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Recognizing Personhood and the Right to Die with Dignity

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Abstract / Death cannot be viewed properly as either an event or a configuration. Indeed, multiple parts of the body can continue to live long after the disintegration of its central organization is recorded. Instead of collapsing at a moment in time, technological mechanisms are capable of sustaining the major bodily processes indefinitely — all designed to allow for the harvesting of needed organs for transplantation. State legislative efforts have been undertaken in America to define those specific circumstances when death occurs legally. Although always allowed to exercise reasonable discretion in their decision making, attending physicians will nonetheless be aided by these laws that not only limit their legal liability but assure for the patient that his final choices will be honored consistent with basic principles of self-determination. The Law Reform Commission of Canada recommended in 1987 that criminal liability be rejected for the offenses of helping, advising, or inciting a person to commit suicide. This is an exceedingly wise and humane position to follow. Instead of being held captive to words such as “rational suicide” or “euthanasia”, what is needed is an acceptance of more contemporary watchwords such as autonomy and self-determination. When at all possible, final choices about death should be made by the patient’s family and their medical advisers — and not be subjected to judicial scrutiny.

Résumé / On ne peut considérer la mort comme un événement isolé et sans suite. Car, après la désintégration du système de vie, de nombreuses parties du corps humain peuvent survivre encore longtemps. Déjà, la mort signifiait la fin, mais la technologie médicale est maintenant capable de maintenir la vie biologique dans le but de prélever des organes pour la transplantation. En Amérique du nord, de nombreuses législations ont été adoptées afin de déterminer quand, légalement, la mort survient. Même si les médecins ont toujours joui de beaucoup de latitude dans

leur prise de décisions, il n’en demeure pas moins que non seulement ces lois les protègent légalement mais qu’elles rassurent également le patient quant au respect de ses dernières volontés. En 1987, la Commission de Réforme du Droit recommandait que l’aide ou l’incitation au suicide ne soit plus reconnue comme un acte criminel. Cette décision est particulièrement sage et humaine. Au lieu de s’attarder à discuter sur des mots comme *suicide rationnel* ou *euthanasie*, il faudrait plutôt utiliser des concepts plus contemporains comme *autonomie* et *auto-détermination*. Enfin il est toujours préférable que les décisions finales relèvent du médecin traitant et de la famille, non pas de la loi.

To be treated as a person, one must not only enjoy states of consciousness but also have intentional states, have the capacity to have experiences which occur at different times and are linked together by memory (1), and have a capacity for love and engaging in interpersonal relationships (what has been termed the “relational potential”) (2). Whether rationality or socially interactive capacities are the controlling criteria to establish personhood remains an open philosophical question. It has been suggested that an individual’s moral standing as part of the moral community should be permitted to end only when a reasonable deduction can be made that a clear breakdown between bodily integrity and mental or social capacity has occurred (3).

COMPETENCY VERSUS INCOMPETENCY

To assist in determining when life may be terminated from the view of moral justification, various questions may be posited (4). Nine of the most relevant ones are:

1. Is the individual in question characterized as a person?

2. If it is so characterized, does it desire its own death — and if this is the case, is that a rational desire?
3. If the person is sustained, what quality of life will be enjoyed?
4. What are the economic costs of maintaining this person's life?
5. Is the person in an unconscious state and technologically impossible of being restored to consciousness?
6. Would the termination of life be a matter of active intervention or but a matter of exercising restraint in saving the person's life?
7. Is the case in point one involving direct or indirect "killing"?
8. Does the action contemplated require "extraordinary" or only "ordinary" means in order to maintain the person alive?
9. Is the nature of the illness suffered by the individual *in extremis* of a fatal nature? (5)

Another complementary framework for helpful analysis has been set out as so-called indicators of "humanhood" which, it is thought, when evaluated provide a profile of some 15 qualities or attitudes regarded as necessary for one to be regarded as a "person". Among the indicators are self-awareness, self-control, time consciousness, a sense of futurity, a sense of memory, a capability to relate to others, an ability to communicate, the ability to display curiosity instead of indifference, rationality, the ability to be emotive and intuitive, and — ultimately — the capacity for neocortical functions (6).

In the absence of the synthesizing function of the cerebral cortex, the *person* is non-existent.

Such individuals are objects not subjects...

Personal reality depends on cerebration and to be dead 'humanly' speaking is to be ex-cerebral, no matter how long the body remains alive (7).

What the nine questions posted previously regarding the point at which life may be terminated and the indicators of humanhood have in common is the shared focus upon the brain and its proper functioning as the key to the advancement or — as the case may be — the preclusion of all of the complex human responses and attitudes which identify and recognize a human as a functioning person.

TOWARD A UNIFORM DETERMINATION OF DEATH?

