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COMMENTS

THE DILEMMA OF THE PERSON IN A PERSISTENT VEGETATIVE STATE: A PLEA TO THE LEGISLATURE FOR HELP

This comment promotes adoption by the legislature of Senate Bill 139,¹ the Health Care Surrogate Law of Missouri. This bill allows a citizen of Missouri to make an advance directive appointing a surrogate to make all decisions concerning the giving or withholding of medical treatment in the event that the declarant is unable to make those decisions personally. This Comment will, first, review the establishment of the right to refuse treatment and the law in this area. Then it will discuss the only Missouri case on point. It will set out the provisions of the Senate Bill 139 and compare it with other states’ laws on the issue to show that additional legislation is needed in Missouri regarding this issue. Although the Health Care Surrogate Law of Missouri is a step in the right direction, the bill could be greatly improved by the addition of several provisions.

I. INTRODUCTION

The “evolution of medical technology is compelling the public, through the courts... [and] legislatures, to formulate new standards and procedures for the health care of patients with irreversible brain damage.”² Medical miracles now force us to distinguish between life as we have known it and life in which the body lives in some fashion but the brain (or a significant part of it) does not.³ If all cognitive function of the brain has already died within a body, should we allow the living part of that body to die also? Therein lies the dilemma of the person in a persistent vegetative state.

Consider this scenario: Your father (mother, spouse, brother, sister, child) is involved in a serious automobile accident. In spite of (or, rather,

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¹ S. 139, 85th Leg., 1st Sess. (1989), [hereinafter Health Care Surrogate Law of Missouri].
² Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334, 1344 (Del. 1980).
³ Id.
as a result of) heroic medical measures, your father is now in a comatose state. Although his heart, lungs and kidneys function normally, he does not respond in any way when you speak to or touch him. He must be turned every two hours to prevent bedsores. He has no control over his bowels or bladder. He does not swallow therefore must receive artificially the nutrition and hydration his body needs. Someone, probably a nurse, but perhaps a machine, must feed him a nutritionally balanced liquid. The liquid may be fed through a tube inserted into his nose and passed to his stomach, or through a tube that has been surgically placed through the abdominal wall into the stomach or small bowel. Your father does not move any of his muscles. It is necessary for someone else to move his arms and legs for him every so often to prevent the muscles and joints from becoming fixed in one position. These bodily functions are controlled by a part of the brain, which for your father, is no longer working properly.

Despite the lack of normal brain functioning, physicians say that your father may "live" or remain in this state for another twenty to thirty years. If your father is in Missouri, there may be nothing that you can do but visit him.

This troubling scenario exists for many families throughout the United States. Such situations are, if not commonplace, at least not extraordinary because of the advances in medical science over the past several decades. It has been estimated that there are five to ten thousand permanently comatose patients alive today.

When should life-support measures for these patients be terminated, and who should decide if, or when, it should be done? Essentially, the question is to what extent should an individual be able to determine the point beyond which life should not be continued for himself or his loved one. In the past, this question has been dealt with quietly and privately between the patient and the doctor. Recent decisions have held that judicial intervention is not necessary in determining when life-sustaining measures should be terminated, unless unusual circumstances exist. These circumstances include conflicts among health care professionals, or among family

4. Heroic measures may include such things as cardiovascular resuscitation, respirator use, defibrillation (electric shock to the heart), or treatment with drugs that affect the vascular system.
8. Id.
members, or between the family members and the health care professionals. Unfortunately, fear of civil and criminal liability has often forced family members or physicians to seek judicial intervention before health care professionals will decide to withdraw treatment.

II. HISTORICAL LEGAL TREATMENT OF LIFE-SUPPORT TERMINATION

Over the past decade, numerous judicial decisions have focused on determining who can decide to terminate life-support measures for a comatose or terminally ill patient. The landmark case In re Quinlan established the right to refuse medical treatment. Karen Quinlan, diagnosed as being in a persistent vegetative state, was kept alive (or so her physicians, family and the court thought) by means of artificial respiration with the use of a mechanical ventilator.

Her father, appointed as her legal guardian, petitioned the court to allow the respirator to be removed. The petition eventually reached the New Jersey Supreme Court. The court found Karen had a constitutionally protected right to privacy with regard to medical decisions affecting her.

The court in Quinlan found no specific United States Supreme Court decision directly on point. Therefore, the Quinlan court looked to the decisions of the Supreme Court dealing with personal privacy. By comparing the right to refuse medical treatment to the right a woman has to terminate a pregnancy under certain conditions, the Quinlan court found the unwritten constitutional right of privacy includes the decision to terminate life-support measures under certain conditions.
As a result of her incompetency, the only practical way Karen Quinlan could assert that right was through her father as guardian.\textsuperscript{20}

The Appellate Division of the New York Supreme Court in \textit{Eichner v. Dillon} \textsuperscript{21} followed the \textit{Quinlan} analysis:

By parity of reasoning, the constitutional right to privacy [announced in \textit{Roe v. Wade}, U.S. Sup. Ct., 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973)], we believe, encompasses the freedom of the terminally ill but competent individual to choose for himself whether or not to decline medical treatment where he reasonably believes that such treatment will only prolong his suffering needlessly, and serve merely to denigrate his conception of the quality of life. . . . Individuals have an inherent right to prevent "pointless, even cruel, prolongation of the act of dying." (quotations omitted).\textsuperscript{22}

The \textit{Eichner} court also found that the patient's guardian can make a "substituted" or "proxy" judgment.\textsuperscript{23}

After \textit{Quinlan}, other courts also recognized the right to refuse medical treatment using an additional judicial pathway. Along with finding a constitutional right of privacy, those courts also based their decisions on the common law right of a person to control his or her own body absent an overriding state interest.\textsuperscript{24} The United States Supreme Court articulated this concept in 1891.\textsuperscript{25} The Court held that a plaintiff could not be ordered to submit to a surgical examination, stating:

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.\textsuperscript{26}

In addition to the right to refuse medical treatment, early courts dealt with the issue of the type of medical treatment which could be refused or

\begin{footnotesize}
\begin{enumerate}
\item Id. at 41, 355 A.2d at 664.
\item Id. at 476, 426 N.Y.S.2d at 548.
\item 141 U.S. 250 (1891).
\item Id. at 251.
\end{enumerate}
\end{footnotesize}
They allowed individuals to refuse "extraordinary" measures, distinguishing them from "ordinary" ones.28

In *In re Storar*,29 the Appellate Division of the New York Supreme Court compared blood transfusions to nutrition and hydration or other ordinary measures which could not be stopped. Under this reasoning the court refused to permit the cessation of transfusions, even though the patient would eventually die from the bladder cancer necessitating the transfusions.30

In *Brophy v. New England Sinai Hospital, Inc.*,31 the Massachusetts Supreme Court took a different viewpoint regarding nutrition and hydration. The *Storar* court had viewed nutrition and hydration as a fundamental need. It was therefore considered an ordinary measure and could not be terminated. The *Brophy* court, however, held that receiving nutrition and hydration through a gastrostomy tube, which could keep a person alive for up to thirty-seven years, was an invasive procedure. The court found the procedure extraordinary and that finding was a factor in allowing the termination.32 Later courts found the distinction between extraordinary and ordinary measures no longer applicable.33 Instead, they focused on "whether the burden of treatment so clearly outweighs its benefit to the patient that to continue would be inhumane."34 In other words, the focus became whether the treatment is proportionate or disproportionate in terms of benefits gained versus the burdens caused.35

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28. See supra note 27. But see *President's Commission Report*, supra note 5, at 61-62 (respirators and cardiac defibrillation are considered "extraordinary" measures as compared to "ordinary" measures such as providing nutrition and hydration through the use of intravenous and other tubes).


