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LOUISIANA'S NATURAL DEATH ACT AND DILEMMAS IN MEDICAL ETHICS

Michael Vitiello*

In 1984, Louisiana joined the trend towards legislative recognition of a right to refuse medical treatment.¹ The need for legislative action in this area is generally acknowledged: courts have frequently requested legislative guidance to resolve issues presented by withdrawal or denial of questionable medical treatment.² The public shares an interest in the

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1. La. R.S. 40:1299.58.1 - 58.10 (Supp. 1985). 1985 La. Acts No. 187 amended and reenacted La. R.S. 40:1299.58.1 through 1299.58.8 and enacted 1299.58.1A.

As of 1983, thirteen states and the District of Columbia had enacted natural death acts. These states included: Alabama, Ala. Code §§ 22-8A-1 to -10 (1984); Arkansas, Ark. Stat. Ann. §§ 82-3801 to -3802 (Supp. 1985); California, Cal. Ann. Health & Safety Code §§ 7185-7195 (Supp. 1985); Delaware, Del. Code Ann. tit. 16, § 2501(e) (1983); Idaho, Idaho Code Ann. §§ 39.4501-.4508 (1985); Kansas, Kan. Stat. Ann. §§ 65-28, 101-109 (1980); Nevada, Nev. Rev. Stat. §§ 449.540.690 (1983); New Mexico, N.M. Stat. Ann. §§ 24-7-1 to -7-11 (Supp. 1981); North Carolina, N.C. Gen. Stat. §§ 90-320 to -323 (1985); Oregon, Or. Rev. Stat. §§ 97.050-.090 (1984); Texas, Tex. Stat. Ann. art. 4590(h) (1985); Vermont, Vt. Stat. Ann. tit. 18, §§ 5252-5262 (Supp. 1985); and Washington, Wash. Rev. Code Ann. §§ 70.122.010-.122.905 (Supp. 1985). See President's Commission for the study of Ethical Problems in Medicine and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* at 318-87 (1983) [hereinafter cited as *Commission Report*].

Since 1983, many more states including Louisiana, have followed suit. Among them are Arizona, Ariz. Rev. Stat. Ann. §§ 36-3201 to -3210 (Supp. 1985); Colorado, Colo. Rev. Stat. §§ 15-18-101 to -103 (Supp. 1985); Florida, Fla. Stat. Ann. §§ 765.01-.15 (Supp. 1985); Georgia, Ga. Code Ann §§ 31-32-1 to -12 (Supp. 1984); Illinois, Ill. Ann. Stat. ch. 110 1/2, 701-709 (Supp. 1985); Indiana, Ind. Code Ann. §§ 16-8-11-1 to -11-12 (Supp. 1985); Iowa, 1985 Iowa Legis. Serv. p. 2 (West) (Senate File 25); Maine, Me. Rev. Stat. Ann. tit. 22, § 2921 (Supp. 1985); Maryland, Md. Health Gen. Code Ann. §§ 5-601 to -614 (Supp. 1985); Mississippi, Miss. Code Ann. §§ 41-41-101 to -121 (Supp. 1985); Missouri, Mo. Rev. Stat. § 459.010 (Supp. 1985); New Hampshire, N.H. Rev. Stat. Ann. §§ 137H:1 to -16 (Supp. 1985); Oklahoma, Okla. Stat. Ann. tit. 63, § 3101 (Supp. 1985); Tennessee, Tenn. Code Ann. § 32-11-101 (Supp. 1985); Utah, Utah Code Ann. § 75-2-1101 (Supp. 1985); Virginia, Va. Code §§ 54-325:8.1-8.13 (Supp. 1984); West Virginia, W. Va. Code 16-30-1 to -30-10 (Supp. 1984); Wisconsin, Wis. Stat. Ann. §§ 154.01 to -.15 (Supp. 1984); and Wyoming, Wyo. Stat. Ann. §§ 36-26-144 to -152 (Supp. 1985).

Several additional states have durable power of attorney statutes which allow a person to appoint an agent specifically to make medical decisions on his behalf if he becomes incompetent. See *Commission Report*, supra, at 146-46, 393-422.

2. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1346 (Del. 1980) (inviting the legislature's "prompt attention" to enact state policy governing these matters); *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980) (stating that this type of issue is addressed better in a legislative forum); accord *In re Conroy*, 98 N.J. 321, 344-45, 486, A.2d 1209, 1221 (1985); *In re Storar*, 52 N.Y.2d 363, 382-83, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 (1981) (emphasizing that enlargement of the judiciary's role in these

subject. Many people have executed "living wills,"³ even without enabling legislation, in the hope of being spared unwanted treatment.⁴ Well-drafted legislation permits a patient or a surrogate to assert the patient's rights without the burden of litigation.⁵ Such legislation assists health care providers to establish policies governing withdrawal or denial of treatment.⁶ Further, it frees them from concern about criminal and civil liability in cases where termination of treatment leads to a patient's death.⁷

situations, if desirable, should be made by the legislature); *In re Colyer*, 99 Wash. 2d 114, 139, 660 P.2d 738, 752 (1983) (inviting the legislature to address this "sensitive" issue).

3. The terms "living will," "advance directive," and "declaration" are used interchangeably to refer to a document which "lets people anticipate that they may be unable to participate in future decisions about their own health care." See *Commission Report*, supra note 1, at 136. The Commission Report distinguishes between an "instruction directive," which "specifies the types of care a person wants (or does not want to receive)," and a "proxy directive," which "specifies the surrogate a person wants to make such decisions if the person is ever unable to do so." *Id.* Most living wills circulated by right-to-die groups or authorized by statute are "instruction directives," rather than "proxy directives," despite some clear advantages provided by "proxy directives." *Id.* at 145-51.

4. One group, Concern for Dying, has circulated millions of copies of standard form "living wills." See *Questions and Answers About the Living Wills* (pamphlet) (Concern for Dying, New York), cited by *Commission Report*, supra note 1, at 139, nn. 49, 52. This concern is, in part, motivated by dramatic advances in medical technology which may be able to delay the moment of death although not curing the patient's underlying illness. *Id.* at 1 n.1.

5. Apart from the obvious cost of litigation, judicial proceedings frequently resolve the dispute after the patient has died. See, e.g., *John F. Kennedy Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984) (patient died over three years before final decision); *In re Conroy*, 98 N.J. 321, 341, 486 A.2d 1209, 1219 (1985) (patient died before New Jersey Supreme Court's decision); *In re Storar*, 52 N.Y.2d 363, 369, 420 N.E.2d 64, 66, 438 N.Y.S.2d 266, 268 (consolidated cases in which both patients died prior to the decision of the New York Court of Appeals), cert. denied, 454 U.S. 858 (1981).

6. See, e.g., Bayley, *Who Should Decide*, in *Legal and Ethical Aspects of Treating Terminally Ill Patients*, 3, 10-11 (A. Doudera & J. Peters eds. 1982) [hereinafter cited as *Legal and Ethical Aspects*] (commentary on living will legislation); Van Scoy-Mosher, *An Oncologist's Case for No-Code Orders*, *id.* at 14, 17 (discussing drafting of guidelines for writing order not to resuscitate); Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 *Am. J.L. & Med.* 233, 242 (1978) (stating that physicians should seek legislative protection in cases involving denial or withdrawal of life-sustaining treatment).

7. See, e.g., Oakes, *A Prosecutor's View of Treatment Decisions*, in *Legal and Ethical Aspects*, supra note 6, at 194, 199 (withdrawal of life support could subject physicians to criminal liability); Robertson, *Legal Aspects of Withdrawing Medical Treatment from Handicapped Children*, *id.* at 213, 217-18 (liability of attending physician regarding defective newborns); Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 *Stan. L. Rev.* 213, 224-35 (1975) (discussing criminal liability of physicians and other health care providers that refuse ordinary lifesaving medical care for defective infants). It is generally assumed that the risk of criminal or civil suit in such cases is quite low. See, e.g., Mnookin, *Two Puzzles*, 1984 *Ariz. St. L.J.* 667, 669-71

Despite this trend, natural death acts may have created more problems than they solve. As observed by a leading commentator on medical ethics, "[t]he intent of these statutes is simple, . . . [to] mak[e] 'Living Wills' legally binding documents. Yet the resulting statutes are, in my view, so cumbersome and restrictive as to be useless at best, and possibly very mischievous."⁸ Some statutes, for example, are so narrow that the almost never apply to the cases confronting patients and care providers.⁹ Further, health care providers and courts may construe statutory provisions as constituting a seriously ill patient's exclusive rights, leading to inappropriate treatment of the dying patient.¹⁰ Indeed, provisions of Louisiana's natural death act have already been amended to correct a misreading of the act.¹¹ Apparently on advice of counsel, health care providers routinely compelled parents of seriously ill minors to seek court approval to authorize the hospital to terminate nonbeneficial life-sustaining treatment.¹²

Natural death acts are seldom drafted to answer all of the complex moral dilemmas that have arisen when patients or their surrogates have resisted treatment.¹³ Over the past decade courts, acting to fill a legislative void, have established a right to refuse medical treatment.¹⁴ At the same

(arguing that law in action is vastly different from law on the books, and noting an absence of criminal and neglect proceedings in cases involving seriously ill newborns). There is evidence, however, that the threat of suit is increasingly real. See, e.g., *United States v. University Hosp.*, 575 F. Supp. 607, 609 (E.D.N.Y. 1983) (suit by government to compel production of medical records for seriously ill newborn), *aff'd*, 729 F.2d 244 (2d Cir. 1984); *Weber v. Stony Brook Hosp.*, 60 N.Y.2d 208, 456 N.E.2d 1186, 469 N.Y.S.2d 63 (suit by "stranger" to compel treatment of seriously ill newborn), *cert. denied*, 104 S. Ct. 560 (1983).

8. Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment*, 1984 *Ariz. St. L.J.* 647, 652. Professor Capron was the Executive Director of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research.

9. See, e.g., Cal. Health & Safety Code §§ 7188, 7191(b) (Supp. 1985) (requiring re-execution of declaration at least 14 days after diagnosis of terminal illness). See *Commission Report*, *supra* note 1, at 142-43 (The California act is very narrow because few patients will remain competent fourteen days after diagnosis that death is imminent.).

10. See *Commission Report*, *supra* note 1, at 144-45 (suggesting that health care providers may view a natural death act as the exclusive means to implement a decision to forego treatment despite legislative disclaimer).

11. See 1985 La. Acts No. 187, amending La. R.S. 40:1299.58.1.

12. See Vitiello, *Letting Seriously Ill Minors Die: A Review of Louisiana's Natural Death Act*, 31 *Loy. L. Rev.* 67 (1985) (discussing crisis in health care for dying minors caused by misunderstanding of Louisiana's natural death act).

13. See *infra* notes 255-364 and accompanying text.

14. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980) (holding that surrogate may authorize withdrawal of life-support system, even absent legislation, based on constitutional right of privacy); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980) (holding that competent patient has right to refuse medical treatment, even absent legislation, based on right to

time, commentators and courts have tried to reconcile that right with traditional prohibitions against suicide and euthanasia.¹⁵ Thus, a patient's right to resist medical treatment cannot be understood solely by reference to recent natural death acts.

This article analyzes Louisiana's natural death act from several perspectives. Section one discusses important provisions of the Act and its recent amendments. The second section contrasts Louisiana's act with representative legislation from other jurisdictions.¹⁶ Section three analyzes whether the Act violates the prohibition against euthanasia.¹⁷ Section four discusses some problems that have arisen in other jurisdictions and analyzes how those cases might be resolved in Louisiana.¹⁸ Finally, section five discusses some shortcomings of the Act, most notably its provisions governing withdrawal of treatment from seriously ill minors.¹⁹ Despite these failings, this article concludes that Louisiana's statute, as amended, is one of the most enlightened natural death acts to date.

A REVIEW OF LOUISIANA'S NATURAL DEATH ACT²⁰

As originally enacted, Louisiana's natural death act recognized that it was a fundamental right of all competent adults "to control the

privacy); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (holding that guardian may request removal of artificial feeding device under appropriate circumstances, even absent legislation, based on right to privacy).

15. See, e.g., *Satz*, 362 So. 2d at 162 (declining life-sustaining treatment is not suicide because death is primarily the result of underlying disease, not self-inflicted injury); *In re Quinlan*, 70 N.J. 10, 51-52, 355 A.2d 647, 669-70 (death resulting from exercise of constitutional right of privacy is not homicide), cert. denied, 429 U.S. 922 (1976). See also Cantor, *Quinlan Privacy, and the Handling of Incompetent Dying Patients*, 30 Rutgers L. Rev. 243, 263 (1977) (criminal culpability is absent because no affirmative duty owed to patient based on good medical practice). But see Kamisar, *A Life Not (Or No Longer) Worth Living: Are We Deciding the Issue Without Facing It?* (Mitchell Lecture delivered at the State University of New York at Buffalo, Nov. 10, 1977) (arguing that in *Quinlan*, the New Jersey Supreme Court authorized involuntary euthanasia without acknowledging that fact).

16. See *infra* notes 92-151 and accompanying text.

17. La. Const. art. I, § 20 (1974) provides, *inter alia*, that "no law shall subject any person to euthanasia. . . ." See *infra* notes 152-254 and accompanying text.

18. See *infra* notes 255-364 and accompanying text.

19. See *infra* notes 365-435 and accompanying text.

20. Passage of Louisiana's natural death act was the culmination of several unsuccessful previous attempts to do so. The following account appears in an unpublished paper by Judge P.J. Laborde, Jr., entitled "Death with Dignity: A Proposed Natural Death Act for Louisiana":

The introduction of House Bill 996 marks the fourth attempt in Louisiana to enact a statute providing for living wills. House Bill 1240 of 1977 by Representative Hainkel and House Bill 1085 of 1978 by Representative Leblanc were never scheduled for hearing in committee. Senate Bill 578 of 1977 was a duplicate of House Bill 1240. It died in senate committee. One other measure, Senate Bill 113 of 1979 by Senator Casey was introduced and it also died in committee.

decisions relating to their own medical care," most importantly, in instances when that person was suffering from "a terminal and irreversible condition."²¹ The Act was intended to prevent a patient's "loss of individual and personal dignity"²² by recognizing a competent adult's right "to make an oral or written declaration" designating a surrogate to make treatment decisions for the patient or instructing specific treatment to be withdrawn.²³ The Act went further, however, and established procedures for incompetent patients who had not made declarations²⁴ and for terminally ill minors.²⁵ Finally, the Act was also intended to clarify the rights and duties of health care professionals²⁶ and life insurance companies²⁷ when an insured patient dies as a result of the withdrawal of medical treatment.

Recent amendments make clear that the Act applies to all persons, not merely to competent adults.²⁸ More importantly, the legislature has underscored the fact that recourse to a declaration is not "the exclusive means by which life-sustaining procedures may be withheld or withdrawn."²⁹ Health care professionals are not required to apply "medically inappropriate treatment" to a patient in cases where he or his family has not executed a declaration.³⁰ That is, physicians, patients, and patients' families may continue to make critical medical decisions based on patients' best interests without complying with the Act: compliance with the act is "voluntary," and "making of a declaration . . . is merely illustrative as a means of documenting a patient's decisions relative to withholding . . ." treatment.³¹

Louisiana Revised Statutes 40:1299.58.3 governs the execution and form of a declaration, and notification of its existence. A competent adult may execute a written declaration at any time, not merely after

In 1983, the House of Representatives failed to report favorably on H.B. 996, Reg. Sess. 1983; instead, it referred the bill for joint study by both houses of the legislature. House Concurrent Study Request No. 30 (1983). The act as passed mirrors H.B. 996, with minor modifications. Compare H.B. 996, Reg. Sess. 1983, with S.B. 271, Reg. Sess. 1984.

21. La. R.S. 40:1299.58.1(A) (Supp. 1986).

22. La. R.S. 40:1299.58.1(B) (Supp. 1986).

23. La. R.S. 40:1299.58.1(C) (Supp. 1986).

24. La. R.S. 40:1299.59.5 (Supp. 1986).

25. La. R.S. 40:1299.58.6 (Supp. 1986).

26. La. R.S. 40:1299.58.7-.58.8 (Supp. 1986).

27. La. R.S. 40:1299.58.10 (Supp. 1986).

28. See, e.g., La. R.S. 40:1299.58.1(A) (Supp. 1986) (changing "all competent adults" to "all persons"); La. R.S. 40:1299.58.1(C) (Supp. 1986) (recognizing the right of "such persons," not just of "a competent adult," as originally promulgated).

29. La. R.S. 40:1299.58.1(D) (Supp. 1986); see also La. R.S. 40:1299.58.1A(A)-(C) (Supp. 1986) (clarifying intent of the Act).

30. La. R.S. 40:1299.58.1(D) (Supp. 1986).

31. La. R.S. 40:1299.58.1A(C) (Supp. 1986).

she is confronted with a diagnosis of terminal illness.³² To be valid under the statute, a declaration must be signed in the presence of two witnesses.³³ The witnesses must be competent adults, neither related to the declarant nor entitled to any portion of the estate of the person from whom treatment is to be withdrawn.³⁴ The witnesses are to guarantee that the declarant's signature is authentic, and, apparently, to attest that the declarant is of sound mind.³⁵ The statute does not require a declaration to be reexecuted at any time.³⁶

Section 1299.58.3(B) of the Act places responsibility on the declarant to notify her attending physician that she has made a declaration. If the declarant is unable to do so, any other person may notify the physician.³⁷ The physician must then make the declaration a part of the declarant's medical records. If the declaration is oral, the physician must include in the medical records an explanation of why the patient could not make a written declaration.³⁸

The statute provides a standard form declaration.³⁹ That form, in essence, provides that upon a diagnosis of a terminal and irreversible illness, life-sustaining procedures may be withheld or withdrawn. The form is not mandatory and "may include other specific directions including" appointment of a surrogate decisionmaker.⁴⁰

The statute also permits a patient to make an oral declaration.⁴¹ Like the written declaration, an oral declaration must be made in the presence of two witnesses. By contrast, the statute contains several additional safeguards. An oral declaration must also be witnessed by

32. La. R.S. 40:1299.58.3(A) (Supp. 1986).

33. *Id.*

34. La. R.S. 40:1299.58.2(9) (Supp. 1986). That provision originally barred the patient's attending physician, and any employee of the physician or health care facility from serving as a witness.

