The meaning of the word is therefore: an easy, painless death. To relieve the pains that precede death is the duty of every doctor and may truly be called one of the outstanding missions of the medical profession. This explains why this particular form of euthanasia is universally recognized and accepted.

Rud, *Euthanasia*, J. OF CLINICAL AND EXPERIMENTAL PSYCHOPATHOLOGY, Jan.-Mar. 1953, at 1.

4. *Id.*

5. For further examples, see State v. Ehlers, 98 N.J.L. 236, 119 A.15 (1922); People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920); People v. Kirby, 2 Park Crim. Rep. (N.Y.) 28 (1823); and Rex v. Simpson, 84 L.J.R. (n.s) 1893 (K.B. 1915).

6. See Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

7. *Id.*, at 971 nn.11, 12, & 13.

furnished by *People v. Werner*,[8] involving a sixty-nine year old defendant who suffocated his wife, a hopelessly crippled, bedridden arthritic. In arraignment proceedings, the state waived the murder charge and permitted the defendant to enter a plea of guilty to a charge of manslaughter. The court then found the defendant guilty of this charge on his stipulated admission of the killing. After hearing the testimony of the defendant's children and pastor concerning his unfailing care and devotion during the deceased's two-year illness and reading a letter from her doctor attesting to her excruciating pain and mental despair, the court allowed the defendant to withdraw his plea and entertained a plea of not guilty and then found the defendant not guilty because under the circumstances the jury "would not be inclined to convict." Because there was no reason to be concerned about recidivism, the court withheld the "stigma" of a finding and judgment of guilty and allowed the defendant "to go home . . . and live out the rest of [his] life in as much as [he] can find it in [his] heart to have."

Despite the statutory provisions to the contrary, the court in this case based its decision on the defendant's motives. The procedure followed by the court was criticized as not having been authorized by statute.[9] Although the court had the discretion to permit the defendant to withdraw his plea of guilty, this discretion is limited to those particular instances where it appears that there is doubt as to the defendant's guilt, or that he has any defense at all worthy of consideration by a jury, or that the ends of justice will be served by submitting the case to a jury.[10] These criteria were absent in this case. Nevertheless, in view of the facts, the court's action accords with what may be regarded as a sense of justice. That juries, too, often disregard the dictates of the law on this point is well evidenced by the *Waskin*[11] case and by cases in other jurisdictions.[12]

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8. Crim. No. 58-3636, Cook Co. Ct., Ill., Dec. 30, 1958, *reported in* Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178, 184 & n.15 (1966); and *noted in* 34 NOTRE DAME LAW. 460 (1959).

9. 34 NOTRE DAME LAW. 460 (1959).

10. People v. Throop, 359 Ill. 354, 194 N.E. 553 (1935); People v. Kleist, 311 Ill. 179, 142 N.E. 486 (1924).

11. For other examples of cases of juries superimposing their own beliefs upon the law, see Kamisar, *supra* note 6, at 1019, 1021; and N.Y. Times, May 9, 1939, at 48, col. 1; May 12, 1939, at 1, col. 6; Jan. 23, 1939, at 24; Oct. 2, 1939, at 1, col. 3; Oct. 3, 1938 at 34, col. 3; Oct. 19, 1938 at 46, col. 1.

12. The *Suzanne van de Put* case received international attention. This case involved the trial in Liege, Belgium, of a woman for the murder of her eight day old daughter, born deformed as a result of the use of thalidomide during pregnancy. The husband, mother, sister, and family doctor were arraigned as abettors. Popular sympathy in Belgium and elsewhere was with the defendants, who had acted from what they had imagined were unselfish motives. At the end of a six day trial, the jury acquitted all five defendants. The verdict was greeted with exultation throughout the city. N. St. JOHN-STEVAS, THE RIGHT TO LIFE ch. 1 (1964); Oulahan, *Euthanasia: Should One*

MERCY KILLING NO DIFFERENT FROM OTHER KILLING

Clearly, although conceptually the law does not treat mercy killing differently from other cases involving the taking of human life, in practice an exception does exist. Prosecutors, judges and juries do approach a mercy killing case differently. Public opinion simply does not reflect the same revulsion against an act of mercy killing that it does towards other instances of murder. Therefore, society is not prone to inflict the same type of punishment. Although there may be opposition to mercy killing in principle, there is sympathy for the mercy killer. Significantly, in *People v. Roberts*,[13] one of the few cases where a mercy killer was convicted of first degree murder and sentenced to life imprisonment, the decision was rendered by a judge without a jury.