30. *Id.* at 381-82, 420 N.E. 2d at 73, 438 N.Y.S.2d at 275.


32. *Id.* at 437-38, 497 N.E.2d at 637. A gastrostomy tube is a soft tube surgically attached so that one end lies in the interior of the stomach while the opposite end is brought through to the outside of the abdominal wall, generally on the lower left side of the abdomen. One reason for placing a G-tube is to provide an alternate feeding method when a person cannot swallow. Once the G-tube is in place, a nutritional liquid can be instilled directly into the stomach. 497 N.E.2d at 630.


The Brophy court used a balancing test to decide whether life-support measures should be removed. The court balanced the person's constitutional right of privacy and his common law right to refuse medical care against the state's interest. In weighing the burdens and benefits, the court held that the distinction between ordinary and extraordinary, although a factor to be considered, was not controlling. In Brophy, the court found the patient's rights outweighed the state's interest in preserving life or any other interest the state may have, and allowed the surrogate to decide whether to terminate the life-support.

Courts and commentators have identified four countervailing state interests that may limit a person's right to refuse medical treatment: preserving life, preventing suicide, safeguarding the integrity of the medical profession and protecting innocent third parties. Of these four, the state's interest in preserving life has been the central focus when balancing the state's interest against a person's rights.

It is not too difficult for courts to find the person's rights outweigh the state's interest when the incompetent person's life is prolonged by a respirator. The more difficult question arises when the life-support measure to be terminated is nutrition and hydration. The distinction may be based on the emotional symbolism of infant care, providing food and water to a person incapable of self-care. Numerous courts have grappled with the question of whether a surrogate may decide to discontinue nutrition and hydration for an incompetent ward. In all but two cases, the surrogate was allowed to make that decision.

38. Id. at 437, 497 N.E.2d at 637.
39. Id. at 439, 497 N.E.2d at 638.
40. Farrell, 108 N.J. at ___, 529 A.2d at 410-11. See also Rasmusson, 154 Ariz. at ___, 741 P.2d at 683; Conroy, 98 N.J. at ___, 486 A.2d at 1223; President's Commission Report, supra note 5, at 31-32.
43. Cruzan, ex rel. Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (en banc); In re Westchester County Medical Center, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).
In *In re Westchester County Medical Center*, a hospital sought permission to insert a nasogastric feeding tube into a 77 year old, incompetent woman over her daughters' objections. The court found that although the patient was incompetent due to a series of strokes, she was not in a coma, persistent vegetative state or terminally ill. She was simply an elderly patient unable to feed herself in the normal manner because she had lost her ability to swallow with her most recent stroke. In fact, she was awake and conscious, and could respond to simple commands and carry on limited conversations.

The court required clear and convincing evidence showing that the person held a firm and settled commitment to the termination of life-support in the circumstances presented. Factors to be considered as proof include "the persistence of the person's statements, the seriousness with which those statements were made, and the inferences, if any, that may be drawn from the surrounding circumstances" in which they were made.

In the past, the patient in *Manchester County* made statements about declining artificial means of life-support. Due to the circumstances in which they were made the court found that these statements were not controlling. The court held the circumstances to be some evidence of "whether the infirmities she was concerned with and the procedures she eschewed are qualitatively different than those now presented."

The statements this patient had made regarded terminally ill patients, particularly ones with cancer. At the time of the petition, the patient was not terminally ill, nor did she have cancer. Her circumstances were very different from the situations which prompted her declarations concerning the termination of life-support measures. The court noted that it did not intend that one must specify an exact condition for a declaration to be effective. Nonetheless, the court refused to expand the circumstances in which this patient's declarations would be effective to the present situation. Additional statements of "never wishing to be a burden" on her children were also held to be insufficient evidence of her wishes in her present condition. The patient's daughters, who opposed the insertion of the feeding tube, admitted they were unsure of what their mother would want.

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45. *Id.* at 522, 531 N.E.2d at 608, 534 N.Y.S.2d at 887.
46. *Id.* at 533, 531 N.E.2d at 615, 534 N.Y.S.2d at 894.
47. *Id.*
48. *Id.*
49. *Id.* at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.
50. *Id.* at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.
51. *Id.* at 533, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.
52. *Id.* at 533, 531 N.E.2d at 615, 534 N.Y.S.2d at 894.
53. *Id.* at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.
54. *Id.*
done under the present circumstances. In light of all the facts, the Westchester County court permitted the hospital to insert the tube and provide nutrition and hydration in that manner.

III. MISSOURI'S TREATMENT OF LIFE-SUPPORT TERMINATION

Cruzan v. Harmon is a case of first impression for the Missouri Supreme Court; Cruzan dealt with a young woman diagnosed as being in a persistent vegetative state. The Missouri Supreme Court, like many other courts confronted with this issue, balanced the state’s interest against the burden of the treatment and the patient’s rights. However, unlike any other court, the Cruzan court found that the state’s “concern with the sanctity of life rests on the principle that life is precious and worthy of preservation without regard to its quality.” To the Missouri Supreme Court, this interest outweighed any right Nancy Cruzan had in determining her own treatment.

The court found no express right of privacy under Missouri’s constitution nor under the federal constitution. Unlike other courts, Missouri’s Supreme Court read the United States Supreme Court decisions of Bowers v. Hardwick and Roe v. Wade as limiting the right of personal privacy to exclude the right to terminate life-support measures, thereby also excluding a surrogate’s right.

The court found that Nancy Cruzan does have a common law right to refuse medical treatment. Nevertheless, given the fact that Nancy is alive, and that the burdens of the treatments are not excessive for her, the court found that the “immense, clear fact of life in which the state maintains a vital interest” clearly outweighs her common law rights.

55. Id. at 534, 531 N.E.2d at 615, 534 N.Y.S.2d at 894.
56. Id. at 552, 531 N.E.2d at 608, 534 N.Y.S.2d at 887.
57. 760 S.W.2d 409 (Mo. 1988) (en banc).
58. Id. at 410.
59. Id. at 412.
60. Id. at 419.
61. Id. at 424.
62. Id. at 417.
64. 478 U.S. 186 (1986) (the Supreme Court refused to extend the right to privacy beyond those relationships centered within the bonds of marriage or related to procreation).
65. 410 U.S. 113 (1973) (the Supreme Court limited a woman’s right to privacy in her decision to have an abortion).
66. Cruzan, 760 S.W.2d at 418.
67. Id. at 416-17.
The Cruzan decision directly contrasts with the majority of other decisions on this issue. Nearly unanimously, all courts but Missouri’s have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought. 69

IV. LEGISLATIVE RESPONSE TO THE NEED FOR ADVANCE DIRECTIVES

The fear of criminal and civil liability often prompts physicians and health care organizations to require judicial sanction of the removal of life-support systems for the terminally ill incompetent. 70 This is true despite the fact that courts have consistently upheld both the right of a competent person to refuse treatment and of a family member to act on behalf of an incompetent person. 71

The number of cases regarding termination of life support 72 demonstrates that some other method is needed to resolve this issue. Courts have repeatedly requested state legislatures to take up the issue. 73 The Missouri Supreme Court stated:

69. Id. at 420.

70. Capron, Legal and Ethical Problems in Decisions for Death, 14 LAW, MED. & HEALTH CARE 141, 142 (1986).

71. Id. See Gallups v. Cotter, 534 So. 2d 585 (Ala. 1988). Gallups involved civil action brought by the parents of a deceased minor against her attending physicians in which they requested damages for wrongful death, breach of contract, fraud and outrage. After three flat electroencephalograms showing brain death, physicians consulted the family and obtained its consent to remove the life-support system. The father pleaded in the action that the family had not given its approval. The court sustained a motion for summary judgement in favor of defendant physicians because the evidence presented by plaintiffs was void of any indication that defendants acted intentionally or recklessly, an element necessary to establish a claim of emotional distress. Additionally, under Ala. Code §§ 22-31-4, 22-31-1 (1984), death may be pronounced before termination of life support measures. Thus, the statute provides immunity from civil liability for anyone acting in accordance with the statute. Gallups, 534 So. 2d at 587-88; Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). Barber involved criminal charges of murder and conspiracy to commit murder against two physicians who removed a life-support system from a vegetative person pursuant to family wishes. The prognosis was that the condition was permanent with little hope of recovery. The charges were later dismissed.