35. The definition section of the Act does not explain the function of the witness. *Id.* But the sample form provides as follows: "The declarant has been personally known to me and I believe him or her to be of sound mind." La. R.S. 40:1299.58.3(C)(1) (Supp. 1986). That is the preferred role for a witness. See *Commission Report*, *supra* note 1, at 149.

36. La. R.S. 40:1299.58.3(A) (Supp. 1986) (providing that any adult may prepare a declaration at any time; no provision is made for re-execution of the document).

37. La. R.S. 40:1299.58.3(B) (Supp. 1986) provides in part:

It shall be the responsibility of the declarant to notify his attending physician that a declaration has been made. In the event the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of the declaration. Any attending physician who is so notified shall promptly make the declaration or copy of the declaration, if written, a part of the declarant's medical record.

38. La. R.S. 40:1299.58.3(B) (Supp. 1986).

39. La. R.S. 40:1299.58.3(C)(1) (Supp. 1986).

40. *Id.* The Act also provides that a specific invalid directive is severable from valid instructions; La. R.S. 40:1299.58.3(C)(2) (Supp. 1986).

41. La. R.S. 40:1299.58.3(A) (Supp. 1986).

the attending physician. It is not binding unless it is made after a diagnosis of a terminal and irreversible condition.⁴² Prior to passage, the Act was amended to require that the reasons why the declarant could not make a written declaration be included in the patient's medical records, and that the content of the oral declaration also be recited in the medical records.⁴³

Revocation of either written or oral declaration is appropriately easy: (1) a declarant may destroy or direct that another person destroy the document;⁴⁴ (2) he may make a signed and dated written revocation;⁴⁵ or (3) he may revoke the prior declaration orally.⁴⁶

Although all natural death acts provide for a written declaration, the more common problem faced by health care professionals, families, and courts is whether treatment should be withdrawn from an incompetent patient who has not made a declaration.⁴⁷ The Louisiana statute provides for a procedure in such cases when a patient, incapable of making a treatment decision, is diagnosed as terminally and irreversibly ill.⁴⁸ Originally applicable only to adults, the Act was amended to apply to all qualified patients.⁴⁹

A declaration may be made on behalf of an incompetent⁵⁰ only after he is declared a "qualified patient."⁵¹ The declaration may be made by

42. *Id.*

43. The Act provides: "If the declaration is oral, the physician shall promptly make a recitation of the reasons the declarant could not make a written declaration and make the recitation a part of the patient's medical records." La. R.S. 40:1299.58.3(B)(4) (Supp. 1986). Prior to amendment, House Bill 996 provided simply: "If the declaration is oral, the physician shall promptly make the fact of such declaration a part of the patient's medical record." H.B. 996, Reg. Sess. (1983).

44. La. R.S. 40:1299.58.4(1) (Supp. 1986).

45. La. R.S. 40:1299.58.4(2)(a) (Supp. 1986).

46. La. R.S. 40:1299.58.4(3)(a) (Supp. 1986).

47. See Rosoff, Living Wills and Natural Death Acts, in *Legal and Ethical Aspects*, supra note 6, at 186, 191 (stating that statutes reviewed fail to meet "one of the most pressing societal needs . . . what to do . . . where the individual has not executed a document and is in a persistent vegetative state.").

48. La. R.S. 40:1299.58.5 (Supp. 1986).

49. La. R.S. 40:1299.58.5(A) (Supp. 1986). That section was amended, deleting the requirement that a patient be "an adult," to apply to "a qualified patient." But more particular provisions apply to similarly situated "minors." La. R.S. 40:1299.58.6 (Supp. 1986). Presumably if a minor did not have a spouse or parents to act as a surrogate as provided in La. R.S. 40:1299.58.6 (Supp. 1986), provisions of La. R.S. 40:1299.58.5(1), (5), & (6) (Supp. 1986) would apply.

50. La. R.S. 40:1299.58.5(A) (Supp. 1986). Incompetence can arise from being comatose, from any other physical or mental condition which renders a person "incapable of communication," or from minority. La. R.S. 40:1299.58.5(A), 1299.58.6 (Supp. 1986).

51. *Id.* The Act defines a "qualified patient" as "a patient diagnosed and certified in writing as having a terminal and irreversible condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient." La. R.S. 40:1299.58.2(7) (Supp. 1986).

specified individuals "in the following order of priority, if there is no individual in a prior class . . . reasonably available, willing and competent to act:"⁵² first, a judicially appointed tutor or curator;⁵³ second, the patient's spouse if not judicially separated;⁵⁴ third, an adult child or adult children;⁵⁵ fourth, the patient's parents;⁵⁶ fifth, a sibling;⁵⁷ sixth, any other ascendants or descendants.⁵⁸ The declaration must be made before at least two witnesses.⁵⁹ In cases involving children, parents, siblings, or other relatives, the decision must apparently be unanimous.⁶⁰

The Act provides more detailed provisions for terminally ill minors. Section 1299.58.6(A) indicates that a minor may not prepare a declaration.⁶¹ Instead, if a minor is terminally and irreversibly ill,⁶² a document *may* be executed on behalf of the minor. The document may be executed only (1) by the minor's spouse, "if [the spouse] has reached the age of majority";⁶³ or (2) absent a qualifying spouse, by "either the parent or guardian of the minor."⁶⁴ The appropriate party may not execute a declaration, quite sensibly, if the terminally ill minor objects.⁶⁵ More difficult to justify is the provision that a parent or guardian may not execute the document "if he has actual notice of opposition by either another parent or guardian, or a spouse who has attained the age of majority."⁶⁶

52. La. R.S. 40:1299.58.5(A) (Supp. 1986).

53. La. R.S. 40:1299.58.5(A)(1) (Supp. 1986).

54. La. R.S. 40:1299.58.5(A)(2) (Supp. 1986).

55. La. R.S. 40:1299.58.5(A)(3) (Supp. 1986).

56. La. R.S. 40:1299.58.5(A)(4) (Supp. 1986).

57. La. R.S. 40:1299.58.5(A)(5) (Supp. 1986).

58. La. R.S. 40:1299.58.5(A)(6) (Supp. 1986).

59. La. R.S. 40:1299.58.5(B) (Supp. 1986). The purpose for the presence of these witnesses is difficult to determine. La. R.S. 40:1299.58.2(9) (Supp. 1986), defining "witness," does not require that a witness possess medical knowledge, but does disqualify a relative and people who are entitled to a portion of the declarant's estate. La. R.S. 40:1299.58.2(9) (Supp. 1986). Thus the witness may not be qualified to confirm the diagnosis and may be a stranger to the parties.

60. The Act provides: "If there is more than one person within the above named class in paragraphs (3) through (6), then the declaration shall be made by all of that class available for consultation upon good faith efforts to secure participation of all of that class." La. R.S. 40:1299.58.5(A) (Supp. 1986).

61. La. R.S. 40:1299.58.6(A) (Supp. 1986) provides that certain individuals may prepare a declaration on the minor's behalf. Section 1299.58.3, allowing execution of a declaration by a person on his own behalf is limited to "any adult person." La. R.S. 40:1299.58.3(A) (Supp. 1986).

62. La. R.S. 40:1299.58.6(A) (Supp. 1986) requires that the minor be a "qualified patient" before the document may be executed on his behalf. In turn, a "qualified patient" is one who is "diagnosed and certified in writing as having a terminal and irreversible condition." La. R.S. 40:1299.58.2(7) (Supp. 1986).

63. La. R.S. 40:1299.58.6(A)(1) (Supp. 1986).

64. La. R.S. 40:1299.58.6(A)(2) (Supp. 1986).

65. La. R.S. 40:1299.58.6(B)(1) (Supp. 1986).

66. La. R.S. 40:1299.58.6(B)(2) (Supp. 1986). For criticism of these provisions, see *infra* notes 389-435 and accompanying text.

Prior to recent amendments, the Act required judicial supervision in any case in which the minor's surrogates chose to execute a declaration pursuant to section 1299.58.6.⁶⁷ The statute did not clearly state the purpose of the district court's involvement.⁶⁸

Despite language to the contrary,⁶⁹ lawyers for some health care providers counselled their clients that court proceedings were necessary in all cases in which a family sought to terminate or to resist life-sustaining procedures for a terminally ill minor.⁷⁰ That interpretation of the Act led to unwarranted intrusion by the judiciary into treatment decisions properly left to the affected parties.⁷¹

Recent amendments were aimed primarily at correcting that misunderstanding of the Act. Thus, the amendments now permit the appropriate decisionmaker⁷² to prepare a declaration on behalf of a minor

67. La. R.S. 40:1299.58.6(D) (Supp. 1986), deleted in recent amendments, provided that "[A]ny person executing a declaration pursuant to the provisions of this Section shall petition the district court in the parish in which the minor is domiciled or the parish in which the minor is being maintained for certification upon the face of the document."

68. The Act stated that the district court shall certify the document upon its face if "all requirements of this Part have been satisfied and . . . the document was executed in good faith." La. R.S. 40:1299.58.6(D)(4) (Supp. 1986). The court was required to appoint an attorney to represent the minor, but an evidentiary hearing was optional. La. R.S. 40:1299.58.6(D)(2) (Supp. 1986). The purpose of the evidentiary hearing was unclear. Provisions governing adults contemplate judicial proceedings only if no appropriate family member is available, and then for the limited purpose of appointing a surrogate decisionmaker, not for determining the merits of whether the patient should have treatment or of whether the patient would want treatment. That is so because La. R.S. 40:1299.58.6 (Supp. 1986) may have contemplated a far broader role for the court. The court may have been required to conduct a hearing on the merits. That is because La. R.S. 40:1299.58.6(D) (Supp. 1986) required the appointment of an attorney for the minor and made permissive the holding of an evidentiary hearing. *Id.* The purpose of the hearing was not specified, but it would offer opportunity for a challenge to the proposed course of treatment.

69. La. R.S. 40:1299.58.6(A) (Supp. 1986) provided, in relevant part: "If a minor has been certified as a qualified patient, the following individuals may execute the document on his behalf."

70. See, e.g., *Impact Weekly*, Vol. 4, No. 39, Nov. 16, 1985, in which an attorney for the Louisiana Hospital Association stated that the Act "is considered by several attorneys, including myself, to be mandatory. It is written to encompass all situations and is perceived to include 'no code' and 'Do not resuscitate situations.'" Thus, he advised: "If a No Code or DNR order is issued, there should be documentation in the record substantiating such an order. That documentation should include a copy of the 'living will' executed by the patient or someone authorized by the patient or by law to act on the patient's behalf." See also *Decision to Allow Child to Die Not Theirs Alone*, *Parents Find*, *New Orleans Times Picayune-States Item*, Dec. 2, 1984, at A1 (quoting several New Orleans physicians and hospital attorneys who believed that the Act required futile treatment for dying minors, absent a court-approved living will).

71. See *Vitiello*, *supra* note 12. Louisiana's Attorney General gave the Act a sensible interpretation, rejecting the view that the Act was mandatory. See *A. G. Opin. 85-57* (Jan. 28, 1985).

72. La. R.S. 40:1299.58.6(A) (Supp. 1986) allows (1) "the spouse if he has reached the age of majority;" or, absent a qualifying spouse, (2) "either the parent or guardian of the minor" to prepare a declaration.

without court intervention.⁷³ Further, the minor's parents or spouse are not required to execute a declaration in order to terminate life-sustaining procedures.⁷⁴ That is, the legislature has made clear by amendment what was implicit in the original act: a declaration is an additional option for patients and their families. It did not supplant traditional practice that allowed nonbeneficial treatments to be withheld based exclusively on consultation between the physician and the dying patient's family.⁷⁵

Section 1299.58.7 addresses a physician's responsibilities with regard to a terminally and irreversibly ill patient. A physician, aware of the existence of a declaration or of the decision to withdraw treatment made by a properly designated surrogate, must certify in writing a diagnosis of terminal and irreversible illness and arrange for a second physician to confirm the diagnosis.⁷⁶ The second physician's diagnosis must also be certified in writing.⁷⁷ A physician who disagrees with the decision to withdraw treatment must make reasonable efforts to transfer the patient to another physician.⁷⁸

The Act includes a grant of partial immunity to health care professionals.⁷⁹ To be entitled to the statutory immunity from criminal and civil liability, the health care professional must be acting pursuant to a good faith belief concerning the patient's intention and must be acting only after a patient has been found to be a "qualified patient."⁸⁰ In any proceedings against the health care provider, the burden of proof

73. The amendments deleted La. R.S. 40:1299.58.6(C) (Supp. 1986) (requiring certification by district court) and (D) (requiring appointment of attorney to represent the minor and permitting an evidentiary hearing).

74. La. R.S. 40:1299.58.6 (Supp. 1986) now provides, in relevant part:

Nothing in this Section shall be construed to require the making of a declaration for a terminally ill minor. The legislature intends that the provisions of this Part are permissive and voluntary . . . the making of a declaration pursuant to this Part merely illustrates a means of documenting the decision relative to withholding or withdrawal of medical treatment or life-sustaining procedures on behalf of a minor.

75. See *Commission Report*, supra note 1, at 145 (encouraging sensible advice from attorneys and interpretation by courts where natural death bills are enacted to prevent them from being "a means that limits decisionmaking of patients who have not executed binding directives pursuant to the act.").

76. La. R.S. 40:1299.58.7(A) (Supp. 1986) provides that the attending physician "shall take necessary steps to provide for written certification of the patient's terminal and irreversible condition . . ." Section 1299.58.58.2(7) requires a written certification by a second physician. La. R.S. 40:1299.58.2(7) (Supp. 1986).

77. La. R.S. 40:1299.58.2(7) (Supp. 1986).

78. La. R.S. 40:1299.58.7(B) (Supp. 1986).

79. La. R.S. 40:1299.58.8 (Supp. 1986).

80. La. R.S. 40:1299.58.8(A) (Supp. 1986). Subsection (C) provides that such immunity is inapplicable if the person seeking the immunity did not act in good faith.

is on the state or, in civil litigation, on the plaintiff to show the lack of good faith.⁸¹

The recent amendments to the Act have expanded the immunity granted to health care professionals. Section 1299.58.8(B) grants the same immunity as did the original act even if the health care provider is not acting pursuant to a statutory declaration.⁸² That is, the immunity applies if life-sustaining procedures are withheld or withdrawn pursuant to "an alternative voluntary means" to the statutory declaration.⁸³

Section 1299.58.9 established penalties for certain violations of the Act.⁸⁴ Subsection (A) provides for civil liability for anyone who damages a written declaration or falsifies a revocation.⁸⁵ That is, a person is civilly liable for keeping a patient alive against his will. Subsection (B) provides for criminal penalties for a person who forges a declaration or conceals a revocation.⁸⁶ Thus, a person may be prosecuted, presumably for homicide, if he hastens the death of a critically ill patient.⁸⁷

Section 1299.58.10 attempts to clarify the relationship of the Act to other legal provisions.⁸⁸ First, it specifically disclaims that the Act

81. La. R.S. 40:1299.58.8(C) (1) (Supp. 1986) provides that immunity shall be available "unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures did not . . . act, in good faith"

82. La. R.S. 40:1299.58.8(B) (Supp. 1986).

83. *Id.* This provision would appear to reflect what is already common practice among prosecutors. See, e.g., Ginex, A Prosecutor's View on Criminal Liability for Withholding or Withdrawing Medical Care: The Myth and the Reality, in *Legal and Ethical Aspects*, supra note 6, at 205, 210.

84. La. R.S. 40:1299.58.9 (Supp. 1986).

85. Specifically, La. R.S. 40:1299.58.9(A) (Supp. 1986) provides: "Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without such declarant's consent or who falsifies or forges a revocation or the declaration of another shall be civilly liable."

86. Specifically, La. R.S. 40:1299.58.9(B) (Supp. 1986) provides:

Any person who falsifies or forges the declaration of another or willfully conceals or withholds personal knowledge of a revocation of a declaration with the intent to cause the withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby because of such act directly causes life-sustaining procedures to be withheld or withdrawn and death thereby to be hastened may be subject to prosecution under Title 14 of the Louisiana Revised Statutes of 1950.

87. The reference in La. R.S. 40:1299.58.9(B) (Supp. 1986) to the Louisiana Criminal Code is not entirely clear, but it presumably authorizes indictment for murder based on the notion that any shortening of life constitutes homicide. See W. LaFave & A. Scott, *Handbook on Criminal Law* § 67 (1972). Given that a patient must be diagnosed by two physicians as terminally and irreversibly ill, such a prosecution for murder appears unduly harsh. The harshness was mitigated somewhat by an amendment of H.B. 996 which originally stated that "a person who falsifies or forges the declaration of another . . . shall be subject to prosecution." H. B. 996, Reg. Sess. 1983, § 1299.58.9(B).

88. La. R.S. 40:1299.58.10 (Supp. 1986).

condones euthanasia. Instead, the Act merely eliminates obstacles to the natural process of dying.⁸⁹ Second, for purposes of insurance claims, withdrawal of life-support systems is not to be deemed the cause of death.⁹⁰ Third, the statute states that its provisions are "cumulative with existing law pertaining to an individual's right to consent or refuse to consent to medical or surgical treatment."⁹¹

Thus, the statute creates three classes of adult patients: (1) competent adults who may prepare written declarations at any time; (2) competent adults who may make oral declarations, but only if unable to prepare a written declaration and only after being confronted with a diagnosis of a terminal and irreversible condition; and (3) incompetent patients who have been diagnosed as terminally and irreversibly ill and who have never made declarations, but for whom decisions may be made by specified surrogates. In all cases, upon proper certification of a terminal and irreversible illness, the declaration or the surrogates' decision may be honored.

