

Indiana's Living Wills and Life-Prolonging Procedures Act: A Reform Proposal

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Indiana's Living Wills and Life-Prolonging Procedures Act¹ (Indiana Act) became effective September 1, 1985. The law articulates² the right of persons who are at least eighteen years old to execute a document that contains directions concerning the signer's medical treatment.³ The document becomes operative only if the signer becomes terminally ill and incompetent to participate in decisions concerning his treatment.⁴ Thirty-five other states, including the District of Columbia, have enacted living will statutes.⁵ Part I of this Article provides an overview of the legislation adopted in the other states. Parts II and III outline the provisions of the Indiana Act and discuss the problems that are likely

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¹IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1986). For a general discussion of the Indiana Act, see Kolb, *Indiana's Living Will and Life Prolonging Procedures Act*, 19 IND. L. REV. 285 (1986).

²The verb "articulates" is used rather than "grants" because it is arguable that such a right exists even without legislation. See Paris & McCormick, *Living-Will Legislation, Reconsidered*, AMERICA, Sept. 5, 1981, at 86, 87. The North Carolina living will statute establishes a "nonexclusive procedure" by which a patient can exercise his right to control the decisions relating to his own medical care. N.C. GEN. STAT. § 90-320 (1985). Legislation, however, makes clear the legal implications of the exercise of such a right.

³IND. CODE ANN. § 16-8-11-11 (West Supp. 1986).

⁴*Id.* § 16-8-11-12(b), (c).

⁵The following is a list of the state statutes authorizing the use of living wills: ALA. CODE §§ 22-8A-1 to -10 (1984); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1987); COLO. REV. STAT. §§ 15-18-101 to -113 (Supp. 1986); Conn. Death with Dignity Act, Pub. Act No. 85-606, 1986 Conn. Legis. Serv. 541-542 (West); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1986); FLA. STAT. ANN. §§ 765.01-.15 (West 1986); GA. CODE ANN. §§ 88-4101 to -4112 (Harrison 1986); IDAHO CODE §§ 39-4501 to -4508 (1985 & Supp. 1986); ILL. ANN. STAT. ch. 110-1/2, paras. 701-710 (Smith-Hurd Supp. 1986); IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1986); IOWA CODE ANN. §§ 144A.1-.11 (West Supp. 1986); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1986); LA. REV. STAT. ANN. §§ 40:1229.58.1-.10 (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1986); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1986); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1986); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1987); MONT. CODE ANN. §§ 50-9-101 to -206 (1985); NEV. REV. STAT. §§ 449.540-.690 (1985); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (Supp. 1986); N.M. STAT. ANN. §§ 24-7-2 to -10 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1987); OR. REV. STAT. §§ 97.050-.090 (1984); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1985); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 1-11 (Vernon Supp. 1986); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251-5262 (Supp. 1986); VA. CODE ANN. §§ 54-325.8:1 to :12 (Supp. 1986); WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1987); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1986); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1986).

to arise from its implementation. Part IV recommends that the Indiana legislature repeal the Indiana Act and replace it with the Uniform Rights of the Terminally Ill Act (Uniform Act), adopted by the National Conference of Commissioners on Uniform Laws in August 1985.⁶

I. OVERVIEW OF LIVING WILLS LEGISLATION

Generally speaking, a living will is a written document signed by a competent adult that states that if the signer becomes terminally ill and incompetent to participate in decisions concerning his medical treatment, life-sustaining procedures should not be used to postpone his death.⁷ Living will statutes ordinarily allow physicians and other health care providers to withhold or withdraw life-sustaining medical care under specified circumstances on the basis of the patient's living will, without prior court approval and without adverse legal consequences. The purpose of such documents is to protect the individual's right to be free from unwanted medical treatment, a right based upon both the common law right to bodily integrity⁸ and the constitutional right to privacy.⁹

The term "living will" was first used in 1969 by Luis Kutner.¹⁰ He used the term to describe a document that could be used not only to

⁶UNIF. RIGHTS OF THE TERMINALLY ILL ACT §§ 1-18, 9A U.L.A. 455-64 (1985) [hereinafter UNIFORM ACT].

⁷See generally Horan, *The "Right to Die": Legislative and Judicial Developments*, LINACRE Q., Feb. 1979, at 57; Kutner, *The Living Will: Coping with the Historical Event of Death*, 27 BAYLOR L. REV. 39 (1975); Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969) [hereinafter Kutner, *Due Process*]; Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779 (1984); Raible, *The Right to Refuse Treatment and Natural Death Legislation*, MEDICOLEGAL NEWS, Fall 1977, at 6; Note, *The "Living Will": The Right to Death with Dignity?*, 26 CASE W. RES. L. REV. 485 (1976); Note, *Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute*, 64 IOWA L. REV. 573 (1979); Note, *In re Living Will*, 5 NOVA L.J. 445 (1981); Note, *The Right to Die a Natural Death and the Living Will*, 13 TEX. TECH. L. REV. 99 (1982); Note, *The Right to Die: A Proposal for Natural Death Legislation*, 49 U. CIN. L. REV. 228 (1980); Comment, *The Living Will: Already a Practical Alternative*, 55 TEX. L. REV. 665 (1977).

⁸The common law right to bodily integrity is a right to be free from unwanted bodily contact. See *Natanson v. Kline*, 186 Kan. 393, 406-08, 350 P.2d 1093, 1104 (1960); *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). This common law of right is the basis for the doctrine of informed consent, see Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639, 640-48 (1968), and its logical corollary, the right to refuse treatment.

⁹The constitutional right to privacy is a right to be free from governmental interference in fundamental matters, i.e. a right of self-determination. The right to privacy, interpreted more broadly than seclusion or secrecy, was first announced by the United States Supreme Court in *Griswold v. Connecticut*, 381 U.S. 479 (1965). See Posner, *The Uncertain Protection of Privacy by the Supreme Court*, 1979 SUP. CT. REV. 173, 197. The right was later expanded in *Roe v. Wade*, 410 U.S. 113 (1973). The first case to extend the right of privacy to decisions to forgo medical care was *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

¹⁰See Kutner, *Due Process*, supra note 7, at 551.

direct the withholding of life-sustaining procedures from terminally ill patients, but that also could be used by a Christian Scientist to refuse all medical treatment or by a Jehovah's Witness to prohibit blood transfusions.¹¹

It was not until 1976, with *In re Quinlan*¹² as an impetus, that California became the first state to enact living will legislation. The California Act,¹³ which has since served as a model for legislation in several other states, has a significantly narrower operating sphere than that contemplated by Mr. Kutner. The law gives legal effect to a private medical directive signed by a competent adult and witnessed by two persons who have no special interest in the patient's estate.¹⁴ The directive, the form for which is set forth in the statute,¹⁵ states that life-sustaining procedures are to be withheld or withdrawn if the declarant is affected with a terminal condition and his death is imminent whether or not life-sustaining procedures are utilized.¹⁶ Because technological advances make it possible to sustain most lives indefinitely, the requirement that death be imminent even if life-sustaining procedures are used severely restricts the utility of the act.¹⁷ Furthermore, life-sustaining procedures are narrowly defined as mechanical or artificial means to sustain, restore, or supplant a vital function that serve only to prolong the moment of death.¹⁸ Medication is specifically excluded from the statute along with all procedures necessary to alleviate pain.¹⁹

In addition to having a relatively narrow scope, the California Act provides that a living will is not binding upon the patient's physician unless it is executed or reexecuted at least fourteen days after the patient is diagnosed as being in a terminal condition.²⁰ If executed before the expiration of the required waiting period, the directive may or may not be followed at the physician's option.²¹ In any event, a directive is effective for only five years, at the end of which it must be reexecuted.²² The statute grants immunity from civil or criminal liability to any licensed

¹¹*Id.*

¹²70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

¹³CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1987).