72. Cruzan, 760 S.W.2d at 412 n.4. The Cruzan court cited at least fifty cases from seventeen jurisdictions decided from 1976 to the present.

73. Satz v.Perlmutter, 379 So. 2d 359, 360 (Fla. 1980) (“It is the type issue which is more suitably addressed in the legislative forum”); Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517, 535 (1980) (“an act of the Legislature would be most welcome and appropriate”); In re Farrell, 108 N.J. 335, 529 A.2d 404, 407-08 (1987) (“Because the issue with all its ramifications is fraught with complexity ... [it] is the type of issue which is more suitably addressed in the legislative forum.”); In re Conroy, 98 N.J. 321, 486 A.2d 1209, 1220 (1985) (“Perhaps it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients.”).
Broad policy questions bearing on life and death issues are more properly addressed by representative assemblies. These have vast fact and opinion gathering and synthesizing powers unavailable to the courts; the exercise of these powers is particularly appropriate where issues invoke the concerns of medicine, ethics, morality, philosophy, theology and law.\textsuperscript{74}

The New Jersey Supreme Court expressed the same concern, namely that the legislature is better equipped to develop and frame a comprehensive plan for resolving the problems raised by this issue.\textsuperscript{75}

**Legislative Responses**

Most states now have some form of legislation concerning refusal of medical treatment made by a patient or a surrogate.\textsuperscript{76} States enacted laws to meet the realities of contemporary law and medicine.\textsuperscript{77} They are generally codifications of existing common law rights and are titled "Natural Death Acts," "Medical Treatment Decisions Acts," "Death With Dignity Acts," "Right to Terminate Treatment Acts," "Life-Sustaining Procedure Acts"

\textsuperscript{74} Cruzan, 760 S.W.2d at 426.

\textsuperscript{75} Conroy, 98 N.J. at —, 486 A.2d at 1244 (1985).

\textsuperscript{76} A current list of living will statutes or natural death acts is as follows:


or "Living Will Acts." They allow a person to make an "advance directive."

Advance directives are expressions of a competent person's self-determination and privacy rights as they bear on the person's future health care. These advance directives allow people to anticipate that they may be incapable of making a decision regarding their own health care at a future time. The directive allows individuals to specify, in advance, what treatment they do and do not want, given certain circumstances. Some acts also allow a person to designate a surrogate person to make the decisions for them.

1. Living Wills

"Living wills" are one form of an advance directive. Living wills are generally documents which a legally competent adult writes as an affirmative directive to medical personnel to withhold artificial life-support systems in certain circumstances. One can make a living will before a terminal illness or disease strikes but often does so after he or she is diagnosed as terminal. This is particularly true in situations where the diagnosis is a disease that may persist for a period of time, such as cancer or AIDS (acquired immune deficiency syndrome).

"Living wills" were initially developed as documents without binding legal effects; they simply gave directives to family and other health care professionals about the person's wishes. Prior to the statutory adoption of the living will, one individual sent his living will to a large medical center in Houston, Texas. He was subsequently informed by the hospital that it would not honor the document. The hospital also informed him that if he was admitted as a patient there, the hospital would do "whatever it deemed necessary irrespective of the patient's wishes." The first "natural death" acts were a response to this type of attitude by health care organizations and gave legal recognition to living wills, provided the living will followed certain procedural requirements. Their enforceability has rarely been litigated. Thirty-eight states and the District of Columbia have

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80. President's Commission Report, supra note 5, at 136.
81. Martyn & Jacobs, supra note 77, at 787.
82. President's Commission Report, supra note 5, at 139.
83. Legal Problems of the Aged and Infirm, supra note 7, at 26.
84. Id.
85. Id.
86. Gelfand, supra note 78, at 739.
statutorily authorized the use of a living will, thus reducing the possibility that it will be litigated in the future. A few cases have discussed the role of a living will absent statutory authorization. In *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, the Florida Supreme Court held that judicial approval was not necessary to relieve family members, physicians, and hospitals from civil and criminal liability when they relied on a living will to terminate life-support systems from a terminally ill, comatose person. In order for there to be criminal or civil liability, the court held it must be shown that the actions were not in good faith but were intended to harm the person. In *Bludworth*, the court stated:

> [I]f such a person, while competent, had executed a so-called “living” or “mercy” will, that will would be persuasive evidence of that incompetent person’s intention and it should be given great weight by the person or persons who substitute their judgment on behalf of the terminally ill incompetent.

Although there was no living will in issue in *In re Conroy*, the New Jersey Supreme Court held that a living will would be relevant evidence of a person’s intent. Since the New Jersey Legislature had not enacted a statute recognizing the validity of a living will or prescribing the means to execute such wills, the court did not address the issue of whether a living will was legally binding. Regardless of its legal effect, however, the court held it would be a relevant expression of intent, to which the court should give weight.

In *Conroy*, the court used a subjective standard and asked what the particular person would have done if able to choose for himself or herself. This contrasts with the objective standard—what a reasonable or average person would choose under similar circumstances.

The court said that a carefully considered position, especially a written position, might be evidence of a person’s clear intent. A carefully considered position, according to the court, is one a person had maintained over a number of years or had acted upon in comparable circumstances. Courts and commentators have recognized that advance directives are the optimal devices for determining when life-support measures may be withheld

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87. See supra note 76 for a current listing of the living will statutes.
88. 452 So. 2d 921 (Fla. 1984).
89. *Id.* at 922.
90. *Id.* at 926.
91. *Id.* However, no Florida statute providing for the execution of a living will was cited in the opinion.
93. *Id.* at ____, 486 A.2d at 1229 n.5.
94. *Id.* at ____, 486 A.2d at 1229-30.
95. *Id.* at ____, 486 A.2d at 1229.
96. *Id.* at ____, 486 A.2d at 1230.
97. *Id.*
or withdrawn from incompetent patients. Statutes authorizing the living will are not without their problems, however, and in some circumstances may create more problems than they solve. For example, California's statute said that advance directives were legally binding only for those patients who were diagnosed as having a "terminal condition and only if the patient waited fourteen days after being told of the diagnosis before he or she signed the directive." "Terminal condition" was defined as an incurable condition in which death is "imminent" regardless of the life-sustaining procedures used. A survey of California physicians, taken one year following enactment of the Natural Death Act, found that only about one half of the patients diagnosed as terminally ill remained conscious for the required fourteen days after the diagnosis was made. The California Legislature has subsequently remedied that problem. In addition, it passed a "durable power of attorney" act to supplement the Natural Death Act.

A "durable power of attorney" is a power of attorney that continues in effect after the declarant is incapacitated and, in this case, allows a designated third person to make all subsequent medical decisions.

