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The Right to Die in North Dakota: The North Dakota Living Will Act

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THE RIGHT TO DIE IN NORTH DAKOTA: THE NORTH DAKOTA LIVING WILL ACT

I. INTRODUCTION

A. IN RE BAYER: A FIRST LOOK AT AN INCOMPETENT'S RIGHT TO REFUSE TREATMENT IN NORTH DAKOTA

On April 13, 1986, sixty-one year old Ione Bayer suffered a severe heart attack which caused her to stop breathing for at least twenty five minutes.[1] During these twenty-five minutes, Mrs. Bayer's brain was severely damaged due to lack of both oxygen and blood flow necessary to sustain normal brain functions.[2] As a result of this brain damage Mrs. Bayer's level of brain functioning was reduced to a "persistive vegetative state" where the capacity for body movement is diminished to reflex motions only, and the individual is incapable of any emotional functioning.[3] This "persistent vegetative state" necessitated the use of a nasogastric tube which enabled Mrs. Bayer to receive nutrition and hydration.[4]

Prior to her heart attack, Mrs. Bayer had frequently and adamantly spoken to her family and friends of her opposition to being kept alive by respirators, ventilators, or other life prolonging machines.[5] Mrs. Bayer was unambiguous about her feelings against being kept alive through the use of life-prolonging measures should she become incompetent and unable to care for herself.[6] However, Mrs. Bayer had not taken any affirmative step to

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1. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 3.

2. *Id.* The cerebral cortex of Mrs. Bayer's brain was damaged as a result of blood and oxygen deprivation. *Id.* This portion of the brain controls cognitive functions, consciousness, awareness, emotion, feeling, thinking, seeing, and hearing. *Id.*

3. *In re* Bayer, at 4. Persistent vegetative state has been described as follows:

> Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heartbeat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level condition responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

In re Jobes, 108 N.J. 394, __, 529 A.2d 434, 438 (1987) (quoting Dr. Fred Plum's testimony offered at the *Jobes* trial).

4. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 4. A nasogastric feeding tube is inserted into the nose, and runs through the posterior pharanyx and esophagus and into the stomach, allowing water and nutrition to be introduced into an individuals stomach or intestine through the tube. *See* THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING, 59-62 (1987).

5. Telephone interview with Ruth Sharp, Mrs Bayer's daughter (May 11, 1990). In the few days following that visit, as Ione Bayer watched her sister in law die, Ione Bayer clearly and unequivocally expressed to both her family members and numerous friends that she did not ever want her life sustained by machines or by any other artificial means. *Id.*

6. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 5. The *Bayer* court

ensure that her wishes would be respected in the event of her incompetency.[7] In order to respect Mrs. Bayer's wishes, her family was required to petition for the appointment of a guardian.[8] The guardianship was granted to Mrs. Bayer's husband Lyle, and on September 25, 1986, he petitioned the court for an order authorizing removal of the nasogastric feeding tube.[9]

The Bayer Court examined several factors to determine whether such an order should be granted.[10] These factors included: 1) Mrs. Bayer's extensive and irreversible brain damage, which left her incapable of experiencing feelings or emotions or physical sensations of pain, hunger or thirst;[11] 2) Mrs. Bayer's right to refuse life prolonging treatment, which could be asserted by her guardian;[12] 3) the societal interest in preserving or prolonging a life;[13] and, 4) the prospect of continual medical treatment, which the Court found to be both intrusive and invasive where there was no chance for recovery.[14] The Court balanced these four factors and on February 5, 1987 granted Mr. Bayer's petition for an order authorizing removal of his wife's feeding tube.[15]

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heard testimony from several family members regarding the prolonging of Ione Bayer's life through artificial means. *Id.* The testimony revealed Mrs. Bayer's strong opinions against life support systems and contained specific references to her desire not to be maintained in that manner if she were in a position where she could not enjoy a cognitive existence. *Id.* Family members agreed unequivocally that Mrs. Bayer would adamantly reject any effort to artificially maintain her life in its present form. *Id.*

7. *See generally In re* Bayer, No. 87-4131 (N.D. Burleigh County Ct. Feb. 5, 1987). At the time Mrs. Bayer became incapacitated, it was possible to plan ahead for incapacity through the use of a Durable Power of Attorney. *See* N.D. CENT. CODE §§ 30.1-30-01 to -05 (Supp. 1989). The Durable Power of Attorney allows the appointment of a proxy or surrogate decisionmaker remaining effective even after the principal's incapacity. *Id. But see* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841 (1990). The United States Supreme Court held that the Constitution does not forbid Missouri to require that evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment be proved by clear and convincing evidence. *Id.* at 2843.

8. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 1.

9. *Id.* at 1. In authorizing Mr. Bayer to seek the removal of his wife's feeding tube, the *Bayer* court relied on *In re* Torres, 357 N.W.2d 332 (Minn. 1984). In *Torres*, the Minnesota Supreme Court found that a probate court had the authority to authorize the request by a conservator for the removal of a conservatee's life support systems. *Id.* at 337.

10. *In re* Bayer, No. 87-4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 19. The *Bayer* court reviewed existing right to refuse medical treatment decisions in the process of making the determination to allow the removal of Mrs. Bayer's feeding tube. *Id.* at 7-19.

11. *In re* Bayer, No. 4131 (Burleigh County Ct. Feb. 5, 1987) at 19.

12. *Id.*

13. *Id.* In looking at the societal interest in preserving or prolonging a life, the Court balanced four state interests. *Id.* at 7. These interests include: "1) The state's interest in preserving life; 2) Protection of innocent third parties; 3) Prevention of suicide; and, 4) [the] Maintenance of the ethical integrity of the medical profession." *Id.* The state's concern for the preservation and sanctity of all life is balanced with a concern for the individual in question. *Id.*

14. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 19.

15. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 20. The Bayer court gave Lyle Bayer, Mrs. Bayer's husband and guardian, the authorization to request the removal of her nasogastric tube. *Id.*

Following the court order of February 5, 1987, Mrs. Bayer's nasogastric tube was removed.[16] Acting independently, her attending physician ordered the use of a second type of force feeding mechanism, a tracheostomy, which enabled Mrs. Bayer to reflexively "swallow" her food.[17] Neither Mrs. Bayer's husband nor the other family members were aware of the decision to insert the tracheostomy until after it was implemented.[18] Upon learning of this procedure, Mr. Bayer petitioned the court for permission to remove the cuffed tracheostomy.[19] At the hearing, the physician and the nursing home asserted that the tracheostomy allowed Mrs. Bayer to ingest food by swallowing rather than by force.[20] Both the physician and the nursing home contended that Mrs. Bayer's ability to swallow significantly changed the issues being considered by the court.[21]

The court reviewed the feeding process involved with the cuffed tracheostomy and concluded that the placement of food and water by a syringe into Mrs. Bayer's mouth, and her reflexive response of swallowing, was not a natural process and did not indicate a higher level of brain functioning than exhibited while the nasogastric tube was in place.[22] The court found the tracheostomy as an artificial feeding method to be both intrusive and invasive and affirmed the original decision of February 5, 1987.[23]

It took the Bayer family almost two years to work through the judicial and medical restraints which had prevented Mrs. Bayer's right to self determination from being exercised.[24] In the *Bayer*

16. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Dec. 11, 1987) at 1.

17. *Id.* The attending physician ordered the use of a cuffed tracheostomy tube. *Id.* The cuffed tracheostomy tube allowed feeding by the "depositing of pureed and blended foods in [Mrs. Bayer's] mouth coincidental with the inflation of a balloon in the cuffed tube." *Id.* "The balloon prevent[ed] entry of food or liquids into [Mrs. Bayer's] lungs." *Id.*

18. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Dec. 11, 1987) at 1.

19. *Id.*

20. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Dec. 11, 1987) at 3.

21. *Id.*

22. *Id.* at 7-8. The court considered testimony from the nursing home nursing staff and Mrs. Bayer's daughter, Ruth Sharp, also a nurse. *Id.* at 5. Mrs. Sharp was experienced in the use of tracheostomies and characterized its use here as "forced feeding." *Id.* at 6. She added that her mother would not be able to ingest food without the use of the tracheostomy or another artificial feeding device. *Id.*

23. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Dec. 11, 1987) at 7. Following the December 1987 court order, both the physician and the nursing home continued to refuse to permit removal of Mrs. Bayer's feeding tube. Telephone interview with Ruth Sharp, Mrs. Bayer's daughter (May 11, 1990). The family wrote almost 200 letters over the next few months, attempting to locate another physician who would comply with the court order. *Id.* In February 1988, one physician agreed to accept Mrs. Bayer as a patient, conditioned upon his anonymity. *Id.* On March 18, 1988, Mrs. Bayer was transported to her daughter's home, and under the care of the anonymous physician and the local hospice, quietly died 12 days later, on March 30. *Id.*

24. Telephone interview with Ruth Sharp, Mrs. Bayer's daughter (May 11, 1990). Mrs.

opinion, Burleigh County Court Judge Burt Riskedahl noted the difficulties in deciding right to die issues not previously dealt with by a judicial forum in North Dakota.[25] The Judge also noted the absence of a state living will statute addressing the right to refuse life sustaining treatment through artificial means, which could have provided the court with guidance with the *Bayer* decision.[26] In 1986, at the time of this tragedy, North Dakota was one of only eleven states without living will legislation.[27] It would be another three years before legislation of this type was available to the citizens of North Dakota.[28] Additionally, once available, North Dakota's Living Will Act did not include nutrition and hydration within the definition of "life-prolonging treatment."[29] Nevertheless, the statute is a significant part of the continuing process of defining and clarifying an individual's right to control medical treatment decisions.

Four years after *In re Bayer*, the United States Supreme Court addressed right to die issues for the first time in a case from Missouri in which the family of a young woman in a persistent vegetative state sought termination of artificial nutrition and hydration.[30] The Court held that the Constitution permitted Missouri to refuse to accept the families substituted judgment for Nancy Beth Cruzan without clear and convincing evidence that she wished to have life sustaining treatment withdrawn if she were in a persistent vegetative state.[31] However, all but one member of the Court recognized a constitutionally protected liberty interest in refusing unwanted medical treatment.[32] O'Connor's concurring decision in *Cruzan* reinforces the importance of the North Dakota

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Bayer entered a persistent vegetative state in April of 1986 following her heart attack and the final decision authorizing the removal of her feeding mechanism came on December 11, 1987. *See In re* Bayer, No. 4131 (N.D. Burleigh County Ct.) Feb. 5, Dec. 11, 1987.

25. *In re* Bayer, No, 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 5.

26. *Id.*

27. *See* SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS, 28-29 (1987 ed.) Prior to North Dakota's law, 39 other states had passed living will legislation. These include Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. *Id.*

28. *See* N.D. CENT. CODE §§ 23-06.4-01 to -14 (Supp. 1989).

29. N.D. CENT. CODE § 23-06.4-02(4)(Supp. 1989).

30. Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841 (1990).

31. *Id.* at 2854.

32. Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2863 (1990) (Scalia, J., concurring). Justice Scalia asserts that there is no constitutionally protected Due Process liberty interest at issue in *Cruzan*. *Id.* There are "reasonable and humane limits that ought not to be exceeded in requiring an individual to preserve his own life . . . but they are not set forth in the Due Process Clause." *Id.*

Living Will legislation in authorizing a certain means of providing clear and convincing evidence on the basis of which substituted judgment can be exercised on behalf of an incompetent patient.[33] *Cruzan* also makes it clear that the Living Will authorized by the North Dakota Statute is merely an alternative, not an exclusive, means by which such evidence may be provided.[34]