¹⁴*Id.* § 7188.

¹⁵*Id.*

¹⁶*Id.*

¹⁷Such provisions have been criticized as prohibiting the applicability of living wills to the very situations they are designed to address. *See generally* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 142 (March 1983) [hereinafter DECIDING TO FOREGO].

¹⁸CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1987).

¹⁹*Id.*

²⁰*Id.* § 7191.

²¹*Id.* § 7191(c).

²²*Id.* § 7189.5.

health care professional who complies with a properly executed directive,²³ but the physician is left with the burden of determining whether the document was properly executed.²⁴ If the directive is binding rather than optional, a physician's failure to withdraw treatment, or to transfer the patient to another physician willing to do so, constitutes unprofessional conduct.²⁵

In addition to the above core provisions, the California Act contains a number of important clarifying provisions:

1. The Act shall not be taken to condone mercy killing or to permit any affirmative act or deliberate omission to end life other than to permit the natural process of dying.²⁶
2. The Act is not intended to supersede any existing right to withdraw or withhold life-sustaining procedures in any lawful manner.²⁷
3. The directive is not effective if the declarant is pregnant.²⁸
4. Withholding treatment in accordance with a directive shall not be considered suicide.²⁹
5. Making a directive shall not inhibit procuring a life insurance policy, nor can anyone be forced to sign a directive as a prerequisite to obtaining medical insurance.³⁰

Several of the living will statutes in the thirty-five remaining jurisdictions³¹ were modeled after the California Act.³² There are, however, significant differences in the statutes regarding the type of treatment

²³*Id.* § 7190.

²⁴*Id.* § 7191(a).

²⁵*Id.* § 7191(b). However, the physician may not be held criminally or civilly liable for failure to follow the directive. A charge of unprofessional conduct is the only sanction available. *Id.*

²⁶*Id.* § 7195.

²⁷*Id.* § 7193.

²⁸*Id.* § 7188.

²⁹*Id.* § 7192(a).

³⁰*Id.* § 7192(b), (c).

³¹For a list of all such statutes, see *supra* note 5.

³²Some of the statutes modeled after the California Act contain distinctions. For instance, Texas has a California-type statute, TEX. REV. CIV. STAT. ANN art. 4590h, §§ 1-11 (Vernon Supp. 1986), but it contains no requirement that a directive be reexecuted every five years. *Id.* § 5. Since most statutes contain liberal revocation provisions, such a requirement is generally thought unnecessary.

Washington also has a California-type statute, WASH. REV. CODE ANN. § 70.122 (Supp. 1987), but the directive's effectiveness does not depend upon its being executed after a diagnosis of a terminal illness. *Id.* § 70.122.060(2). Nevada's statute, NEV. REV. STAT. §§ 449.540-690 (1985), also tracks the California law, but physicians are never legally bound by the directive. *Id.* § 449.640.

that may be withdrawn³³ and how serious the patient's condition must be before the directive becomes operative.³⁴ For example, in Kansas, a

³³Most statutes cover "life-sustaining" or "life-prolonging" procedures. See ALA. CODE § 22-8A-4 (1984); ARIZ. REV. STAT. ANN. § 36-3202 (1986); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1987); COLO. REV. STAT. § 15-18-104 (Supp. 1986); D.C. CODE ANN. § 6-2422 (Supp. 1986); FLA. STAT. ANN. § 765.04 (West 1986); GA. CODE ANN. § 88-4103 (Harrison Supp. 1986); IDAHO CODE § 39-4504 (1985 & Supp. 1986); ILL. ANN. STAT. ch. 110-1/2, para. 703 (Smith-Hurd Supp. 1986); IND. CODE ANN. § 16-8-11-12 (West Supp. 1986); IOWA CODE ANN. § 144A.3 (West Supp. 1986); KAN. STAT. ANN. § 65-28,103 (1985); LA. REV. STAT. ANN. § 40:1299.58.1(A)(1)-(2) (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, § 2922 (Supp. 1986); MD. HEALTH-GEN. CODE ANN. § 5-602 (Supp. 1986); Miss. CODE ANN. § 41-41-103 (Supp. 1986) (life-sustaining mechanisms are defined as extraordinary techniques); MONT. CODE ANN. § 50-9-103 (1985); NEV. REV. STAT. § 449.600 (1985); N.H. REV. STAT. ANN. § 137-H:3 (Supp. 1986); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1987); OR. REV. STAT. § 97.055 (1984); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1986); UTAH CODE ANN. § 75-2-1104 (Supp. 1986); VA. CODE ANN. § 54-325.8:3 (Supp. 1986); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1987); W. VA. CODE § 16-30-3 (1985); Wis. STAT. ANN. § 154.03 (West Supp. 1986); WYO. STAT. § 33-26-145 (Supp. 1986).

Two statutes limit their scope to "extraordinary" treatment. See N.C. GEN. STAT. § 90-321 (1985); VT. STAT. ANN. tit. 18, § 5253 (Supp. 1985). In contrast, Arkansas permits a declaration to direct withholding or discontinuance of "artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong life." ARK. STAT. ANN. § 82-3802 (Supp. 1985). Tennessee authorizes a declaration directing the withholding or withdrawal of "medical care," which is broadly defined. TENN. CODE ANN. §§ 32-11-103(5), -104 (Supp. 1985).

³⁴Most living wills are effective only if the patient is certified by his physician to be in a terminal condition and/or the patient's death is "imminent" or expected "within a short time." See ALA. CODE §§ 22-8A-3(6), -4(a) (1984); ARIZ. REV. STAT. ANN. § 36-3202 (1986); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1987); COLO. REV. STAT. § 15-18-104 (Supp. 1986); Conn. Death with Dignity Act, Pub. Act No. 85-606, § 2, 1986 Conn. Legis. Serv. 541 (West); DEL. CODE ANN. tit. 16, § 2503 (1983); D.C. CODE ANN. § 6-2422 (Supp. 1986); FLA. STAT. ANN. §§ 765.03(6), .04(1) (West 1986); GA. CODE ANN. § 88-4103 (Harrison Supp. 1986); IDAHO CODE § 39-4504 (Supp. 1986); ILL. ANN. STAT. ch. 110-1/2, paras. 702(f), 703 (Smith-Hurd Supp. 1986); IND. CODE ANN. § 16-8-11-12(b) (West Supp. 1986); IOWA CODE ANN. § 144A.3 (West Supp. 1986); KAN. STAT. ANN. § 65-28,103 (1986); LA. REV. STAT. ANN. § 40:1299.58.3(A)(1) (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, §§ 2921-2922 (Supp. 1986); MD. HEALTH-GEN. CODE ANN. §§ 5-601(g), -602 (Supp. 1986); Miss. CODE ANN. §§ 41-41-107, -113 (Supp. 1986); Mo. ANN. STAT. §§ 459.010(6), -.015(3) (Vernon Supp. 1987); MONT. CODE ANN. §§ 50-9-102(7), -103 (1985); NEV. REV. STAT. §§ 449.600, .610 (1985); N.H. REV. STAT. ANN. §§ 137-H:2 (III), -H:3 (Supp. 1986); N. M. STAT. ANN. § 24-7-3 (1986); N.C. GEN. STAT. § 90-321 (1985); OKLA. STAT. ANN. tit. 63, §§ 3102(H), 3103(A) (West Supp. 1987); OR. REV. STAT. §§ 97.050(5), .055(1) (1984); TENN. CODE ANN. § 32-11-105 (Supp. 1985); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1986); UTAH CODE ANN. § 75-2-1104(4) (Supp. 1986); VT. STAT. ANN. tit. 18, § 5253 (Supp. 1986); VA. CODE ANN. §§ 54-325.8:2, :3 (Supp. 1986); WASH. REV. CODE ANN. § 70.122.020(4), .030 (Supp. 1987); W. VA. CODE § 16-30-3 (1985); Wis. STAT. ANN. § 154.03 (West Supp. 1986); WYO. STAT. §§ 33-26-144(vi), -145 (Supp. 1986).