Another example of problems which a natural death act creates is found in Louisiana. A misreading of the state's act led to serious results. Health care providers, presumably relying on counsel's interpretation of the statute, routinely required judicial authorization before terminating life-support measures of terminally ill minors.

The Missouri Legislature passed a living will act in 1985, which took effect on September 28, 1985. Missouri's act is unique in that the Missouri Legislature set out, within the act itself, the four ethical and moral considerations which courts have described as the state's interest to be weighed against the individual's rights of privacy and control over their person.

100. Id.
101. Id.
Under the act, a competent person may execute a declaration for withholding or withdrawal of a death-prolonging procedure. The act defines a competent person as a person eighteen years or older, of sound mind, who is able to receive and evaluate information and to communicate a decision. The definition of a death-prolonging procedure "shall not include the administration of medication or the performance of medical procedure deemed necessary to provide comfort, care or to alleviate pain nor the performance of any procedure to provide nutrition or hydration." The declaration becomes operable when the declarant's condition is determined to be terminal and the declarant is unable to make treatment decisions. A "terminal condition" is an incurable or irreversible condition which, in the opinion of the attending physician, is such that death will occur within a short time, regardless of the application of medical procedures.

Although Missouri's living will act is a step in the right direction, it is not without criticism. For example, there is a question on what is considered to be a "short time" and who is to decide how long a "short time" is. To a terminally ill person, a short time may be any defined period of life, from a few days to a few years. Additionally, patients like Karen Quinlan and Nancy Cruzan would not fall within the boundaries of the act, even if they had made a living will while competent and the act was in effect at the time of their accident. The act applies only to terminally ill persons, not to those persons diagnosed as being in a persistent vegetative state.

Another problem arises from the use of vague statutory language. Section 459.025, Missouri Revised Statutes, states that the declaration does not become effective until the declarant is unable to make treatment decisions. In addition, the directions of a declarant able to make treatment decisions shall at all times supersede the declaration. This language would imply that a conscious, incompetent person would be bound by the language of the directive. Yet the law provides for revocation, regardless of physical or mental condition. It remains unclear whether a mentally incapacitated patient can revoke the provisions of a living will previously documented. If the declarant can revoke a declaration "in any manner by which the declarant is able to communicate his intent to revoke, without regard to

113. See Murphy, A New Form of Medical Malpractice?: Missouri's "Living Will" Statute, 42 J. Mo. B. 11 (1986).
114. Id. at 16.
115. Id.
116. Id.
mental or physical condition,"" who will decide when, and if, a revocation has been made? This language seems to place the medical profession in a dilemma, forcing a determination of whether there has been a revocation of the living will.\textsuperscript{118}

In \textit{Cruzan v. Harmon},\textsuperscript{119} the trial court held that the living will act\textsuperscript{120} sets forth the public policy of the General Assembly. That policy prohibits the withholding and withdrawal of nutrition and hydration under all circumstances. The trial court determined that, as written, the statute violates Nancy Cruzan's right to liberty, due process of law and equal protection under the state and federal constitution.\textsuperscript{121} None of the parties in \textit{Cruzan} argued to the Missouri Supreme Court that the Living Will Act applied.\textsuperscript{122} The Living Will Act did not take effect until after her accident, and in any event, Nancy had not executed a living will.\textsuperscript{123}

The supreme court held that the living will act was not an issue in \textit{Cruzan} except that it states the Missouri Legislature's interest in the sanctity of life.\textsuperscript{124} ""We intend no judgment here as to whether the common law right to refuse medical treatment is broader than the living will statute. . . . The trial court erred in finding its provisions unconstitutional.""\textsuperscript{125} Therefore, the constitutionality of the provision in Missouri's Living Will Statute which prohibits the removal of nutrition and hydration remains an issue for the court to determine.

2. Health Care Surrogates or Durable Powers of Attorney

Another form of an advance directive is the durable power of attorney. The most fundamental purpose of a durable power is to ensure reliance by third parties on the agent's or surrogate's authority, so that the wishes of the person creating the power will be effectuated.\textsuperscript{126} It allows an individual to delegate powers to an agent, directing the agent to act during periods of disability or incapacity of the principal. The durable power of attorney also ensures that the agent's authority will be honored by third parties at all times.\textsuperscript{127} Already effective for property and financial matters, the durable power of attorney is now being extended to the area of health care decisions.

\begin{footnotesize}
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\item \textsuperscript{117} Mo. Rev. Stat. § 459.020(1) (1986).
\item \textsuperscript{118} Borron, \textit{supra} note 107, at 30.
\item \textsuperscript{119} 760 S.W.2d 408 (Mo. 1988) (en banc).
\item \textsuperscript{120} Mo. Rev. Stat. §§ 459.101(3), 459.055 (1986).
\item \textsuperscript{121} \textit{Cruzan}, 760 S.W.2d at 410.
\item \textsuperscript{122} \textit{Id.} at 420.
\item \textsuperscript{123} \textit{Id.}
\item \textsuperscript{124} \textit{Id.}
\item \textsuperscript{125} \textit{Id.}
\item \textsuperscript{127} \textit{Id.}
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\end{footnotesize}
The designated agent will have the legal authority to decide if, or when, to terminate life-support measures for the principal in the event the principal is no longer competent.\textsuperscript{128}

Durable powers of attorney acts may also be known as "Health Care Surrogate Laws." These laws protect the interests of an incapacitated person by ensuring his or her well-being and self-determination. A durable power of attorney, through which people may designate others to make health care decisions on their behalf, is the most preferable type of advance directive.\textsuperscript{129} It provides a better vehicle than a living will for patients to exercise self-determination.\textsuperscript{130} Durable powers of attorney allow a person to control decision making in a far broader range of situations than living wills.\textsuperscript{131} Nevertheless, living wills are the most common statutorily authorized form.\textsuperscript{132}

In life-support refusal or termination cases, durable powers of attorney are preferred to living wills or natural death acts because they are unencumbered by the many limitations that attend the natural death act directives.\textsuperscript{133} By allowing the declarant to appoint a surrogate, there is an increased likelihood that treatment decisions will be made in accord with the declarant’s personal preferences.\textsuperscript{134} As one court stated:

Medical choices are private, regardless of whether a patient is able to make them personally or must rely on a surrogate. They are not to be decided by societal standards of reasonableness or normalcy. Rather, it is the patient’s preferences—formed by his or her own unique personal experiences—that should control.\textsuperscript{135}

Some living will statutes specifically permit appointment of a surrogate.\textsuperscript{136} Other states have enacted statutes which provide specific durable powers for health care decisions.\textsuperscript{137} In addition, there is precedent for the

\textsuperscript{128} Martyn & Jacobs, supra note 77, at 787.
\textsuperscript{129} President’s Commission Report, supra note 5, at 4.
\textsuperscript{130} Id.
\textsuperscript{131} Id. at 145.
\textsuperscript{132} See supra note 76 for a current listing of living will statutes.
\textsuperscript{133} Alexander, supra note 102, at 93.
\textsuperscript{134} Rhoden, supra note 6, at 438.
\textsuperscript{135} In re Peter ex rel. Johanning, 108 N.J. 365, ___, 529 A.2d 419, 423 (1987).
proposition that a general durable power of attorney may be sufficient to give the agent control over health care decisions of an incompetent person.\textsuperscript{138}

In \textit{In re Peter ex rel Johanning},\textsuperscript{139} Hilda Peter was diagnosed as being in a persistent vegetative state.\textsuperscript{140} Prior to becoming ill, Ms. Peter executed a durable power of attorney authorizing Eberhard Johanning to make all medical decisions for her, should she become incapacitated.\textsuperscript{141} Mr. Johanning was made legal guardian of Ms. Peter after she became incompetent.\textsuperscript{142} He petitioned the Ombudsman for the Institutionalized Elderly, as required by New Jersey statute, to have the nasogastric feeding tube removed from Ms. Peter. In addition, he requested that nutrition and hydration and life-support measures be terminated.\textsuperscript{143} The Ombudsman denied the request and a suit ensued.\textsuperscript{144} The New Jersey Supreme Court granted the removal of the feeding tube.