II. A COMPARISON WITH OTHER NATURAL DEATH ACTS

California enacted the first natural death statute less than ten years ago.⁹² Subsequently, twenty-five states and the District of Columbia enacted natural death acts.⁹³ Despite their popularity with state legislatures, natural death acts have been subjected to criticism. For example, Professor Capron, Executive Director of the President's Commission of the Study of Ethical Problems in Medicine and Biomedical Research, has observed that such acts are "so cumbersome and restrictive to be useless at best, and possibly very mischievous."⁹⁴ This section examines Louisiana's act in light of some of those criticisms. A significant majority of natural death acts⁹⁵ have been modeled on the California natural death act⁹⁶ and a subsequently drafted model act.⁹⁷ Thus, those two acts warrant close scrutiny.

89. La. R.S. 40:1299.58.10(A) (Supp. 1986). But see *infra* notes 152-254.

90. La. R.S. 40:1299.58.10(B) (Supp. 1986).

91. La. R.S. 40:1299.58.10(C) (Supp. 1986).

92. Cal. Ann. Health & Safety Code §§ 7185-7195 (Supp. 1985) (Natural Death Act).

93. See *supra* note 1.

94. Capron, *supra* note 8, at 652.

95. See, e.g., Idaho Code Ann. §§ 39.4501-.4508 (1985) (Natural Death Act); Nev. Rev. Stat. §§ 449.540-.690 (1983) (withholding or withdrawal of life-sustaining procedures); Or. Rev. Stat. Ann. §§ 97.050.090 (1983) (rights with respect to terminal illness); Tex. Ann. Civ. Stat. art. 4590(h) (Supp. 1985) (Natural Death Act); Wash. Rev. Code Ann. §§ 70.122.010-.122.905 (Supp. 1985) (Natural Death Act).

96. Cal. Ann. Health & Safety Code §§ 7185-7195 (Supp. 1985).

97. Medical Treatment Decision Act (Model Bill) §§ 1-8, reprinted in *Commission Report*, *supra* note 1, at 313-17.

The California act requires a declarant to use a standard form provided in the act.⁹⁸ The form provides that if death is imminent, life-sustaining procedures should be withheld or removed.⁹⁹ The declaration must be re-executed every five years¹⁰⁰ and is binding only if it has been executed or re-executed at least fourteen days after a patient has been diagnosed as terminally ill.¹⁰¹ A non-complying directive is not binding but may be considered as one factor in a physician's decision whether to withdraw treatment.¹⁰² Further, the statute offers no procedures to govern cases of incompetent patients who have not executed formal declarations.

The California act, drafted partially in response to the *Quinlan* case,¹⁰³ demonstrates Professor Capron's criticisms. The fourteen day waiting period, for example, often defeats the right recognized by the statute. The statute requires that a patient be faced with a prognosis of imminent death and that he then wait fourteen days before executing a binding declaration.¹⁰⁴ In the interim, many patients will have died. Prior to death, they may have been forced to accept unwanted treatment. Alternatively, the patient may become incompetent during the waiting period, and thereby be disqualified from executing a binding directive.¹⁰⁵

The statute also violates a patient's right to self-determination. By requiring a prior prognosis of terminal illness, the act implies that a competent, healthy person cannot decide his own fate. Commentators are virtually unanimous that competent adults have a fundamental right to determine their own course of medical treatment.¹⁰⁶ The California

98. Cal. Ann. Health & Safety Code § 7188 (Supp. 1985).

99. *Id.*

100. Cal. Ann. Health & Safety Code § 7189.5 (Supp. 1985).

101. Cal. Ann. Health & Safety Code § 7188 (Supp. 1985).

102. Cal. Ann. Health & Safety Code § 7191(C) (Supp. 1985).

103. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). See *Commission Report*, supra note 1, at 143 ("Although the California statute was in part inspired by the situation of Karen Quinlan, . . . it would not apply in a case like hers.")

104. Cal. Ann. Health & Safety Code §§ 7188, 7191(B) (Supp. 1985).

105. *Commission Report*, supra note 1, at 142, offers the following criticism of California's waiting period:

A patient must wait 14 days after being told of the diagnosis before he or she can sign a directive, which would require a miraculous cure, a misdiagnosis, or a very loose interpretation of the word "imminent" in order for the directive to be of any use to a patient. . . . [A] study of California physicians one year after the new law was enacted found that only about half the patients diagnosed as terminally ill even remain conscious for 14 days.

106. Advocates of the right to refuse treatment contend that our society recognizes a fundamental right of self-determination. See, e.g., *Concern for Dying, A Legal Guide to the Living Will 4* (1979) (discussing rights of competent patients); *Commission Report*, supra note 1, at 43 (discussing patient's interest in self-determination). That right is reflected in the common law doctrine of informed consent, see, e.g., *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914); and in the

act represents a form of unwarranted paternalism because it effectively denies a patient that right.

Similarly, insistence on a standard form¹⁰⁷ interferes with a patient's right of self-determination. A declarant may misunderstand the statute's general language.¹⁰⁸ Thus someone else's understanding of the patient's "will" becomes determinative of the appropriate course of treatment.¹⁰⁹ Even if the patient understands the form, he may want to allow some forms of treatment which would be discontinued under the terms of the statute. For example, under some circumstances, artificial feeding devices,¹¹⁰ coronary pulmonary resuscitation,¹¹¹ and respirators¹¹² may all be "life-sustaining" procedures. But a patient may hope to resist CPR while allowing application of a respirator. The standard form prevents that flexibility.

Perhaps most troublesome, the California act does not apply in the most frequently recurring situation—those cases in which decisions must be made on behalf of incompetent patients who have not prepared advance directives.¹¹³ The legislature failed to provide for procedures in such cases. Although this is the area in which courts have most frequently requested legislative action.¹¹⁴

constitutional right to privacy. See, e.g. *Quinlan*, 70 N.J. 10, 38-42, 355 A.2d 647, 622-64 (finding that vegetative patient had constitutional right to privacy). See also La. Const. art. I, § 5 (1974) (protecting individual's right to privacy). Philosophers have also found a right of a patient to make his own treatment decisions, grounded in principles of autonomy and of respect for the person. Contravention of that right is generally an objectionable form of medical paternalism. See, e.g., J. Childress, *Who Should Decide?* 162-85 (1982).

107. See, e.g., Cal. Ann. Health & Safety Code § 7188 (Supp. 1985).

108. See *Commission Report*, supra note 1, at 137 (advance directive may not demonstrate contemporaneous personal choice), 142-43 (recognizing that decision to execute living will may be made on hypothetical, not real facts about patient's illness and dying process), 145 (advantages of "proxy" directives over "instruction" directives).

109. For example, the Act may allow the physician discretion to interpret the directive; see, e.g., N.C. Gen. Stat. § 90.321(C) (Supp. 1983) (attending physician may rely upon signed declaration).

110. See, e.g., *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (nasogastric feeding tube may be withdrawn under appropriate circumstances).

111. See, e.g., *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1977) (court approval not required before entering No-Code in dying patient's medical chart).

112. See, e.g., *Severns v. Wilmington Med. Center*, 421 A.2d 1334 (Del. 1980) (comatose patient may be withdrawn from respirator, consistent with family's determination of patient's desire).

113. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980) (involving decision to remove comatose patient from respirator); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980) (involving decision to terminate dialysis for senile patient); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978) (involving decision to enter order not to resuscitate in comatose patient's medical record); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (involving decision to withdraw nasogastric feeding tube from senile, but conscious patient).

114. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1011, 195 Cal. Rptr. 484, 486 (1983) (stating that issue had not been adequately addressed by the legislature);

In response to some of the failings of the California act, the Society for the Right to Die commissioned a model act.¹¹⁵ Following Kansas' lead,¹¹⁶ several states have adopted that act.¹¹⁷

Unlike the California statute, the Model Act permits a person to prepare a declaration at any time.¹¹⁸ A patient need not be informed that he is terminally ill. The directive is valid when executed and does not require a waiting period.¹¹⁹ Revocation is made extremely easy.¹²⁰ A physician who refuses to comply with a declaration or to transfer the patient may be found to have acted unprofessionally.¹²¹ The Model Act also penalizes a person who hastens another's death by falsifying a declaration or a revocation¹²² and provides a non-binding model declaration which specifies that a patient may resist "life-sustaining procedures" under certain circumstances.¹²³

While the Model Act avoids some of the glaring inadequacies of the California act,¹²⁴ it is less than perfect. Like the California act, it fails to establish procedures in cases in which an incompetent patient

Severns v. Wilmington Medical Center, 421 A.2d 1334, 1346 (Del. 1980) (inviting legislature to enact comprehensive policy governing these matters); *In re Conroy*, 98 N.J. 321, 345, 486 A.2d 1209, 1221 (1985) (legislature had failed to enact procedures for situation facing the court).

115. See Rosoff, *Living Wills and Natural Death Acts*, in *Legal and Ethical Aspects*, supra note 6, at 186, 191.

116. Kan. Stat. Ann. §§ 65-28, 101-109 (1980).

117. See, e.g., Ala. Code, §§ 22-8A-1 to -10 (1984) (Natural Death Act); D.C. Code Ann. 6-2401-2430 (Supp. 1984); Wash. Rev. Code Ann. §§ 70.122.010-905 (Supp. 1985).

118. Medical Treatment Decision Act (Model Bill) § 3, supra note 97.

119. *Id.*

120. *Id.* at § 4 which provides:

A Declaration may be revoked at any time by the declarant, without regard to his or her mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his or her presence and by his or her direction.

(b) By a written revocation of the declarant expressing his or her intent to revoke, signed and dated by the declarant. The attending physician shall record in the patient's medical record the time and date when he or she received notification of the written revocation.

By a verbal expression by the declarant of his or her intent to revoke the declaration. Such revocation shall become effective upon communication to the attending physician by the declarant or by a person who is reasonably believed to be acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date and place of the revocation and the time, date and place, if different, of when he or she received notification of the revocation.

121. *Id.* at § 5.

122. *Id.* at § 7(C).

123. *Id.* at § 3.

124. Cal. Ann. Health & Safety Code §§ 7035-7195 (1985). See supra notes 92-114 and accompanying text.

has not prepared an advance directive.¹²⁵ Further, while the Model Act does not mandate the form of the declaration, its sample form is limited to resisting "life-sustaining" treatment.¹²⁶ It does not recognize a declarant's right to appoint a surrogate decisionmaker if the declarant becomes incompetent. That alternative was adopted, for example by the Delaware legislature,¹²⁷ in a provision which has been described as avoiding the "serious shortcomings" of other natural death acts.¹²⁸

Louisiana's natural death act, while relying on the Model Act,¹²⁹ avoids many of the pitfalls of the earlier acts. Unlike the California act, the Louisiana statute allows a competent patient to execute a written declaration at any time and does not require its re-execution.¹³⁰ The waiting period provided for in the California statute reflects a concern that a patient not make a hasty decision, but it also substantially impairs the patient's ability to make a competent decision about a course of medical treatment.¹³¹ By contrast, Louisiana recognizes the patient's right of self-determination when not faced with a diagnosis of terminal illness. In place of a waiting period, the Louisiana act makes the revocation of an advance directive extremely easy.¹³² The Act also gives express recognition of the right of a competent adult to make an oral declaration when so incapacitated that he cannot prepare a written document.¹³³ The required formalities limit the possibility that a patient will refuse painful treatment in a moment of stress.

Unlike both California's act and the Model Act, the Louisiana legislature has established a procedure for a comatose patient who has not executed a declaration.¹³⁴ Failure to provide for such cases may do more harm than good: health care professionals may infer that lack of legislative recognition of rights of incompetent patients means that no

125. The act is intended only to "recognize the right of an adult person to make a written declaration. . . ." Medical Treatment Decision Act, *supra* note 97, at § 1.

126. *Id.* at § 3.

127. Del. Code Ann. tit. 16, § 2501(e) (1983).

128. *Commission Report*, *supra* note 1, at 145 ("Proxy directives allow patients to control decisionmaking in a far broader range of cases than the instruction directives authorized by most existing natural death acts.").

129. Medical Treatment Decision Act, *supra* note 97. Louisiana has borrowed generously from the act. Compare, e.g., La. R.S. 40:1299.58.2 (Supp. 1986) with Medical Treatment Decision Act § 2; La. R.S. 40:1299.58.3 (Supp. 1986) with Medical Treatment Decision Act § 3; La. R.S. 40:1299.58.4 (Supp. 1986) with Medical Treatment Decision Act § 4.

130. La. R.S. 40:1299.58.3 (Supp. 1986).

131. See *Commission Report*, *supra* note 1, at 142-43.

132. La. R.S. 40:1299.58.4 (Supp. 1986).

133. La. R.S. 40:1299.58.3(A) (Supp. 1986).

134. La. R.S. 40:1299.58.5 (Supp. 1986).

such rights exist.¹³⁵ Further, the procedure adopted by the Louisiana legislature will be expeditious. In most cases, judicial intervention is unnecessary. If the patient does not have a statutorily designated surrogate, court proceedings are necessary solely for appointment of a surrogate.¹³⁶ The statute does not contemplate that the court decide the underlying medical question or the desires of the incompetent patient.¹³⁷

Following the lead of Delaware¹³⁸ and improving on the Model Act,¹³⁹ the Louisiana legislature had provided not only that its suggested form is optional, but also that a person may choose to appoint a surrogate decisionmaker instead of simply listing unwanted treatments.¹⁴⁰ As discussed above,¹⁴¹ use of a standard form presents difficulties. A person may sign a form without understanding ambiguous language or considering all of the relevant circumstances. The President's Commission's Report recommends that execution of an advance directive be undertaken only after discussion with a physician.¹⁴² Short of that, appointment of a surrogate increases the likelihood that treatment decisions will be made by a person familiar with the patient's preferences.

Critics have suggested that a natural death act may create more problems than it solves.¹⁴³ As indicated, recent amendments to the Louisiana act were mandated when health care providers erroneously construed the act as mandatory in cases involving seriously ill minors.¹⁴⁴ It has been argued elsewhere that this interpretation was erroneous.¹⁴⁵ But that crisis was illustrative of the harm that may be caused by the existence of a natural death act: the act may be read as the sum of a patient's rights, rather than merely as a legislative recognition of the validity of living wills.¹⁴⁶

135. See *Commission Report*, supra note 1, at 145 (such statutes are intended to establish additional, not exclusive rights).

136. La. R.S. 40:1299.58.5(A) (Supp. 1986).

137. *Id.*

138. Del. Code Ann. tit. 16, § 2502(b) (1983).

139. Medical Treatment Decision Act, supra note 97.

140. La. R.S. 40:1299.58.3(C) (Supp. 1986).

141. See supra notes 107-12 and accompanying text.

142. *Commission Report*, supra note 1, at 4, 137.

143. See, e.g., Capron, supra note 8, at 652; *Commission Report*, supra note 1, at 144-45 ("Paradoxically, natural death acts may restrict patient's ability to have their wishes about life sustaining treatment respected.").

144. See, e.g., Impact Weekly, supra note 70.

145. See Vitiello, supra note 12. See also La. A. G. Opin. No. 85-57 (Jan. 28, 1985).

146. There has been surprisingly little case law involving living wills in jurisdictions with or without natural death acts. In 1984, the Florida Supreme Court held that, even absent enabling legislation, a living will was persuasive evidence of how a person would decide, were he competent to do so. *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921, 923-24 (Fla. 1984). Shortly thereafter, Florida enacted its Life Prolonging Procedure Act. Fla. Stat. Ann. §§ 765.01-.15 (Supp. 1985).

As amended, Louisiana's act avoids that result.¹⁴⁷ The legislature has made it clear that the statutory procedures are "voluntary," and that the declaration "is merely illustrative as a means of documenting a patient's decision relative to withholding or withdrawal of medical treatment."¹⁴⁸ Further, the Act is not intended to compel "medically inappropriate treatment."¹⁴⁹ In effect, the Act simply recognizes a person's right to prepare a living will or to have a surrogate do so under certain circumstances.¹⁵⁰ It implicitly recognizes that patients and their families have rights apart from the right to prepare an advance directive.¹⁵¹

The Louisiana legislature has avoided the worst features of earlier statutes, such as unnecessarily burdensome procedures. The Louisiana statute includes an expeditious procedure for withdrawing treatment from the hopelessly ill, incompetent patient who has not drafted a declaration. It is appropriately flexible in allowing a patient to choose the form of her declaration, including the appointment of an agent. The statute's flexibility is in keeping with the value underlying the right to refuse treatment—that society should honor an individual's autonomy. It also makes clear that the legislature does not believe that the Act is the final word on a patient's rights.

III. LOUISIANA'S NATURAL DEATH ACT AND THE PROHIBITION AGAINST EUTHANASIA

Like other American jurisdictions,¹⁵² Louisiana expressly condemns euthanasia. For example, Article I, section 20 of the Louisiana Constitution states that "no law shall subject any person to euthanasia, . . ."¹⁵³ Louisiana's natural death act explicitly disclaims that the Act authorizes euthanasia.¹⁵⁴

Some critics have argued that withdrawal of treatment where death

147. Several statutes make clear that the rights secured by the act are cumulative with other rights, see, e.g., Medical Treatment Decision Act, *supra* note 97, § 8(d); Cal. Ann. Health & Safety Code § 7193 (Supp. 1985).

148. La. R.S. 40:1299.58.1(A) (Supp. 1986).

149. La. R.S. 40:1299.58.1A(C) (Supp. 1986).

150. That is the primary purpose of such statutes. See Capron, *supra* note 8, at 652.

151. Louisiana already provided that rights created by the act were cumulative with other rights, La. R.S. 40:1299.58.10(C) (Supp. 1986).