But see ARK. STAT. ANN. § 82-3801 to -3803 (Supp. 1986) (no requirement of terminal illness or imminent death); UTAH CODE ANN. § 75-2-1105 (Supp. 1986) (authorizing a directive executed after incurring an injury, disease, or illness; effectiveness of such a directive is not conditional upon declarant being in a terminal condition or upon death

living will operates when the patient is in a terminal condition, but there is no requirement that death be imminent.³⁵ In New Mexico, a declaration may request that all maintenance medical treatment (as opposed to life-sustaining procedures) be withheld.³⁶ Maintenance medical treatment is basically defined as all treatment designed solely to sustain the life process.³⁷ It might therefore include medication, intravenous hydration, and nasogastric tube feedings—treatment that is implicitly or explicitly excluded from the coverage of many acts. The New Mexico Act also allows family members to execute a living will on behalf of a terminally ill minor.³⁸ In 1984, New Mexico extended the scope of its statute to include irreversibly comatose persons in addition to those who are terminally ill.³⁹

Arkansas has perhaps the most broadly applicable statute.⁴⁰ It comes close to saying that anyone⁴¹ can refuse any type of treatment (“artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong his life”).⁴² The Arkansas Act also allows declarations to be prepared on behalf of minors and incompetent adults.⁴³ Given the fact that the document may be prepared by someone other than the patient and may cover a broad range of treatments, the law arguably authorizes involuntary euthanasia.

In addition to legitimizing the advance directive, several states authorize a person to name an agent who can make medical decisions on behalf of the patient should the patient become incapable of participating

being imminent).

However, the statutes define terminal condition in quite different ways. Approximately one-third of the living will statutes define “terminal condition” as an incurable condition which, within reasonable medical judgment, will produce death and which is such that the application of life-sustaining procedures will merely postpone the moment of death.

In a similar vein, several states define a terminal condition as incurable and one which will result in death regardless of the use of medical treatment. *See* DEL. CODE ANN. tit. 16, § 25019(e) (1983); GA. CODE ANN. § 88-4102(10) (Harrison 1986); MD. HEALTH-GEN. CODE ANN. § 5-601 (Supp. 1986); N.M. STAT. ANN. § 24-7-2(f) (1986); TENN. CODE ANN. § 32-11-103(9) (Supp. 1985). In contrast, several other states define a terminal condition as an incurable condition which, without the administration of life-sustaining procedures, will result in death within a short time. *See* ALA. CODE § 22-8A-4 (1984); ARIZ. REV. STAT. ANN. § 36-3201 (1986); IOWA CODE ANN. § 144A.2 (West Supp. 1986); ME. REV. STAT. ANN. tit. 22, § 2921(8) (Supp. 1986); MONT. CODE ANN. § 50-9-102(7) (1985).

³⁵KAN. STAT. ANN. § 65-28,103 (1985).

³⁶N.M. STAT. ANN. § 24-7-3 (1986).

³⁷*Id.* § 24-7-2.C.

³⁸*Id.* § 24-7-4. Other statutes also contain such a provision. *See* ARK. STAT. ANN. § 82-3803 (Supp. 1985); LA. REV. STAT. ANN. § 40:1299.58.6 (West Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4D (Vernon Supp. 1986).

³⁹N.M. STAT. ANN. § 24-7-3 (1986).

⁴⁰ARK. STAT. ANN. § 82-3801 to -3803 (Supp. 1985).

⁴¹*Id.* § 82-3802. The Arkansas statute does not restrict the effectiveness of living wills to terminally ill declarants.

⁴²*Id.*

⁴³*Id.* § 82-3803.

in treatment decisions.⁴⁴ The use of agents has been recommended by several commentators⁴⁵ who observe that the imprecise terminology used in most living wills leaves open questions, such as whether the patient's condition makes the declaration operative and whether the proposed treatment is the type that the declarant wished to have withheld. An agent can use his knowledge of the patient's personal desires as well as information about the patient's condition and the risks and benefits of the proposed treatment to formulate a decision on the patient's behalf.⁴⁶

Eleven states permit treatment to be withdrawn from an incompetent patient who has not signed a living will if certain procedures are followed.⁴⁷ Generally these provisions allow treatment to be withheld only upon agreement of the patient's physician and a patient surrogate, whether the surrogate be a guardian, an agent, or a close family member.⁴⁸

⁴⁴See DEL. CODE ANN. tit. 16, § 2502(b) (1983); FLA. STAT. ANN. § 765.05(2) (West 1986); IOWA CODE ANN. § 144A.7(1)(a) (West Supp. 1986); LA. REV. STAT. ANN. § 40:1299.58.3(C)(1) (West Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3(e) (Vernon Supp. 1986); UTAH CODE ANN. § 75-2-1106 (Supp. 1986); VA. CODE ANN. § 54-325.8:4 (Supp. 1986); WYO. STAT. § 33-26-145(d) (Supp. 1986).

In addition, a few states have amended their durable power of attorney statutes specifically to authorize appointment of an attorney-in-fact to make medical decisions. See CAL. CIV. CODE § 2430-44 (West Supp. 1987); 20 PA. CONS. STAT. ANN. § 5603(h) (Purdon Supp. 1986).

⁴⁵See Martyn & Jacobs, *supra* note 7, at 787, 795-802; Paris & McCormick, *supra* note 7, at 88-89; DECIDING TO FOREGO, *supra* note 17, at 141-51; Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985, 998-1005 (1984).

⁴⁶Some states limit the agent's authority to situations where the patient is terminally ill and either comatose or otherwise incapable of expressing his own views. See FLA. STAT. ANN. § 765.05(2) (West 1986); IOWA CODE ANN. § 144A.7(a) (West Supp. 1986); LA. REV. STAT. ANN. § 40:1299.58.3(C)(1) (West Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4B (Vernon Supp. 1986); VA. CODE ANN. § 54-325.8:4 (Supp. 1986). Other states do not require that the patient be in a terminal condition before the agent has authority to act. See DEL. CODE ANN. tit. 16, § 2502(c) (1983); UTAH CODE ANN. § 75-2-1105 (Supp. 1986); WYO. STAT. § 33-26-145(d) (Supp. 1986). In the latter states, the agent may act on the patient's behalf whenever the patient is incapable of making a decision.

⁴⁷See ARK. STAT. ANN. § 82-3803 (Supp. 1985); Conn. Death with Dignity Act, Pub. Act No. 85-606, § 2, 1986 Conn. Legis. Serv. 541, 541-42 (West); FLA. STAT. ANN. § 765.07 (West 1986); IOWA CODE ANN. § 144A.7 (West Supp. 1986); LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1987); N.M. STAT. ANN. § 24-7-8.1 (1986); N.C. GEN. STAT. § 90-322 (1985); OR. REV. STAT. § 97.083(2) (1984); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4C (Vernon Supp. 1986); UTAH CODE ANN. § 75-2-1107 (Supp. 1986); VA. CODE ANN. § 54-325.8:6 (Supp. 1985).