Although the New Jersey Power of Attorney Statute did not specifically authorize conveyance of powers to make medical decisions, the court found that the statute should be interpreted to do so.\textsuperscript{145} The court stated that the specific granting of the authority to terminate life-support systems would have been preferable.\textsuperscript{146} Nevertheless, the court allowed Mr. Johanning to make any decisions concerning medical care for Ms. Peter.\textsuperscript{147} A significant amount of evidence indicating Ms. Peter's views on life-support measures influenced the court's decision.\textsuperscript{148}

Most durable power of attorney statutes are not enacted to deal expressly with the issue of health care decisions for the incompetent person. Still, the New Jersey Supreme Court construed its statute broadly enough to

\begin{itemize}
\item \textsuperscript{138} Iowa's Life-Sustaining Procedures Act allows life sustaining treatment to be withheld or withdrawn from a person who is terminally ill, and comatose, incompetent or otherwise mentally incapacitated, even though that person has not made a declaration. One person statutorily authorized to make that decision, in conjunction with the attending physician, is "[t]he attorney in fact designated to make treatment decisions for the patient should such person be diagnosed as suffering from a terminal condition, if the designation is in writing and complies with section 633.705." IOWA \textsc{Cod}e § 144A.7 (1987). Section 633.705 is the general power of attorney statute. Thus, a general power of attorney will be sufficient to grant an attorney the legal power to make medical decisions, if there is a provision granting power of attorney.
\item \textsuperscript{139} 108 N.J. 365, 529 A.2d 419 (1987).
\item \textsuperscript{140} \textit{Id.} at 
\item \textsuperscript{141} \textit{Id.}, 529 A.2d at 422.
\item \textsuperscript{142} \textit{Id.}, 529 A.2d at 422.
\item \textsuperscript{143} \textit{Id.}, 529 A.2d at 422.
\item \textsuperscript{144} \textit{Id.}, 529 A.2d at 422.
\item \textsuperscript{145} \textit{Id.} at 
\item \textsuperscript{146} \textit{Id.}, 529 A.2d at 426.
\item \textsuperscript{147} \textit{Id.}, 529 A.2d at 426.
\item \textsuperscript{148} \textit{Id.}, 529 A.2d at 426.
\end{itemize}
include the power to refuse or terminate medical treatment.149 Other courts may not be as expansive. In order to ensure the legal authority to delegate such powers, specific legislation is preferable to reliance on judicial interpretation of the existing power of attorney statutes.

V. MISSOURI'S PROPOSED STATUTE

Senate Bill No. 139 was proposed and approved by the Probate and Trust Committee of the Missouri Bar on September 18, 1987.150 The Board of Governors approved the bill on October 30, 1987 for sponsorship by the Missouri Bar in the 1988 session of the Missouri Legislature.151 Although not submitted at that time, Senator Robert Johnson filed the bill in the 1989 Missouri General Assembly.

Unlike the "Living Will Act," the "Health Care Surrogate Law of Missouri" would specifically authorize health care providers to comply with instructions of a surrogate pertaining to the administration or withdrawal of any care, treatment, service or procedure.152 The Missouri Legislature's Committee on Aging recommended that this be altered to exclude any procedure performed to provide nutrition and hydration.153 Because of this amendment, the Probate and Trust Committee of the Missouri Bar contemplated withdrawing its support of the bill.154

According to the bill, the surrogate would be able to make any health care decisions that his or her designee would have made for themselves if he or she had decisional capacity.155 Decisional capacity, as defined by the bill, is the ability to make and communicate a health care decision.156

The Senate bill is the statutory framework to specifically authorize the appointment of a health care surrogate. The bill allows each citizen of

149. In re Peter ex rel. Johanning, 108 N.J. 365, 529 A.2d 419 (1987). This case is one of three cases decided simultaneously by the New Jersey Supreme Court, each dealing with the termination of life-support systems. In each of the three cases, the court allowed the termination of the systems. See In re Farrell, 108 N.J. 335, 529 A.2d 404 (1987) (competent but terminally ill person with amyotrophic lateral sclerosis [Lou Gehrig's Disease] permitted to decide to have a respirator removed); In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (surrogate decision-maker could make determination to remove life-sustaining medical treatment of person in a persistent vegetative state).


151. Id. at 1.

152. Id.


155. Health Care Surrogate Law of Missouri, supra note 1, § 6, 3.

156. Id. § (1).
Missouri ("Grantor") to designate a person to make health care decisions concerning that citizen in the event the citizen is unable, for any reason, to make those decisions personally.\textsuperscript{157} It also provides health care providers with a statutorily authorized person on whose decisions they can rely without fear of criminal or civil liability.\textsuperscript{158}

The practical benefit of this bill is that it provides a mechanism which allows legally enforceable medical decisions to be made for a person, even though the person may be incapacitated for only a short period of time and is not terminally ill. A situation under which this might occur would be if the person is incapacitated due to a stroke. Although the prognosis of recovery may be good, the person is unable to communicate their wishes. The bill would allow a surrogate to transfer the person to another health care facility which offered more extensive therapy or was less costly to the person. Another example of temporary incapacitation would be where the person is in a delusional state. A surrogate, under this bill, could legally authorize the administration of medication to correct the condition.

Under this bill, "health care decisions" include, but are not limited to the following decisions: "consent to, refusal to consent to, withdrawal of consent to, or prohibition of any care, treatment, service, or procedure."\textsuperscript{159} The grantor must have decisional capacity at the time of making the designation of a surrogate.\textsuperscript{160} Mere incapacity (whether actual or judicially determined) may not deprive the grantor of his or her right to make health care decisions.\textsuperscript{161} The grantor may be incapable of making business or personal financial decisions, but still retain the mental capacity necessary to make personal decisions determining the use or refusal of any medical intervention that may be necessary.\textsuperscript{162}

Two or more surrogates may be named to serve at the same time. The grantor may also name a successor or alternate surrogate.\textsuperscript{163} This provision allows the grantor flexibility and greater security. In the event the designated surrogate could not serve as a health care surrogate, the grantor retains control by having named an alternate or co-surrogate. In addition, by making alternative designations, the likelihood that a surrogate will be available is improved. The grantor has total control over the choice of the surrogate and how many surrogates he or she desires. If the grantor names two or more surrogates to act simultaneously, all decisions made by the surrogates must be unanimous unless the designation provides otherwise.\textsuperscript{164}

\begin{itemize}
  \item \textsuperscript{157} Redd, \textit{supra} note 150, at 1.
  \item \textsuperscript{158} \textit{Id.} at 2.
  \item \textsuperscript{159} Health Care Surrogate Law of Missouri, \textit{supra} note 1, § 2(4), 2.
  \item \textsuperscript{160} Redd, \textit{supra} note 150, at 2. \textit{See Comment section}.
  \item \textsuperscript{161} \textit{Id}.
  \item \textsuperscript{162} \textit{Id}.
  \item \textsuperscript{163} Health Care Surrogate Law of Missouri, \textit{supra} note 1, § 3(1), 2.
  \item \textsuperscript{164} \textit{Id}.
\end{itemize}
A surrogate may resign at any time by giving written notice to the grantor, immediate successor surrogate(s), and any health care provider who is then waiting for the surrogate to make a health care decision. The act prohibits an employee, owner, director, or officer of a health care facility where the grantor is a patient or resident from acting as a surrogate, unless related to the grantor within the fourth degree of consanguinity. This prohibition protects elderly patients who may be residents of nursing homes or other long-term health care facilities from the decisions of a surrogate with a possible conflict of interest. The emphasis of the bill on the value of preserving life makes this provision necessary. The goal is to prevent decisions from being made by a surrogate with a monetary interest in the person’s demise.