The traditional legal definition of death has been "the cessation of life; permanent cessation of all vital functions and signs" (8). As to the determination of death from a biological standpoint, the

law has generally treated the matter as a question of medical fact, determined according to those criteria established by the medical profession in each state (9), and consequently no consensus is to be found among the states regarding the matter. Limited application of a brain death standard has been authorized by 33 states, with 27 states having codified brain death statutes (10) and the remaining six validating brain death determination by judicial cognizance (11).

State legislative approaches to determining death may be grouped into a three-pronged classification. The first prong consists of seven states which have chosen to follow an "alternative" approach — mandating that the occurrence of death will be recognized when a patient suffers an irreversible cessation of spontaneous cardio-respiratory function or sustains irreversible cessation of spontaneous brain function (12). It is obvious that this approach allows for a perception — inaccurate though it may be — that there is a recognition of two entirely different phenomena of death (13).

The second prong is found among eight states and, while providing for alternative standards for determining death, is careful to elucidate the specific conditions under which each standard is to be applied (14). Typically, these statutes provide that death is recognized legally when there is an irreversible cessation of cardio-respiratory function — unless respiration and heartbeat are maintained by means of artificial support, in which case death occurs when the brain function is determined to be irreversible (15).

Finally, the third prong has been developed and applied in 12 states by legislative enactment, and applies a brain death standard for determining the occurrence of death (16). Within this group, some legislative directions require irreversible cessation of brain functions to indicate death and thus recognize the strictly exclusive criterion of brain death (17); whereas other statutes require that death be recognized when there is an irreversible cessation of brain function but go further and allow the use of other medically accepted standards to determine death (18).

By dictating exclusive reliance upon brain death as the determiner of death, physicians are effectively precluded from tying the circumstances of each individual case to the ordinary medical procedures used for determining death. Statutes of this nature also preclude the necessary flexibility when advances in medical technology eclipse the traditional brain death standard and would otherwise allow the harvesting of vital organs for critical transplant surgeries.

In 1968, in an effort to assist themselves as a profession and assist the law as well, and to seek some degree of uniformity in the area of death, a number of physicians at the Harvard Medical School issued a report which established four criteria for the diagnosis of irreversible coma (19): unreceptivity and unresponsivity to externally applied stimuli and inner need, no spontaneous muscular movements or spontaneous respiration, no elicitable brain reflexes, and a flat EEG or electroencephalogram (20). The report also suggested that in a patient where findings of this type were made, a subsequent verification of them be undertaken at least 24 hours later. It was furthermore suggested that, upon the fulfillment of the criteria and before any effort was undertaken to disconnect a respirator, the patient be officially declared dead (21). The committee's report was not presented for the purpose of replacing the more traditional standards for determining death; on the contrary, these criteria were urged only as a complement to them (22).

In 1981 Dr. William Street, a member of the original medical committee that wrote the Harvard brain death criteria, observed that in actual implementation the criteria have been found to be too strict as to some and too lax as to others. Of particular concern to him was the fact that the criteria fail to make an adequate distinction between irreversible coma and brain death. He did note that there are no present records disclosing any recovery for patients who met the criteria (23).

The National Conference of Commissioners on Uniform State Laws approved in 1978 the Uniform Brain Death Act that states:

For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards (24).

Before this Act was superseded in 1980 by the Commissioners' adoption of the Uniform Determination of Death Act, four states passed legislation adopting its original provisions (25).

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded in 1981 that the states should adopt a model statute entitled "The Uniform Determination of Death Act," which would establish much-needed clarity and certainty (26). Under this statute,

An individual who has sustained either (a) irreversible cessation of circulatory and respiratory functions or (b) irreversible cessation of all functions of the entire brain, including the brain

stem, is dead. A determination of death must be made in accordance with accepted medical standards (27).

Since the issuing of this report and its recommendation and the subsequent approval of the Uniform Act by the National Conference of Commissioners on Uniform State Laws in August, 1980, it has been adopted legislatively in 24 states and the District of Columbia (28) and judicially in two (29).

Interestingly, public acceptance of the concept of brain death has not been uniform; the average person still perceives stoppage of the heart as the sole determinant of death (30). With time, however, and more dramatic "real life" news coverage of tragic Karen Quinlan-type cases, the public will hopefully become more aware and more fully educated on this matter (31).