⁴⁸See Conn. Death with Dignity Act, Pub. Act No. 85606, § 2, 1986 Conn. Legis. Serv. 541, 541-42 (West); FLA. STAT. ANN. § 765.07 (West 1986); IOWA CODE ANN. § 144A.7 (West Supp. 1986); N.M. STAT. ANN. § 24-7-8.1 (1986); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4C (Vernon Supp. 1986); UTAH CODE ANN. § 75-2-1107 (Supp. 1986); VA. CODE ANN. § 54-325.8:6 (Supp. 1986); *cf.* N.C. GEN. STAT. § 90-322 (1985); OR. REV. STAT. § 97.083 (1984) (both statutes ordinarily require agreement of physician and specified family members or a guardian, but if none of them is available the attending physician acting alone may withhold or discontinue extraordinary treatment). *But see* ARK. STAT. ANN. § 82-3803 (Supp. 1985); LA. REV. STAT. ANN. § 40:1299.58.5(A)(1)-(2) (West Supp. 1987) (living will may be executed on behalf of an incompetent adult by specified

There has been almost no court activity involving living wills. There are only two reported cases, both of which were decided in jurisdictions without living will legislation at the time of the decisions.⁴⁹ Both courts stated that a patient's living will is persuasive evidence of the incompetent person's intent and should be given great weight.⁵⁰

The living will laws probably have not had much pragmatic impact because of the restrictive scope of many of the statutes and the problems attendant to determining whether, given the patient's condition, a particular treatment is one that the signer intended to refuse. In enacting the statutes, however, the legislatures have acknowledged what the courts have asserted for years: that people have a right to refuse treatment even if the refusal ultimately leads to their deaths.

II. THE INDIANA ACT

The Indiana Act,⁵¹ like the legislation in other states, allows competent adults to state their desires as to medical treatment should they become terminally ill or injured and unable to communicate their wishes. To do this, one may execute a living will declaration, which expresses a desire to forgo life-sustaining procedures that would merely postpone the moment of death;⁵² or, a patient may sign a life-prolonging procedures declaration, which expresses a desire to continue any treatment that may extend life.⁵³ The statute provides a form for each type of declaration

family members or a legal guardian; concurrence of the physician is not required).

Oregon permits withdrawal of extraordinary treatment in the absence of a declaration only if the patient's condition is terminal and the patient is comatose with no reasonable possibility that he will return to a cognitive state. *See* OR. REV. STAT. § 97.083 (1984). New Mexico's procedure is available if the patient is terminally ill *or* in an irreversible coma. N.M. STAT. ANN. § 24-7-8.1 (1986). The remaining states permit life-sustaining procedures to be withdrawn from a terminally ill adult who is incapable of communicating his thoughts for any reason, whether or not the patient is comatose. *See* Conn. Death with Dignity Act, Pub. Act No. 85-606, § 2, 1986 Conn. Legis. Serv. 541, 541-42 (West); FLA. STAT. ANN. § 765.07 (West 1986); IOWA CODE ANN. § 144A.7 (West Supp. 1986); LA. REV. STAT. ANN. § 40:1299.58.5(A)(1)-(2) (West Supp. 1987); N.C. GEN. STAT. § 90-322 (1985); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4C (Vernon Supp. 1986); UTAH CODE ANN. § 75-2-1107 (Supp. 1986); VA. CODE ANN. § 54-325.8:6 (Supp. 1986); *cf.* ARK. STAT. ANN. § 82-3803 (Supp. 1985) (a living will prepared on behalf of an incompetent requires a statement signed by two physicians that extraordinary means would have to be used to prolong life).

⁴⁹*John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Saunders v. State*, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985).

⁵⁰*Bludworth*, 542 So. 2d at 926; *Saunders*, 129 Misc. 2d at 54-55, 492 N.Y.S.2d at 517.

⁵¹IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1986).

⁵²*Id.* § 16-8-11-12(b).

⁵³*Id.* § 16-8-11-12(c). Only two other statutes expressly authorize directions to continue treatment. *See* ARK. STAT. ANN. § 22-3802 (Supp. 1985); MD. HEALTH-GEN. CODE ANN. § 5-611 (Supp. 1986). Three other statutes state that a person has a right to instruct a doctor to provide care, but the statutes contain no provision implementing that right. *See* FLA. STAT. ANN. § 765.02 (West 1986); IOWA CODE ANN. § 144A.1 (West Supp. 1986); N.H. REV. STAT. ANN. § 137-H:1 (Supp. 1986).

and, to be effective, all declarations must be substantially in the statutory form.⁵⁴ Declarations must be signed by the maker and two disinterested witnesses.⁵⁵

The two types of declarations have different effects. A life-prolonging procedures declaration obligates the physician to use life-prolonging procedures.⁵⁶ A living will declaration does not obligate a physician to withhold or withdraw life-prolonging procedures,⁵⁷ but the physician is not entirely free to do as he sees fit. If the physician does not wish to follow the living will directive, he must make a reasonable effort to transfer the patient to a physician willing to comply.⁵⁸ However, the requirement does not apply if the physician has reason to believe the declaration was not validly executed or there is evidence that the patient no longer intends the declaration to be enforced.⁵⁹ In such instances, the physician must attempt to ascertain the patient's wishes and to determine the validity of the declaration.

If the physician follows a living will declaration and withholds or withdraws life-prolonging procedures, the physician is relieved of civil and criminal liability, but only if the patient has a terminal condition and has properly executed the living will.⁶⁰

Either type of declaration may be revoked by its maker by oral expression, destruction of the document, or a signed and dated writing.⁶¹ The statute provides penalties for forging a living will or forging a revocation⁶² and provides that disciplinary action may be brought against a physician who fails to comply with the statute.⁶³ The statute includes a number of statements that attempt to clarify the intent of the statute and its interaction with other bodies of law, for example:

1. The statute shall not be construed to authorize euthanasia.⁶⁴
2. The statute creates "no presumption concerning the intention of a person who has not executed a living will."⁶⁵
3. A death resulting from withdrawal of life-prolonging procedures does not constitute suicide.⁶⁶
4. The act does not impair or supersede any existing legal right

⁵⁴IND. CODE ANN. § 16-8-11-12 (West Supp. 1986).

⁵⁵*Id.* § 16-8-11-11.

⁵⁶*Id.* § 16-8-11-11(g).

⁵⁷*Id.* § 16-8-11-11(f).

⁵⁸*Id.* § 16-8-11-14(e). Though a physician is excused from honoring the directive if, after reasonable investigation, he is unable to find another doctor willing to honor the document, the meaning of "reasonable investigation" is unclear. See Kolb, *supra* note 1, at 293 (recommending that such efforts to transfer the patient be well documented).

⁵⁹IND. CODE ANN. § 16-8-11-14(e)(1) (West Supp. 1986).

⁶⁰*Id.* § 16-8-11-14(c), (d).

⁶¹*Id.* § 16-8-11-13.

⁶²*Id.* §§ 16-8-11-16 and -17.

⁶³*Id.* § 16-8-11-22.

⁶⁴*Id.* § 16-8-11-20.

⁶⁵*Id.* § 16-8-11-19.