152. See, e.g., Ala. Code § 22-8A-10 (1984) (act does not authorize "mercy killing"); Cal. Ann. Health & Safety Code § 7195 (1985) (same); Del. Code Ann. tit. 16, § 3 (1983) (same); D.C. Code Ann. § 6-2430 (1985) (same); Nev. Rev. Stat. § 449.670 (1977) (act permits no "affirmative or deliberate act or omission which ends life other than to permit the natural process of dying.").

153. La. Const. art. 1, § 20 (1974).

154. La. R.S. 40:1299.58.10(A) (Supp. 1986).

is the intended or foreseeable¹⁵⁵ result is euthanasia.¹⁵⁶ According to that analysis, courts and legislatures have countenanced euthanasia through careless analysis of the problem at hand.¹⁵⁷ For example, Professor Yale Kamisar has criticized the *Quinlan*¹⁵⁸ decision as follows: "The New Jersey Supreme Court, I fear, may have provided euthanasia proponents with something that has eluded them for decades—the bridge between voluntary and involuntary euthanasia, between the 'right to die' and the 'right to kill.'"¹⁵⁹ Kamisar contends that we have maintained an official morality condemning euthanasia, while doctors practice it and judges approve it "only . . . [by] avoiding *the term* euthanasia—not *the practice*."¹⁶⁰

Louisiana's natural death act may be said, by some, to sanction a form of euthanasia in violation of Article I, section 20,¹⁶¹ however, the constitutional redactors specifically intended to permit withdrawal of treatment in cases contemplated by the Act. In addition, the right to refuse treatment is a federally guaranteed right.¹⁶² Therefore, even if one concludes that the Act permits a limited form of euthanasia, the state cannot prohibit exercise of the patient's right to refuse treatment.

A. Article I, Section 20

Louisiana's natural death act allows treatment to be withdrawn from a person who has executed a declaration,¹⁶³ and from an incompetent patient who has not done so.¹⁶⁴ The two cases present different issues under Article I, section 20.

In the first case, a patient who executes a declaration has made

155. Some commentators have argued that a distinction should be drawn between intended consequences and unintended but foreseeable consequences. See, e.g., C. Fried, *Right and Wrong* 7-53 (1978); Jonsen, *Traditional Distinctions for Making Ethical Judgments*, 1984 *Ariz. St. L.J.* 661, 662-64. That distinction has been rejected elsewhere see, e.g., *Garratt v. Dailey*, 46 *Wash. 2d* 197, 279 *P.2d* 1091 (1955) (defining intent necessary to commit a tortious battery as doing an act "for the purpose of causing the contact . . . or with knowledge on the part of the actor that such contact . . . is substantially certain to be produced."). See also W. LaFave & A. Scott, *supra* note 87, at 197 ("the word 'intent' in the substantive criminal law has generally not been limited to the narrow, dictionary definition of purpose, aim, or design, but . . . it has often been viewed as encompassing much of what would ordinarily be described as knowledge.").

156. See, e.g., Kamisar, *supra* note 15, at 32-34.

157. *Id.* at 32.

158. *Quinlan*, 70 *N.J.* 10, 335 *A.2d* 647.

159. Kamisar, *supra* note 15, at 16.

160. *Id.* at 33 (emphasis added).

161. La. R.S. 40:1299.58.10(A) (Supp. 1985).

162. See *infra* notes 184-254 and accompanying text.

163. La. R.S. 40:1299.58.3(A) (Supp. 1986) (by written or oral declaration).

164. La. R.S. 40:1299.58.5-.58.6 (Supp. 1986).

clear that under certain narrow circumstances death is preferable to intensive medical treatment.¹⁶⁵ The Act contemplates withdrawal from medical treatment; it does not sanction the administration of drugs or other death-producing agents intended to hasten death.¹⁶⁶ Thus, if the withdrawal of treatment is a form of euthanasia,¹⁶⁷ it is voluntary passive euthanasia.

The express language of section 20 suggests that the state constitutional prohibition does not include voluntary euthanasia. Section 20 states that "no law shall subject any person to euthanasia, . . ."¹⁶⁸ A person who voluntarily chooses death has not been subjected to euthanasia.

That conclusion is buttressed by the history of Louisiana's constitutional convention. Professor Hargrave has observed in his comprehensive article on the 1973 convention that section 20 "applies to state action, not to individuals,"¹⁶⁹ and that the provision was amended by the delegates "to make clear that the prohibition is limited to laws requiring persons to be subjected to euthanasia."¹⁷⁰ The delegates expressed abhorrence of a bill unsuccessfully introduced in the Florida legislature which would have, in effect, compelled certain individuals to die.¹⁷¹

Section 1299.58.3 of Louisiana's natural death act does not permit the state or third parties to compel a person to accept death.¹⁷² It recognizes a means whereby a person can assert his will "after [he is] no longer able to participate actively in decisions concerning" his medical care.¹⁷³

165. La. R.S. 40:1299.58.3(A) (Supp. 1986) allows a patient to request withdrawal or withholding of "life-sustaining procedures." Since the declaration provided is not mandatory, the declarant may specify whether he wishes to resist all or some life sustaining procedures. La. R.S. 40:1299.58.3(C)(1) (Supp. 1986) (declaration "may, but need not, be in the following form and may include other specific directions."). Some critics, while conceding that there is a strong case in favor of voluntary euthanasia, believe that voluntary informed consent is virtually impossible to secure. See, e.g., Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 *Minn. L. Rev.* 969, 978-1005 (1958).

166. See, e.g., La. R.S. 40:1299.58.3(A) (Supp. 1986) (allowing a person to execute a directive "directing the withholding or withdrawal of life-sustaining procedures" under certain circumstances).

167. Any discussion of euthanasia is confounded by the varied definitions of that term. See *infra* notes 185-88 and accompanying text.

168. La. Const. art. I, § 20 (1974).

169. Hargrave, *The Declaration of Rights of the Louisiana Constitution of 1974*, 35 *La. L. Rev.* 1, 63 n.336 (1974).

170. The original provision stated: "No person shall be subjected to euthanasia." *Id.* at 63 n.332.

171. *Official Journal of the Proceedings of the Constitutional Convention of 1973 Verbatim Transcripts*, Sept. 8, 1973, at 1189, 1191.

172. La. R.S. 40:1299.58.3(A) (Supp. 1986).

173. La. R.S. 40:1299.58.1(C) (Supp. 1986).

The second case, that of the incompetent patient without a declaration, is harder than the case in which a person's desires are memorialized in a declaration. While Louisiana's natural death act is not a compulsory euthanasia law,¹⁷⁴ it might be argued that the Act does subject the seriously ill, incompetent patient to euthanasia. That is, the Act does not require treatment to be withdrawn from seriously ill patients, but it does give a third party the right to have treatment terminated, possibly leading to the incompetent's death.¹⁷⁵

Constitutional history, however, demonstrates that the act does not violate section 20. As initially introduced at the convention, section 20 provided that "[n]o person shall be subjected to euthanasia."¹⁷⁶ That language was rejected because the delegates "feared that this language might be construed to prevent a physician from halting extraordinary life-continuation treatments of a dying patient."¹⁷⁷

"Extraordinary" treatment is an ambiguous term,¹⁷⁸ but is used appropriately to refer to medical care in which the burdens outweigh the benefits to a seriously ill patient.¹⁷⁹ The Act permits a surrogate to refuse life-sustaining treatment for a "qualified patient,"¹⁸⁰ a patient who has been certified by at least two physicians to be terminally and irreversibly ill,¹⁸¹ but it does not authorize a denial of treatment that can reverse the death process or cure the underlying anomaly.¹⁸² Additionally, the Act permits a surrogate to resist treatment for a patient that almost certainly would be "extraordinary" treatment that, at best, would only delay the imminent death process.¹⁸³ Thus, the Act is consistent with section 20; neither requires all available therapies to be applied to every patient without regard to the patient's condition.

B. The Right to Privacy

The history of Louisiana's constitutional convention indicates that the natural death act does not violate Article I, section 20. But that does not end the inquiry as to whether the Act has authorized euthanasia, despite the express disclaimer by the legislature.¹⁸⁴ This section concludes that the Act does condone a limited form of euthanasia, it rejects efforts

174. See *supra* notes 169-73 and accompanying text.

175. La. R.S. 40:1299.58.5-58.6 (Supp. 1986).

176. Hargrave, *supra* note 169, at 63 n.332.

177. *Id.* at 63.

178. See *Commission Report*, *supra* note 1, at 83-89 (criticizing use of "extraordinary" and "ordinary" care because of different meanings given those terms).

179. *Id.* at 87-88.

180. La. R.S. 40:1299.58.5(A); 58.6(A) (Supp. 1986).

181. La. R.S. 40:1299.58.2(7) (Supp. 1986).

182. See La. R.S. 40:1299.58.2(8) (Supp. 1986) (defining "terminal condition").

183. La. R.S. 40:1299.58.2(8) (Supp. 1986).

184. La. R.S. 40:1299.58.10(A) (Supp. 1986).

to distinguish treatment decisions which lead to death from euthanasia, and argues that a limited form of euthanasia is part of a person's constitutional right to privacy.

Discussion about euthanasia is confounded by imprecision in defining that term. It has been defined, for example, as "a painless death,"¹⁸⁵ as "mercy killing,"¹⁸⁶ and as "the act or practice of killing individuals that are hopelessly sick or injured, for reasons of mercy."¹⁸⁷ Those definitions suggest that euthanasia involves active intervention,¹⁸⁸ as distinguished from the failure to act to prevent death.

There is considerable evidence that physicians, among others, accept a distinction between active intervention intended to kill a dying person and failure to treat the patient to allow the patient to die.¹⁸⁹ Pediatric surgeons have admitted publicly that they counsel parents of defective newborns that they may refuse to consent to surgery that may save the infant's life, but that does not correct the underlying anomaly.¹⁹⁰ The same surgeons do not sanction active intervention to bring about a quicker death.¹⁹¹ Some courts have accepted a similar distinction.¹⁹²

While the distinction between active and passive euthanasia has psychological appeal,¹⁹³ its logic is suspect. Some advocates of the distinction argue that the failure to treat a dying patient is not the cause of the resulting death.¹⁹⁴ In such a case, the argument goes, "the ensuing

185. American Heritage Dictionary 248 (1980). See generally D. Horan & D. Mall, *Death, Dying and Euthanasia* 596-601 (1977).

186. Kamisar, *supra* note 165, at 969.

187. Hargrave, *supra* note 169, at 63 n.336.

188. For example, famous euthanasia cases which have come to court have usually involved defendants who have actively intervened to bring about the victim's death. See, e.g., D. Magine, *Death by Choice* 23-25 (1974) (citing cases in which the accused has defended against a charge of murder on the ground of mercy).

189. See, e.g., Kamisar, *supra* note 15, at 25-27 (citing example of physician and parents of seriously ill newborns who accept that distinction).

190. Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 *New Eng. J. Med.* 890 (1973); Shaw, *Doctor, Do We Have a Choice?*, *N.Y. Times*, Jan. 30, 1972 (Magazine), at 44, 54.

191. See Kamisar, *supra* note 15, at 27.

192. See, e.g., *In re Infant Doe*, No. GU 8204-00 (Cir. Ct. Monroe County, Ind. April 12, 1982) (trial court refused to compel surgery for infant suffering from Down's syndrome and needing life-saving corrective surgery), writ of mandamus dismissed sub nom., *State ex rel. Infant Doe v. Baker*, No. 482 S140 (Ind. Sup. Ct. May 27, 1982).

193. See Capron, *supra* note 8, at 648 ("the distinction [between withholding and withdrawing treatment] has more to do with psychology than with philosophy.')

194. See, e.g., *Quinlin*, 70 N.J. at 51-52, 355 A.2d at 669-70. There may be contexts in which a distinction between active killing and passive "allowing to die" may be important. Active intervention, for example, by injecting air into the victim's blood stream is likely to result in a sure-kill. Failure to provide antibiotics for a cancer patient who contracts pneumonia may not result in his death. Similarly, allowing a seriously ill newborn to starve slowly leaves open a chance that parents will reverse their decision not to treat the infant or that a third party will intervene. See, e.g., Wilkes, *When Do We Have The*

death . . . [is the] expiration from existing natural cause."¹⁹⁵

That view is based on a misunderstanding of causation. For example, were a stranger to unplug a respirator which had supplanted a dying patient's breathing process, no one would suggest that the stranger's conduct was not a factual cause of the patient's death.¹⁹⁶ Yet courts have sanctioned withdrawal of such treatment by health care providers in numerous cases.¹⁹⁷ Similarly, were a physician to fail to prescribe antibiotics for a patient suffering from pneumonia and death were to follow, no one would suggest that the physician's omission was not a cause-in-fact of death or that the death resulted merely from natural causes.¹⁹⁸

Treatment is often terminated despite the possibility that it will prolong life at least briefly.¹⁹⁹ Denial of treatment is thus one of many factual causes which brings about a patient's death at a given moment.²⁰⁰ As a matter of policy, the law may hold that a person's act or omission was not the proximate or legal cause of another's injuries.²⁰¹ That does not mean the person's conduct was not a cause-in-fact. Only if there is a duty to provide treatment may its withdrawal or denial be said to proximately or legally cause a person's death. But as long as the treatment would have prolonged the patient's life, its withdrawal or denial is a cause-in-fact of the patient's death.

Right to Die, *Life Magazine*, Jan. 14, 1974, at 48, 52 (court order obtained by physician to treat infant with Downs syndrome, suffering from intestinal blockage). But the certainty of death does not always depend on whether death results from action or inaction. One who fails to save an infant in a baby carriage about to roll off a cliff may be far more effective in bringing about his victim's death than a poor marksman who shoots at his intended victim from a great distance.

195. In re Quinlan, 70 N.J. at 52, 355 A.2d at 670.

196. See, e.g., *W. LaFave & A. Scott*, supra note 87, at 250 ("one who hastens the victim's death is a cause of his death"). See also *People v. Bonilla*, 95 A.D.2d 396, 467 N.Y.S.2d 599 (App. Div. 1983) (suggesting that motive of person turning off life support system is relevant to whether subsequent act relieves original actor of criminal liability).

197. See, e.g., *Severns v. Wilmington Med. Center*, 421 A.2d 1334 (Del. 1980); In re P.V.W., 424 So. 2d 1015 (La. 1982); In re Colyer, 99 Wash. 114, 660 P.2d 738 (1983).

198. See Robertson, supra note 7, at 224-25 (discussing criminal liability of physician who withholds treatment from defective infant). One court has correctly analyzed a situation where conduct of multiple parties has factually caused a person's death as an issue of whether the later action is a superseding cause, relieving the original actor of criminal culpability for the patient's death. In re J.N., 406 A.2d 1275 (D.C. 1979). As with proximate cause, superseding cause is a policy question, not solely a factual question. *W. Prosser & R. Keeton, The Law of Torts 301-02* (W. Keeton 5th ed. 1984).

199. See *Commission Report*, supra note 1, at 1 ("For almost any life-threatening condition, some intervention can now delay the moment of death.").

200. *W. Prosser & R. Keeton*, supra note 198, at 264 ("In a philosophical sense, the consequences of an act go forward to eternity, and the causes of an event go back to the dawn of human events and beyond.").

201. *Id.* See also *Commission Report*, supra note 1, at 68-69 (stating that value judgments underlie a decision to identify a factual cause as a legal cause).

A more common rationale for a distinction between active and passive euthanasia is based on the traditional rule that the law does not punish omissions, while it does punish acts.²⁰² There are infamous cases in which the law has sanctioned an immoral failure to act to save another person.²⁰³ But the difference between law and morality can be overstated. A person is legally culpable if he is under a duty to act and his failure to act results in harm.²⁰⁴ For example, if a parent intentionally fails to secure life-saving treatment for his child, he may properly be indicted for murder.²⁰⁵ Or if a parent through ignorance fails to secure medical treatment for his child, he may be guilty of negligent homicide if the child's death results from the omission.²⁰⁶ A physician's failure to treat the child may similarly be criminal if he is under a duty to care for the patient.²⁰⁷ That is, there is universal agreement that a patient's family and treating physician are generally under a duty to provide appropriate medical care, and thus, the failure to provide that care may be homicide if the patient's death results from an omission to treat.²⁰⁸ The patient's family or physician are not ex-

202. See, e.g., Jonsen, *supra* note 155, at 661-62 (the distinction between acts and omissions "is a very important feature of decisions to forego life-sustaining treatment.'). See also W. LaFave & A. Scott, *supra* note 87, at 183 (stating the blackletter rule that "[g]enerally one has no legal duty to aid another person in peril, even when the aid can be rendered without danger and inconvenience to himself.').

203. One of the most infamous cases was that of Kitty Genovese whose murder was witnessed by many of her neighbors, none of whom intervened or called the police. See *Who Are Responsible for the Death of Miss Genovese?*, N.Y. Times, May 27, 1964, at 1, 38, reprinted in J. Golstein, A. Dershowitz, & R. Schwartz, *Criminal Law: Theory and Process* 742 (1974). See also *People v. Beardsley*, 150 Mich. 206, 113 N.W. 1128 (1907) (man owed no duty to his mistress to secure medical assistance when she became critically ill due to ingestion of poison during a weekend spree in his home); *Yania v. Bigan*, 397 Pa. 316, 155 A.2d 343 (1959) (no duty in civil suit where defendant invited business visitor to jump into pool and let him drown).

204. See W. LaFave & A. Scott, *supra* note 87, at 182-90 (discussing exceptions to rule that one has no legal duty to aid another).

205. See Annot., 10 A.L.R. 1137 (1921) (discussing convictions for homicide where liability was based on failure to secure medical or surgical assistance).

206. See, e.g., *Stehr v. State*, 92 Neb. 755, 139 N.W. 676, *aff'd on rehearing*, 142 N.W. 670 (1913) (Manslaughter conviction upheld when son's death resulted from failure to secure medical care despite father's claim of lack of funds and inability to speak English.).

207. See Robertson, *supra* note 7, at 224-35 (discussing various theoretical bases for liability of physicians and hospitals).