A very meritorious and, indeed, persuasive suggestion has been offered as a means of resolving the present confusion and controversy over standards for defining death — specifically, the adoption of neocortical death as the operative and controlling medico-legal standard (32). Defining this type of death as "the irreversible loss of consciousness and cognitive function" (33), the present legal inconsistency of upholding surrogate decisions to terminate life-support systems together with nourishment when incompetent patients irreversibly lose all consciousness and cognitive functions — yet failing to recognize neocortical death — is observed (34). It is then submitted that if this type of death were legally validated, the moral and legal dilemmas inherent within this area would be resolved in large part, because once a physician had made a determination that a patient had lost, irreversibly, all cerebral qualities of human life, the patient would be recognized as legally dead and thus artificial life supports, together with nourishment, could be terminated. Substituted judgement and best-interest tests would no longer be required in order to *guess* what course of treatment or non-treatment should be pursued (35).

While preeminently reasonable, this suggestion is somewhat ahead of its time for social acceptance. Wrenching though the tragic choices are regarding a continuance of "life" or a passive act of cessation of it, this unduly full and open process has a cathartic effect on all parties — and especially the system of justice that demands equality of treatment for all within a forum of open family debate and hoped-for consensus. Put quite simply, oh too many people *feel* that so long as there is breath, there is life, and would surely feel uncomfortable about the utilization of this abrupt, albeit merciful, standard of neocorti-

cal death. To compound the "public relations" matter there is the fact that those who are brain dead still are capable of spontaneous cardio-respiratory functioning. Indeed, adult patients — declared brain dead — may give every appearance of life, especially so to those members of the family unfamiliar with such technologies as mechanical ventilation and total parenteral nutrition. The average family involved here has time and time again shown that the abrupt and final decisions that would be allowed by the adoption and application of the neocortical standard of death are not acceptable to their feelings. Agonizing though such decisions are, given the average unsophistication of the dying and the fear of death, much education will have to be undertaken to prepare the ordinary American for acceptance of this standard as well as about brain death in general.

LIVING WILLS

A so-called "living will" is an instrument that indicates its maker's preference not to be started or maintained on a course of extraordinary treatment (sometimes specific modalities are designated) in the event of accidental or debilitating illness (36). The biggest uncertainty surrounding living wills and their subsequent administration is related to whether health care providers are required — under pain of civil or criminal sanction — to execute the terms of the will. An interlocking concern is whether those participants charged with fulfilling its terms will be assured of immunity from civil or criminal prosecution (37). Whether a refusal of life-sustaining therapies would constitute a suicide remains largely as another vexatious and unresolved issue (38). Regardless of these points of great uncertainty, some 35 states and the District of Columbia have passed living will legislation (39).

Those jurisdictions recognizing living wills are faced with the fact that they must still address the issue of the nature of the medical techniques they will determine to be "extraordinary" and the type of circumstances which will "demonstrate that the person's previously expressed desire to forego treatment continued up to the time immediately prior to his or her disability" (40). Without legislative decisions that tackle forthrightly and with clarity these issues, the courts will be faced with a case-by-case determination of the parameters of life (41).

In an effort to correct some of the weaknesses and uncertainties of living will legislation, more and more states are enacting natural death acts (42). Spurred by California's bold and inno-

vative effort in 1976 in passing a Natural Death Act designed to formally establish the requirements for a "directive to physicians", other states have begun to follow suit and authorize validly executed instruments relieving a physician, staff, and hospital from civil and criminal liability for removing or withholding life-sustaining treatments (43). Considerable differences exist among the various legislative programs regarding the assessment of penalties for either disobeying the directive of a properly executed instrument or preventing the transfer of a patient seeking to come within the provisions of the law to another physician who will respect and follow the patient's wishes (44). And, the triggering mechanisms of the legislation are often cumbersome and self-defeating. In California, for example, before a patient may seek to avail himself of the provisions of the Natural Death Act, he must first receive a diagnosis as being in a terminal condition which is construed as meaning "an incurable condition with death being imminent regardless of life-sustaining procedures" (45).

In actual practice, there is evidence to suggest that a patient's ability to obtain his wishes regarding the prohibition of life-sustaining treatment may be impeded in states where natural death legislation exists (46). For, if such legislation is viewed by attending physicians and health care providers as the sole means for both initiating and implementing a decision to forego treatment, and if a further belief is maintained that a decision of this nature cannot be made by a surrogate on behalf of another but only in strict accordance with an advance directive that has been executed properly by a patient, then dying patients may in fact be subjected to treatment the nature of which is neither requested nor beneficial (47). Additionally, an improper inference may be drawn that if a patient has not executed a directive that is in compliance with natural death legislation, he does not wish methods of life-sustaining treatment to be ended under any and all circumstances (48). The truth of the matter might well reveal that a directive was not executed because of ignorance of its legislative existence, unawareness of its importance, or even uncertainty regarding how it should be composed (49).