Invariably, because of the human interest element involved, a mercy killing case will receive wide press coverage and focus public attention. The tendency is for public sympathy to side with the defendant, as was illustrated in the *Suzanne van de Put* case.[14] In the *Waskin* case the presiding judge, the defendant's father and his lawyer received letters urging that mercy be shown.[15] Although objection may be made as to this treatment of mercy killers, it is necessary to separate what may be regarded as the "ought" from the "is." The judicial process as it "is," deals differently with mercy killers. The defendant may be not prosecuted, found innocent because of insanity, or found guilty of a lesser offense then murder and given a light sentence.

THE ABSENCE OF STANDARDS GOVERNING EUTHANASIA

Thus, the law in regard to euthanasia leaves much to be desired. The absence of at least a semblance of objective determination places a gap within the legal system. The element of symmetry is lacking.[16] The accused in a mercy killing case must rely almost entirely on public sentimentality. Objective criteria are not operating. Conceivably, public sentiment may be misplaced, and a clever manipulator of public opinion could kill with evil motive and escape punishment by posing as a mercy killer. In such a situation, the victim is not assured protection. Moreover, the present state of the law, as it is evolving from judicial practice, may in effect be permitting mercy killing without adequate protection for the victim whose death may be unwarranted and uncanted. Clearly, the lack

Kill a Child in Mercy?, LIFE, Aug. 10, 1962, at 34-35; Gallahan, *Tragedy at Liege, van de Put's Thalidomide Baby*, LOOK, Mar. 12, 1963, at 72-74.

13. See note 8 *supra.*
14. See note 12 *supra.*
15. Chicago Sun-Times, Aug. 18, 1967, at 30.
16. K. LLEWELLYN, THE COMMON LAW TRADITION (1962).

of definiteness in the present state of the law does not comport with notions of due process of law.

From another perspective, the current state of the law does not recognize the right of the victim to die if he so desires. He may be in a terminal state suffering from an incurable illness and literally forced to continue a life of pain and despair. Such a denial may well infringe upon an individual's right of privacy.

Suicide and Euthanasia Aiding and Abetting

Related to euthanasia is the law on suicide. If an individual wishes to die and another assists him by providing him with the means for committing suicide, he may be guilty of murder.[17] In early common law suicide was regarded as a criminal offense. The punishment for one who committed suicide was interment in the highway with a stake driven through the body, and the forfeiture of lands, goods and chattels to the king. While sanctions against the body and property of the suicide have been removed, the attempt of a person in England to end his own life deliberately is still an attempt to commit a felony, though not an attempt to commit murder within the Offences against the Person Act of 1861.[18] Although the English common law on suicide was never fully accepted in the United States, in some jurisdictions, such as New York, suicide—though declared not to be a crime—is censured by statute as a "grave public wrong."[19] In at least one American jurisdiction, attempted suicide is still regarded as a misdemeanor.[20]

Today, immunity of suicide actually means immunity of attempted suicide with the law varying in different jurisdictions as to instigators, aiders and abettors. In jurisdictions where the distinction between accessory and principal is abolished, they are treated as principals in homicide.[21] Where punishment of accessories is predicated upon the criminal character of the act of the principal, the instigator, aider and abettor of suicide enjoy immunity, the act of the principal, not being a crime, as prevailing in Germany and France. Finally, some statutes specifically define instigating, aiding and abetting suicide as independent crimes, *sui generis*.

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17. See, *e.g.*, People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920). The defendant husband was convicted of murder in the first degree. He had prepared a poison and had placed it within his wife's reach upon her request while she was confined to bed with arteriosclerosis.

18. N. St. John-Stevas, *supra* note 12, ch. 4.

19. N.Y. Pen. Law § 2301 (McKinney 1944).

20. Silvig, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. Pa. L. Rev. 350, 371 (1954). The discussion is based on the material presented in this article.

21. N.Y. Pen. Law §§ 2304, 2305 (McKinney 1944).

Generally, the law in the United States does not permit one to assist another to commit suicide regarless of motive or if done at the request of the suicide. Some jurisdictions, however, appear to distinguish situations where one has instigated or suggested to another that he commit suicide from where the idea came to the suicide originally.[22] The law does not generally appear to condone suicide. Adaptation is needed to account for situations where the assistance for the commission of suicide is given to one who freely requests such help.