This Note will review the North Dakota Living Will Act, enacted by the 1989 North Dakota legislature, and the rights available to North Dakotans who execute a living will pursuant to the Act. The Note will include a discussion of the history of the living will movement, including the right to self determination and its limitations as have been determined by both the common law and the North Dakota legislature. Additionally, this Note will include a discussion of the doctrine of substituted judgment and the doctrine of informed consent as the basis for many common law right to die decisions, and compare these doctrines with the provisions of the North Dakota Living Will Act. Finally, this Note will compare the provisions of the North Dakota Living Will Act with three major areas concerned with the right to die in an effort to determine the scope and applicability of the Act: 1) common law right to die decisions; 2) the Uniform Rights of the Terminally Ill Act,[35] upon which North Dakota's Act was based; and 3) living will statutes from other states.[36]

II. THE COMMON-LAW AND CONSTITUTIONAL RIGHT OF SELF DETERMINATION IN MEDICAL DECISIONMAKING

A. PRIMARY RIGHT OF COMPETENT PATIENTS

Individual autonomy, personal liberty and the right of self-determination are concepts of long standing importance in our Anglo-American legal tradition.[37]

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33. *See* N.D. CENT. CODE §§ 23-06.4-01 to -14 (1989).

34. *See* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2857-58 (1990) (O'Connor, J., concurring).

35. *See*, SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 135-47 (1987 ed.). A Uniform Living Will Act was drafted by the National Conference of Commissioners on Uniform State Laws at its Annual Conference in 1985. *Id.* at 135. The North Dakota Living Will Act is based largely on the Uniform Living Will Act. *Compare* UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 609 (Supp. 1987) *with* N.D. CENT. CODE § 23-06.4-01 to -05 (1989).

36. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS, p. 28-29 (1987 ed.).

37. *See* J.S. MILL, ON LIBERTY 271 (43 Great Books of the Western World) (R. Hutchins ed. 1952). Mill, discussing the right to self-determination, notes:

> The only purpose for which power can be rightfully exercised over any member

The concepts of autonomy, liberty and self-determination are especially important where an individual's right to seek or refuse medical treatment is affected.[38] The right to seek or refuse medical treatment presents difficult and demanding legal issues which require more than "mechanical reliance on legal doctrine."[39] In considering medical treatment issues courts have recognized the requirement of informed consent to medical care and a right to privacy which arises both from the common law and the Constitution.[40]

1. *The Doctrine of Informed Consent*

The doctrine of informed consent is a common-law doctrine which protects the personal integrity of an individual's body.[41] The doctrine of informed consent essentially provides that no

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> of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinion of other, to do so would be wise, or even right.

Id. Mill goes on in his classic defense of personal autonomy where he discusses the scope of personal liberty:

> The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

Id. In addition to Mill, the United States Supreme Court discussed the importance of individual liberty and self-determination as early as 1891. Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891). In *Botsford* the court declared: "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." *Id.*

38. *See id.*

39. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, __, 370 N.E.2d 417, 422 (1977).

40. *See* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2847 (1990) (the Constitutional right of bodily integrity is contained in the requirement of informed consent). *See id.* at 2846 (the right to bodily integrity is the logical corollary of the informed consent requirement). For a further discussion of the doctrine of informed consent, *see infra* notes 41-45 and accompanying text. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); Barber v. Super. Ct. of Cal., 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); Satz v. Perlmutter, 362 So.2d 160 (Fla. Dist. Ct. App. 1978); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So.2d 921, (Fla. 1984) (the right of a patient to refuse medical treatment arises both from the common law and the unwritten and penumbra constitutional right to privacy). *See also* Griswold v. Connecticut, 381 U.S. 479 (1965). The constitutional basis for the right to privacy exists in the penumbra of specific guarantees of the Bill of Rights, "formed by emanations from those guarantees that help give them life and substance." *Id.* at 484. The *Griswold* court recognized the unwritten constitutional right to privacy with regard to contraception and its relationship to family life and personal choice. *Id.* at 485. This recognition was expanded in a later case, where the rights to terminate a pregnancy were included within the penumbra of privacy rights afforded by the constitution. *See* Roe v. Wade, 410 U.S. 113 (1973).

41. *See In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (discussing the doctrine of informed consent in the context of the decision to withhold medical treatment).

medical procedure may be performed without a patient's consent.[42] This consent must be obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies.[43] The doctrine of informed consent contains three elements: 1) The patient must have the capacity to reason and make judgments; 2) the patient must be able to make decisions voluntarily; and 3) the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives.[44] Generally, it is the physician's duty to provide necessary medical facts, and it is the patient's role to accept or reject treatment based on those facts.[45] The integrity of the doctrine of informed consent is jeopardized when a patient is incompetent and unable to make decisions or understand the risks of medical treatment.

B. LIMITATIONS ON THE RIGHT OF SELF-DETERMINATION WHEN MAKING MEDICAL DECISIONS FOR AN INCOMPETENT PERSON

When an individual is unable to make an "informed consent" because of incompetency, the doctrine of substituted judgment has enabled surrogate decisionmakers to make medical decisions, protecting the incompetent's right of self determination.[46] In 1976, the New Jersey Supreme Court decided *In re Quinlan*.[47] The *Quinlan* court was asked to decide whether the right of privacy, to seek or refuse extraordinary medical treatment, could be asserted by a third person on behalf of an incompetent individual.[48] Joseph Quinlan had petitioned the court to be given the power to authorize removal of Karen's artificial life support upon

42. *Id.* at 1222 (quoting Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity versus The Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973)).

43. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973). *In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1222 (1985) (quoting *Cantor*, noted that the doctrine of informed consent is the primary means to protect the personal integrity of one's body).

44. *In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1222 (1985) (quoting Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig and Van Eys, *The Physicians' Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 957 (1984)(noting that the prerequisite to informed consent is the patient's competence, and an evaluation of the risks and benefits of medical treatment, based on the information necessary to make an informed decision)).

45. *In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1222 (1985) (quoting Hilfiker, *Sounding Board: Allowing the Debilitated to Die*, 308 NEW ENG. J. MED. 716, 718 (1983)). Physicians may "phrase options, stress information, and present . . . advice" having tremendous influence in determining a patient's chosen course of treatment. *Id.*

46. *See generally In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1227 (1985).

47. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

48. *Id.* at __, 355 A.2d at 651.

which she was dependant.[49] The New Jersey Supreme Court found that Karen's right to seek or refuse medical treatment was present regardless of her competency,[50] and gave Joseph Quinlan the authority to make medical decisions as to the choice of Karen's treating physicians.[51] The "seminal" decision in *Quinlan* was a significant advancement in the area of right to die decision making, characterized by the Supreme Court in *Cruzan* as the right to refuse treatment.[52]

Since *In re Quinlan* was decided in 1976, several state cases have addressed the guardian's right to make medical decisions for an incompetent person.[53] These cases have held that the right to self-determination contains some important limitations. The common-law decisions which have addressed the right to self determination of medical treatment decisions have identified four competing state interests which limit the right to self-determination in seeking or refusing medical treatment.[54] These states interests include: 1) the preservation of life; 2) the protection of interests of innocent third parties; 3) the prevention of suicide; and 4) the maintenance of the ethical integrity of the medical profession.[55] Of these four interests, the state's interest in preserving life is properly accorded the greatest weight in right to die cases.[56]

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49. *Id.* On the night of April 15, 1975, after two fifteen minute periods of breathing cessation, Karen Quinlan was admitted, unconscious to Newton Memorial Hospital. *Id.* at __, 355 A.2d at 653-654. She entered a comatose state, and was characterized by physicians as being in a persistent vegetative state. *Id.* at __, 355 A.2d at 654. Karen required a respirator to assist her breathing due to the vegetative state. *Id.* at __, 355 A.2d at 655. Periodically unsuccessful attempts were made to wean Karen from the respirator. *Id.* Karen's treating physicians testified that she could not continue to breathe without the respirator. *Id.*

50. *Id.* at __, 355 A.2d at 664.

51. *Id.* at __, 355 A.2d at 671. On March 31, 1976, the New Jersey Supreme Court named Joseph Quinlan guardian of his daughter Karen, with full power to consult with physicians in making her medical decisions. *Id.*

52. Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2847 (1990).

53. *See, e.g., In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) (giving the guardian the authority to request that artificial feeding tube be removed, and artificial feeding be discontinued); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986) (setting aside lower court decision enjoining guardian of terminally ill incompetent individual from authorizing the removal of an artificial feeding device and ordering hospital to assist guardian in transferring the patient to a facility where device could be removed); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (noting that family members are in the best position to make medical decisions for relatives who have become incompetent).

54. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 7. *See also* Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, __, 370 N.E.2d 417, 425 (1977) (the *Bayer* court listed the same four state interests as the *Saikewicz* court).

55. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 7; Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, __, 370 N.E.2d 417, 425 (1977).

56. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) at 7. The individual's medical condition and prognosis are important considerations when balancing the state interest in preserving life against the right to refuse treatment. *Id.* at 8. The *Bayer* court recognized that the state's interest in protecting and preserving life is weakened

The state's interest in preserving life must be considered when a terminal affliction "indicates that life will soon, and inevitably, be extinguished."[57] This is particularly true for an incompetent terminally ill patient when treatment of the disease or condition may be more painful and terrifying than the terminal illness.[58] Medical treatment to prolong life may only serve to prolong the suffering of the patient.[59] Further, medical treatment may "isolate the (patient's) family from their loved one at a time when they may be close at hand.[60] Also, extraordinary medical treatment of a terminally ill patient may result in economic ruin for the family of the patient.[61] Given these ramifications, when a patient is afflicted with a terminal, incurable illness, declining further intrusive or invasive medical treatment may outweigh the state's interest in preservation of life.[62]

Recently, the medical profession and the judiciary have recognized and acknowledged that there is an important difference between curing the ill, and comforting the dying.[63] Health care professionals, hospitals and nursing homes have been drawing this distinction, especially with regard to respecting the decision of terminally ill competent patients to refuse life-prolonging measures.[64]

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where a terminally ill individual is undergoing intrusive, invasive treatment. *Id.* (quoting *In re* Quinlan, 70 N.J. 10, __, 355 A.2d 647, 664 (1976)).

57. Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417, 425 (1977).

58. *Id.* at __, 370 N.E.2d at 432 (*Saikewicz* court considered the unique circumstances of the patient's mental incompetence and held that the patient would have no comprehension of the need for treatment, would only suffer confusion and disorientation and a compounding of his pain and fear and thus trial court properly held that not treating patient would be in patient's best interests).

59. *Id.* at __, 370 N.E.2d at 423 (quoting from Lewis, *Machine Medicine and Its Relation to The Fatally Ill*, 206 J. AM. MED. A. 387 (1968)).

60. *Id.*

61. *Id.*

62. *See also*, Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2869 (1990) (Brennan, J., dissenting). Brennan argued that "no State interest could outweigh the rights of an individual in Nancy Cruzan's position." *Id.* Nancy Beth Cruzan was in a permanent vegetative state with no hope of recovery. *Id.* at 2845.

63. *See In re* Quinlan, 70 N.J. 10, 47, 355 A.2d 647, 667 (1976). In *Quinlan*, the New Jersey Supreme Court observed that the range of options available today to prolong life requires physicians to "distinguish between curing the ill and comforting and easing the dying." *Id.*

64. Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, __, 370 N.E.2d 417, 423 (1977) (citing Rabkin, Gillerman & Rice, *Orders Not To Resuscitate*, 293 NEW. ENG. J. OF MED. 364 (1976)).

C. SURROGATE DECISIONMAKING ON BEHALF OF AN INCOMPETENT PATIENT

1. *Substituted Judgment Based on the Wishes of the Patient*

There are two methods used in surrogate decisionmaking. The first method is the common-law doctrine of "substituted judgment" which has been widely discussed in right to die cases following its application in *In re Quinlan*.[65] The doctrine of substituted judgment recognizes that the common-law right to decline life sustaining treatment exists whether or not the individual is able to express a preference.[66] Further, the doctrine permits family and/or close friends to render a surrogate decision regarding the use of life prolonging treatment as the individual would have exercised it.[67]

The doctrine of substituted judgment is intended to represent, as closely as possible, the decision that the incompetent individual would make if competent.[68]

2. *Surrogate Decisions Based on the Best Interests of the Patient*

The second method of surrogate decisionmaking is the "best

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65. 70 N.J. 10, 355 A.2d 647 (1976).