Generally, the right to die or natural death acts apply only to "competent adults" (50), with children and those mentally incompetent being excluded. Yet, some jurisdictions have made provision for proxy consent. In North Carolina, the governing statute allows proxy consent for an irreversibly comatose patient who has not previously executed a living will — with consent

being given by a spouse, legal guardian, or a majority of the relatives of the first degree (51). No reference is made in the statute to any other type of incompetent patient. Virginia legislation does not expressly allude to the rights of patients with inadequate decision-making capacity and refers only to competent patients (52). In New Mexico, provision is made for proxy consent for minors — but not for incompetent adults (53). Arkansas legislation, however, covers minors and incompetent adults alike (54).

DURABLE POWERS OF ATTORNEY

As a consequence of the numerous weaknesses encountered with living will legislation and natural death acts, it has been suggested that additional safeguards should be utilized for implementing advance directions on life-sustaining modalities of treatment. Specifically, adoption of proxy directives through durable power of attorney statutes would go far toward assuring that an individual's desires regarding treatment (or, as the case may be, non-treatment) would be effected (55). Forty-two states have enacted laws authorizing durable powers of attorney that enable the appointment of a proxy after a person becomes incompetent (56). The language of these statutes is usually broad enough to accommodate the appointment of a surrogate to facilitate problems which involve health care for the incompetent — although the statutes were not enacted for remedying the specific problems of incompetence, however (57).

Since the usual power of attorney — which may be either of a general or limited nature — ceases when the principal becomes incapacitated, some states have created specific durable powers of attorney whereby an agent's authority to act is specifically mandated to continue after a debilitating event happens to the principal (58). In this way, the power may be used as an "advance proxy directive" whereby an individual can nominate another whose express duty it will be to make *all* decisions regarding health care in the event the principal becomes incapacitated or otherwise unable to make decisions of that nature (59). As can be seen, this advances greatly the efficiency and fairness of the whole decision-making process for incapacitated persons.

As durable power of attorney statutes begin to be adapted and applied to areas which they were not originally designed to accommodate, care and study must be undertaken to make certain these original procedures — initially enacted to "avoid the expense of full guardianship or conservatorship proceedings when dealing with small prop-

erty interests" — are not abused in cases of application to incapacitated patients (60). At some point in time, procedural safeguards may well have to be designed in order to assure necessary and functional application of the durable powers of attorney. There is no question, however, of their great potential and their already proven success in easing the heavy and emotional burdens of decision making and their added value in allowing the courts to respect individual and familial privacy by not intruding (61).

A STATUTORY CLARIFICATION?

In August, 1985, the National Conference of Commissioners on Uniform State Laws approved and recommended for enactment in all the states a Uniform Rights of the Terminally Ill Act (62). This Act authorizes an adult to execute a declaration to his physicians and health care facilities directing the withholding or withdrawing of life-sustaining treatment in the event he is in a terminal condition of health and thereby unable to participate in decisions concerning medical treatment. The scope of the Act is quite narrow in that it provides but one way for the wishes of a terminally ill person regarding the use of life-sustaining procedures to be fulfilled. It is designed to avoid the inconsistency in approach to decision making which has continued to plague living will statutes, providing simply that a statutory declaration will be executed uniformly in all states.

The Act is not intended to affect any existing rights and responsibilities of persons to make medical treatment decisions. Furthermore, its provisions are limited to treatment that is merely life-prolonging and to those patients whose terminal condition is incurable and/or irreversible, whose death will soon occur, and who are unable to participate in medical treatment decisions. It does not address issues of the treatment of persons who have not executed a statutory declaration of this nature nor does it pertain to treatment issues for minors nor to treatment decisions made by proxy. Although drawing upon the basic structure and substance of similar existing living will legislation, it simplifies procedures, improves drafting, and clarifies language such as the terms "life-sustaining treatment" (63) and "terminal condition" (64). Legislation of this type that endeavors to clarify terms and concepts in this critical area of concern must be applauded as a positive action. It of course remains to be seen whether the states view the model as a clarification or as an obfuscation (65).

A HUMANE AND DIGNIFIED DEATH ACT

The Hemlock Society of California and Americans Against Human Suffering campaigned to amend the California constitution to add the Humane and Dignified Death Act. This proposed act would have recognized and expanded "the inalienable right of privacy [by including] the right of the terminally ill to voluntary, humane, and dignified doctor-assisted aid in dying" (66). To exercise the right, a patient would have had to be certified as terminally ill (67). A patient is defined as terminally ill under the proposal if two physicians state that the patient has less than six months to live. The patient would have had to exercise a durable power of attorney in which the patient conveyed authority to order her death to another if a coma-tose or otherwise mentally disabling condition ensued (68). Although preliminary research indicated strong support for the measure, the initiative received only 130,000 of the needed 450,000 signatures to be placed on the November 1988 ballot (69). However, Americans Against Human Suffering plans another attempt in 1990.

