ETHICAL IMPLICATIONS OF USE OF THE LIVING WILL IN CARE OF THE TERMINALLY ILL

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DEFINITION OF THE LIVING WILL

Medical technology now can sustain basic bodily functions long after active, conscious life is gone. However, not all terminally ill patients wish to take advantage of such technology; rather, some opt to die in a natural, dignified manner. The living will allows for this choice by declaring the signer's intent that no extraordinary means be used to prolong life should he or she suffer an illness or injury for which extraordinary care cannot provide a cure or effectuate significant recovery, and from which death is inevitable.

LEGAL SUPPORT FOR THE LIVING WILL

The notion of the living will is well grounded in American law. Both the doctrine of informed consent and one's constitutional right to privacy allow a terminal patient to refuse extraordinary medical treatment which will not provide cure or effectuate significant recovery. First, under informed consent, no medical procedure may be performed unless the patient agrees, after explanation of the nature of the treatment, the substantial risks, and alternative therapies. As explained by the Kansas Supreme Court:

"Anglo-American law starts with the premise of thoroughgoing self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life saving surgery or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception." (1)

One's right to refuse treatment has also been upheld based on his constitutionally guaranteed right to privacy, which encompasses the right to refuse medical treatment. In In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976), involving a 20 year old woman in a permanently vegetative state whose guardian was allowed to discontinue her respirator; in Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) where the court answered in the negative the question of whether Saikewicz, an incompetent 67 year old man, had to receive chemotherapy treatments for incurable acute monocytic leukemia; (2) in Severns v.
Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. Sup. Ct. 1980), granting the chancery court the power to allow the husband-guardian of an irreversibly comatose patient to order discontinuance of her respirator; in Satz v. Perlmutter, 379 So.2d 359 (Fla.1980), upholding discontinuance of a respirator for a 73 year old terminally ill man; and in In re Welfare of Colyer, 99 Wash. 2d. 114, 660 P. 2d 738 (1983), wherein life support systems for a woman in chronic vegetative state were discontinued, the courts' decisions were based on the patients' constitutional rights of privacy. (3)

In addition to this case-law support for the living will, 39 states in America, plus the District of Columbia, have passed statutes which explicitly authorize the execution of living wills. While these bills vary from state to state, living will legislation characteristically contains the following key provisions:

1. a requirement for medical confirmation of the patient's terminal condition;
2. a requirement that the document be made a part of its author's medical record;
3. immunity of physicians, other health practitioners, and health care facilities for complying with the patients instructions as outlined in the will;
4. censure of physicians for failure either to comply with the document or to transfer the patient to the care of another physician who will;
5. easy revocation procedures if the patient has a change of mind;
6. a form for the living will declaration;
7. procedures for executing the declaration;
8. a statement that execution of a will has no effect on the patient's life insurance or health care benefits.

PROBLEMS WITH LIVING WILL LEGISLATION

Some living will statutes contain restrictive provisions which hinder the utilization of such documents. For instance, Wisconsin's living will law, as originally passed, required 'terminal condition' before a living will could be honored, and it defined 'terminal condition' as that which 'reasonable medical judgment' concludes will result in death within 30 days. Two physicians were required to certify in writing that the patient would die within 30 days, regardless of whether life sustaining procedures were used. Given the difficulty of determining that death will occur within 30 days (as opposed to 31, 32 etc.), physicians understandably were reluctant to honor a living will, despite the legal liability protection section in the law; and it was in large part this reluctance which led to an amendment of that definition of 'terminal condition' in Wisconsin's law. (4)

Another controversial provision in Wisconsin's living will law is the exemption of the provision of fluid maintenance and nutritional support from the list of 'life sustaining procedures' which may be withdrawn or withheld. The law restrictively defines 'life sustaining procedures' which a living will declarant may refuse, as 'any medical procedure or intervention that, in the judgment of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient'. 'Life sustaining procedures' include assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis, and other similar procedures. 'Life sustaining procedures' do not include the provision of fluid maintenance and nutritional support or the alleviation of pain by administering medication or by performing any medical procedure. Despite the legal liability protection section in the law, the express exclusion of 'nutritional support' from the definition of 'life sustaining procedures' may create great discomfort for the physician who,