Proposed Solutions

Glanville Wiliams, a recognized legal scholar who has long been an outspoken advocate of euthanasia, has urged that a statute be enacted to permit "voluntary" mercy killing.[24] As originally formulated, his proposal, which is supported by the euthanasia societies in Britain and the United States, envisions the establishment of a means to immunize relatives or physicians who would administer a means of ending life upon a patient who is suffering great pain from an incurable disease for which there is no cure or relief and which if fatal.

The English Society would require the eligible patient who is over twenty-one and suffering from a disease involving severe pain to forward a specially prescribed application—along with two medical certificates, one signed by the attending physician and the other by a specially qualified physician—to a specially appointed euthanasia referee who would satisfy himself by means of a personal interview with the patient and through other means that the conditions have been met and, if so satisfied, would issue a euthanasia permit.[25]

The American Society would have the eligible patient petition for euthansia in the presence of two witnesses. The petition would then be filed with the certificate of an attending physician in a court of appropriate jurisdiction. The court would then appoint a committee of three, of whom at least two would be physicians, who would forthwith examine the patient and such other persons as they deem advisable or as the court might direct. The committee would then within five days report to the court as to whether or not the petition should be granted. The American

22. Annot., 13 A.L.R. 1259 (1921).

23. Examples include J. Fletcher, Morals and Medicine (1954); Fletcher, *The Patient's Right to Die*, Harper's, Oct., 1960; Fletcher, *Anti-Dysthanasia: The Problem of Prolonging Death*, published by the Euthanasia Society, 1962; Collins, *Should We Let Them Die?*, Sat. Eve. Post, May 26, 1962; Anonymous, *A New Way of Dying*, The Atlantic, Jan. 1957.

24. G. L. Williams, The Sanctity of Life and the Criminal Law (1957); and Kamisar, *supra* note 6.

25. Kamisar, *supra* note 6, at 982ff.

proposal was introduced unsuccessfully as a bill in the legislatures of Nebraska and New York.[26]

However, these proposals cover only "voluntary" euthanasia and do not cover the many instances of "involuntary" mercy killing, such as the *van de Put* case. Moreover, the procedure is too cumbersome and bureaucratic in that it brings the law into a sick room. Furthermore, the safeguards are inadequate. There is always the possibility of a mistaken diagnosis that the patient's condition is incurable.

A difficulty also exists in determining whether the consent of the patient is in fact freely given. A patient who has been subjected to drugs is unlikely to be in a rational state. He may well be subject to suggestion by those around him. Moreover, the study of psychology and psychoanalysis has indicated that all men have a suppressed urge for death, the death wish or *thanos*, which may emerge when an inidvidual is seriously ill. This melancholic impulse may temporarily manifest itself in a desire to end life and then later ebb. The ending of life is a final and irrevocable act which cannot be lightly permitted. The inherent risks involved in such a scheme render the proposal objectionable.

Williams, in urging "voluntary" euthanasia, argues for human freedom, the freedom to end one's life. He urges that the law cannot forbid conduct merely because it is undesirable, but only if the social order is adversely affected. In American law, the case might be made that to forbid "voluntary" euthanasia is an infringement of the constitutionally recognized right of privacy[27] as derived from either the fourth amendment, the ninth amendment, or the due process clauses of the fifth and fourteenth amendments. However, the right of privacy may be subordinated to other supervening legislative ends. In this instance, what is involved is society's concern for the security and preservation of human life. Because the authorization of voluntary euthanasia may result in instances in which individuals might be involuntarily deprived of their life, perhaps even with malice or for personal benefit, the state may be deemed justified in forbidding it.

The advocates of "voluntary" euthanasia appear to regard the promotion of their proposal as an entering wedge for the adoption of so-called mercy killing in other instances as well, such as for the elimination of the aged, the congenitally defective and others.[28] Williams reveals this fact when he writes:

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26. *Id.*

27. Griswold v. Connecticut, 381 U.S. 479 (1965); Katin, *Griswold v. Connecticut: The Justices and the Uncommonly Silly Law*, 42 NOTRE DAME LAW. 680 (1967).