The initiative as drafted would have been an extension of existing state legislation. This legislation allows adults to

execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of execution of the directive (70).

For declarants who are patients in a skilled nursing facility to make a valid directive, one of two witnesses must be a patient advocate or ombudsman designated as such by the California State Department of Aging (71). The declarant can revoke the directive regardless of mental state or competency (72), and an exculpatory clause prohibits imposing "criminal or civil liability on the part of any person for failure to act upon a revocation... unless that person has actual knowledge of the revocation" (73).

No civil or criminal liability is imposed on a physician or licensed health professional acting under the direction of a physician who fails to effectuate the patient's directive unless he fails to transfer the patient to a physician who will comply with the directive (74). More specifically, actions of withholding or withdrawing life-sustaining procedures from a qualified patient are not regarded as contributing to acts of suicide (75). Section 2443 of the California *Civil Code* adds that such actions shall not be construed as condoning, authorizing, or approving mercy killing or permitting "any affirmative or deliberate act or omission to end life other than the withholding or withdrawal of health care pursuant to a durable power of attorney for health care so as to permit the natural process of dying." (76). Moreover, "an attempted suicide by the principal shall not be construed to indicate a desire of the principal that health care treatment be restricted or inhibited" (77). Applying these sections to the proposed Act, the Act would not condone, authorize, or approve mercy killing or permit any affirmative or deliberate act or omission to end life other than by a licensed physician and only when requested by the patient pursuant to a properly executed legal document.

Interestingly, in 1987, the Law Reform Commission of Canada recommended that criminal liability be rejected for the offences of helping, advising, or inciting a person to commit suicide, negligent homicide, manslaughter, or murder (78). Such action was taken with the purpose of allowing palliative care to be administered freely to terminal patients, with palliative care being defined as a medical intervention undertaken by a physician for the primary purpose of alleviating a patient's pain and suffering (79).

JUDICIAL DISRUPTIONS IN THE CADENCE

In 1988, with the case of *In re Westchester County Medical Center*, a majority of the New York Court of Appeals held that the insertion of a nasogastric tube in a 77-year-old widow, Mary O'Connor, who was severely debilitated from a series of strokes, was legally required, thus providing her with nutrition and hydration. Finding no "clear and convincing" evidence of the patient's choice *not* to have the treatment, the court ordered its initiation and maintenance (80). But, interestingly, the court was very divided in its decision — four of the judges signed the opinion, one concurred in the result

but in a separate opinion criticized the standard of clear and convincing evidence of a patient's choice as the primary basis for treatment decisions for incompetent patients, and two other judges dissented (81).

In another divided opinion in 1988, the Missouri Supreme Court ordered that Nancy Cruzan, a young woman in her early thirties who has been in a persistent vegetative state for six years, be maintained through a gastrostomy (82). Rejecting a right of privacy that would extend to decisions to "terminate the provision of food and water to an incompetent patient" (83), considering them to be necessary medical treatment, the court also rejected the right of self-determination (realized through the doctrine of informed consent) for an incompetent patient to end his life (84). Great stress was placed on the fact that not only was the evidence of Nancy's previous disposition toward death before her accident "unreliable", and thus not clear and convincing, but also she "is alive" and "the burdens of her treatment are not excessive for her" (85). Quality of "life" was a non-issue. Indeed, the Court stressed the state's interest in preserving life and acknowledged this interest as outweighing "any rights invoked on Nancy's behalf to terminate treatment in the face of the uncertainty of Nancy's wishes and her own right to life" (86).

The United States Supreme Court granted *certiorari* and heard the Cruzan case in November, 1989 (87). Sadly, it is expected that the High Court will affirm the Missouri Supreme Court by a 5-4 or 6-3 vote and hold that clear and convincing evidence must be shown to allow an incompetent to die with dignity. Interestingly, when presented with discontinuation of treatment case issues comparable to those in *Cruzan* and *O'Connor*, the vast majority of American courts have, however, held such discontinuation to be appropriate (88).

NEW BEGINNINGS?

From this analysis, it can be seen and understood that — in modern times — death cannot be identified easily as one event or configuration, for the very gradualness of it as a process can be apprehended when it is realized that multiple parts of the body can continue to live even after the disintegration of its central organization is recorded (89). Indeed, more and more, an individual's physiological system does not collapse and fail in one moment of time. Rather, technological substitutes are introduced, then integrated by a wondrously "evil" computer. Thus,

while vital signs are indeed present, they are both provided and manipulated by machines.