In order to impress upon the parties the seriousness of the designation, certain procedural safeguards are required. The designation must be in writing, dated and signed by the grantor or at his or her direction. It must be either witnessed by two or more individuals together in the grantor’s presence or acknowledged by the grantor in the presence of a notary public or other person. Any new designation or broadening of authority in an existing designation must be executed in the same way. This is essentially the same procedure necessary for legal execution of a will.

The grantor may designate certain conditions or situations about which the surrogate may or may not make a decision. The grantor may also make a broad statement permitting the surrogate the same scope in decision making as the grantor would have, if capable. Additionally, the grantor may revoke all, or any part of, the authority previously given to a surrogate. The grantor, however, must have decisional capacity at the time of the revocation in order for the revocation to be valid. Revocation or limitation may be oral, written, or by destruction of the document or designation, or at the direction of the grantor. The lack of formality necessary to effect a revocation or limitation is indicative of the strong bias in favor of prolonging life.

A surrogate may not make a health care decision for the grantor if the attending physician has, in good faith, determined that the grantor has decisional capacity. Additionally, if no surrogate is available or willing
to make a health care decision, the health care provider may proceed as
if there were no surrogate designation.\footnote{175}

If the grantor becomes incompetent, the surrogate may exercise his
authority in many situations where it would otherwise be necessary for a
court to be involved. These include: entering into or terminating agreements
with any health care provider, procuring confidential information (medical
records) of the grantor, and authorizing admission to or discharge from
a health care facility.\footnote{176}

The statute provides a form which may be used as a designation of
a health care surrogate, but is not required. The form may be tailored by
the grantor to meet specific needs.\footnote{177} It is appropriate for the grantor to
include any specific directions or to specify particular types of health care
he or she expressly authorizes or forbids.\footnote{178} It is suggested that the des-
ignation of a health care surrogate be made separately from a living will
or power of attorney because of the importance of its nature.\footnote{179} This form,
once given to a health care provider, becomes a part of the grantor's
medical record.\footnote{180} A health care provider who is unwilling to comply with
the provisions must inform the grantor and the designated surrogate promptly
upon receipt of the designation.\footnote{181}

The bill contains several sections which provide protection for third
parties who rely on the declaration. For instance, the bill creates a pres-
sumption that the surrogate’s authority is valid.\footnote{182} No investigation into
the validity is necessary unless a third person possesses information as to
the surrogate’s disqualification.\footnote{183} The bill also protects a health care pro-
vider, acting in good faith reliance on the designation, by providing im-
munity from civil or criminal liability for carrying out the surrogate’s
instructions.\footnote{184}

Designed to complement the Living Will Statute and the Durable Power
of Attorney Act, the bill does not revoke, amend or limit the operation
of any other Missouri law.\footnote{185} Nor does it change the Autopsy Statute or
the Anatomical Gift Act.\footnote{186}

The bill protects persons from being compelled to execute a designation.
It does so by prohibiting any person, corporation or governmental agency

\footnote{175} Id.
\footnote{176} Redd, supra note 150, at 4-5.
\footnote{177} Health Care Surrogate Law of Missouri, supra note 1, § 7, 3-4.
\footnote{178} Redd, supra note 150, at 6.
\footnote{179} Id. at 6. Comment to § 7.
\footnote{180} Health Care Surrogate Law of Missouri, supra note 1, § 8, 4.
\footnote{181} Id.
\footnote{182} Id. § 9(1), 4.
\footnote{183} Id.
\footnote{184} Id.
\footnote{185} Redd, supra note 150, at 7 (Comment to § 10).
\footnote{186} Id.
from requiring a person to execute a health care surrogate designation for a contract, or for the provision of any service, medical treatment or benefit.\textsuperscript{187} Nor will a designation made under this bill affect the sale or procurement of a life insurance policy, or be deemed to modify any existing life insurance policy.\textsuperscript{188} The statute provides protection from insurance companies by stating:

\[\text{n}o\text{twithstanding any term of the policy to the contrary, no policy of life insurance shall be legally impaired or invalidated in any manner by a health care decision made by a surrogate or by the withholding or with-\text{drawal from an insured grantor of any medical procedure or intervention which would serve only to prolong artificially the dying process.}\textsuperscript{189}\]

VI. COMPARISON OF MISSOURI'S STATUTE TO OTHER STATUTES

Missouri's proposed act is a great improvement over the Living Will Act in promoting the citizen's rights of self-determination with regard to medical treatment decisions. While it avoids many of the problems of other statutes,\textsuperscript{189} in some areas it could be improved.

Other states have enacted statutes which provide for a surrogate decision maker. Some of these statutes give only general legal guidelines while others are very specific. Illinois recently enacted a comprehensive statute\textsuperscript{191} which could serve as a guideline for Missouri legislatures. A review of other states' statutes demonstrates the need for some revision of Missouri's bill.

California's Keene Health Care Agent Act\textsuperscript{192} differs from Missouri's in several aspects. The California law provides that a surrogate has "authority to consent, to refuse consent, or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition."\textsuperscript{193} Missouri's act does not distinguish between mental and physical condition, referring only to "any health care decision."\textsuperscript{194} It could be argued that "any" is broad enough to cover both mental and physical health care decisions. But the converse can also be argued, the language says "health care decision" and mental conditions are not included. Using language such as "any health care decision, regardless of whether for physical or mental health care purposes" would avoid ambiguity.

\textsuperscript{187} Id. at 7; Health Care Surrogate Law of Missouri, \textit{supra} note 1, § 9(3), 5.
\textsuperscript{188} Health Care Surrogate Law of Missouri, \textit{supra} note 1, § 9(2), 4-5.
\textsuperscript{189} Id.
\textsuperscript{193} Id. § 2500.
\textsuperscript{194} Health Care Surrogate Law of Missouri, \textit{supra} note 1, § 6, 3.
The California act authorizes a court to revoke the power of an agent or surrogate, if the agent "(1) authorizes anything that is illegal, (2) acts contrary to [the declarant's] known desires, or (3) where [the declarant's] desires are not known, does anything that is clearly contrary to [the declarant's] best interests." The Delaware "Death With Dignity Act" also safeguards the declarant from actions of the agent contrary to the declarant's best interests.

The Illinois' Durable Power of Attorney Statute provides for judicial control, although expressed in broader terms. It simply states that an agent's authority can be revoked by the court if the agent is not acting properly. Missouri's bill is silent on this issue. Perhaps the drafters felt that the right of the court to remove a surrogate acting outside his or her scope of authority was implied. Since most surrogates and persons designating the surrogate will be lay persons, it would be wise to include such a provision that clearly delineates the surrogate's legal responsibilities and provides a remedy should the surrogate act contrary to those responsibilities.