⁶⁶*Id.* § 16-8-11-18(a).

to withdraw or withhold life-sustaining procedures.⁶⁷

5. The living will of a person diagnosed as pregnant has no effect during the pregnancy.⁶⁸

III. PROBLEMS WITH THE INDIANA ACT

A. Physician's Liability

Under the Indiana Act, the protection of the physician from liability is not as clear as it might be. First, with regard to living will declarations, a physician is relieved of liability only when treatment is withdrawn from a terminally ill patient who has properly executed a living will.⁶⁹ Proper execution requires that the patient be at least eighteen years old and of sound mind, and that the patient voluntarily sign and date the declaration in the presence of two competent witnesses who are also at least eighteen years of age. Furthermore, to insure that the witnesses are sufficiently objective, the patient's parent, spouse, or child may not act as a witness, nor may any person who is financially responsible for the patient's medical care. Any person who may be entitled to any part of the patient's estate is also disqualified from acting as a witness.⁷⁰

These requirements are obviously intended to protect the patient, yet they may result in unwanted and unnecessary care if the doctor is uncertain whether the document has been properly executed. Some statutes provide that if the document appears valid on its face and the doctor has no reason to believe that it is invalid, he may assume its validity.⁷¹ The Indiana statute permits the health care provider to presume that the declarant was of sound mind,⁷² but it does not create a presumption of valid execution.⁷³ The doctor is left with the burden of

⁶⁷*Id.* § 16-8-11-18(e).

⁶⁸*Id.* § 16-8-11-11(d). The statute seems to state that the living will of a pregnant woman has no effect during the pregnancy only if the woman has been diagnosed as pregnant. The statute does not directly address the situation where a woman is pregnant but not so diagnosed. Apparently, the statutory language protects a physician who, unaware of an existing pregnancy, complies with a living will.

⁶⁹*Id.* § 16-8-11-14(c).

⁷⁰*Id.* § 16-8-11-11. The statute fails to specify at what point in time the witness must meet these requirements. As noted by Kolb, *supra* note 1, at 289, a qualified witness might become unqualified if the declarant later names the witness as a beneficiary under his or her will.

⁷¹*See, e.g.*, COLO. REV. STAT. § 15-18-110(1) (Supp. 1986); MD. HEALTH-GEN. CODE ANN. § 5-606 (Supp. 1986); OR. REV. STAT. § 97.060 (1984); UTAH CODE ANN. § 75-2-1113 (Supp. 1986).

⁷²IND. CODE ANN. § 16-8-11-15 (West Supp. 1986).

⁷³The code section provides:

If the qualified patient who executed a living will declaration is incompetent at the time of the decision to withhold or withdraw life-prolonging procedures, a living will declaration *executed in accordance with this chapter* is presumed to be valid. For purposes of this chapter, a health care provider may presume in the absence of actual notice to the contrary that the declarant was of sound mind when it was executed.

Id. (emphasis added).

determining whether the witnesses saw the declarant sign, whether they were at least eighteen years of age, whether they may be entitled to some portion of the declarant's estate, etc. In short, the doctor must make legal determinations as well as medical ones.

The statute also requires that the declaration be substantially in the form set forth in the statute.⁷⁴ Before the passage of the Act, many people signed living wills prepared by their attorneys or they signed forms distributed by national organizations. Apparently the doctor is also left with the burden of determining whether a document is substantially in the statutory form, another legal judgment.

If the patient has executed a life-prolonging procedures declaration, the physician apparently is exposed to liability unless he keeps the patient alive as long as possible. The statute in section 11(g) says quite plainly that if the patient has executed such a declaration, the physician is obligated to use life-prolonging procedures.⁷⁵ It is not clear how this obligation relates to the statement in section 18(d) that "this chapter does not impair or supersede any legal right or responsibility that any person may have to effect the withholding or withdrawal of life-prolonging procedures in any lawful manner."⁷⁶ The general consensus is that at some point a patient's condition becomes so hopeless that the doctor has no duty to continue medical treatment, even though it may extend life.⁷⁷ Yet, section 11(g) seems to create an obligation to extend life as long as possible, if that is what the patient wishes.

B. *Scope of the Act*

As is true in many other states, the scope of Indiana's living will statute is rather narrow. First, the definition of life-prolonging procedures specifically excludes nutrition, hydration, and the administration of medication.⁷⁸ The statute does not permit an individual to direct that such treatment be withheld if he becomes terminally ill and incompetent—to refuse these treatments, one must remain competent.

⁷⁴*Id.* § 16-8-11-12.

⁷⁵*Id.* § 16-8-11-11(g).

⁷⁶*Id.* § 16-8-11-18(d).

⁷⁷*See Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1017-18, 195 Cal. Rptr. 484, 491 (1983), which states:

A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless. . . . [I]f the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery.

(quoting Horan, *Euthanasia and Brain Death: Ethical and Legal Considerations*, 315 ANNALS N.Y. ACAD. SCI. 363, 367 (1978), as quoted in DECIDING TO FOREGO, *supra* note 17, at 191 n.50). *See also* Annas, *CPR: When the Best Should Stop*, HASTINGS CENTER REP., Oct. 1982, at 30.

⁷⁸IND. CODE ANN. § 16-8-11-4 (West Supp. 1986).

Second, a living will becomes operative only if death will occur in a fairly short time even if life-prolonging procedures are used. One of the major criticisms of the California Act is that treatment may be withdrawn only when death is imminent, whether or not life-prolonging procedures are used.⁷⁹ The Indiana statute appears at first reading to have solved this problem: the sample declaration states that if the signer is in a "terminal condition," life-prolonging procedures should be withdrawn.⁸⁰ A terminal condition is defined as one that will cause death "within a short period of time" if life-prolonging procedures are *not* used.⁸¹ However, the section that grants immunity to a physician who withdraws treatment in compliance with a directive provides such immunity only if the patient is a "qualified patient."⁸² To be a qualified patient, it must be determined that the patient's death will occur from the terminal condition whether or not life-prolonging procedures are used.⁸³ In order to conclude that death will occur from the terminal condition rather than from some other condition, death must be expected relatively soon even if life-prolonging procedures are used. If life-prolonging procedures can delay death for a long time, the patient is more likely to die of something other than the terminal condition, for example, pneumonia or cardiac arrest. Thus, unless death from the terminal condition is soon expected regardless of treatment, the doctor cannot certify the patient as a qualified patient. If death is imminent regardless of treatment, there may not be much need for a living will.

The Indiana statute, like many others, attempts to balance two important and competing interests. On the one hand, it attempts to preserve for the incompetent patient a voice in determining the course of his medical care. On the other hand, the statute tries to protect the patient from premature termination of treatment. After all, depriving an incompetent patient of treatment to which he is entitled is one of the greatest injustices that can be done. Unfortunately, the protectionist portions of the statute largely deprive it of any significant utility.

IV. REFORM PROPOSAL

In August 1985, after the passage of the Indiana Act, the National Conference of Commissioners on Uniform State Laws approved the Uniform Rights of the Terminally Ill Act (the Uniform Act). The Uniform Act is a model living will statute, the general structure and substance of which are similar to that found in most of the existing legislation.

⁷⁹See DECIDING TO FOREGO, *supra* note 17, at 143; Capron, *The Development of Law on Human Death*, 315 ANNALS N.Y. ACAD. SCI. 45, 55 (1978).

⁸⁰IND. CODE ANN. § 16-8-11-12(b) (West Supp. 1986).

⁸¹*Id.* § 16-8-11-9. This definition is itself problematic. What is a "short period of time"? Is it two years, two months, or two days? See *infra* text accompanying notes 114-15.