These various new medico-legal approaches to aid definitions of death have one great practical merit, however: they endeavor to place and to recognize the moment of death earlier in the continuum of life than earlier practice and definitional structure did. And in so doing, the physician's decision to discontinue therapy, even though what were regarded commonly as "signs of life" are present, is made considerably easier. Death may thus come with dignity and often mercy. Not only does this prevent the immediate and extended family members, as well as attending health care providers, from suffering the deep anguish of dealing with a living corpse, but also precludes the heavy economic burdens of caring for one who has lost the basic attributes or indicators of personhood. Additionally, the body parts that survive death — as thus newly classified and defined — may be harvested and made available to deserving recipients without the physicians being fearful and uncertain that their acts might be considered invasions of privacy or criminal assaults (90).

THE EMERGING CONSTRUCT

The construct for principled decision making is being shaped partially in legislative enactments of the nature thus analyzed — with this being, obviously, the preferred mechanism over judicial intervention and inconsistency. These enactments bear clear and unmistakable evidence that the complex social mechanisms of the day are at force in reestablishing and reasserting the right of every individual to autonomy and enlightened self-determination in deciding his final rite of passage. Passive euthanasia and rational suicide are offensive words from the parlance of a time long gone by. Autonomy and enlightened self-determination are the more contemporary watchwords of today.

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Certain ideas in this essay derive from my article, "All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination? 22 UNIVERSITY OF CALIFORNIA AT DAVIS LAW REVIEW 275 (1989).