Most of the natural death acts and surrogate health care acts do not attempt to address the most frequently recurring situation—those cases in which "decisions must be made on behalf of incompetent patients who have not prepared advance directives." This issue is addressed in Louisiana's Natural Death Act. A forerunner of the Louisiana statute was the Arkansas Living Will Statute (repealed), which allowed a surrogate to execute a living will on behalf of an incompetent adult or minor, who had not previously executed one. This statute differed from the majority of living will acts which allow personal declarations only.

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196. DEL. CODE ANN. tit. 16, § 2506 (1983). Anyone who holds a good faith belief that the withdrawal or withholding of a medical treatment in a particular case is: (1) contrary to the expressed wishes of a declarant; (2) proposed pursuant to a falsified, forged or coerced declaration; or (3) proposed without considering an unlawfully concealed, destroyed, altered or cancelled revocation, may petition the Court of Chancery for appointment of a guardian for such declarant.
197. ILL. ANN. STAT. ch. 110 1/2, para. 80-1 to 804-12 (Smith-Hurd Supp. 1989).
198. Id. at para. 804-10. Illinois' Statutory Short Form Power of Attorney for Health Care requires a "notice" paragraph at the beginning of each declaration which states in capital letters, "A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY."
199. Vitiello, supra note 99, at 272. Although not specifically designated as "surrogate health laws" or "durable power of attorney acts," living will or natural death acts which provide for the appointment of a surrogate are also considered in this comment.
202. See Health Care Surrogate Law of Missouri, supra, note 1; The Keene
In 1987, Arkansas repealed its earlier act and replaced it with the "Arkansas Rights of the Terminally Ill or Permanently Unconscious Act." This statute purposefully addresses the needs of a person who is permanently unconscious. "Life-sustaining treatment" is defined by the Arkansas Legislature as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying or to maintain the patient in a condition of permanent unconsciousness." "Permanently unconscious" is defined as a "lasting condition, indefinitely without change in which thought, feeling, sensations, and awareness of self and environment are absent." The current statute also provides for surrogate decision making.

The Louisiana statute contains a list of persons who may make a declaration on behalf of a qualified patient who is incompetent or comatose and who has not previously made a declaration. There is also a similar provision relating to a terminally ill minor. The list includes the spouse...
and other close relatives such as adult children, siblings, or parents.\textsuperscript{209} It also includes a judicially appointed "tutor" or "curator," if one has been appointed,\textsuperscript{210} although the statute does not require that one be appointed in order for a declaration to be made by a third person on behalf of a qualified person.\textsuperscript{211} If there is more than one person in the class of surrogates listed, the Louisiana statute requires unanimity.\textsuperscript{212} The language in Arkansas' current statute is similar to that found in Louisiana's. Florida, Texas and Utah also have statutes with similar language.\textsuperscript{213}

The Louisiana statute has been praised as making judicial intervention unnecessary in most cases.\textsuperscript{214} If it is necessary for the court to intervene, the only issue for the court is the choice of surrogate.\textsuperscript{215} It need not contemplate the underlying medical question or the desires of the incompetent patient.\textsuperscript{216} While a provision such as this does have potential for abuse, it can be useful in filling gaps like those in the \textit{Quinlan} and the \textit{Cruzan} cases.\textsuperscript{217}

In spite of its benefits and usefulness, portions of Louisiana's provision have been criticized. The requirement of unanimity among class members may give leverage to an unreasonable dissenter within the family, who

relative to withholding or withdrawal of medical treatment or life-sustaining procedures on a minor's behalf:

(1) The spouse if he has reached the age of majority; or
(2) If there is no spouse, or if the spouse is not available, or is a minor, or is otherwise unable to act, then either the parent or the guardian of the minor.

B. An individual named in Subsection A of this Section may not make a declaration:
(1) If he has actual notice of contrary indications by the minor who is terminally ill; or
(2) If, as a parent or guardian, he has actual notice of opposition by either another parent, or guardian, or a spouse who has attained the age of majority.

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

\textsuperscript{210} Id.
\textsuperscript{211} Id.
\textsuperscript{212} Id. at \textsection 40:1299-58.5(3).
\textsuperscript{214} Vitiello, \textit{supra} note 99, at 275.
\textsuperscript{215} Id.
\textsuperscript{216} Id.
\textsuperscript{217} Legal Problems of the Aged and Infirm, \textit{supra} note 7, at 23.
dissents because of his or her own needs rather than for the patient's benefit.\textsuperscript{218} Lack of unanimity may also force the family into court. Since the statute does not provide for an expedited hearing or appeal, taking the dispute to court would lead to a continuation of potentially unnecessary medical treatment.\textsuperscript{219} Given the other safeguards in the statute,\textsuperscript{220} one commentator has suggested that the requirement of unanimity is unnecessary and may, in fact, impair good decision making.\textsuperscript{221}

The most frequently litigated situation, in regard to terminating life-support systems, is that situation where the person is incompetent and no declaration has been made.\textsuperscript{222} It is also the area where the need for legislative resolution is the greatest. Unfortunately, Missouri's bill does not address this situation.

Revocation of a declaration is another area treated in various ways by different statutes. Missouri's bill would allow revocation only if the "grantor has decisional capacity."\textsuperscript{223} Other statutes, including the Uniform Act for the Terminally Ill,\textsuperscript{224} allow revocation of the declaration regardless of the mental state or capacity.\textsuperscript{225}

Although such a provision has potential for manipulation, it "recognizes the ultimate preference for life when [there is] doubt as to the patient's wishes."\textsuperscript{226} One suggestion to prevent manipulation has been to include a counter provision allowing reinstatement of a revoked declaration.\textsuperscript{227} The reinstatement would be on the same or similar terms as before the revocation, so that the underlying document would not be "lost because of a recanted expression of changed intentions."\textsuperscript{228}

Most statutes allow for oral revocation; some require certification of the oral revocation. Delaware requires the oral revocation be made in the

\begin{itemize}
  \item \textsuperscript{218} Vitiello, supra note 99, at 303.
  \item \textsuperscript{219} Id. at 301-02.
  \item \textsuperscript{221} Vitiello, supra note 99, at 302.
  \item \textsuperscript{222} See, e.g., In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); In re Guardianship of Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984). Since In re Quinlan, seventeen states and the District of Columbia have decided cases addressing the issue of the termination of life support. For a comprehensive list, see Cruzan, ex rel. Cruzan v. Harmon, 760 S.W.2d 408, 412-13 n.4 (Mo. 1988) (en banc).
  \item \textsuperscript{223} Health Care Surrogate Law of Missouri, supra note 1, § 5.
  \item \textsuperscript{224} Uniform Rights of Terminally Ill Act, 9B U.L.A. 609, § 4(a) (1985).
  \item \textsuperscript{226} Alexander, supra note 102, at 98.
  \item \textsuperscript{227} Id.
  \item \textsuperscript{228} Id.
\end{itemize}
plea to the legislature

presence of at least two persons, eighteen years of age or older.\textsuperscript{229} Wyoming allows for oral revocation witnessed by only one person, but that person must sign a writing certifying the revocation.\textsuperscript{230} The revocation does not become effective until the attending physician receives the witness' written certification.\textsuperscript{231}

Illinois also requires that the witness to a revocation must sign and date a writing confirming the revocation, made orally or otherwise, by the declarant.\textsuperscript{232}

Missouri's bill has no such safeguards pertaining to an oral revocation. In light of the seriousness of the revocation and the procedural steps necessary to make a new declaration, some sort of certification for witnessing an oral revocation would seem appropriate and necessary. Without safeguards, there is increased potential for a conflict between the surrogate health care agent and third persons who disagree with the surrogate's decision.