208. Apart from the obvious need to encourage parents to secure and physicians to provide appropriate treatment to seriously ill patients unable to secure aid for themselves, reliance on a distinction between acts and omissions (or withdrawing and withholding treatment) is not satisfactory for two other reasons. In many cases, it is unclear whether the chosen course of treatment entails action or inaction. See W. Prosser & R. Keeton, *supra* note 198, at 374 ("In theory the difference between [an act and omission] is fairly clear, but in practice it is not always easy to draw the line and say whether conduct is active or passive.'). Attention would necessarily focus on whether the physician or parent

onerated even if the patient has consented to the decision to withhold treatment. Quite simply, a person cannot consent to his own murder.²⁰⁹

As indicated above,²¹⁰ some observers have distinguished between providing ordinary care and withholding extraordinary care from a dying patient. Death resulting from a denial of ordinary care would amount to a form of euthanasia or homicide, as distinguished from the denial of extraordinary care.

For example, the Catholic church has long maintained that: "No one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the utmost gravity" ²¹¹ That principle prohibits suicide as "equally as wrong as murder." ²¹² It also recognizes that euthanasia may result from "an omission which of itself or by intention causes death" ²¹³

Despite its absolute prohibition against euthanasia and suicide, the church has distinguished cases in which treatment may morally be terminated. In the past, Catholic moralists relied on a distinction between ordinary or morally necessary treatment and extraordinary means which might properly be resisted.²¹⁴ More recently, the church has referred to "due proportion in the use of remedies."²¹⁵ In either case,

it will be possible to make a correct [moral] judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibility of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.²¹⁶

This analysis is limited to cases where death is "imminent in spite of the means used" and where treatment "would only secure a precarious and burdensome prolongation of life" ²¹⁷

had acted, rather than failed to act, when the relevant inquiry ought to be on the actor's duty to the patient. See Capron, *supra* note 8, at 650. Further, if it were made more difficult to withdraw treatment (an act) than to withhold treatment (an omission), physicians would be hesitant to apply treatment initially, fearing that it could not be withdrawn later if it proved unsuccessful. *Commission Report*, *supra* note 1, at 75.

209. See W. LaFave & A. Scott, *supra* note 87, at 408.

210. See *supra* notes 177-83 and accompanying text.

211. Scared Congregation for the Doctrine of the Faith, Declaration of Euthanasia (May 5, 1980), reprinted in *Commission Report*, *supra* note 1, at 300, 302 [hereinafter cited as *Declaration of Euthanasia*].

212. *Id.*

213. *Id.* at 303.

214. *Id.* at 305. See also address by Pope Pius XII to anesthesiologists on November 24, 1957 cited in *In re Quinlan*, 70 N.J. at 30-34, 355 A.2d at 658.

215. *Declaration of Euthanasia*, *supra* note 211, at 305.

216. *Id.* at 305-06.

217. *Id.* at 306.

Such a rule may be difficult to apply in many cases because the variables to be balanced evade precise measurement.²¹⁸ But the underlying distinction has received wide support.²¹⁹ Louisiana's natural death act would appear consistent with that distinction.²²⁰

As persuasive as that rationale may ultimately be to decide cases appropriate for nontreatment,²²¹ it does not explain why the resulting death is not a form of euthanasia.²²² It must be conceded that "extraordinary" treatment will prolong a patient's life to some measurable extent.²²³ Or, in other words, its denial will hasten a person's death. The law has long recognized that any shortening of life of another constitutes homicide and that the perpetrator cannot defend on the basis that the victim's death was imminent from other causes.²²⁴ Thus, a denial of extraordinary treatment may lead to a merciful death; death has come sooner to a patient beyond cure. But hastening a death in such a case, even by passive means,²²⁵ is euthanasia.²²⁶ Even if withdrawal of life-sustaining procedures is euthanasia, it would be inappropriate to deny a patient the right of self-determination and to compel a dying patient to accept burdensome treatment. As discussed in more detail

218. See *Commission Report*, supra note 1, at 88 (suggesting that benefits and burdens may be viewed differently from one patient from another).

219. See, e.g., *id.* See also *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1019, 195 Cal. Rptr. 484, 491 (1983) (rejecting extraordinary/ordinary distinction and adopting proportionate benefit analysis); *In re Conroy*, 98 N.J. 321, 370-74, 486 A.2d 1209, 1234-37 (1985) (adopting Commission's analysis of proportionate benefits).

220. See supra notes 179-83 and accompanying text.

221. See *Commission Report*, supra note 1, at 88-89 (analysis of problem in terms of proportionate benefits is morally persuasive).

222. See Kamisar, supra note 15, at 33.

223. See La. R.S. 40:1299.58.2(4) (Supp. 1986) (defining a "life-sustaining procedure" as one which "would serve only to prolong the dying process").

224. See W. LaFave & A. Scott, supra note 87, at 532-32 (it is homicide to accelerate death even though the victim is already dying or about to be executed). That rule may be appropriate in general where, even if one's victim was going to die anyway, the perpetrator may have been unaware of that fact and, therefore, represented a threat to the community, but it frustrates decisionmaking on behalf of seriously ill patients. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (reversing superior court which had held that doctors who had removed respirator and artificial feeding device could be indicted for murder because any shortening of life amounts to criminal homicide).

225. It is important to recognize that the Act authorizes withholding of treatment (an omission) and withdrawal of treatment (an act). La. R.S. 40:1299.58.3 (Supp. 1986). See also supra note 208.

226. Such a recognition is intellectually honest. Indeed many commentators believe that the active and passive distinction is morally irrelevant. See Maguire, supra note 188 (arguing in favor of active as well as passive euthanasia). See also J. Fletcher, *Morals and Medicine* (1954). Even Professor Kamisar concludes in his forceful critique of the Quinlan decision that "[s]ome passive euthanasia should be permitted, but only when 'honest' or 'straightforward' euthanasia would be permitted." Kamisar, supra note 15, at 32.

below,²²⁷ it is now generally recognized that a person has a right to refuse medical treatment, a right within the constitutional right to privacy.²²⁸ As with other privacy rights,²²⁹ the state may override a person's right to refuse treatment and may compel treatment if the state's interests are sufficiently compelling.²³⁰ Thus, the state generally has the right to intervene to prevent a suicide²³¹ or to compel treatment of a mother in the interest of a dependent infant.²³² But it cannot be seriously argued that the state has a compelling interest in requiring dying patients to accept unwanted, burdensome treatment.²³³ Thus, because the right to refuse treatment is guaranteed by the Constitution,²³⁴ a state law prohibiting euthanasia would have to yield to exercise of the federal right if a conflict existed.²³⁵

Once a court recognizes that a competent patient has a right to determine a course of treatment, it does not necessarily follow that a patient will exercise that right.²³⁶ Indeed, there is ample evidence that

227. See *infra* notes 264-97 and accompanying text.

228. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *Staz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Quintan*, 70 N.J. 10, 355 A.2d 647; *In re Yetter*, 62 Pa. D. & C. 619 (C.P. Northhampton County 1973).

229. See, e.g., *Roe v. Wade*, 410 U.S. 113, 164-65, 93 S. Ct. 705, 732-33 (1973) (interest in life of viable fetus sufficiently compelling to permit regulation of third trimester abortions).

230. *In re Conroy*, 98 N.J. at 348-55, 486 A.2d at 1223-26 (discussing four state interests to be balanced against patient's right to privacy). See also *Commissioner of Correction v. Myers*, 379 Mass. 255, 261, 399 N.E.2d 452, 456 (1979) (state interest sufficient to justify order compelling state prison inmate to submit to kidney dialysis).

231. *Satz v. Perlmutter*, 362 So. 2d at 162; *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 426; *In re Conroy*, 98 N.J. at 350, 486 A.2d at 1224. See also Greenburg, *Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U. L. Rev. 227 (1974) (attempted suicide justifies active intervention by public officials and at least temporary confinement).

232. *In re President of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978, 84 S. Ct 1883 (1964) (decision to order blood transfusion for nonconsenting Jehovah's Witness justified, in part, by interest of patient's seven-month old infant).

233. See *In re Conroy*, 98 N.J. at 353, 486 A.2d at 1225 ("the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death.").

234. The Supreme Court has yet to decide the constitutional status of the right to refuse medical treatment. See comment, *The Right to Die—A Current Look*, 30 Loy. L. Rev. 139, 140 (1984). Recently, however, a federal district court became the first federal court to recognize a right of a competent adult patient suffering from a terminal condition "to demand the cessation of life support once begun." *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1456 (D.D.C. 1985).

235. Cf. *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973) (invalidating state statute prohibiting abortion in violation of constitutional right to privacy).

236. Indeed, one of the values underlying a right to refuse treatment is that of self-determination. See *Commission Report*, *supra* note 1, at 26. See also Cantor, *Privacy*

many competent patients choose some intrusive treatments that others may consider too burdensome.²³⁷ It also does not necessarily follow that the right to refuse treatment extends to incompetents.

Interestingly, most of the leading cases stating that a competent patient has a constitutional right to refuse treatment have involved incompetent patients.²³⁸ Courts have relied on principles of equal protection to extend the same right to the incompetent patient.²³⁹ The obvious difficulty with that position is that "an affirmation of a comatose patient's independent right of choice . . . would ordinarily be based upon her competency to assert it."²⁴⁰ In *Quinlan*, the New Jersey Supreme Court resolved that dilemma by resorting to the substituted judgement test: "The only practical way to prevent destruction of her right is to permit the guardian and family of [the incompetent patient] to render their best judgment" as to her choice concerning continued treatment.²⁴¹

In some cases, the substituted judgement test poses no difficulty. For example, a person may have discussed with close associates whether he would want to be sustained on a respirator if he became comatose.²⁴² Or a dying patient may have drafted a living will even though the relevant jurisdiction had not adopted enabling legislation.²⁴³ Or the comatose patient may have been active in right-to-die organizations.²⁴⁴ The surrogate might readily find evidence of the patient's desires.

and the Handling of Incompetent Dying Patients, 30 Rutgers L. Rev. 233, 250 (1977) (governmental recognition of right to refuse treatment reflects concern for individual self-determination).

237. See Kamisar, *supra* note 15, at 8-12 (discussing evidence that most patients resist an "easy" death).

238. See, e.g., Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (comatose patient); Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. 1980) (comatose patient); Custody of Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (seriously ill newborn); In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980) (senile patient); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (severely retarded resident of state facility); In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (senile patient in nursing home); *Quinlan*, 70 N.J. 10, 355 A.2d 647 (comatose patient).

239. See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

240. *Quinlan*, 70 N.J. at 42, 355 A.2d at 664.

241. *Id.*

242. See In re Storar, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, cert. denied, 454 U.S. 858 (1981) (companion case, involving 83 year-old Brother Fox, who became comatose during surgery occurring shortly after he expressed support for the *Quinlan* result to members of his Catholic order).

243. See John F. Kennedy Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984) (patient's living will, even absent enabling legislation, was found to be persuasive evidence of patient's desires concerning discontinuance of treatment).

244. See Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. 1980) (family sought to withdraw respirator from comatose patient who was an active member of local euthanasia society).

Other cases pose more substantial difficulties. Some patients may never have expressed their views on whether they would want to be sustained on a respirator.²⁴⁵ Even clearer, incompetence prevents many patients from forming views on the subject. Infants²⁴⁶ and the severely retarded²⁴⁷ quite obviously have not formed values that permit a surrogate to infer the patient's choice.

In the latter class of cases, rather than compelling burdensome and futile therapies, some courts have insisted that the substituted judgment test applies without regard to the nature of the patient's incompetence.²⁴⁸ But the Massachusetts Supreme Judicial Court has acknowledged that in such cases, the test amounts to a best interest test.²⁴⁹ In effect, an incompetent patient has a constitutional right to be treated in a manner consistent with his best interests.²⁵⁰ Thus, treatments that provide no net benefit may be withdrawn.

245. The Quinlan case raises an interesting issue. The court rejected evidence of statements made by Karen Quinlan because they were so "remote and impersonal [that they] lacked significant probative weight . . ." *Quinlan*, 70 N.J. at 22, 355 A.2d at 653. Nonetheless, the court remanded to allow the patient's guardians "to render their best judgement, . . . as to whether she would exercise it in these circumstances." *Id.* at 42, 355 A.2d at 664. Professor Kamisar has argued that because "[p]resumably the guardian and family of Karen had presented to the court everything they knew bearing on Karen's supposed choice," the family could make its ultimate decision only on the "basis of the same remote and impersonal previous conversations" found inconclusive by the court. Kamisar, *supra* note 15, at 6-7. He argues, therefore, that the court authorized involuntary euthanasia because evidence of her intent was absent. Unquestionably, there are many patients who have not expressed their views on life-support systems. More recently, however, the New Jersey Supreme Court has rethought the facts in *Quinlan*:

[A]ny . . . information bearing on the person's intent . . . may be [an] appropriate aid in determining what course of treatment the patient would have pursued. In this respect, we now believe that we were in error in *Quinlan* . . . to disregard evidence of statements that Mrs. Quinlan made to friends concerning artificial prolongation of the lives of others who were terminally ill.

In *re Conroy*, 98 N.J. at 364, 486 A.2d at 1230. further, it established separate standards (a) for patients who have made a clear statement; (b) for patients for whom there is "some trustworthy evidence that the patient would have refused the treatment," where that evidence is less than an "unequivocally expressed" desire to terminate treatment; and (c) for patients who have never expressed a view or were never able to do so. *Id.* at 365-66, 486 A.2d at 1232.

246. See, e.g., *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982) (involving need to get judicial order to terminate treatment of dying newborn).

247. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (chemotherapy might be refused on behalf of severely retarded sixty-seven year-old ward of the state).

248. *Id.*

249. *Custody of a Minor*, 385 Mass. 697, 710 n.10, 434 N.E.2d 601, 608 n.10 (1982) (in such a case, a substituted judgement test is consistent with a best interest test); See also Guthiel & Appelbaum, *Substituted Judgement: Best Interests in Disguise*, *Hastings Center Rep.*, June 1983, at 8. The New Jersey Supreme Court has stated that for incompetents who have never developed a view on the subject, the surrogate is to apply the best interest test. In *re Conroy*, 98 N.J. 321, 365-66, 468 A.2d 1209, 1231-32 (1985).

250. See *In re Conroy*, 98 N.J. at 365-66, 486 A.2d at 1231-32. Cf. *City of Akron*

Under the foregoing analysis, Louisiana's natural death act neither authorizes impermissible conduct nor offends Louisiana's constitutional prohibition. Most importantly, Article I, Section 20 was not intended to prevent withdrawal of extraordinary care.²⁵¹ Further, the weight of authority supports the view that withdrawal of life-support systems from dying patients under the proper auspices²⁵² is permissible,²⁵³ and even if characterized as euthanasia, a patient may be freed from inappropriate treatment because the constitutional right to privacy encompasses medical treatment decisions.²⁵⁴

IV SOME RECURRING PROBLEMS

A. Dying Patients Whose Lives Can Be Saved

Critics have argued that natural death acts are so restrictive that they may be useless or even mischievous. This section discusses some recurring cases where natural death acts provide no guidance. Specifically, it focuses on the dilemma created (1) when a seriously ill patient refuses surgical removal of gangrenous tissue and (2) when a person resists life-saving medical treatment because of religious principles. But once it is concluded that those patients are beyond the scope of natural death acts, it must be determined whether nonetheless they may resist treatment.

Similar to many other statutes,²⁵⁵ Louisiana's natural death act allows withdrawal of life-sustaining treatments only if a patient is certified as a "qualified patient," a person suffering from a "terminal and irreversible condition."²⁵⁶ The statutory definition of a "terminal and irreversible condition" demonstrates the Act's narrow applicability. A patient is terminally and irreversibly ill only if he suffers from a condition "which, within reasonable medical judgement, would produce death and the application of life sustaining procedures would serve only to postpone the moment of death."²⁵⁷ Thus death must be reasonably certain to follow in the near future even if treatment is provided.

v. Akron Center for Reproductive Health, 462 U.S. 416, 103 S. Ct. 2481, (right to privacy protects immature minor's right to an abortion if in her best interests).

251. See supra note 174-83 and accompanying text.

252. That is not to suggest that, were an unauthorized stranger to withdraw the life support system, she would not be criminally liable. See supra note 196. For example, prior to her death, Karen Ann Quinlan had to be cared for behind a heavy metal security door to protect her from thrill seekers and from "fanatics [who] have threatened to 'put her out of her misery'." The Commercial Appeal, May 26, 1985, at E1, col. 1. Karen Ann Quinlan died approximately ten years after she became comatose. USA Today, June 12, 1985 at A1, col.2.

253. See supra note 210-20 and accompanying text.

254. See supra notes 228-35, 238-50 and accompanying text.

255. See, e.g., Ala. Code § 22-8A-3(5)(1984); Cal. Health & Safety Code § 7187(e) (Supp. 1985); Kan. Stat. Ann. § 65-28, 102(e) (1980).

256. La. R.S. 40:1299.58.2(7) (Supp. 1986).

257. La. R.S. 40:1299.58.2(8) (Supp. 1986).

The Act is inapplicable to the two recurring cases mentioned above. For example, courts have been confronted frequently with Jehovah's Witnesses whose faith prohibits blood transfusions.²⁵⁸ In cases that have come to court, usually at the insistence of a hospital attempting to compel treatment, the patient's death without transfusions is probable.²⁵⁹ But treated and supplied with blood, the patient has a good chance of full recovery.²⁶⁰ Thus, that patient falls outside the Act because treatment would cure the underlying anomaly, not simply prolong the dying process. Likewise, a patient suffering from gangrene may be near death if the condition is untreated.²⁶¹ But surgical removal of a patient's affected extremity may offer a continued life for an undetermined time. Life may be impaired because the patient may be an invalid, but surgery has not merely prolonged the dying process.²⁶²

Courts have addressed those problems, usually without legislative guidance.²⁶³ Cases preceding *Roe v. Wade*²⁶⁴ and *In re Quinlan*²⁶⁵ did not rely on a constitutional right to refuse treatment.²⁶⁶ But several principles have emerged from more recent cases. Our society has long recognized a fundamental right to bodily integrity: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."²⁶⁷ That principle underlies the

258. See, e.g., *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978, 84 S. Ct. 1883 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Brooks Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (N.Y. S. Ct. 1965). Their refusal to accept blood transfusions is based on the Biblical prohibition that "Ye shall eat the blood of no manner of flesh." See Paris, *Compulsory Medical Treatment and Religious Freedom: Whose Law Shall Prevail?*, 10 U.S.F. L. Rev. 1, 3 n.10.