NOTES

1. Tooley. Decisions to terminate life and the concept of persons. In J. Ladd, ed. *Ethical Issues Relating to Life and Death*; 1979, pp. 85-87.
2. McCormick. To save, or let die: the dilemmas of modern medicine. In R. McCormick, ed. *How Brave a New World?*; 1981, pp. 339-349. Also see Smith, *Death be not proud: medical, ethical and legal dilemmas in resource allocation*. *J. Contemp Health Law and Policy* 47, 62 (1987).
3. Veatch R., *A Theory of Medical Ethics*; 1981, p. 240-244. See also G. Smith, *The New Biology: Law, Ethics and Biotechnology*. Ch. 8; 1989.
4. Id. Professor Tooley lists 13 such questions. *Supra* note 1.
5. *Supra* note 1, pp. 62-63.
6. Fletcher. Indicators of Humanhood: A Tentative Profile of Man. *Hastings Center Report* No. 1; 1972.
7. Id. p. 3. See also Engelhardt, T. *The Foundations of Bioethics*. Ch. 6; 1986.
8. *Black's Law Dictionary*. 5th ed.; 1979, p. 360. In an article entitled "On Defining a 'Natural Death,'" Daniel Callahan has attempted to provide a stipulative definition of "Natural Death" thusly: "the individual event of death at that point in a life span when (a) one's life work has been accomplished; (b) one's moral obligations to those for whom one has had responsibility have been discharged; (c) one's death will not seem to others as offense to sense or sensibility, or tempt others to despair and rage at human existence; and finally (d) one's process of dying is not marked by unbearable and degrading pain." *Hastings Center Report*; 1979, p. 33.
9. See Brennan & Delgado, *Death: Multiple Definitions or a Single Standard?*, 54 *Southern California Law Review* 1323 (1981); Dornette, *How Does Your State Define Death?*, 8 *Legal Aspects Medical Practice* 19 (No. 5, 1980). See also, High, *Is 'Natural Death' an Illusion?*, *Hastings Center Report*. 37 (Aug. 1978) where the author suggests the central concern should not be directed to determining natural death, but rather three more critical issues: the right to refuse treatment; an analysis of whether or not a particular treatment is — as to each individual case — medically indicated; and what standards are needed to assure proper care for the dying in order that they may die with dignity. Id. at 42.
10. G. Smith, *Final Choices: Autonomy in Health Care Decisions* 81, n. 10 (1989).
11. See *Arizona v. Fierro*, 603 P. 2d 74, 77-78 (Ariz. 1979) (adoption of Uniform Brain Death Act); *Lovato v. District Court*, 601 P. 2d 1072, 1081 (Colo. 1979) (adoption of Uniform Brain Death Act); *Swafford v. State*, 421 N.C. 2d 596, 602 (Ind. 1981) (adoption of Uniform Determination of Death Act); *Commonwealth v. Golston*, 366 N.E. 2d 744, 748-49 (Mass. 1977) (adoption of brain death standard), *cert. denied*, 434 U.S. 1039 (1978); *New York City Health & Hosp. Corp. v. Sulsona*, 81 Misc. 2d 1002, 1007, 367 N.Y.S. 2d 686, 691 (Sup. Ct. 1975) (adoption of brain death standard for transplantation purposes); *In re Welfare of Bowman*, 617 P. 2d 731, 738 (Wash. 1980) (adoption of Uniform Determination of Death Act).
12. IDAHO CODE §54-1819 (Supp. 1981) (Uniform Determination of Death Act); KAN. STAT. ANN. §77-202 (Supp. 1981); MD. ANN. CODE, art. 43, §54f (1980); MISS. CODE ANN. §41-36-3 (1981) (Uniform Determination of Death Act); N.M. STAT. ANN. §12-2-4 (1978); OR. REV. STAT. §146.001 (Supp. 1981); VA. CODE §54-325.7 (Supp. 1980).
13. See Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 *University of Pennsylvania Law Review* 87, 109 (1972).
14. See ALA. CODE §22-31-1 (Supp. 1981); ALASKA STAT. §09.65.120 (Supp. 1981); FLA. STAT. ANN. §382.085 (Supp. 1981); HAWAII REV. STAT. §327C-1 (Supp. 1979); IOWA CODE §702:8 (1979); LA. REV. STAT. ANN. §9:111 (West Supp. 1981); MICH. COMP. LAWS §333.102 (1980); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1981).
15. Id.
16. *Supra* note 10 at 82, n. 16.
17. Id. at 82, n. 17.
18. See CAL. HEALTH & SAFETY CODE §7100 (West Supp. 1981); CONN. GEN. STAT. ANN. §19-139(i)(b) (West Supp. 1981); GA. CODE ANN. §88-1717 (1979); N.C. GEN. STAT. §90-323 (1981). See also, *State v. Fierro*, 603 P. 2d 74, 77-79 (Ariz. 1979) (common law definition still sufficient to establish death despite adoption of brain death standard); *Lovato v. District Court*, 601 P. 2d 1072, 1081 (Colo. 1979) (adoption of Uniform Brain Death Act does not preclude continuing recognition of common law standard).
19. *A Definition of Irreversible Coma: Report of the Ad Hoc Committee of The Harvard Medical School to Examine the Definition of Brain Death*, 204 *JAMA* 337 (1968).
20. Id.
21. Id.
22. *Refinements in Criteria for The Determination of Death: An Appraisal, A Report of The Task Force on Death and Dying of The Institute of Safety, Ethics and the Life Sciences*, 221 *JAMA* 50 (1972).
23. *Washington Post*, April 22, 1981, at A27, col. 2.
24. 12 UNIF. LAWS ANN. 1 (1988 Supp.). See Capron & Kass, *A Statutory Definition of The Standards for Determining Human Death: An Appraisal and A Proposal*, *University of Pennsylvania Law Review* 87 (1972). See also, I. Kennedy, *Treat Me Right*, chs. 15, 16 (1988).
25. ALS CODE §22-31-1(b) (1975); NEV. REV. STAT. §451.007 (1979); W. VA. CODE §§16-10-1 to 16-10-3 (1980); WYO. STAT. §35-19-101 (1979). See Comment, *Medical-Legal Agreements on Brain Death: An Assessment of The Uniform Determination of Death Act*, 8 *J. Contemp. Law* 97 (1982).
26. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death* 9, 10, 172, 173 (1983) (hereinafter cited as President's Commission).
27. 12 UNIF. LAWS ANN. §1 (1985) (Supp.).
28. See Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or merely Enlightened Self-Determination*. 22 *U. Cal. Davis Law Review*. 275, 326 at n. 378 (1989).
29. *Swafford v. State*, 421 N.E. 2d 596, 602, (Ind. 1981); *In re Bowman*, 617 P. 2d 731, 738 (Wash. 1980).
30. Joynt, *A New Look at Death*, 252 *JAMA* 680, 681 (1984).
31. See generally, Abram, *The Need for Uniform Law on the Determination of Death*, 27 *N.Y. Law School Law Review*, 1187 (1981); J. Feinberg, *Offense to Others* (1984).
32. Smith, *Legal Recognition of Neocortical Death*, 71 *Cornell Law Review*, 850 (1986).
33. Id. at 851.
34. Id. at 888.
35. Id.
36. *Supra* note 26 at 139.
37. *Supra* note 26, at 140.
38. Id. One jurisdiction, the New Jersey Supreme Court, held *In re Conroy*, 486 A. 2d 1209, 1224 (N.J. 1985) that declining life sustaining medical treatment should not be viewed as an attempt to commit suicide.
39. *Supra* note 10 at 84, n. 39. See Gelland, *Living Will Statutes: The First Decade, 1987 Wisconsin Law Review* 737.