Safeguards are also included to specify who may witness a declaration. A close family member will usually be named as the surrogate, since he or she is most likely to know what the declarant would want in a given situation. Requiring unbiased, disinterested persons to witness the declaration protects the declarant from coercion and also protects the surrogate from an inference of self-interest.

According to the Louisiana statute, witnesses to the designation cannot be related to the declarant by blood or marriage, or entitled to any portion of the declarant's estate.\textsuperscript{233} Similar language is found in the Washington and Delaware statutes.\textsuperscript{234} This requirement negates the inference of a conflict of interest or coercion that might arise when close family members are the witnesses to the designation, especially when they are also named as the surrogates. In Rhode Island, a witness cannot be: "(1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, [or] (5) the employee of a community care facility."\textsuperscript{235} Oklahoma requires that a declaration be signed in the presence of, and with the approval of, the judge of the district court in which the declarant is a resident.\textsuperscript{236}

\begin{itemize}
  \item \textsuperscript{229} \textit{Del. Code Ann.} tit. 16, § 2504(a)(2) (1983).
  \item \textsuperscript{230} \textit{Wyo. Stat.} § 35-22-103(iii) (1988).
  \item \textsuperscript{231} \textit{Id.}
  \item \textsuperscript{234} \textit{Del. Code Ann.} tit. 16, § 2503(b) (1983); \textit{Wash. Rev. Code} § 70.122.030(1) (Supp. 1989). Florida requires one of the two attesting witnesses to be unrelated by blood or marriage. \textit{Fla. Stat.} § 765.04(1) (1986).
  \item \textsuperscript{235} \textit{R.I. Gen. Laws} § 23-4.10-2(9) (Supp. 1988).
  \item \textsuperscript{236} \textit{Okla. Stat.} tit. 58, § 3101 (Supp. 1989). A judge may give his approval
\end{itemize}
Missouri’s bill restricts only employees, owners, directors, or officers of a health care facility in which the declarant is a resident from being witnesses, unless related to the declarant. Rhode Island’s language appears to be the most comprehensive and provides the most protection without going to the extremes found in Oklahoma. Given the potential conflicts of interest, Missouri would be prudent to adopt language similar to that of Rhode Island.

Under California, Rhode Island, and Nevada’s statutes, a spouse designated as health care surrogate automatically becomes ineligible if the marriage is dissolved. Missouri’s bill has no provision for a substitution in place of a spousal surrogate in the event of divorce. In light of the number of divorces today the legislature should include a provision to cover this eventuality. The legislature has recognized the necessity for a similar provision in relation to wills.

A central purpose of the bill is to provide a legal method by which surrogates can make health care decisions for incompetents. One way of accomplishing this is to negate any liability associated with the decision. Most states, in their statutes for surrogate decisionmaking, include the release of criminal and civil liability for health care providers who act in good faith on the directions of the surrogate. Missouri’s bill also provides for the release from criminal and civil liability. In addition, Missouri releases the surrogates from financial responsibility for any of the grantor’s medical expenses. This unique, beneficial provision will encourage people to accept the responsibility of health care surrogacy without fear of liability for expenses. Illinois imposes liability on the surrogate for negligent exercise only if: (1) the declarant requests approval; (2) the attorney-in-fact consents to serve; (3) the judge is satisfied, after any examination and investigation he deems appropriate, that the principal is a person covered by the act who reasonably understands the nature and purpose of the power, and that the attorney-in-fact is a suitable person to carry out the obligations imposed upon him; and (4) the principal has observed the provisions of the act. The judge may give approval informally in chambers or any other convenient place without the necessity of service of summons or other notice and shall be indorsed upon the face of the original instrument. Id. § 1051(b).

237. Health Care Surrogate Law of Missouri, supra note 1, § 3(3).
239. Mo. REV. STAT. § 474.420 (1986).
241. Health Care Surrogate Law of Missouri, supra note 1, § 9(1).
242. Id. § 9(4).
of the durable power, thus exposing the surrogates to financial recriminations.243

Another area consistently addressed by states is the effect of a declaration on existing or future contracts for life insurance. Similar language concerning the effect of the designation and the surrogate's decisions on life insurance policies are found in statutes of Delaware, Washington, and Wyoming and in Missouri's bill.244 No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining measures from an insured, qualified patient, notwithstanding any terms of the policy to the contrary.245 This provision allows surrogates to make decisions without fearing the loss of life insurance benefits if death results to the declarant. The grantor is free to make his or her wishes known and acted upon, secure in the knowledge that beneficiaries will remain protected under any life insurance policies.

California and Rhode Island provide an additional safeguard not found in other statutes. Both limit the effectiveness of a declaration to seven years, unless the declarant specifies a shorter time period.246 This safeguard takes into account the possibility of changed circumstances, for example, when the declarant has forgotten that a declaration has been made that names a person the declarant may no longer want as a surrogate. The more probable result will be that the declarant continues to rely on his past declaration when its effectiveness has lapsed under the statute. For this reason, the provision should not be included in Missouri.

VII. Conclusion

Public education and future legislation should now focus on assisting competent individuals to "clarify the circumstances under which they would choose to discontinue medical treatment."247 The goal should be to provide a method by which a person may exercise his or her constitutional right to control medical treatment in accordance with individual wishes. In

244. Health Care Surrogate Law of Missouri, supra note 1, § 9 (2); DEL. CODE ANN. tit. 16, § 25079(b) (1983); WASH. REV. CODE § 70.122.070 (1989); WYO. STAT. § 35-22-108(b) (1977). See also ARK. STAT. ANN. § 20-17-210(b) (Supp. 1987); FLA. STAT. § 765.12 (1986).
addition, the method should allow this right to continue even after the person is no longer capable of making those decisions personally. The development of clear legal instruments that provide a method of evidencing the individual's intent, through durable powers of attorney or surrogate health care decision makers, should be among the highest priorities for both law and medicine.\textsuperscript{248}

In most respects, the durable powers of attorney or surrogate health care acts are similarly constructed to provide a method of individual self-determination concerning life-sustaining procedures and release of liability to health care providers who act in reliance on those designations.

Missouri's proposed legislation allows surrogates to act for an incompetent grantor in a wide range of situations. This flexibility is preferable to the rigid directives found in living wills. Additional provisions to the legislation, however, would result in a more thorough law that would avoid the need for future revision. As the bill is written, many potential problem areas are not addressed, and adoption would only necessitate litigation or further legislation to resolve those issues.

The bill, although a great improvement over existing legislation, still does not address the issue presented to the Missouri Supreme Court in \textit{Cruzan}. Since this is the area which is most litigated, adoption of a bill that does not address this situation would be short-sighted. A provision regarding incompetent minors should also be included.

The amendment which excludes removal of nutrition and hydration takes away much of the effectiveness of the bill. It, in effect, allows the state to decide what is to be considered beneficial or burdensome to a person. For some people, living in a comatose state, even though not in pain, may be excessively burdensome. For others, that may not be true. The flexibility of the surrogate health care bill, as originally written, would allow persons to decide for themselves and to have those wishes communicated to others through their chosen surrogate. It would be unfortunate for the bill to pass with the amendment intact.

Additional provisions which relate to the effect of a divorce or separation on a spousal surrogate also need the attention of the legislature. Furthermore, safeguards that provide for unbiased, disinterested witnesses to the declaration should be included.

Even if the General Assembly adopts the language of the bill as introduced, without the changes recommended by this comment, the new statute will meet a need of patients, their families and the medical community in Missouri. In order to more completely meet that need, the legislatures should address the situation of the person in a persistent vegetative state

\textsuperscript{248} \textit{Id.}
who has made no advance directive; the legislature should not except nutrition and hydration from the bill’s coverage.

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