⁸²IND. CODE ANN. § 16-8-11-14(c) (West Supp. 1986).

⁸³*Id.* § 16-8-11-14(a).

A competent person eighteen years of age or older may execute a declaration directing the withholding or withdrawal of life-sustaining procedures if the declarant is in a terminal condition and unable to make treatment decisions.⁸⁴ Unlike some of the broader state statutes,⁸⁵ the Uniform Act does not authorize execution of such declarations on behalf of minors or incompetent adults. It also does not provide for appointment of an agent to make medical decisions, nor does it address treatment of persons who have not executed a declaration.⁸⁶

The Uniform Act streamlines the procedures for execution and revocation of a living will. Proper execution simply requires that the declaration be signed by the declarant or another person at the declarant's direction, and that the signing be witnessed by two persons.⁸⁷ The Uniform Act does not require that the witnesses meet any specific qualifications. In contrast, most state statutes,⁸⁸ including Indiana's,⁸⁹ state that the witnesses cannot be related to the declarant by blood or marriage and

⁸⁴UNIFORM ACT § 2, 9A U.L.A. 455, 458 (1985).

⁸⁵See *supra* notes 38, 43, 44, 47 and accompanying text.

⁸⁶The omission from the Uniform Act of such provisions was intentional. See UNIFORM ACT Prefatory Note, 9A U.L.A. 455, 455 (1985). The narrow scope of the Uniform Act apparently was chosen to encourage its widespread adoption. Like the Uniform Act, the Indiana Act does not authorize execution of a declaration on behalf of minors or incompetent adults, nor does it contain a provision regarding treatment of persons who have not executed a declaration. The Indiana Act, however, does implicitly recognize a patient's right to appoint an attorney-in-fact to make treatment decisions on behalf of the terminally ill patient.

The Indiana Act does not explicitly authorize the appointment of agents to make medical treatment decisions. If a physician doubts the validity of a patient's living will, however, the statute directs the physician to consult certain persons to ascertain the patient's intention. See *supra* note 59 and accompanying text. The physician is directed to consult first the patient's legal guardian, if any, and second, "[t]he person or persons designated by the patient in writing to make the treatment decision for the patient should the patient be diagnosed as suffering from a terminal condition." IND. CODE ANN. § 16-8-11-14(g)(2) (West Supp. 1986). That provision implicitly recognizes the patient's ability to make such a designation.

If the Indiana legislature adopts the Uniform Act but wishes to authorize the use of agents to make medical decisions, the legislature could amend the state's durable power of attorney statute to authorize specifically the use of an attorney-in-fact to make medical decisions.

⁸⁷UNIFORM ACT § 2(a), 9A U.L.A. 455, 458 (1985). The Uniform Act unfortunately is unclear about whether the witnesses must actually see the declarant sign the document or whether the declarant's acknowledgment of his signature to the witnesses is sufficient. The comment following section 2 states that the declaration is to be signed by the declarant in the presence of the witnesses, but the actual language of the act is not explicit. Section 2(a) states: "The declaration must be signed by the declarant or another at the declarant's direction, and witnessed by 2 individuals." *Id.* The ambiguity could be eliminated by providing: "The declaration must be signed by the declarant, or another at the declarant's direction, in the presence of two persons each of whom must also sign as a witness."

⁸⁸See, e.g., ALA. CODE § 22-8A-4 (1984); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1987); GA. CODE ANN. § 88-4103 (Harrison Supp. 1986); MISS. CODE ANN. § 41-41-111 (Supp. 1986); UTAH CODE ANN. § 75-2-1104 (Supp. 1986).

⁸⁹IND. CODE ANN. § 16-8-11-11 (West Supp. 1986).

that the witnesses cannot be entitled to any part of the declarant's estate either under the state intestacy laws or under the declarant's will. The drafters of the Uniform Act believe that whatever protection is afforded the patient by the more elaborate witness procedures can be provided by established hospital procedures⁹⁰ without unduly burdening both patients and physicians with complicated execution requirements.⁹¹

The Uniform Act provides that a declaration may be revoked in any manner by which the declarant is able to communicate an intent to revoke.⁹² To be effective, of course, the revocation must be communicated to the health care provider.⁹³ This is in sharp contrast to the Indiana provision,⁹⁴ and to virtually all other state statutes,⁹⁵ which list specific means by which a declaration can be revoked: a signed, dated writing; physical cancellation or destruction; or oral expression of intent to revoke. The Uniform Act's general revocation provision permits revocation by the broadest range of means. In addition to the methods typically enumerated, a physical sign communicating an intent to revoke would be sufficient to effect a revocation.⁹⁶

A sample declaration is included in the Uniform Act.⁹⁷ The form is not mandatory, as some statutes require,⁹⁸ nor is it necessary that a declaration be "substantially" similar to the sample, as required by Indiana.⁹⁹ In keeping with the Uniform Act's general philosophy, the example provided is uncomplicated, demonstrating that such declarations are legally sufficient.¹⁰⁰ More elaborate statements are, of course, also permitted.

Elimination of complex witness procedures and of the requirement that a declaration be in a particular form relieves physicians of much of the burden of determining the validity of a living will. The Uniform Act goes one step further, however, and explicitly states that "[i]n the

⁹⁰UNIFORM ACT § 2 comment, 9A U.L.A. 455, 458-59 (1985).

⁹¹*Id.* The comment notes that the absence of witness qualifications relieves physicians of the inappropriate burden of determining whether a declaration has been properly witnessed. Since many physicians would be hesitant to make such legal decisions, elaborate witness requirements jeopardize the effectiveness of living wills. *See supra* notes 69-73 and accompanying text.

⁹²UNIFORM ACT § 4, 9A U.L.A. 455, 459 (1985).

⁹³*Id.* It may be communicated either by the declarant or by anyone who witnessed the revocation.

⁹⁴IND. CODE ANN. § 16-8-11-13 (West Supp. 1986).

⁹⁵*See, e.g.,* ARIZ. REV. STAT. ANN. § 36-3203 (1986); DEL. CODE ANN. tit. 16, § 2504 (1983); FLA. STAT. ANN. § 765.06 (West 1986); IDAHO CODE § 39-4505 (1985); LA. REV. STAT. ANN. § 40:1299.58.4 (West Supp. 1987); N.H. REV. STAT. ANN. § 137-H:7 (Supp. 1986).

⁹⁶UNIFORM ACT § 4 comment, 9A U.L.A. 455, 459-60 (1985).

⁹⁷*Id.* § 2(b), 9A U.L.A. at 458.

⁹⁸*See* CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1987); IDAHO CODE § 39-4504 (1985 & Supp. 1986); OR. REV. STAT. § 97.055 (1984); WIS. STAT. ANN. § 154.03 (West Supp. 1986).

⁹⁹IND. CODE ANN. § 16-8-11-12 (West Supp. 1986).