28. Kamisar, *supra* note 6.

> Much of the literature discussing voluntary euthanasia has concerned the 'merciful release' of those who are painfully diseased. Yet this is only part of a wider problem of easing the passage of all those who are burdened with the ills frequently associated with old age.
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> . . . .
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> We should, in short, try to shake off the neurotic attitude towards death that has afflicted us for so long, and replace it with a realistic appreciation of death's biological function. To quote Dr. Slater . . . 'death plays a wholly favorable, indeed an essential, part in human economy. Without natural death, human societies and the human race itself would certainly be unable to thrive.' Perhaps when we realize this, we may come to realize at the same time that there is a point in the degeneration of our bodies when life loses its value, and we may then be prepared voluntarily to leave the scene to our successors.[29]

The experience of Nazi Germany illustrates the danger of the wedge problem. There euthanasia was expanded from the "voluntary" variety to the elimination of mentally ill and defective and then used as a rationale for genocide.[30] Indeed, the Nazi authorities had even contemplated the elimination of all cardiac cases. To cite the Nazi example is more than a mere paralogism, for implicit in the rationale behind the advocates of euthanasia is a subordination of the value of human life. Man is not considered an end of himself, but as subordinate to the advancement of other social purposes. When this philosophy becomes predominant, the nature of the social order is subordinate to radical change.

To meet the problem of dealing with the perpetrator of a mercy killing, reference has been made to other legal systems.[31] The German approach of providing the defense of necessity for preserving the community is unacceptable, as there should be neither exculpation nor reduction of sentence where death is administered for the benefit of any person or persons other than the suffering patient.[32] In Modern European codes, motive is considered relevant in classifying an offense. If the motive is the altruistic desire to comply with the victim's request to be killed, the homicide turns into the separate crime of "homicide upon request,"

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29. Williams, *supra* note 8.

30. Kamisar, *supra* note 6; Alexander, *Medical Science under Dictatorship*, 241 NEW ENGLAND MEDICINE 39 (1949); Ivy, *Nazi War Crimes of a Medical Nature*, 139 J.A.M.A. 131 (1949); Koessler, *Euthanasia in the Hadamar Sanitarium and International Law*, 43 J. CRIM. L. C. & P.S. 735 (1953).

31. Silvig, *supra* note 20.

32. *Id.*

punishable by imprisonment in terms of only a few years. The mercy killer is then provided with a more lenient treatment under statutory provisions rather than by resort to more devious means. Moreover, since special treatment is warranted by statute, there is more assurance of uniformity in the adjudication of euthanasia cases.

These concepts could be extended to American law to cover euthanasia. That the concept of motive is not totally alien to the Anglo-American legal system is illustrated by the provision in English law for the offense of infanticide, a modern felony created by statute in 1922 and modified in 1938. A woman who kills her child under the age of twelve months while her mind is disturbed from the effects of giving birth is held to be guilty of manslaughter rather than murder, thereby leaving the sentence to the discretion of the judge.[33]

Another facet of euthanasia involves the situation in which a doctor acts to prolong the life of a patient. The law recognizes a patient's right to consent to or to refuse treatment whether it be an injection or an operation.[34] The Illinois Supreme Court has refused to condone the authorization of blood transfusions to a competent adult who had steadfastly asserted her religious beliefs against such a transfusion despite the fact that she was *in extremis*.[35] The attitude of the law is to recognize the inviolability of the human body. The patient's consent must be voluntary and informed.[36] These notions are buttressed by the constitutionally recognized right to privacy. Clearly, then, a patient may refuse treatment which would extend his life. Such a decision must rest with the patient.

However, when a patient is unconscious or is not in a position to give his consent, the law assumes a constructive consent to such treatment as will save his life.[37] The physician's authority to proceed with treatment is based upon the presumption that the patient would have consented to treatment necessary to protect his life of health if he had been able to do so. But the problem arises as to how far such constructive consent should extend.

A patient may be in a coma suffering from cancer or cerebral hemorrhage. The doctor acts to prolong his life by a series of operations and

33. N. St. John-Stevas, *supra* note 12.

34. Morse, *Legal Implications of Clinical Investigations*, 20 Vand. L. Rev. 747, 752 (1967).

35. *In re* Brooks' Estate, 32 Ill. 2d 361, 205 N.E.2d 435 (1965). A similar decision was reached by a New York court in Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.YS.2d 705 (Sup. Ct. 1962). A different approach is taken with regard to a minor when the parent refuses permission for blood transfusion. Note, 41 Notre Dame Law. 722 (1966).