259. See, e.g., *In re Georgetown College*, 331 F.2d at 1007 (patient faced almost certain death without transfusions).

260. *Id.* (full recovery probable if given transfusions).

261. See, e.g., *In re Quackenbush*, 156 N.J. Super. 282, 284, 383 A.2d 785, 787 (Morris County Ct. 1978) (patient would die within three weeks without surgery).

262. *Id.* ("probability of recovery from amputation is good and the risks involved are limited"). See also *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).

263. See, e.g., *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), reh'g denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978, 84 S. Ct. 1883 (1964); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978).

264. 410 U.S. 113, 93 S. Ct. 705 (1973).

265. 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

266. See, e.g., *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978, 84 S. Ct. 1883 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *In re Brooks Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

267. *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251, 11 S. Ct. 1000, 1001 (1891). See also *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (every competent adult "has right to determine what shall be done with his own body"), overruled, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957).

doctrine of informed consent, "a primary means developed in the law to protect this personal interest in the integrity of one's body."²⁶⁸

Following *Roe v. Wade*,²⁶⁹ courts have gone beyond common law doctrines.²⁷⁰ The New Jersey Supreme Court found in reliance on *Roe* that the constitutional right of privacy "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances,"²⁷¹ even if death results from that decision.

As with other privacy rights,²⁷² however, the right to refuse medical treatment is not absolute. It may be overridden by a compelling state interest.²⁷³ As recently observed by the New Jersey Supreme Court, "[c]ourts and commentators have commonly identified four state interests that may limit a person's right to refuse medical treatment: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties."²⁷⁴

The most important factor is preservation of human life.²⁷⁵ The state has an interest in the life of the patient and in preserving the sanctity of life generally.²⁷⁶ But prolongation of life alone is not sufficient to override a person's exercise of his constitutional right. Were it otherwise, the state could compel any life-prolonging treatment, no matter how marginal the benefit to the patient.²⁷⁷ Further, when a competent

268. *In re Conroy*, 98 N.J. 321, 346, 486 A.2d 1209, 1222 (1985).

269. 410 U.S. 113, 93 S. Ct. 706 (1973).

270. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *John F. Kennedy Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *Quinlan*, 70 N.J. 10, 355 A.2d 647; *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983). Only the New York Court of Appeals has not followed *Quinlan's* constitutional holding; instead, it found a similar right to refuse treatment based on the common law. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d, cert. denied, 454 U.S. 858 (1981).

271. 70 N.J. at 40, 355 A.2d at 663.

272. See, e.g., *Roe v. Wade*, 410 U.S. 113, 164-65, 93 S. Ct. 705, 732-33 (1973) (state interest in life of viable fetus sufficiently compelling to allow regulation of third trimester abortions).

273. See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980) (holding that state interests were insufficient to compel treatment for dying patient); *Commissioner of Corrections v. Myers*, 379 Mass. 255, 261, 399 N.E.2d 452, 456 (1979) (holding that state interest in prison discipline was sufficient to compel prisoner to accept dialysis).

274. *In re Conroy*, 98 N.J. at 348-49, 486 A.2d at 1223.

275. *Id.*

276. See *Cantor*, *supra* note 236, at 249.

277. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 425-26 (1977):

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

patient has chosen, in effect, to die, the state has a lesser interest in protecting the patient's life than in cases where a surrogate may not adequately protect the patient's interest in continued existence.²⁷⁸ In such a case, the abstract concern in sanctity of life does not outweigh the patient's decision.²⁷⁹

One might insist that a refusal of medical treatment, even that offering only limited benefit to the patient, is a form of suicide.²⁸⁰ A patient who consciously chooses to resist treatment does so with the knowledge that treatment would prolong his life at least briefly. Although a technical similarity exists between refusing treatment and suicide, these cases can be distinguished.²⁸¹ The New Jersey Supreme Court has summarized frequently relied on arguments to distinguish refusal of treatment from suicide:

Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury . . .

In addition, people who refuse life-sustaining medical treatment may not harbor a specific intent to die, . . . rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering. . . .

Recognizing the right of a terminally ill person to reject medical treatment respects that person's intent, not to die, but

issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended. Even if we assume that the State has an additional interest in seeing to it that individual decisions on the prolongation of life do not in any way tend to "cheapen" the value which is placed in the concept of living, . . . we believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness. The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice of self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

278. See *In re Conroy*, 98 N.J. at 349-50, 486 A.2d at 1223 (state interest in protecting life of competent dying patient is less than interest in protecting actual or potential life that cannot adequately protect itself).

279. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 742, 379 N.E.2d at 426 (refusal to honor patient's choice lessens value of life). See also Cantor, *supra* note 236, at 250 ("Government tolerance of the choice to resist treatment reflects concern for individual self-determination, bodily integrity, and avoidance of suffering, rather than a depreciation of life's value").

280. See *W. LaFave & A. Scott*, *supra* note 87, at 532-33 (it is homicide to accelerate death even though the victim is already dying or about to be executed).

281. See, e.g., *Declaration on Euthanasia*, *supra* note 211, at 300-07 (distinguishing suicide from death resulting from dying patient's refusal to accept burdensome treatment).

to suspend medical intervention at a point consonant with the "individual's view respecting a personally preferred manner of concluding life." . . . The difference is between self-infliction or self-destruction and self-determination.²⁸²

While courts have included preservation of the integrity of the medical profession as a state's interest,²⁸³ that interest will seldom, if ever, be a sufficient condition to compel treatment.²⁸⁴ Medical ethics do not require treatment in all cases: "[P]hysicians distinguish between curing the ill and comforting and easing the dying"²⁸⁵ More importantly, even if a patient might be successfully treated, the "moral and professional imperative, at least in cases of patients who were clearly competent, presumably would not require doctors to go beyond advising the patient of the risks of foregoing treatment and urging the patient to accept the medical intervention."²⁸⁶ In effect, a corollary of our society's insistence on informed consent is that doctor may know best, but he must respect a patient's foolish disregard of his advice.²⁸⁷

Finally, the state has an interest in protecting innocent third parties dependent on the patient for support.²⁸⁸ A review of the case law indicates that this factor has been relied upon often.²⁸⁹ Thus, that a parent's death will deprive a dependent child of financial and emotional support may justify a court's decision to order treatment.²⁹⁰

282. *In re Conroy*, 98 N.J. at 351-52, 486 A.2d at 1224. Cf. Engelhardt & Malloy, *Suicide and Assisting Suicide: A critique of Legal Sanctions*, 36 W.L.J. 1003, 1013-20 (1982) (contending that arguments in favor of constitutional right to privacy support legality of suicide and assisted suicide).

283. See, e.g., *In re Conroy*, 98 N.J. at 353-354, 486 A.2d at 1224-25. See also *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), reh'g denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

284. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 743-747, 370 N.E.2d at 426-27:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores: such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the state's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient.

285. *In re Conroy*, 98 N.J. at 352, 486 A.2d at 1225, citing *In re Quinlan*, 70 N.J. at 47, 355 A.2d at 667.

286. *Id.*

287. *Id.*

288. See, e.g., *In re Georgetown College*, 331 F.2d 1000 (criticized in *Paris*, supra note 258 at 17-20); *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125, 130 (N.D. Ill. 1972).

289. See *In re Conroy*, 98 N.J. at 352, 486 A.2d at 1225.

290. See, e.g., *In re Georgetown College*, 331 F.2d at 1008 (parent's death would amount to the "most ultimate of voluntary abandonments").

Applying the same analysis, courts have refused to order surgical removal of gangrenous extremities from seriously ill, competent adults.²⁹¹ The patients in those cases were old, expressed little interest in life, and abhorred the idea of being an invalid.²⁹² Because a balancing of interests is necessarily imprecise, the result might differ if the court were asked to compel similar treatment for a parent of small children, especially if the parent was young enough to adjust to life as an invalid.²⁹³

Courts have not always been consistent in their treatment of Jehovah's Witnesses.²⁹⁴ But, perhaps because of concern about religious freedom,²⁹⁵ some courts have refused to authorize health care providers to give transfusions over the patient's refusal to consent.²⁹⁶ Many of the cases can be lined up as follows: the patient has a right to refuse treatment; that right will be honored if the patient's decision is clearly communicated by the patient when competent; that right will be overridden to protect innocent third parties, most notably dependent children.²⁹⁷

As indicated, the Louisiana act does not resolve how such cases should be decided.²⁹⁸ However, some natural death statutes have pro-

291. See *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978). See also *In re Yetter*, 62 Pa. D. & C. 619 (C.P. Northampton County 1973) (upholding competent patient's decision to refuse mastectomy). Critical to a court's decision is a finding that the patient is competent to refuse treatment. See, e.g., *State Dept. of Human Services v. Northern*, 653 S.W.2d 197 (Tenn. Ct. App.), appeal dismissed, 436 U.S. 923 (1978) (upholding order authorizing guardian to consent to amputation of incompetent patient's gangrenous feet, overriding patient's refusal to consent).

292. See, e.g., *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d at 1234:

[The patient] has been unhappy since the death of her husband . . . she does not wish to be a burden to her children; . . . she does not believe that the operation will cure her; . . . she does not wish to live as an invalid or in a nursing home; . . . she does not fear death but welcomes it.

293. Compare *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (court refused to order chemotherapy for sixty-seven year-old severely retarded patient) with *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978) (court ordered similar treatment for two year-old child with similar prognosis to Saikewicz).

294. Compare *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) with *In re Brooks' Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

295. An individual's beliefs are given absolute protection. See, e.g., *Torcaso v. Watkins*, 367 U.S. 488, 81 S. Ct. 1680 (1961) (state constitutional provision requiring public official to declare belief in God held unconstitutional violation of first amendment). But the Court has permitted some regulation of religious activity. See, e.g., *Brounfeld v. Brown*, 366 U.S. 599, 81 S. Ct. 1144 (1961) (Court upheld Sunday closing laws despite impact on Orthodox Jews). It is less than clear when a state may regulate religious activity. See *J. Nowak, R. Rotunda & J. Young, Handbook on Constitutional Law 1057-63* (2d ed. 1983). To date, however, the transfusion cases have not been squarely decided on religious freedom grounds. *Id.* at 1067-68.

296. See, e.g., *In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Brooks' Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

297. See *In re Conroy*, 98 N.J. at 353-54, 486 A.2d at 1225-26.

298. See *supra* notes 255-62 and accompanying text.

duced "mischief" in such cases.²⁹⁹ Health care professionals may construe the statute as the exclusive source of patients' rights. Therefore, because not protected by the statute, the patient may be compelled to litigate or to accept unwanted medical treatment. Further, a court may similarly misconstrue the statute. For example, a Florida trial court recently denied a petition to have a feeding tube removal from a patient who had been in a persistently vegetative state for three years.³⁰⁰ According to one account, the court did so because Florida's Life Prolong Procedure Act of 1984³⁰¹ "clearly expresses the legislature's view that life-prolonging procedures that may be withdrawn or withheld do not include the provision of sustenance."³⁰² Once a litigant relies on a constitutional right to privacy,³⁰³ the court's insistence that the act does not authorize withdrawal of treatment is, of course, a *non sequitur*.

Spurred by a similar misunderstanding of Louisiana's natural death act,³⁰⁴ the legislature quickly amended the Act to prevent such mischief.³⁰⁵ Thus the Act now provides that its provisions are "merely illustrative,"³⁰⁶ and are not "the exclusive means by which life-sustaining procedures may be withheld or withdrawn . . ."³⁰⁷ Even prior to this amendment, the Act made clear that its provisions were cumulative with other rights possessed by the patient.³⁰⁸ The legislature's intent is now clear: the Act authorizes the use of living will, but does not impair additional rights of patients to informed consent or to constitutionally protected privacy.

The Louisiana Supreme Court has yet to intimate its view of whether it accepts *Quinlan's* constitutional analysis of patients' rights.³⁰⁹ But given the almost universal recognition of that right,³¹⁰ counsel for health care providers might reasonably expect Louisiana to follow that analysis. At a minimum, it cannot be contended that the sum of patients' rights are to be found in Louisiana's natural death act.

299. See Capron, *supra* note 8, at 652. See also Vitiello, *supra* note 12.

300. Concern for Dying Newsletter, Vol. 11, no. 2, at 3 (Spring 1985).

301. F.S.A. §§ 765.01 - .15 (Supp. 1985).

302. Concern for Dying Newsletter, Vol. 11, no. 2, at 3 (Spring 1985).

303. Florida's Supreme Court has recognized that right. See, e.g., *John F. Kennedy Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980), *aff'g* 362 So. 2d 160 (Fla. Dist. Ct. App. 1978).

304. La. R.S. 40:1299.58.1 (Supp. 1986). For a discussion of that crisis, see Vitiello, *supra* note 12.

305. 1985 La. Acts No. 187, amending La. R.S. 40:1299.58.1-58.10 (Supp. 1985).

306. La. R.S. 40:1299.58.1(A) (Supp. 1986).

307. La. R.S. 40:1299.58.1(C) (Supp. 1986).

308. La. R.S. 40:1299.59.10(C) (Supp. 1986).

309. See *In re P.V.W.*, 424 So. 2d 1015 (La. 1982) (while citing *Quinlan*, the court did not resolve constitutional question because case was decided under La. R.S. 40:1299.36.1 (Supp. 1986)).

310. See *supra* notes 271-90 and accompanying text. See also *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964).

B. Removal of Artificial Feeding Devices

Treatment withdrawal cases decided in the past ten years were preoccupied with whether or not a respirator might properly be withdrawn from a seriously ill patient.³¹¹ That issue has been laid to rest. The issue at the cutting edge of medical ethics today is whether health care professionals may withdraw artificial feeding devices from patients for whom continued nourishment provides little benefit.³¹² This section reviews Louisiana's natural death law, its "Infant Doe" statute,³¹³ and case law from other jurisdictions to suggest how that issue might be resolved in Louisiana.

Louisiana's natural death act permits a patient or his surrogate to refuse "life-sustaining procedures" under certain circumstances.³¹⁴ That term is defined as "any medical judgement, would serve only to prolong the dying process."³¹⁵ The Act is silent on whether an artificial feeding device is a "life-sustaining procedure."³¹⁶

One might argue that artificial feeding devices are not within the scope of the Act because they are not medical interventions. Quite obviously, eating is not a medical procedure or intervention. But artificial feeding devices have more in common with medical procedures than they do with the act of "consuming" or "devouring" food.³¹⁷ As observed by one court, "[A]rtificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding—they are medical procedures with inherent risks and possible side effects, instituted by skilled healthcare providers to compensate for impaired physical functioning."³¹⁸

The Louisiana act also provides that the medical intervention be

311. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re P.V.W.*, 424 So. 2d 1015 (La. 1982); *Quintan*, 70 N.J. 10, 355 A.2d 647; *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

312. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *In re Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). See also Capron, *Ironies and Tensions in Feeding and Dying*, *Hastings Center Rep.*, Oct. 1984, at 32; Lynn & Childress, *Must Patients Always Be Given Food and Water?*, *Hastings Center Rep.*, Oct. 1983, at 17.

313. La. R.S. 40:1299.36.1-36.3 (Supp. 1985).

314. La. R.S. 40:1299.58.3(A), 1299.58.5, 1299.58.6 (Supp. 1986).

315. La. R.S. 40:1299.58.2(4) (Supp. 1986).

316. *Id.* During April 6, 1984 hearings before the subcommittee of the House of Representative's Committee on Civil Law And Civil Procedure, representatives expressed concern that the Act might be construed as allowing withdrawal of artificial feeding devices (author's personal observation).

317. See *American Heritage Dictionary* 156, 225 (1980) (defining "eat" as "to consume", defining "consume" as "to eat up; devour").

318. *In re Conroy*, 98 N.J. at 374, 486 A.2d at 1236.

one that "would serve only to prolong the dying process."³¹⁹ Intravenous feedings are not intended to cure the patient, but merely to replace or to supplement a person's inability to feed himself through the normal ingestion process.³²⁰ For the terminally and irreversibly ill patient, such a device merely prolongs the dying process. It would appear, therefore, that the Act permits withdrawal of such devices.

Before that conclusion is accepted, however, some other factors should be considered. A number of commentators have insisted that feeding is distinct from other forms of care.³²¹ Despite some resemblance to medical care, feeding is charged with "emotional symbolism."³²² Infants cannot feed themselves though they breathe without assistance. Nurturing and caring are often expressed through feeding.³²³ Perhaps for that reason, some legislators expressed concern during hearings on Louisiana's natural death act that it might be construed as allowing denial of food to a dying patient.³²⁴

Elsewhere, commentators have expressed consternation over the denial of nutrition to seriously ill newborns.³²⁵ For example, in 1982, health care providers and parents of a Down's syndrome infant agreed to deny the infant surgery to repair blockage of his esophagus and a fistula between the infant's stomach and esophagus.³²⁶ A trial court refused to order surgery and the Indiana Supreme Court refused to intervene.³²⁷ The infant's slow death by starvation and dehydration³²⁸ led to a prompt reaction critical of the decision, including promulgation of regulations by the United States Department of Health and Human Services aimed at requiring nutrition and medical care for handicapped newborns.³²⁹

319. La. R.S. 40:1299.58.2(4) (Supp. 1986).

320. *Commission Report*, supra note 1, at 190.