66. *See In re* Quinlan, 70 N.J. 10, __, 355 A.2d 647, 664 (1976); John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So.2d 921, 926 (Fla. 1984). The doctrine of substituted judgment has been developed through the common law to afford the rights of self-determination in medical decisions to an incompetent individual. *Bludworth*, 452 So.2d at 926. The judgment of the individual is made by substitutes or surrogates. *Id.* Generally the surrogates include the individual's physician, in consultation with family members or close friends. *Id.*

67. *In re* Jobes, 108 N.J. 394, __, 529 A.2d 434, 444 (1987). The *Jobes* court discussed *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1977). *Jobes*, 108 N.J. at __, 529 A.2d at 444. Both Karen Quinlan and Nancy Jobes were incompetent, in persistent vegetative states and unable to assert their right to decline life prolonging treatment. *Compare Jobes*, 108 N.J. at __, 529 A.2d at 444 *with Quinlan*, 70 N.J. at __, 355 A.2d at 654. In *Quinlan*, the court found that Karen's father had a right to choose her treating physicians, and to consult with them about her care on her behalf. *Quinlan*, 70 N.J. at __, 355 A.2d at 671. The *Quinlan* court held that the patient's family members were the proper parties to make a substituted medical judgment. *See Jobes*, 108 N.J. at __, 529 A.2d at 444. The *Jobes* court made the same determination. *Id.* at 447. The *Jobes* court concluded that "almost invariably the patient's family has an intimate understanding of the patient's medical attitudes and general world view and therefore is in the best position to know the motives and considerations that would control the patient's medical decisions." *Id.* at 445.

68. *Jobes*, 108 N.J. at __, 529 A.2d at 445. The *Jobes* court recognized that families are most familiar with the incompetent individual's entire "prior mental life . . . philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived. . . ." *Id.* (quoting Newman, *Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician and the State*, III N.Y.L.SCH. HU. RTS. ANNUAL 45-46 (1985)). Families are best qualified to make judgments on behalf of an incompetent person. *Jobes*, 108 N.J. at __, 529 A.2d at 445.

interests" analysis.[69] The best interests analysis is used in circumstances where an individual has never been competent to make medical decisions, or where the surrogate is unaware of the individual's wishes or desires.[70] Under these circumstances, the surrogate decisionmaker must make decisions that seek to implement what the surrogate "believes would be in the patient's best interests."[71] The purpose which underlies the best interests analysis is the protection of an individual's welfare.[72] In making a decision in the best interest of an individual, the surrogate decisionmaker may take into account certain factors, including 1) the preservation or restoration of functioning; and 2) the need for relief from suffering.[73]

The doctrine of substituted judgment requires the family and/or close friends making a substituted judgment to consider the individual's prior statements concerning medical issues or life-prolonging procedures.[74] In the absence of prior statements or comments, a "best interests analysis" has been used by a substitute decisionmaker to make medical decisions for an individual who is no longer able to indicate treatment choices independently.[75]

In *Cruzan*, the Supreme Court upheld the Missouri decision which provided a procedural safeguard for surrogate decisions made for incompetent patients.[76] The Supreme Court rejected the claim that Missouri must accept the substituted judgment of close family members without clear evidence of the wishes of the

69. *See, e.g., In re* Jobes, 108 N.J. 532, __, 529 A.2d 434, 457 (1987) (Handler, J., concurring); *In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1232 (1985); *In re* Grant, 109 Wash 2d. 545, 567, 747 P.2d 445, 457 (1987).

70. The Right to Forego Medical Treatments, What are the Legal Limits? 73 Op. Att'y Gen. 25, 27 (Md. 1988). When a surrogate or substitute decision-maker is unaware of the patient's wishes or desires, a best interests analysis must be employed. *Id.*

71. *Id.* at 27.

72. *Id.* at 27-28. Although incompetent to make medical decisions, a patient's behavior may be considered as an indication of his best interests. *Id.* at 28 n.38. Examples of this type of behavior would include forcible resistance to the insertion of a feeding tube or a continued effort to remove a feeding tube in place. *Id.*

73. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 135 (1983). *See also, In re* Grant 109 Wash.2d 545, 747 P.2d 445 (1987). In *Grant*, the Washington Supreme Court held that it was in the best interest of a 22-year-old patient suffering from an incurable neurological disorder to have all life-sustaining procedures, including artificially administered sustenance withheld. *Id.* at 568, 747 P.2d at 457.

74. John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So.2d 921, 926 (Fla. 1984). In *Bludworth*, the Supreme court of Florida noted that in the context of substituted judgment, oral or written forms of evidence of the incompetent patient's wishes would be persuasive evidence of their intentions. *Id.*

75. *In re* Grant, 109 Wash.2d 545, 567, 747 P.2d 445, 457 (1987)(noting that a best interests analysis is appropriate where the incompetent party had not indicated what treatment choices they would make if unable to do so because of incompetence).

76. *See* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2852-55 (1990).

incompetent patient.[77] The Court noted that "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had [the patient] been confronted with the prospect of [the] situation while competent."[78] While recognizing that many states have less narrow procedures for surrogate decisionmaking, the *Cruzan* court held that the Constitution did not require Missouri to accept a surrogate decision to discontinue nutrition and hydration in the absence of clear and convincing evidence of the patient's wishes.[79]

3. *Surrogate Decisionmaking and Living Wills*

Some evidence is more probative than other evidence for a surrogate decisionmaker making an informed consent decision for an incompetent individual.[80] The best evidence for a terminally ill incompetent individual requiring treatment decisions is a living will stating specifically the individual's preferences about life-sustaining treatment.[81] Living wills or advanced directives allow competent persons to assert their legal right to indicate the preference for, or against, life-prolonging treatment when no longer competent and faced with an incurable terminal illness.[82] The purpose of living will legislation is to assure that an individual's treatment preferences are related to, and respected by, health care providers, family, and guardians after the individual is no longer able to directly make those decisions.[83]

Properly executed, the living will is "presumptive evidence of the declarant's desires concerning the use, withholding, or with-

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77. *Id.* at 2855-56.

78. Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2856 (1990).

79. *Id.* at 2854. *But see id.* at 2856 n.12 (the Court reserved the question of whether a State must defer to a surrogate's decision when clear evidence establishes that the patient had expressed a desire that the decision to terminate life sustaining treatment be made on the patient's behalf by a surrogate).

80. *In re* Peter, 108 N.J. 365, __, 529 A.2d 419, 426 (1987).

81. *Id. See also* Saunders v. State, 129 Misc. 2d 45, __, 492 N.Y.S.2d 510, 517 (Sup. Ct. 1985) (Saunders, living will was clear and convincing evidence of her intention to decline medical treatment if in a terminal condition). In *Saunders*, Thelma Saunders executed a living will through an attorney in Pennsylvania. *Id.* at __, 429 N.Y.S.2d at 512. She became ill in New York, prior to the enactment of a living will statute. *Id.* at __, 492 N.Y.S.2d at 511-12, 516. In a hearing on the validity and effectiveness of Mrs. Saunder's living will executed pursuant to Pennsylvania law, the court found that the document was valid as an "Informed Medical Consent Statement" and could be considered authorization to refuse or discontinue life-prolonging medical treatment. *Id.* at __, 492 N.Y.S.2d at 516.

82. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 6 (1987 ed.) (noting that living wills have become broadly accepted in recent years due to the growing awareness of issues surrounding the right to die, through personal experience and growing media coverage of a number of court cases).

83. Marzen, *The "Uniform Rights of the Terminally Ill Act:" A Critical Analysis*, 1 ISSUES IN LAW AND MEDICINE 441, 443 (1986).

drawal of [life prolonging] treatment. . . ."[84] Correspondingly, those who carry out the provisions in a properly executed living will are offered certain statutory protections when they do so.[85]

III. NORTH DAKOTA'S LIVING WILL LEGISLATION

In view of *Cruzan's* holding that a state may constitutionally limit a surrogate decision to discontinue nutrition and hydration to situations in which there is clear and convincing evidence of a patient's wishes, such as a living will, North Dakota's statute is of considerable interest.[86] The North Dakota Living Will Act, codified at Section 23-06.4-01 to -14 of the North Dakota Century Code was enacted by the 1989 legislative session.[87] The North Dakota Living Will Act is based largely on the Uniform Living Will Act, adopted in 1985 by the Commissioners on Uniform State Laws.[88] The Uniform Living Will Act form was chosen by the sponsors of the bill because most of the wording and intent of the Uniform Act was consistent with the values of the people of North Dakota.[89] The Uniform Act seeks to achieve a simple, consistent, uniform declaration which can be effective nationwide.[90] At the

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84. N.D. CENT. CODE § 23-06.4-04 (Supp. 1989).

85. *See* N.D. CENT. CODE § 23-06.4-09 (Supp. 1989). Actions taken pursuant to a valid living will are not subject to criminal or civil liability. *Id.*

86. *Cf.* N.D. CENT. CODE § 23-06.4 (Supp. 1989) (North Dakota's Living Will provides clear and convincing evidence of a patient's wishes for use by a surrogate decisionmaker). *But see generally* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841 (1990)(nothing in *Cruzan* suggests, however, that a living will in compliance with a state statute is the only possible means to provide clear and convincing evidence of the wishes of the incompetent patient).

87. The North Dakota's Living Will Act was enacted on April 10, 1989, after House Bill No. 1481 was passed by both the House of Representatives and the Senate of the Fifty-first Legislative Assembly of North Dakota. 1989 N.D. LAWS ch. 309. It became effective on July 10, 1989. *Id.*

88. The legislative history of the North Dakota Living Will Act indicates that it was based on the Uniform Act. *See* The Uniform Rights of Terminally Ill Act: Hearings on H.B. 1481 Before the Sen. Comm. on Human Serv. and Vet. Affairs, 51st N.D. Legislative Session (March 3, 1989) (statement by Representative Judy DeMers, prime sponsor of House Bill 1481).

89. *Id.* Representative DeMers stated that:

> The sponsors [of the living will bill] recognize that House Bill 1481 attempts to resolve very complex legal, personal, moral, medical, and health care issues. In its development, we utilized the "living will" bill of [the] last [1987] session, which was based on the Uniform Law recommended by the National Commission on Uniform State Laws and which had been modified to meet concerns relevant to North Dakota. . . .

Id. Among the concerns particular to North Dakota, were the provisions for nutrition, hydration and comfort care as medical treatment, and the effectiveness of an otherwise valid declaration during pregnancy. *Id.*

90. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 609 (1987). The Prefatory Note of the Uniform Rights of the Terminally Ill Act sets out the purposes of the Act. *Id.* These purposes are:

> (1) to present an Act which is simple, effective, and acceptable to persons desiring to execute a declaration and to physicians and health-care facilities

time of this writing, ten states have enacted living will legislation that is based on significant portions of the Uniform Act.[91]

The scope of the Uniform Act is narrow. The Uniform Act provides that there is no presumption of an individual's wishes for or against life prolonging treatment where death is imminent, unless that individual has actually written a declaration pursuant to the Act.[92] Additionally, the provisions of the Uniform Act are limited to treatment which is life prolonging, and then, only for patients whose condition is terminal or irreversible.[93]

A. LEGISLATIVE INTENT OF THE NORTH DAKOTA LIVING WILL ACT

The legislative intent of the North Dakota Living Will Act is found in North Dakota Century Code section 23-06.4-01.[94] Section 23-06.4-01 provides generally, that it is the intent of the act to provide competent adults with the right to control decisions relat-

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whose conduct will be affected, (2) to provide for the effectiveness of a declaration in states other than the state in which it is executed through uniformity of scope and procedure, and (3) to avoid the inconsistency in approach which has characterized the early statutes.

Id.

91. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, §§ 1-18, 9B U.L.A. 82 (Supp. 1990). The ten states which have written living will statutes relying on portions of the Uniform Act include Alaska (ALASKA STAT. §§ 18.12.010 to -.100 (1986)); Arkansas (ARK. STAT. ANN §§ 20-17-201 to -218, (1987 & Supp. 1989)); Hawaii (HAW. REV. STAT. § 327D-1 to -27 (Supp. 1989)); Iowa (IOWA CODE ANN. § 144A.1 to .11 (West 1989)); Maine (ME. REV. STAT. ANN. tit. 22, § 2921 to 2931 (Supp. 1989)); Maryland (MD. HEALTH-GEN. CODE ANN. § 5-601 to 614 (1990)); Missouri (MO. ANN. STAT. § 459.010 to .055 (Vernon's Supp. 1990)); Montana (MONT. CODE ANN. § 5-9-101 to 206 (1989)); North Dakota (N.D. CENT. CODE § 23-06.4-01 to -14 (Supp. 1989)); and Oklahoma (OKLA. STAT. ANN. tit. 63, § 3101 to 3111 (West Supp. 1990)).

92. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 609 (1987). *See also In re* Gardner, 534 A.2d 947 (Me. 1987). *Gardner* involved an action to discontinue life-sustaining procedures on a hospital patient in a persistent vegetative state. *Id.* at 949. Joseph Gardner had been in a coma for two years following an automobile accident. *Id.* He had not written a living will prior to his accident. *Id.* at 952. In its decision, the Maine Supreme Court recognized Maine's recently enacted living will legislation, but found it not relevant to the case at bar. *Id.* at 952 n.3. The court did note that "[t]he legislature, however, expressly provided that the Act creates no presumption concerning the intention of a person who does not have a document that qualifies as a 'living will'. . . ." *Id.*

93. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 609 (1987).

94. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989). Section 23-06.4-01, entitled Legislative intent provides:

> Every competent adult has the right and the responsibility to control the decisions relating to the adult's own medical care, including the decision to have medical or surgical means or procedures calculated to prolong the adult's life provided, withheld, or withdrawn. Communication about such matters is encouraged between each person and the person's family, the physician, and other health care providers. This chapter does not condone, authorize, approve, or permit mercy killing, euthanasia, or assisted suicide or permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

Id.

ing to their medical care, including the decision to have medical procedures withheld or withdrawn.[95] Section 23-06.4-01 goes on to state that it is not the intent of the Act to condone mercy killing, euthanasia or assisted suicide.[96] This intent is consistent with the Constitutional right to privacy, the Fourteenth Amendment liberty interest identified in *Cruzan*,[97] and the common-law right to decline life sustaining medical treatment.[98] The legislative intent of the North Dakota Living Will Act clearly indicates that the right to self-determination is not absolute, and must be balanced with the conflicting state interest against euthanasia, mercy killing or assisted suicide.[99] The right set forth in the North Dakota Living Will Act permitting "the natural process of dying" is based on an individual's right to self-determination, and the desire to be free from judicial intervention, rather than a specific intent to die.[100] Thus, the refusal of medical treatment or the removal of life support systems, allowing natural death to occur, is distinguished from an affirmative act hastening the advent of death.[101]

B. TERMS DEFINED IN THE NORTH DAKOTA LIVING WILL ACT

North Dakota's Living Will Act defines key terms which are used in the statute.[102] Although the North Dakota Living Will Act

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95. *Id.*

96. *Id.*

97. Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2851 (1990) (the *Cruzan* Court noted that after *Quinlan* most right to die decisions were based on both a common law right and a constitutional right to privacy. *Cruzan* identified a Fourteenth Amendment liberty interest in unwanted medical decisions as an additional consideration when evaluating an individual's right to die).

98. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989). The legislative intent states that every competent adult has the right and responsibility to make decisions regarding health care. *Id.* Similarly, the *Belchertown* court discussing the common law right to die precedent noted: "We take the view that the substantive rights of the competent and incompetent person are the same in regard to the right to decline potentially life-prolonging treatment." Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, __, 370 N.E.2d 417, 423 (1977).

99. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989).

100. N.D. CENT. CODE § 23-06.4 (Supp. 1989).

101. *See, e.g.*, Satz v. Perlmutter, 362 So.2d 160, 162 (Fla.Dist.Ct.App. 1978); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 743, 370 N.E.2d 417, 426 n.11 (1986); Brophy v. New England Sinai Hosp. Inc., 398 Mass. 417, __ n.29, 497 N.E.2d 626, 635 n.29 (1986); *In re* Colyer, 99 Wash.2d 114, __, 660 P.2d 738, 743 (1983); *In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1224 (1985).

102. N.D. CENT. CODE § 23-06.4-02 (Supp. 1989). The text of § 23-06.4-02 provides:

> Definitions. In this chapter, unless context otherwise requires:
> 1. "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.
> 2. "Declaration" means a writing executed in accordance with the requirements of subsection 1 of section 23-06.4-03.
> 3. "Health care provider" means a person who is licensed, certified, or

is based on the Uniform Act, some of the key terms have been changed to reflect the intent given the statute by the North Dakota legislature.[103] The terms defined by the Living Will Act include "declaration," "life-prolonging treatment (termed life-sustaining treatment under the Uniform Act)," "qualified patient" and "terminal condition."[104]

1. *The Definition of "Declaration"*

The term "declaration" is defined in the North Dakota Living Will Act as an actual physical writing, in the manner set forth in section 23-06.4-03 of the statute.[105] Subsections (a) and (b) of Section 23-06.4-03(3) provide the form which the declaration must take when requesting the provision, withholding, or withdrawal of life prolonging procedures when death is imminent.[106] The statute requires that the form set out in the statute must be "substantially" followed if a declaration is to be given effect.[107] The statute's requirement that the declaration "substantially" follow the form set out in the statute could indicate that a terminally ill

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otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.
4. "Life-prolonging treatment" means any medical procedure, treatment, or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying and where, in the judgment of the attending physician, death will occur whether or not the treatment is utilized. The term does not include the provision of appropriate nutrition and hydration or the performance of any medical procedure necessary to provide comfort, care, or alleviate pain.
5. "Physician" means an individual licensed to practice medicine in this state pursuant to chapter 43-17.
6. "Qualified patient" means a patient eighteen or more years of age who has executed a declaration and who has been determined by the attending physician and other physician who has personally examined the patient to be in a terminal condition.
7. "Terminal condition" means an incurable or irreversible condition that, without the administration of life-prolonging treatment, will result, in the opinion of the attending physician, in imminent death. The term does not include any form of senility, Alzheimer's disease, mental retardation, mental illness, or chronic mental or physical impairment, including comatose conditions that will not result in imminent death.