¹⁰⁰UNIFORM ACT § 2 comment, 9A U.L.A. 455, 458-59 (1985).

absence of knowledge to the contrary, a physician or other health-care provider may presume that a declaration complies with this [Act] and is valid."¹⁰¹

While in some respects the coverage of the Uniform Act is not as broad as that of some statutes,¹⁰² in other ways it is broader. As previously noted, most living wills are operative only when the declarant is in a terminal condition.¹⁰³ Some statutes define terminal condition as one in which death is imminent, "whether or not" or "regardless" of whether life-sustaining treatment is used.¹⁰⁴ If death is imminent even with aggressive treatment, a living will offers little relief. The Uniform Act avoids this pitfall by defining terminal condition as "an incurable or irreversible condition that, *without* the administration of life-sustaining procedures will, in the opinion of the attending physician, result in death within a relatively short time."¹⁰⁵ While this definition is similar to that in the Indiana statute,¹⁰⁶ the Uniform Act defines a "qualified" patient, one from whom a physician may withhold treatment with immunity, as a patient in a terminal condition who has executed a declaration.¹⁰⁷ To be a "qualified patient" under the Indiana statute, however, there also must be a determination that the patient will die from the terminal condition whether or not life-prolonging procedures are used.¹⁰⁸ The Indiana definition of a qualified patient substantially undercuts the breadth of its definition of a terminal condition.¹⁰⁹

The Uniform Act's definition of "life-sustaining" procedures also expands the scope of the Act. Life-sustaining procedures are defined as "any medical procedures or intervention that, when administered to a qualified patient, will serve only to prolong the dying process."¹¹⁰ Unlike the Indiana statute, which specifically excludes nutrition, hydration, and medication,¹¹¹ the Uniform Act's broad definition affords a declarant greater autonomy. Because there is no prescribed form to follow, de-

¹⁰¹*Id.* § 11, 9A U.L.A. at 463.

¹⁰²*See supra* note 85 and accompanying text.

¹⁰³*See supra* note 34 and text accompanying note 7.

¹⁰⁴*See, e.g.,* CAL. HEALTH & SAFETY CODE § 7187 (West Supp. 1987); GA. CODE ANN. § 88-4102(10) (Harrison 1986); MD. HEALTH-GEN. CODE ANN. §§ 5-601, -602(c) (Supp. 1986); *cf.* MO. ANN. STAT. § 459.010 (Vernon Supp. 1987) (terminal condition is such that "death will occur within a short time regardless of the application of medical procedures"); TENN. CODE ANN. § 32-11-103(9) (Supp. 1985) (terminal condition defined as one which is expected to cause death "within a short period of time regardless of the use or discontinuance of medical treatment"); WIS. STAT. ANN. § 154.01(8) (West Supp. 1986) (terminal condition is one which is expected to cause death "within 30 days, regardless of the application of life-sustaining procedures").

¹⁰⁵UNIFORM ACT § 1(9), 9A U.L.A. 455, 456 (1985) (emphasis added).

¹⁰⁶*See* IND. CODE ANN. § 16-8-11-9 (West Supp. 1986); *see also supra* note 81 and accompanying text.

¹⁰⁷UNIFORM ACT § 1(7), 9A U.L.A. 455, 456 (1985).

¹⁰⁸IND. CODE ANN. § 16-8-11-8 (West Supp. 1986); *see also supra* note 83.

¹⁰⁹*See supra* notes 79-83 and accompanying text.

¹¹⁰UNIFORM ACT § 1(4), 9A U.L.A. 455, 456 (1985).

¹¹¹IND. CODE ANN. § 16-8-11-4 (West Supp. 1986).

clarants may direct that no life-sustaining procedures be used or they may, if they choose, narrow the kind of treatment to be withheld.

Unfortunately, the definitions in the Uniform Act of both "terminal condition" and "life-sustaining procedure" are imprecise. A terminal condition is one expected to cause death within a "relatively short time"¹¹² and a life-sustaining procedure is treatment which serves "only to prolong the dying process."¹¹³ Neither of these phrases is devoid of ambiguity; yet, the Indiana Act also uses both definitions.¹¹⁴ The use of the short period of time language avoids the problems caused by using the term "imminent" and provides greater flexibility than setting a fixed time period such as six months or a year.¹¹⁵ Although the comments to the Uniform Act reflect a bias against the use of a fixed time period,¹¹⁶ the ability of declarants under the Act to tailor their instructions allows those who wish to restrict their physicians' discretion to do so, an ability not clearly countenanced by the Indiana Act.¹¹⁷

Defining life-sustaining procedures as those that "only prolong the dying process"¹¹⁸ of a qualified patient is equally imprecise. Because a qualified patient must suffer from a terminal condition,¹¹⁹ and a terminal condition is one that is incurable or irreversible,¹²⁰ the phrase "only prolongs the dying process" cannot mean simply that the life-sustaining procedures will not cure the condition. Such a reading would make the phrase superfluous. At a minimum, the language must mean that death is not merely postponed if a procedure counteracts a disease which

¹¹²UNIFORM ACT § 1(9), 9A U.L.A. 455, 456 (1985).

¹¹³*Id.* § 1(4), 9A U.L.A. at 456.

¹¹⁴IND. CODE ANN. §§ 16-8-11-4, -9 (West Supp. 1986).

¹¹⁵UNIFORM ACT § 1 comment, 9A U.L.A. 455, 456-58 (1985). The phrase "relatively short time" was suggested by medical experts. *Id.* at 457.

¹¹⁶The comment to section 1 one states:

The "relatively short time" formulation is employed to avoid both the unduly constricting meaning of "imminent" and the artificiality of another alternative—fixed time periods, such as 6 months, 1 year, or the like. The circumstances and inevitable variations in disorder and diagnosis make unrealistic a fixed time period. Physicians may be hesitant to make predictions under a fixed time period standard unless the standard of physician judgment is so loose as to be unenforceable

UNIFORM ACT § 1 comment, 9A U.L.A. 455, 457 (1985).

¹¹⁷The Indiana Act requires a declaration to "be substantially in the form set forth [in § 12], but the declaration may include additional specific directions. The invalidity of any additional specific directions does not affect the validity of the declaration." IND. CODE ANN. § 16-8-11-12 (West Supp. 1986). The apparent intent of that language is to permit declarants to replace the general language in the statute with specific directions. The problem is that physicians are left with the burden of determining first whether the altered declaration is substantially like the sample, and second whether the additional directions should be honored. To avoid the expense and delay of a court hearing to determine the validity of a declaration, declarants would be well advised simply to follow the statutory sample.

¹¹⁸See *supra* note 113.

¹¹⁹See *supra* note 107.

¹²⁰See *supra* note 105.

cannot be cured. For example, although diabetes and certain kidney disorders are incurable, insulin and dialysis do more than simply postpone death. It is unclear, however, whether procedures that only afford the patient some opportunity for continued personal interaction are considered to do more than merely prolong the dying process. Unfortunately, it is unlikely that greater precision in defining life-sustaining procedures can be obtained without unduly restrictive language. However, under the Uniform Act,¹²¹ but not the Indiana Act,¹²² declarants are free to be as specific in their directions as they please.

The Uniform Act and Indiana Act differ with regard to a physician's liability for failure either to comply with a living will or to transfer the patient to another physician willing to carry out the declarant's wishes. The Indiana Act states that a living will does not obligate a physician to withhold or withdraw life-prolonging procedures,¹²³ although an unwilling physician should ordinarily transfer the patient to another physician.¹²⁴ A physician who knowingly fails to do either does not face criminal liability but is subject only to disciplinary sanctions, as if the physician had violated a rule promulgated by the medical licensing board.¹²⁵ On the other hand, the Uniform Act suggests that willful failure to comply with the Act should be punishable as a misdemeanor.¹²⁶ However, all of the specific medical judgments called for throughout the Uniform Act are expressly subject to "reasonable medical standards."¹²⁷ Whatever incentive there is to act precipitously to avoid criminal liability for failure to comply with a declaration is tempered by the fact that immunity from liability for withdrawing treatment is available only if the physician's decisions are in accord with reasonable medical standards.¹²⁸

¹²¹See *supra* notes 97-112 and accompanying text.