40. J. Nowak, R. Rotunda J. Young, *Constitutional Law* 765 (2d ed. 1983).
41. *Id.*
42. Twenty-one states and the District of Columbia have either natural death or death with dignity legislation. See *supra* note 10 at 84, n. 42 for a complete listing of the statutes. At pages 318-387 of the President's Commission (Report), may be found a verbatim reproduction of the state natural death acts. *Supra* note 26.
43. *Supra* note 26 at 141.
44. *Id.*
45. See CAL. HEALTH & SAFETY CODE §§7187(e), 7191(b) (Deering Supp. 1982). In *Bartling v. Superior Court of Los Angeles County* (Glendale Adventist Center), 163 Cal. App. 3d 186, 209 Cal. Rptr. 226 (1984), the court observed that even with a set of statutory guidelines as those found in the California Natural Death Act, such guidelines were "So cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires." 163 Cal. App. 3d at 194, n. 5, 209 Cal. Rptr. at 224, n. 5 (quoting *Barber v. Superior Court of Los Angeles County*, 147 Cal. App. 3d 1006 at 1015, 195 Cal. Rptr. 484 at 489 (1983)).
46. *Supra* note 26, at 144.
47. *Id.*
48. *Id.*
49. *Id.*
50. See e.g., Natural Death Act, CAL. HEALTH & SAFETY CODE §7188 (West Supp. 1984); Natural Death Act, KAN. STAT. ANN. §§65-28, 102 (1980); Withholding or Withdrawal of Life Sustaining Procedures, NEV. REV. STAT. §499.590.610 (1983); Natural Death Act, WASH. REV. CODE ANN. §70.122.020 (Supp. 1985).
51. N.C. GEN. STAT. §90.322 (1981 & Supp. 1983).
52. VA. CODE §54-325.8.1 (Supp. 1985). See generally, Comment, Proxy Decisionmaking for the Terminally Ill: The Virginia Approach, 70 Virginia Law Review 1269 (1984).
53. N.M. STAT. ANN. §24-7-4 (1981).
54. ARK. STAT. ANN. §82-3803 (Michie Supp. 1983).
55. *Supra* note 26, at 145, 146.
56. See McCarrick, Living Wills and Durable Powers of Attorney: Advance Directive Legislation and Issues, Scope Note #2, Nat'l Ref. Center for Bioethics Lit., Kennedy Institute of Ethics, Georgetown Univ. (1990); *Supra* note 10 at 85-86, n. 56. At pages 393-437 of The President's Commission (Report), may be found verbatim reproductions of the Durable Power of Attorney statutes. *Supra* note 26. See generally, Martyn & Jacobs, Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney, 63 Nebraska Law Review. 779 (1984).
57. *Supra* note 26 at 147.
58. *Id.*
59. *Id.* at 146.
60. *Id.* at 147.
61. *Id.*
62. Uniform Rights of The Terminally Ill Act, 9A UNIF. LAWS ANN. §§1-18 (Supp. Pamph. 1987).
63. Defined as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying." Sec. 1(4).
64. Defined as "an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time." Sec. 1(9).
65. See Marzen, The Uniform Rights of The Terminally Ill Act: A Critical Analysis, 1 Issues Law and Medicine 441 (May 1986).
66. The Hemlock Society of California. Humane and Dignified Death Initiative §1(a) (proposing to amend article 1 of the California Constitution); see also Bond, Hemlock Society Forms New Organization to Push Assisted Suicide Initiative, National Right to Life News, Dec. 18, 1986, at 1, col. 1.
67. Parachini, The California Humane and Dignified Death Initiative, Hastings Center Report, (Special Supplement), 10 (1989).
68. *Id.*
69. *Id.*
70. CAL. HEALTH & SAFETY CODE §7188 (West Supp. 1989).
71. *Id.*
72. *Id.* §7189(a).
73. *Id.* §7189(b).
74. *Id.* §7189(c).
75. *Id.* §7192.
76. CAL. CIV. CODE §2443 (West Supp. 1989).
77. *Id.*
78. Law Reform Commission of Canada, Report 30: Recodifying Criminal Law (Revised & Enlarged Ed.) 185-86 (1987).
79. See Casswell, Rejecting Criminal Liability for Life-Shortening Palliative Care, 6 J. Contemp. Health, Law, and Policy (1990 in press).
80. 73 N.Y. 2d 517, 531 N.E. 2d 607, 534 N.Y.S. 2d 886 (1988).
81. See Johnson, From Medicalization to Legislation to Politicization: O'Connor, Cruzan and Refusal of Treatment in the 1990s, 21 Connecticut Law Review 685 (1989).
82. *Cruzan v. Harmon*, 760 S.W. 2d 408 (Mo. 1988).
83. *Id.* at 418.
84. *Id.* at 417.
85. *Id.* at 424.
86. *Id.* at 426.
87. *Cruzan v. Missouri Dep't of Health*, 109 S. Ct. 3240 (1989).
88. *Supra* note 81 at 691, n's 42, 43.
89. Morrison, Death: Process or Event?, 173 Science 694, 695 (Aug. 20, 1971).
90. *Id.* See Callahan, Modernizing Mortality: Medical Progress and The Good Society, 20 Hastings Center Report 28 (1990).