36. Morse, *supra* note 34.

37. *Id.*

intervenous treatment which continues interminably. The patient may be paralyzed or completely unresponsive to the world about him. The question arises as to how far the physician should go to preserve the patient's life. Catholic theologians have taken the position that the doctor is obliged to take all ordinary means but not extraordinary means.[38] Ordinary means include those medicines and treatment which can be used without causing unnecessary pain or expense. The distinction between ordinary and extraordinary means will vary with time, place, and circumstances. This position may be related to the legal obligation of exercising due care, with ordinary means taken to be coincident with exercise of due care. The standard should be that which is generally practiced.

Under German law a physician's failure to prolong artifically an expiring painful life by applying stimulants is not regarded as homicide.[39] A distinction is made, however, where the victim is not incurably ill. Although the criminality of inaction by a physician has not been decided by American courts, as in the German system of jurisprudence where there is a duty to act, deliberate nonfeasance with intent to cause death is, generally, punishable homicide.[40] The physician's dilemma is further complicated where the patient's immediate illness is not incurable but where a cure will leave him a permanent sufferer. American law apparently requires that life be prolonged in such situations. But inaction when motivated by the physician's desire not to prolong the patient's suffering, is clearly distinguishable from active mercy killing. The argument may be made that since the physician's duty to act is contractual and predicated upon the patient's consent, there being no basis in such instances for presumptive consent, nonfeasance should be unpunished even though active euthanasia remains punishable.[41]

An aspect of this issue came to a head in Britain when it was revealed that a government supported hospital had followed a practice of denying the use of a resuscitator to patients who were aged. A clamor of public protest arose, and the government ordered that such a policy should be reversed.[42] In the United States, such a policy could be regarded as a denial of equal protection for persons in an arbitrarily designated class. The aged would be singled out for denial of essential medical treatment. However, the suspicion lingers that a person of modest means who is brought to a hospital is given less intensive care than would be the case with the wealthy. Less concern may be given to the poverty stricken or the

38. N. St. John-Stevas, *supra* note 12, at 52.
39. Silvig, *supra* note 20.
40. *Id.*
41. *Id.*
42. N.Y. Times, Sept. 24, 1967.

derelict. On the other hand, a patient of considerable means—or whose relatives are wealthy—may receive special attention. There is the possibility that the physicians and the hospital have a vested interest in keeping the patient alive in order to receive extensive remuneration.

A related problem arises as to at what point should the patient be assumed to be regarded as dead. The suggested criterion has been the point where an electroencephalograph indicated that no electrical discharges are being emitted from the brain. Difficult issues arise as to the lengths to which the physician should go to maintain life in such a situation and the fact that such decisions must presently be made renders euthanasia a seemingly less radical proposal.

A Suggested Approach and Conclusions

This survey indicates that the law effecting euthanasia in practice differs from its conceptual basis in that, in practice, the judicial process treats a mercy killer differently from a murderer with malice. The criminal code is in need of adaptation to account for this situation. The suggested approach is to adopt the standard of motive as indicated by the codes of other legal systems. The punishment for an accused who killed at the request of the victim, where the victim was suffering from an incurable disease and was in great pain, would be milder than in other incidents of homicide. A somewhat harsher, but still mild punishment, would be inflicted upon the accused who killed where the victim did not request to be killed or was incapable of giving his rational consent, but was suffering from an apparent physical or mental affliction and there was no element of malice or personal gain. Such an approach would accord with notions of due process. It is submitted that to subject the accused to life imprisonment or execution would constitute excessively cruel and inhumane punishment in contravention to the eighth amendment of the Constitution.

Proposals to date to legalize voluntary euthanasia have been rejected as incapable of providing the necessary safeguards and as being too cumbersome in application. Moreover, such proposals appear to be an entering wedge which opens the door to possible mass euthanasia and genocide.