¹²²See *supra* notes 99, 117 and accompanying text.

¹²³IND. CODE ANN. § 16-8-11-11(f) (West Supp. 1986); see also *supra* note 57 and accompanying text.

¹²⁴IND. CODE ANN. § 16-8-11-14 (West Supp. 1986). A physician who refuses to withhold or withdraw life-prolonging procedures from a qualified patient is directed to transfer the patient to a physician who will honor the living will declaration unless the "attending physician, after reasonable investigation, finds no other physician willing to honor the patient's declaration," *id.* § 16-8-11-14(f), or "the physician has reason to believe the declaration was not validly executed or there is evidence that the patient no longer intends the declaration to be enforced," *id.* § 16-8-11-14(e)(1)-(2). If the physician refuses to transfer a patient for the latter reasons, the statute imposes upon the physician an obligation to attempt to ascertain the validity of the declaration and the patient's intention by consulting with certain individuals, such as the patient's legal guardian, health care agent, enumerated family members or the patient's clergy. *Id.*

¹²⁵*Id.* § 16-8-11-22.

¹²⁶UNIFORM ACT § 9, 9A U.L.A. 455, 461 (1985).

¹²⁷*Id.* § 8(b), 9A U.L.A. at 461.

¹²⁸Under the Uniform Act, reasonable medical standards apply to all medical decisions, i.e., diagnosing the patient as "terminal" and characterizing a procedure as one which only prolongs the dying process. A physician who negligently diagnoses a patient as terminal and withdraws treatment can be liable for his actions. *Id.* § 8 comment, 9A

The Uniform Act, like most others, contains a number of miscellaneous statements that clarify the operation and intent of the statute. Like the Indiana statute,¹²⁹ it provides:

1. The act does not condone, authorize or approve of euthanasia.¹³⁰
2. The act creates no presumption concerning the intention of a person who has not executed a living will.¹³¹
3. Death resulting from withholding or withdrawing life-sustaining procedures pursuant to a declaration does not constitute suicide.¹³²
4. The act does not impair or supersede any right or responsibility any person has to withhold or withdraw medical care.¹³³
5. Unless the declaration otherwise provides, the declaration of a pregnant patient has no force or effect, if it is probable that the fetus could develop to the point of live birth with continued use of life-sustaining procedures.¹³⁴

Unlike the Indiana Act, the Uniform Act also contains a section recognizing the validity of living wills executed in another state in com-

U.L.A. at 462.

The Indiana Act does not state that the attending physician's decisions are subject to reasonable medical standards. *See* IND. CODE ANN. § 16-8-11-14(c) (West Supp. 1986). Curiously, however, a health care provider or an employee is accorded immunity for participation in withholding or withdrawing life-prolonging procedures only if he acts "in good faith; and . . . [i]n accordance with reasonable medical standards." *Id.* § 16-8-11-14(d). It is doubtful that the Indiana legislature intended to hold attending physicians only to a good faith standard and not to reasonable medical standards. In fact, since it is lawful under the Indiana Act for an attending physician to withhold or withdraw treatment only from a "qualified" patient, a negligent diagnosis of a "terminal condition" would probably expose a physician to liability for withholding or withdrawing treatment. If the patient's condition is not terminal, the patient is not properly characterized as "qualified" and the immunity provided by the statute would not be available. It is unfortunate, however, that such a crucial matter is not made clear on the face of the statute.

¹²⁹*See supra* notes 64-68 and accompanying text.

¹³⁰UNIFORM ACT § 10(g), 9A U.L.A. 455, 463 (1985).

¹³¹*Id.* § 10(d), 9A U.L.A. at 463. The Uniform Act is broader than the Indiana Act. The Indiana Act simply states that it creates no presumption concerning the intention of a person who has not executed a living will. IND. CODE ANN. § 16-8-11-19 (West Supp. 1986). The Uniform Act says that it creates no presumption concerning the intention of an individual who has revoked or has not executed a living will. UNIFORM ACT § 10(d), 9A U.L.A. 455, 463 (1985).

¹³²UNIFORM ACT § 10(a), 9A U.L.A. 455, 462 (1985).

¹³³*Id.* § 10(e), 9A U.L.A. at 463.

¹³⁴*Id.* § 6(c), 9A U.L.A. at 460. Unlike the Indiana Act, this provision of the Uniform Act permits a woman specifically to decline treatment even though she may be pregnant and it is probable that the fetus could develop to a point of viability outside the womb. The United States Catholic Bishops' Committee for Pro-Life Activities has criticized this provision as well as the ambiguity of certain definitions and the failure of the Uniform Act to recognize adequately the benefit of nutrition and hydration in sustaining life. *See* Committee for Pro-Life Activities, *The Rights of the Terminally Ill*, 16 ORIGINS 222 (1986).

pliance with the law of that state or in compliance with the Uniform Act.¹³⁵

The greatest difference between the Indiana Act and the Uniform Act is that the Uniform Act does not authorize a declaration requesting the use of life-prolonging procedures.¹³⁶ If protection of autonomy is a primary goal of the legislation, such declarations should be authorized as long as they obligate physicians to continue only those life-sustaining procedures that reasonable medical judgment indicates are appropriate.¹³⁷ The problem with the Indiana provision is that it obligates physicians to use any medical procedure that would serve to prolong life,¹³⁸ apparently even procedures that might not be medically appropriate. For example, for many ninety-year-old patients, heart by-pass surgery offers insufficient benefits in comparison to its burdens to justify the surgery. A life-prolonging procedures declaration under the Indiana Act arguably compels physicians to perform such surgery as long as any expectation exists that the surgery could extend the patient's life for even a brief period of time. While protecting patient autonomy may be laudable, the appropriateness of permitting patients to demand treatment that is not medically indicated is doubtful.

V. CONCLUSION

The Uniform Act is superior to the existing Indiana Act in several ways. First, the breadth of its definitions of "terminal condition," "life-sustaining procedures" and "qualified patient" grants the individual greater freedom to decide the course of his medical treatment without abandoning the normative constraint of making living wills operative only if the patient is in a terminal condition. At the same time, the Uniform Act permits one who wishes to narrow the situation in which the declaration is to operate or the kinds of treatment to be withheld to do so. Second, physicians are freed of the burden of determining the legal validity of the instrument and thus are likely to be less hesitant to effectuate it. Yet, in all instances physicians are protected only if their actions are in accord with reasonable medical standards. For these reasons, the Indiana legislature should consider replacing its Living Wills

¹³⁵*Id.* § 12, 9A U.L.A. at 463. The Indiana Act is silent not only as to the validity of declarations executed in other states, but also as to the validity of declarations executed in Indiana prior to September 1, 1985, the effective date of the Indiana Act.

¹³⁶The Uniform Act does not prohibit such declarations. It provides only a non-exclusive way by which a terminally ill patient's desires can be legally implemented. See UNIFORM ACT Prefatory Note, 9A U.L.A. 455, 455 (1985). For discussion of the Indiana provision, see *supra* notes 56, 75-77 and accompanying text.

¹³⁷If the Indiana legislature adopts the Uniform Act, the Act could be amended to include a provision explicitly authorizing such a life-prolonging procedures declaration. Of course, such an amendment at least partially defeats the attempt at uniformity among the states.

¹³⁸IND. CODE ANN. § 16-8-11-11(g) (West Supp. 1986).

and Life-Prolonging Procedures Act with the Uniform Rights of the Terminally Ill Act.