321. See, e.g., *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983), rev'd, 98 N.J. 321, 486 A.2d 1209 (1985). See also J. Piccione, *Last Rights: Treatment and Care Issues in Medical Ethics* (1984).

322. Capron, supra note 312, at 34.

323. *In re Conroy*, 98 N.J. at 374, 486 A.2d at 1236.

324. See supra note 316.

325. See, e.g., Reagan, *Abortion and the Conscience of the Nation*, 9 Hum. Life Rev. 7, 9-10 (1983); Kamisar, supra note 15, at 23-28; Robertson & Fost, *Passive Euthanasia of Defective Newborns*, 58 J. Pediatrics 883 (1976).

326. *In re Infant Doe*, No. GU 8204-00 (Cir. Ct. Monroe County, Ind. Apr. 12, 1982), writ of mandamus dismissed sub nom., *State ex rel. Infant Doe v. Baker*, No. 482 S 140 (Ind. Sup. Ct. May 27, 1982).

327. See Mathieu, *The Baby Doe Controversy*, 1984 Ariz. St. L.J. 605. See also J. Robertson, *The Rights of the Critically Ill* 88 (1983); *Commission Report*, supra note 1, at 224 n.92.

328. The infant's condition made normal feeding impossible. Mathieu, supra note 327, at 605.

329. See *Discrimination Against the Handicapped by Withholding Treatment or Nourishment; Notice to Health Care Providers*, 47 Fed. Reg. 26,027 (1982). These regulations and subsequent regulations are criticized in Mathieu, supra note 327, at 607-26; Vitiello, *The Baby Jane Doe Litigation and Section 504: An Exercise in Raw Executive Power*, 17 Conn. L.Rev. 95 (1984).

Louisiana also responded quickly by enacting an "Infant Doe" statute.³³⁰ Although medical treatment may be withheld under certain circumstances,³³¹ the Act states: "No infant born alive shall be denied or deprived of food or nutrients, water, or oxygen by any person whomsoever with the intent to cause or allow the death of the child for any reason"³³² Elsewhere, the Act permits a child³³³ to be withdrawn from a life support system "or other medical treatment" if the child is "in a profound comatose state" and "has no reasonable chance of recovery."³³⁴ On the other hand, there is an absolute prohibition against denial of food, water, and oxygen; on the other, certain medical treatment may be withdrawn. Thus, it would appear that at least in its "Infant Doe" statute, the legislature has distinguished between nutrition and medical treatment.³³⁵

An analysis of Louisiana's natural death act as consistent with the "Infant Doe" statute does not end the inquiry. If the constitutional right to privacy encompasses decisions regarding medical treatment, legislation that impairs that right must obviously fail.³³⁶ Thus, even if the legislature were to prohibit withdrawal of artificial feeding devices from dying patient's, a court might find that such an act violated a patient's fundamental right to privacy.³³⁷ Whether artificial feeding devices may be withdrawn has been addressed by several courts.³³⁸ A consensus has

330. La. R.S. 40:1299.36.1-36.3 (Supp. 1986).

331. See, e.g., La. R.S. 40:1299.36.1(C) (Supp. 1986) (parents and physician may discontinue medical treatment for child in irreversible coma); La. R.S. 40:1299.36.1(D) (Supp. 1986) (parents and physicians are not required to provide treatment which lacks sufficient medical benefit to the child).

332. La. R.S. 40:1299.36.1(A) (Supp. 1986).

333. The Act was apparently intended to apply to seriously ill newborns. See, e.g., Preamble ("[r]elative to nutritional or medical deprivation of infants"). But elsewhere, the Act refers generally to children. See, e.g., La. R.S. 40:1299.36.1 (Supp. 1986) ("Infants born alive and other children."); La. R.S. 40:1299.36.1(B) (Supp. 1986) (referring to "minor child").

334. La. R.S. 40:1299.36.1(C) (Supp. 1986).

335. Health care providers face a similar problem in determining whether an oxygen tent is "medical treatment" which may be terminated. Difficulty arises because La. R.S. 40:1299.36.1 (Supp. 1986) prohibits denial of oxygen under all circumstances.

336. Cf. *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973) (holding state statute prohibiting abortion violative of individual's right to privacy).

337. Congress has enacted legislation to prevent withdrawal of medical treatment from certain seriously ill newborns. See H.R. 1904, 98th Cong., 1st Sess. (1983), amending Child Abuse Prevention and Treatment Act, 42 U.S.C. §§ 5101-07 (Supp. 1982). That legislation may be subject to constitutional challenge. See Vitiello, *supra* note 329, at 154-59.

338. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *In re Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). Recently, a Florida trial court held that artificial feeding devices could not be withdrawn from a comatose patient. See *Concern for Dying Newsletter*, Vol. 11, no. 2, at 3 (Spring 1985).

begun to emerge that artificial feeding devices may be withdrawn under the same analysis that justifies denial of other medical treatment.³³⁹

*In re Conroy*³⁴⁰ is the first such decision by a state supreme court and provides extensive discussion of the relevant ethical considerations. Claire Conroy was adjudged incompetent because of an organic brain syndrome.³⁴¹ During Ms. Conroy's hospitalization due to dehydration, her treating physician inserted a nasogastric feeding device "that extended from her nose through her esophagus to her stomach,"³⁴² which was subsequently left in place even after her return to the nursing home in which she was confined.³⁴³ Subsequently, her guardian sought a court order permitting removal of the device, an act which would lead to Ms. Conroy's death.³⁴⁴ The trial court granted the order,³⁴⁵ but was subsequently reversed by the appellate division.³⁴⁶ In the interim, the patient died.³⁴⁷ The supreme court reversed the appellate court and indicated that but for the patient's death a remand would have been in order.³⁴⁸

The court reviewed the considerable case law and commentary since its decision in *Quinlan*,³⁴⁹ and reaffirmed its holding that a person has an "interest in freedom from nonconsensual invasion of her bodily integrity," which, on the facts of the case before it, outweighed any countervailing state interests.³⁵⁰ It also extended its decision in *Quinlan*, that a guardian may make appropriate medical decisions on behalf of comatose patients, to incompetent patients generally.³⁵¹

The court first discussed incompetent patients whose preference about treatment withdrawal might be ascertained: "[W]e hold that life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved."³⁵² The court indicated that the patient's actual or subjective preference might be determined in several ways. The court gave express recognition to the "living will"

339. See *Barber*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484; *In re Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

340. 98 N.J. 321, 486 A.2d 1209 (1985).

341. *Id.* at 336, 486 A.2d at 1216.

342. *Id.*

343. Efforts to wean Ms. Conroy from the device were unsuccessful. *Id.* at 337, 486 A.2d at 1217.

344. *Id.* at 335, 486 A.2d at 1216.

345. *In re Conroy*, 188 N.J. Super. 523, 457 A.2d 1232 (Ch. Div. 1983).

346. *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983).

347. *In re Conroy*, 98 N.J. 321, 342, 486 A.2d 1209, 1219 (1985).

348. *Id.* at 388, 486 A.2d at 1244.

349. *Id.* at 342-54, 486 A.2d at 1219-26.

350. *Id.* at 355, 486 A.2d at 1266.

351. *Id.* at 358-61, 486 A.2d at 1228-29.

352. *Id.* at 360-61, 486 A.2d at 1229.

as probative evidence, even absent enabling legislation.³⁵³ It also indicated that an oral directive, a durable power of attorney, or even a discussion between the patient and some other party, might serve as a basis to show the patient's choice.³⁵⁴ Further, the court indicated that the patient's decision might be inferred from his religious beliefs or from a "consistent pattern of conduct with respect to prior decisions about his own medical care."³⁵⁵

The court also addressed directly a problem discussed above,³⁵⁶ whether one can withdraw treatment from an incompetent patient whose preference cannot be clearly ascertained.³⁵⁷ Here the court drew some fine lines when it articulated two separate tests for those incompetent patients:

Under the limited-objective test, life-sustaining treatment may be withheld or withdrawn from a patient in Claire Conroy's situation when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied, that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him. . . . This limited-objective standard permits the termination of treatment for a patient who had not unequivocally expressed his desires before becoming incompetent, when it is clear that the treatment in question would merely prolong the patient's suffering. . . .

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or withdrawn from a formerly competent person like Claire Conroy if a third, pure-objective test is satisfied. Under that test, as under the limited-objective test, the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane.³⁵⁸

353. *Id.* at 361, 486 A.2d at 1229. The court cited with approval the Florida Supreme Court decision in *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921 (Fla. 1984), 98 N.J. at 361 n.5, 486 A.2d at 1229 n.5.

354. 98 N.J. at 361-62, 486 A.2d at 1229-30.

355. *Id.*

356. See *supra* notes 245-50 and accompanying text.

357. 98 N.J. at 363-65, 486 A.2d at 1231-32.

358. *Id.* at 365-66, 486 A.2d at 1232.

The court expressly endorsed a proportionate benefit analysis in such cases.³⁵⁹

The court then analyzed artificial feeding devices in terms of those principles. It concluded that, apart from emotional symbolism of food, those devices are medical procedures.³⁶⁰ Thus, "withdrawal or withholding of artificial feeding, like any other medical treatment, would be permissible if there is sufficient proof to satisfy the subjective, limited-objective, or pure-objective test."³⁶¹

The New Jersey court's analysis is more thorough than that of other courts which have addressed the problem, but it does reflect the consensus among appellate courts.³⁶² Further, that approach is consistent with the view of many medical ethicists:

The problem that many have in deciding how to regard feeding . . . is that its symbolic role as part of "caring" is so predominant that it becomes impossible to place it into a realistic appraisal of a patient's medical needs. . . . [A]s the courts have . . . recognized, we should not be insensitive to either the real or the symbolic harm that is done when patients without prospect of recovery or of human interaction are held on the cusp of death by feeding tubes.³⁶³

It is important to recognize that Louisiana's natural death act does not resolve whether a patient or his surrogate may resist artificial feeding devices. The language of the Act seems to allow that result, but other evidence suggests that the legislature did not intend to go that far.³⁶⁴ This writer suggests, however, that the weight of reason and judicial authority favors treating artificial feeding devices as a form of medical treatment which, under appropriate circumstances, may be resisted.

V. CRITICISMS OF LOUISIANA'S NATURAL DEATH ACT

Recent amendments to Louisiana's natural death act have eliminated some of the confusion feared by critics of natural death acts generally. Those amendments make clear that people in Louisiana may execute living wills resisting specified treatment or appointing a surrogate,³⁶⁵ and that the Act is intended only to supplement other means of effectuating

359. *Id.* at 369-72, 486 A.2d at 1233-35 (accepting the analysis of the *Commission Report*, *supra* note 1).

360. *Id.* at 372-73, 486 A.2d at 1236.

361. *Id.* at 374, 486 A.2d at 1236.

362. See *Barber*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484; *In re Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984).

363. Capron, *supra* note 312, at 34-35.

364. See *supra* notes 314-35.

365. La. R.S. 40:1299.58.3 (Supp. 1986).

patients' rights.³⁶⁶ This section addresses two problems with the Act. First, this writer believes that the legislature erred when it enacted section 1299.58.5(A)(3)-(6), governing procedures in the absence of a declaration, to require unanimity among multiple surrogate decisionmakers.³⁶⁷ Second, the Act is unnecessarily restrictive and, arguably, unconstitutional in its treatment of minors.³⁶⁸

A. Family Unanimity

Section 1299.58.5(A) provides for appointment of a surrogate decisionmaker if an incompetent patient has not made a declaration.³⁶⁹ The statute provides, in descending order, that a judicially appointed tutor or curator,³⁷⁰ spouse,³⁷¹ adult child,³⁷² parent,³⁷³ sibling,³⁷⁴ or other relative³⁷⁵ shall be empowered to act on behalf of the incompetent patient. As introduced in an earlier legislative session, section 1299.58.5(A)(3) stated that the decision to withdraw treatment was to be made by "[a]n adult child of the patient or, if the patient has more than one child, by a majority of the children who are reasonably available for consultation."³⁷⁶ Prior to passage, the bill was amended to require unanimous agreement among the children and other surrogate decisionmakers. In event that unanimity is lacking, apparently the family must have recourse to the courts prior to withdrawal of treatment.³⁷⁷

Obviously, forcing the case into court will increase expense. Worse, many families will have insufficient funds to litigate the appointment of a surrogate decisionmaker.³⁷⁸ Failure to litigate will result in the

366. See, e.g., La. R.S. 40:1299.58.1(A) (Supp. 1986).

367. See *infra* notes 369-88 and accompanying text.

368. See *infra* notes 389-435 and accompanying text.

369. La. R.S. 40:1299.58.5(A) (Supp. 1986).

370. La. R.S. 40:1299.58.5(A)(1) (Supp. 1986).

371. La. R.S. 40:1299.58.5(A)(2) (Supp. 1986).

372. La. R.S. 40:1299.58.5(A)(3) (Supp. 1986).

373. La. R.S. 40:1299.58.5(A)(4) (Supp. 1986).

374. La. R.S. 40:1299.58.5(A)(5) (Supp. 1986).

375. La. R.S. 40:1299.58.5(A)(6) (Supp. 1986).

376. H.B. 996, Reg. Sess. 1983, § 1299.58.5(A)(3).

377. La. R.S. 40:1299.58.5(A) (Supp. 1986) now provides, in relevant part:

When a comatose or incompetent person or a person who is physically or mentally incapable of communication has been certified as a qualified patient and has not previously made a declaration, any of the following individuals in the following order of priority, if there is no individual in a prior class who is reasonably available, willing and competent to act, may make a declaration on the qualified patient's behalf

378. The statute does not require a hearing on the merits; that is, the court will not be required to determine the appropriate course of treatment. *Id.* But the proceedings may be protracted if the family members are already divided over the appropriate course of treatment; it follows that they will also divide on who is the appropriate surrogate. Thus the judicial proceeding will often not be ministerial.

continuation of potentially unnecessary treatment. Even when family members seek judicial appointment, the statute does not provide for an expedited hearing or expedited appeal.³⁷⁹ Thus, unnecessary treatment will often be continued during the course of protracted litigation. The statute applies only to "terminally and irreversibly" ill patients, that is, patients for whom the dying process is merely prolonged by treatment.³⁸⁰ Even brief delay will often make moot the family's application for appointment of a surrogate decisionmaker.

Those disadvantages might be offset if the unanimity requirement resulted in better decisionmaking. But it is easy to imagine situations in which the unanimity requirement will give leverage to an unreasonable dissenter within the family who dissents because of his own needs, rather than for the patient's benefit.³⁸¹ Thus, the rule may impair good decisionmaking.

Further, given other protections in the bill, any benefit of the unanimity requirement is likely quite small. Even if all family members agree, several conditions must be met before life-support systems can be withdrawn from an incompetent patient. The patient must be incompetent and have failed to prepare a directive;³⁸² he must be terminally and irreversibly ill as certified by two physicians,³⁸³ and only treatment that prolongs dying may be withdrawn.³⁸⁴ Thus, patients covered by the Act are the seriously ill for whom continued treatment promises little or no benefit. Treatment offering no net benefit to the patient is difficult to justify.

Further, the requirement of medical certification provides a built-in deterrent to hasty decisionmaking. Family members may improperly wish a quick death for a patient still capable of a continued, if limited, existence. But physicians are unlikely to conspire to bring about the

379. *Id.*; cf. La. R.S. 40:1299.36.3 (Supp. 1986) (providing for expedited proceedings in cases involving seriously ill newborns).

380. See La. R.S. 40:1299.58.3(A); 1299.58.5(A) (Supp. 1986).

381. Cf. *Swanson v. Swanson*, 121 Ill. App. 2d 182, 257 N.E.2d 194 (1970) (plaintiff sought damages for emotional distress resulting from his brother's deliberate refusal to inform him of his mother's death).

382. La. R.S. 40:1299.58.5(A) (Supp. 1986).

383. La. R.S. 40:1299.58.7(A) (Supp. 1986) requires that an attending physician "at the request of the proper person as provided in La. R.S. 40:1299.58.5 or La. R.S. 40:1299.58.6, shall take the necessary steps to provide for written certification of the patient's terminal and irreversible condition, so that the patient may be deemed to be a qualified patient as defined in La. R.S. 40:1299.58.2." La. R.S. 40:1299.58.2(7) (Supp. 1986) defining a "qualified patient" requires that the patient be certified as terminally and irreversibly ill by two physicians.

384. La. R.S. 40:1299.58.5(A) (Supp. 1986) (authorizing that "life-sustaining procedure" to be withdrawn). A life-sustaining procedure is a "medical procedure or intervention which, within reasonable medical judgment, would serve only to prolong the dying process." La. R.S. 40:1299.58.2(4) (Supp. 1986).

death.³⁸⁵ The attending physician's written diagnosis must be confirmed by a second physician,³⁸⁶ increasing the attending physician's motivation for accuracy. Especially when physicians are on notice that a minority of family members do not want treatment withdrawn, they will no doubt be aware of a possible lawsuit by those disgruntled family members.³⁸⁷ That risk will also motivate an accurate diagnosis.

As enacted, section 1299.58.5(A)(3) benefits dissenting family members. But those benefits are gained at the expense of a majority of the family members and worse, at the expense of the seriously ill, incompetent patient. Since the statute allows withdrawal only of treatment offering little or no benefit and only after due consideration by at least two physicians, other precautions are unnecessary. Although not without some disadvantages, a rule allowing a majority family members to decide if treatment should be withdrawn would have served the patient and his family better than the bill as enacted.³⁸⁸

B. Decisionmaking on Behalf of Minors

Section 1299.58.6 was substantially modified by recent amendments.³⁸⁹ Those amendments eliminated a requirement that a district court certify a declaration made on behalf of a minor.³⁹⁰ Further, the amendments make clear that a minor's representative³⁹¹ does not have to prepare a declaration before inappropriate treatment may be with-

385. The Act provides no protection for a physician who actively intervenes to bring about a patient's death, La. R.S. 40:1299.58.10(A) (Supp. 1986) (prohibiting "mercy killing or euthanasia"), or who does not act in good faith concerning the decision to terminate treatment, La. R.S. 40:1299.58.8 (Supp. 1986) (providing "good faith" immunity under certain circumstances).