The law, however, does recognize that a patient has a right to refuse to be treated, even when he is *in extremis,* provided he is an adult and capable of giving consent. Compliance with the patient's wishes

43. N.Y. Times, Oct. 1, 1967; Miami Herald, Feb. 14, 1967.

44. "The House of Lords defeated a Bill that would have permitted voluntary euthanasia in Britain. Opponents said the Bill would allow 'suicide by proxy.'" [Associated Press Release, London: Chicago's American, Mar. 26, 1969, at 10, col 8].

in such circumstances is not the same as voluntary euthanasia. Where, however, the patient is incapable of giving consent, such as when he is in a coma, a constructive consent is presumed and the doctor is required to exercise reasonable care in applying ordinary means to preserve the patient's life. However, he is not allowed to resort to extraordinary care especially where the patient is not expected to recover from the comatose state.

The standard to be applied should reflect the state of the medical art, the condition of the patient and the wishes of the relatives. To assure that patients are not arbitrarily deprived of ordinary medical care and to determine the state where the point has been reached where the patient's life has been deemed to have ended, a special ombudsmen-type board should be established to review each case. Every person, regardless of age or economic circumstance, should be deemed to have a right to life and to the same intensive type of medical treatment which would accord with a standard of ordinary care. Extraordinary care would be given if requested by the relatives. The answer lies in the Rule of Law carefully processed by a judicial determination based upon the best available evidence that merciful termination of a human life shall be decreed.

THE LIVING WILL

The law provides that a patient may not be subjected to treatment without his consent. But when he is in a condition in which his consent cannot be expressed, the physician must assume that the patient wishes to be treated to preserve his life. His failure to act fully to keep the patient alive in a particular instance may lead to liability for negligence. But it may well be that a patient does not desire to be kept in a state of indefinite vegetated animation. How then can the individual patient retain the right of privacy over his body—the right to determine whether he should be permitted to die, to permit his body to be given to the undertaker?

The law clearly prohibits mercy killing, even if undertaken at the patient's request. Thus, the patient cannot request another to end his life. Such an action would subject the actor to prosecution for murder. But an individual does have the right to refuse to permit a doctor to treat him, even if such treatment would prolong his live. If a doctor should act contrary to his wishes, he would be subject to liability.

Where a patient undergoes surgery or other radical treatment, the surgeon or the hospital will require him to sign a legal statement indicating his consent to the treatment. The patient, however, while still retaining his mental faculties and the ability to convey his thoughts, could append to such a document a clause providing that, if his condition becomes incurable and his bodily state vegetative with no possibility that he could

recover his complete faculties, his consent to further treatment would be terminated. The physician would then be precluded from prescribing further surgery, radiation, drugs or the running of resuscitating and other machinery, and the patient would be permitted to die by virtue of the physician's inaction.

The patient may not have had, however, the opportunity to give his consent at any point before treatment. He may have become the victim of a sudden accident or a stroke or coronary. Therefore, the suggested solution is that the individual, while fully in control of his faculties and his ability to express himself, indicate to what extent he would consent to treatment. The document indicating such consent may be referred to as "a *living will*," "a declaration determining the termination of life," "testament permitting death," "declaration for bodily autonomy," "declaration for ending treatment," "body trust," or other similar reference.

The document would provide that if the individual's bodily state becomes completely vegetative and it is certain that he cannot regain his mental and physical capacities, medical treatment shall cease. A Jehovah's Witness whose religious principles are opposed to blood transfusions could so provide in such a document. A Christian Scientist could, by virtue of such a document, indicate that he does not wish any medical treatment.

The document would be notarized and attested to by at least two witnesses who would affirm that the maker was of sound mind and acted of his own free will. The individual could carry the document on his person at all times, while his wife, his personal physician, a lawyer or confidant would have the original copy.

Each individual case would be referred to a hospital committee, board or a committee of physicians. A precedent for the functioning of such committees or boards already exists in many hospitals for determining whether an abortion is medically necessary. The committee or board would consider the circumstances under which the document was made in determinining the patient's intent and also make a determination as to whether the condition of the patient has indeed reached the point where he would no longer want any treatment.

The individual could at any time, before reaching the comatose state, revoke the document. Personal possession of the document would create a strong presumption that he regards it as still binding. Statements and actions subsequent to the writing of the document may indicate a contrary intent. If the physicians find that some doubt exists as to the patient's intent, they would give treatment pending the resolution of the matter. The document, if carried on the patient's person, should indicate what

persons should be contacted if he reaches a comatose state. The physician would consult with them in making a determination.

A *living will* could only be made by a person who is capable of giving his consent to treatment. A person who is a minor, institutionalized, or adjudged incompetent could not make such a declaration. A guardian should not be permitted to make such a declaration on behalf of his ward nor a parent on behalf of his child. If an individual makes a *living will* and is subsequently adjudged incompetent, the *will* would be deemed to be revoked. However, this revocation would not apply where the state of incompetency resulted from the medical condition which was contemplated in making the declaration.

The *living will* is analogous to a revocable or conditional trust with the patient's body as the *res*, the patient as the beneficiary and grantor, and the doctor and hospital as the trustees. The doctor is given authority to act as the trustee of the patient's body by virtue of the patient's consent to treatment. He is obligated to exercise due care and is subject to liability for negligence. The patient is free at any time to revoke the trust. From another perspective, the patient in giving consent to treatment is limiting the authority the doctor and other medical persons may exercise over his body. The patient has the ultimate right to decide what is to be done with him and may not irrevocably confer authority on somebody else. The patient may not be compelled to undergo treatment contrary to his *will*. He should not be compelled to take certain drugs, receive innoculations or therapy or undergo surgery without his express assent. At any point he may stop treatment or he may change physicians.

One problem to be encountered by the *living will* concept is mental illness. An individual who becomes mentally ill has the same rights as any other patient. He may, by the *living will*, anticipate mental illness and limit his consent to treatment accordingly. If in the course of his mental illness he enters an incurable comatose state, treatment may cease. The problem, however, is that, on becoming mentally ill, the court may find him incompetent and appoint a guardian.

Could or should the guardian revoke the *living will* or is it deemed to have become revoked? Here the approach of the trust concept is suggested. The trust relationship between the doctor and the patient was created by the *living will* with the patient as grantor. It was the patient's intent, in creating the trust and drawing the trust document—the *living will*—to cover contingencies wherein he would be incapable of granting or withholding assent to treatment. Incompetency because of mental illness is precisely such a situation. Therefore, the *living will* remains in effect. The guardian may not nullify it. However, when the patient is mentally ill, he may still have instances when his mind is lucid. During such

instances he may indicate to his guardian that he wishes the *will* revoked and the guardian could then act accordingly. He might also indicate this intent to the physician who would so inform the guardian and have the *will* revoked.

The *living will* may be used within another context affecting a mentally ill patient. In agreeing to be committed for treatment to a hospital, he could condition the kind of treatment to be given to him. By voluntarily committing himself he does not automatically confer upon the doctor the right to perform a lobotomy, insulin or electric shock therapy, to deny him the right to choose another doctor, to deny him the right to receive visitors or to enjoy other rights. The *living will* could provide that he be released from the hospital if he fails to receive any treatment or does not respond to therapy. If he is confined against his will, the *living will* could be used as a basis for invoking a writ of habeas corpus to effectuate his release.

The *living will* is limited in its initial creation to adult patients who are capable of exercising their will. It applies to those patients who have the right to decide whether they may receive treatment. It does not apply to a parent acting on behalf of his child. Thus, while an adult patient may refuse to undergo an operation or receive a blood transfusion which will save his life, a parent may not deprive a child of such treatment. Though the state recognizes the rights of parents in relation to their children, it acts *in loco parentis* to protect the rights of the children. But the state may not interfere to infringe upon the rights of a mature individual as to the disposition of his body; the law is required to protect the autonomy of the patient.

However, while a patient may determine the type of medical treatment he may receive, he may not use the *living will* as a means for directing a doctor or another individual to *act* affirmatively to terminate his life. He may not authorize the commission of euthanasia. The Law of Trusts recognizes that certain types of trusts for certain designated purposes may be contrary to public policy. Similarly, a *living will* authorizing mercy killing is contrary to public policy. In this instance, public policy considerations outweigh the apparent rights of the patient. The basic function of the law is to protect human life. Because of the possibility that, if mercy killing be permitted without judicial controls, an individual would be killed contrary to his will and the law now extant cannot permit legalized euthanasia. The right to life is basic and the possibility of some persons being murdered regardless of their *will* means that euthanasia may not be condoned. Therefore, as of now, a doctor cannot be directed to act affirmatively to terminate a patient's life. He may, however, be directed and exculpated to act passively by inaction.

However, the patient's *living will* adjudicated by a court and buttressed by medical and lay testimony and evidence, can create the affirmative inaction termination of a patient's life. This can be resorted to in instances where the hospital board on euthanasia may decline to assume the responsibility.