386. See *supra* note 383.

387. An absence of reported cases on point is explained by a lack of compensable damages. In one recent case, however, Louisiana's Fourth Circuit Court of Appeal affirmed an award of loss of love and affection to parents of a semicomatose child whose death was hastened by the defendant hospital's negligence. See *Taylor v. Charity Hosp.*, 466 So. 2d 736 (La. App. 4th Cir. 1985).

388. Cf. *Commission Report* *supra* note 1, at 127-28 (recommending that one surrogate be appointed and noting that "the Commission believes that the health care practitioner is responsible for determining who should act as the patient's surrogate").

389. See 1985 La. Acts No. 187, § 1299.58.6, amending La. R.S. 40:1299.58.6 (Supp. 1985).

390. See S.B. 271, Reg. Sess. 1984, § 1299.58.6(D). It is important to observe that the procedures were required only if a surrogate wanted to prepare a declaration; but a declaration was intended only as one means of making a decision on behalf of a dying minor. See A. G. Opin. No. 85-57, Jan. 28, 1985, at 4-5.

391. La. R.S. 40:1299.58.6(A) (Supp. 1985) provides that a spouse who has attained majority, the parents of the minor, or her guardian may qualify as the appropriate decisionmaker(s).

drawn.³⁹² However, these amendments did not resolve the conflict between a minor's right to privacy and his surrogate's ability to veto the exercise of that right.

Section 1299.58.6 establishes several prerequisites before a declaration can be made on behalf of a terminally and irreversibly ill minor.³⁹³ In contrast to its treatment of adults,³⁹⁴ the statute applies only to "qualified" minors; that is, minors already diagnosed as terminally and irreversibly ill.³⁹⁵ A minor cannot draft his own declaration, even if he is competent and emancipated. Instead a declaration may only be executed on his behalf by a spouse who has attained majority,³⁹⁶ or by a parent or guardian.³⁹⁷ A spouse may not execute a declaration if he is aware of his minor spouse's desire to continue treatment.³⁹⁸ Conversely, even if the minor desires termination of treatment, the spouse apparently retains complete veto power over the minor's decision.³⁹⁹ Similarly, a parent or guardian may not execute a declaration on behalf of the minor if the *other parent* or guardian dissents, even if the minor desires treatment terminated.⁴⁰⁰

The Supreme Court has not decided whether a person has a constitutional right to refuse medical treatment or whether an incompetent patient has a constitutional right to be withdrawn from treatments that a surrogate believes the patient would resist.⁴⁰¹ But state courts have been virtually unanimous in finding the right to refuse medical treatment to be within a person's constitutional right of privacy.⁴⁰² It is, therefore, reasonable to conclude that the Supreme Court would follow that line of reasoning.

392. The Act now provides:

Nothing in this Section shall be construed to require the making of a declaration or living will for a terminally ill minor. The legislature intends that the provisions of this Part are voluntary and making of a declaration pursuant to this part is merely illustrative as a means of documenting the decision relative to withholding or withdrawal of medical treatment or life-sustaining procedures on behalf of a minor. La. R.S. 40:1299.58.6 (Supp. 1986).

393. *Id.*

394. La. R.S. 40:1299.58.2 (Supp. 1986) (an adult may prepare a declaration at any time).

395. La. R.S. 40:1299.58.6(A) (Supp. 1986) (providing that the act applies to "a minor . . . certified as a qualified patient"); La. R.S. 1299.52.2(7) (Supp. 1986) (defining "qualified patient" as one diagnosed as "terminally and irreversibly" ill).

396. La. R.S. 40:1299.58.6(A)(1) (Supp. 1986).

397. La. R.S. 40:1299.58.6(A)(2) (Supp. 1986).

398. La. R.S. 40:1299.58.6(B)(1) (Supp. 1986).

399. La. R.S. 40:1299.58.6(B)(2) (Supp. 1986).

400. *Id.*

401. See *supra* note 234.

402. See *supra* notes 269-90 and accompanying text. One federal district court has recently joined this trend. *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452 (D.D.C. 1985).

Once one concludes that an adult has a constitutional right to refuse medical treatment, it does not necessarily follow that a court will accord the same right to a minor. Majority is a precondition for the exercise of some rights.⁴⁰³ Elsewhere, the Supreme Court has held that a right may be extended to a minor subject to conditions inapplicable to adults.⁴⁰⁴ The question is whether minors enjoy a right to privacy.

Although the Supreme Court has not addressed that question in the context of medical treatment, there is substantial precedent in the abortion cases. Because *Roe v. Wade* has been viewed by state courts as controlling on the general issue,⁴⁰⁵ *Roe's* progeny would seemingly provide courts guidance on the rights of minors.

The Supreme Court has held unequivocally that a minor has a constitutional right of privacy, including a right to an abortion.⁴⁰⁶ Third party consent has been a more difficult issue. For example, in *Planned Parenthood v. Danforth*,⁴⁰⁷ the Supreme Court invalidated a Missouri statute requiring parental consent for all unmarried minors under the age of eighteen. There, the Court observed that "[T]he state does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient, regardless of the reason for withholding the consent."⁴⁰⁸

That *Danforth* created an absolute bar to third party consent was soon put in question. In *Bellotti v. Baird*,⁴⁰⁹ the Court abstained in order to give the state court an opportunity to interpret an ambiguous statute. It was unclear whether the Massachusetts statute permitted a parental veto or simply expressed a preference for parental consultation. Subsequently, the Massachusetts statute was declared unconstitutional when the same parties returned to the Supreme Court,⁴¹⁰ but the Court divided on the issue of the extent to which a third party might veto a minor's decision to have an abortion.

403. See, e.g., *McKeiver v. Pennsylvania*, 403 U.S. 528, 91 S. Ct. 1976 (1971) (right to trial by jury not required in juvenile proceedings).

404. See, e.g., *H.L. v. Matheson*, 450 U.S. 398, 101 S. Ct. 1164 (1981) (limiting the right of a minor to procure an abortion); *Carey v. Population Serv. Int.*, 431 U.S. 678, 97 S. Ct. 2010 (1977) (recognizing the right of minors to access to information about contraceptives but suggesting that use of contraceptives for their intended purpose might be punished); *In re Gault*, 387 U.S. 1, 87 S. Ct. 1428 (1967) (due process applies to juvenile proceedings but not necessarily to same extent as to adult proceedings).

405. See, e.g., *In re Quinlan*, 70 N.J. 1, 355 A.2d 647.

406. See, e.g., *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 103 S. Ct. 2481 (1983); *Bellotti v. Baird*, 443 U.S. 622, 99 S. Ct. 3035 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 96 S. Ct. 2831 (1976).

407. 428 U.S. 52, 96 S. Ct. 2831 (1976).

408. *Id.* at 74, 96 S. Ct. at 2843.

409. 443 U.S. 622, 99 S. Ct. 3035 (1976).

410. *Bellotti v. Baird*, 443 U.S. 622, 99 S. Ct. 3035 (1979).

In a plurality opinion, Justice Powell argued that a state may properly limit some constitutional rights of minors because of "the peculiar vulnerability of children; their inability to make critical decisions in an informed mature manner; and the importance of the parental role in child rearing."⁴¹¹ But, unlike dissenting Justice White,⁴¹² the plurality did not validate a complete bar to a minor's decision to have an abortion. According to Justice Powell, a statute must provide prompt judicial or administrative proceedings at which a minor might prove that she is mature enough to make a decision to abort without supervision of her parents or the court.⁴¹³ Even if immature, a minor may still procure an abortion unless the minor fails to secure parental consent *and* the court finds that the abortion is not in the best interest of the minor.⁴¹⁴

More recently, the Court invalidated a Missouri statute requiring a physician to obtain "the informed written consent of one of [the] parents or . . . guardian" of a minor under the age of 15, unless she obtains a court order authorizing the abortion.⁴¹⁵ Justice Powell wrote for a majority of the Court:

In *Bellotti v. Baird* . . . (Bellotti II), a majority of the Court indicated that a State's interest in protecting immature minors will sustain a requirement of a consent substitute, either parental or judicial. . . . The *Bellotti II* plurality cautioned, however, that the state must provide an alternative procedure whereby a pregnant minor may demonstrate that she is sufficiently mature to make the abortion decision herself or that, despite her immaturity, an abortion would be in her best interests. . . . Under these decisions, it is clear that Akron may not make a blanket determination that *all* minors under the age of 15 are too immature to make this decision or that an abortion never may be in the minor's best interests without parental approval.⁴¹⁶

Thus, the Court has developed some guidelines for the exercise of a minor's right of privacy. It is clear that such a right exists. It is subject to a compelling state interest in the health of minors. Further-

411. *Id.* at 663, 99 S. Ct. 3043 (Justice Powell's plurality opinion was joined by Chief Justice Burger and Justices Stewart and Rehnquist).

412. *Id.* at 656-57, 99 S. Ct. at 3048

413. *Id.* at 643-44, 99 S. Ct. at 3048.

414. *Id.* at 649-50, 99 S. Ct. at 3051-52.

415. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 439, 103 S. Ct. 2481, 2497 (1983) (citing Akron Codified Ordinances ch. 1870.05(B)).

416. *Id.* at 439, 103 S. Ct. at 2497-98. Despite joining Justice Powell's opinion in *City of Akron*, four justices dissented in a companion case, *Planned Parenthood v. Ashcraft*, 462 U.S. 476, 494, 103 S. Ct. 2517, 2526 (1983). Justice Blackmun, joined by Justices Brennan, Marshall, and Stevens, objected to the Missouri statute because it "permits a parental or a judicial veto of a minor's decision to obtain an abortion."

more, the state has a sufficient interest in promoting the family relationship to justify a requirement that notification of a decision to abort be provided to the unemancipated minor's parents. But the state cannot permit a parental veto. Instead, it is now settled that a state must give the minor an opportunity to prove that she is sufficiently mature to decide for herself and even lacking maturity, she is entitled to a court ordered abortion if the abortion is in her best interest.⁴¹⁷

Judged in light of these principles, some of the requirements of section 1299.58.6⁴¹⁸ are unconstitutional. A state may treat minors differently from adults, based on the vulnerability of children, their immature decisionmaking capabilities, and the traditional role of parents in child rearing.⁴¹⁹ Thus it might be appropriate to limit a minor's ability to make a declaration at any time. Prior to a diagnosis of terminal illness, a minor's consideration of the question would seem "too remote and impersonal."⁴²⁰ But the Louisiana statute never permits a minor to make a declaration on his own behalf.

Instead of recognizing the minor's right under some circumstances, section 1299.58.6 gives the minor's spouse or parents an absolute veto over the minor's exercise of his right to refuse medical treatment.⁴²¹ Thus, one can easily imagine a seventeen year-old suffering from terminal cancer who finds his condition so painful that he would rather die. His decision is accorded no weight under the statute unless he has a spouse no longer a minor or parents, *all* of whom support his decision.

By contrast, because the right to an abortion is a personal right of the woman, the putative father lacks the authority to veto the decision to abort the fetus.⁴²² Similarly, the Court has rejected states' efforts to allow a parental veto.⁴²³ However, the Court has recognized a limited third party veto.⁴²⁴ A court may refuse to allow a minor to procure an

417. 462 U.S. at 439-40, 103 S. Ct. at 2497-98.

418. La. R.S. 40:1299.58.6 (Supp. 1986).

419. See *supra* note 411 and accompanying text.

420. *In re Quinlan*, 70 N.J. at 22, 355 A.2d at 653. This aspect of the *Quinlan* case has recently been disapproved by that the New Jersey Supreme Court in connection with incompetent adults. See *In re Conroy*, 98 N.J. 321, 362-63, 486 A.2d 1209, 1230 (1985).

421. La. R.S. 40:1299.58.6(B)(2) (Supp. 1986). The common law traditionally required parental consent before a minor could be treated. Prosser & Keaton, *supra* note 198, at 115. But that requirement has been eroded and the law has increasingly recognized a mature minor's right to consent. W. Prosser, J. Wade, & V. Schwartz, *Torts* 104 n.8 (7th ed. 1982).

422. See, e.g., *Planned Parenthood v. Danforth*, 428 U.S. 52, 96 S. Ct. 2831 (1976).

423. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 103 S. Ct. 2481 (1983); *Bellotti v. Baird*, 443 U.S. 622, 99 S. Ct. 3035 (1979). Cf. *H.L. v. Matheson*, 450 U.S. 398, 101 S. Ct. 1164 (1981) (upholding a Utah statute requiring a physician to give notice to a minor's parents before the physician performed an abortion.)

424. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 103 S. Ct. 2481 (1983); *Planned Parenthood v. Ashcraft*, 462 U.S. 476, 103 S. Ct. 2517 (1983).

abortion but only after a finding that she is too immature to make the decision *and* that the abortion would not be in her best interest.⁴²⁵

Not only is section 1299.58.6 potentially violative of a minor's right to privacy, but it also makes little sense in terms of the underlying policy of the Act. Natural death acts are intended to give living wills legal effect.⁴²⁶ A living will is evidence of the *patient's* desires concerning his treatment.⁴²⁷ Even when a surrogate is authorized to decide on behalf of an incompetent,⁴²⁸ the surrogate should attempt to determine how the incompetent patient would decide if he were able to speak in his own behalf.⁴²⁹ When probative evidence of the patient's preference is unavailable, the surrogate should determine whether treatment is in the patient's best interest.⁴³⁰

Section 1299.58.6 allows family members to express their preference concerning treatment for the dying patient.⁴³¹ A dissenting parent or spouse may veto a mature minor's clearly stated preference to terminate treatment.⁴³² Further, the Act does not suggest that surrogates ought to try to make a decision consistent with the *patient's* preferences or best interests.⁴³³ Conceivably, a dissenting party may prevent a declaration from being prepared based on that party's own interests,⁴³⁴ rather than those of the patient.

425. *Akron Center for Reproduction Health*, 462 U.S. 416, 103 S. Ct. 2481; *Bellotti*, 443 U.S. 622, 99 S. Ct. 3035.

426. Capron, *supra* note 8, at 652. Such legislation serves additional purposes: it clarifies, for example, whether health care providers are entitled to good faith immunity from suit; whether death resulting from termination of treatment is suicide for purposes of life insurance. See *Commission Report*, *supra* note 1, at 140.

427. See *In re Conroy*, 98 N.J. 321, 360-61, 486 A.2d 1209, 1229 (1985):

We hold that life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved. The standard we are enunciating is a subjective one, consistent with the notion that the right that we are seeking to effectuate is a very personal right to control one's own life

.....

[The patient's] intent might be embodied in a written document, or "living will," stating the person's desire not to have certain types of life-sustaining treatment administered under certain circumstances.

428. See La. R.S. 40:1299.58.3 (C)(1) (Supp. 1986)(explicitly authorizing the patient to make a proxy directive).

429. See *supra* notes 238-50 and accompanying text.

430. See *In re Conroy*, 98 N.J. 321, 365-68, 486 A.2d 1209, 1232-33 (1985) (discussing treatment for patient's who have not expressed a view concerning a proposed course of treatment). See also *Commission Report*, *supra* note 1, at 134-36 (advocating application of best interest standard for patients whose desires cannot be ascertained).

431. La. R.S. 40:1299.58.6 (Supp. 1986).

432. La. R.S. 40:1299.58.6(B)(2) (Supp. 1986).

433. See, e.g., La. R.S. 40:1299.58.6(B)(2) (Supp. 1986) (providing only that if one has noticed of opposition, the surrogate may not make a declaration).

434. See *Commission Report*, *supra* note 1, at 91-94 (discussing problems that may prevent effectuating decision of a seriously ill patient, including inability to secure co-

The legislature has proven its readiness to remedy the Act when it has caused confusion,⁴³⁵ and it is hoped that it will modify section 1299.58.6 to prevent an arbitrary, third party veto of a patient's right to be free from burdensome treatment. The same end might be achieved through litigation. But litigation can be obnoxious in such cases where physicians and family ought to devote their energy and resources to caring for the dying patient.

VI. CONCLUSIONS

Especially since recent amendments, Louisiana's natural death act is flexible and enlightened. It avoids many of the pitfalls of earlier natural death acts.⁴³⁶ Consistent with patients' self-determination, it makes living wills legally binding, and it permits a declarant to appoint a proxy decisionmaker or to specify specific unwanted therapy.⁴³⁷ Further, it establishes procedures to allow execution of a declaration on behalf of incompetent patients.⁴³⁸ Some problems remain with the Act, especially with its treatment of terminally ill minors.⁴³⁹ It is this writer's hope that the legislature will remedy those difficulties.

Significantly, the Act has made clear that the rights it establishes are cumulative with other rights.⁴⁴⁰ In order to more fully define those rights, the preceding discussion reviewed some recurring situations addressed by courts in other jurisdictions.⁴⁴¹ The logical conclusion to be drawn is that those cases outside the scope of the natural death act should be decided by reference to a patient's constitutional right to privacy consistent with a clear majority of decisions reached in sister jurisdictions.⁴⁴²

operation of others). Some commentators have argued that, at least in cases where third parties have an interest in the death of a seriously ill patient, that benefit to third parties is irrelevant to a medical decision based on a patient's best interests. See, e.g., Robertson, *supra* note 7, at 239-43.

435. See 1985 La. Acts No. 187, amending La. R.S. 40:1299.58.1-.58.8 (Supp. 1986).

436. See *supra* notes 92-151 and accompanying text.

437. La. R.S. 40:1299.58.3(C)(1) (Supp. 1986).

438. La. R.S. 40:1299.58.5-58.6 (Supp. 1986).

439. See *supra* notes 389-434 and accompanying text.

440. See *supra* notes 143-51 and accompanying text.

441. See *supra* notes 255-364 and accompanying text.

442. *Id.*