Id.

103. *Compare* N.D. CENT. CODE § 23-06.4-02 (Supp. 1989) *with* UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 611-12 (1987).

104. N.D. CENT. CODE § 23-06.4-02 (Supp. 1989). Section 23-06.4-02 also defines the terms "Attending physician," "Health care provider," and "Physician." *Id.* (statutory definitions of these terms comport closely with meanings commonly recognized by the courts, and it is unlikely that the statutory definition of these terms will have any effect on developed case law).

105. N.D. CENT. CODE § 23-06.4-02(2) (Supp. 1989). For the text of Section 23-06.4-02.2. *See supra* note 102.

106. N.D. CENT. CODE § 23-06.4-03(3)(a) and (b)(Supp. 1989). For the text of Section 23-06.4-03. *See infra* notes 144.

107. N.D. CENT. CODE § 23-06.4-03(3)(a) and (b) (Supp. 1989).

individual who puts their preference for the use or withdrawal of life prolonging measures into a writing of their own words could have the declaration declared ineffective.[108]

All forty-one states which have enacted living wills legislation require a written document, although the requirements for a valid declaration vary from state to state.[109] The Uniform Act provides a sample declaration form but states that the declaration "may, but need not," be in the form provided.[110] Thus, although North Dakota has based its act on the Uniform Act, and followed the majority of states in requiring that the declarations be in writing, the legislature may have significantly narrowed the definition of a declaration by requiring that the statutory format be substantially followed.[111]

2. *The Definition of a "Qualified Patient"*

The North Dakota Living Will Act provides that a "qualified patient may make decisions regarding life-prolonging treatment as long as the patient is competent."[112] To be a "qualified patient" in terms defined by the North Dakota Living Will Act, three elements must be met: First, the patient must be at least eighteen years of age; second, the patient must have executed a declaration, or living will; and third, the patient must have been diagnosed as terminally ill by two physicians.[113]

The first and second elements required of a qualified patient are relatively self-explanatory, the first requiring that the individual have reached the age of majority, and the second requiring

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108. *Id.*

109. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS (1987). Each of the states which has enacted a living will statute contains the requirement of an actual physical writing. *Id.* at "Checklist Chart of Living Will Laws" (Supp. 1987). Of these states, three have provisions allowing an oral declaration to be valid under special circumstances. *Id.* Florida's living will law permits oral declarations of a living will only if a declarant is unable to sign and a witness signs for and at the direction of the declaration. FLA. STAT. ANN. § 765.01 (1986). In Louisiana, the living will statute allows an oral or nonverbal declaration to be valid, but the physician must note the declaration in the declarant's medical record, and state the reasons for the giving of an oral, rather than a written declaration. LA. REV. STAT. ANN. § 40.1299.58.3 (West Supp. 1990). Virginia's living will statute allows an oral declaration if made in the presence of two witnesses and a physician, after the diagnosis of a terminal condition. VA. CODE ANN. § 54.1-2983 (1988).

110. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9B U.L.A. 614 (1987). The official comments to section two of the Uniform Act state that the declaration form is not mandatory. *Id.* A detailed declaration form was rejected by the drafters for two reasons. First, the drafters did not want to place an elaborate form in the Uniform Act, out of concern that a more simple form would be considered inadequate; second, the drafters attempted to word the declaration in a simple and concise manner, to provide notice to declarants of exactly what would happen should the living will become effective. *Id.*

111. *See* N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989).

112. N.D. CENT. CODE § 23-06.4-07(1) (Supp. 1989).

113. N.D. CENT. CODE § 23-06.4-02(6) (Supp. 1989).

that the individual have executed a living will substantially following the form set forth in Section 23-06.4-03.[114] The third element required of a qualified patient is that two physicians agree that the patient's illness meets the definition of "terminal condition" set forth in the Living Will Act.[115] Each of these three elements must be present before a person is considered a "qualified patient" such that the statute is applicable to that person.[116]

The North Dakota Living Will Act in section 23-06.4-07(4), removes from the definition of a "qualified patient," any declarant who is pregnant unless it is determined that the medical treatment would be harmful to the declarant or the fetus, or unreasonably painful.[117] One of the major concerns addressed during the drafting of the North Dakota Living Will Act was the effect of an otherwise valid declaration where the declarant later becomes pregnant.[118] The express directive limiting the circumstances where a pregnant declarant may be considered a "qualified patient" allows the continuing development of a fetus, if at all possible and is consistent with the common law rights of innocent third parties.[119] The North Dakota Living Will Act specifically requires that treatment must be provided to a pregnant declarant unless *both* the physician and an obstetrician decide that treatment will not maintain the patient so as to all the further development and birth of the fetus, or be harmful or unreasonably painful to the expectant mother.[120]

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114. *Id.*

115. N.D. CENT. CODE § 23-06.4-02(7) (Supp. 1989).

116. N.D. CENT. CODE § 23-06.4-04 (Supp. 1989). The third element of the definition of a "qualified patient" requires determination by the attending physician and a second physician that the declarant is terminally ill. *Id.* Prior to the living will becoming operative, all three elements of the definition of a "qualified patient" must occur. *Id.*

117. The treatment of the pregnant declarant, as well as the management of the qualified patient is found in Section 23-06.4-07 of the North Dakota Living Will Act.

118. *The Uniform Rights of Terminally Ill Act: Hearings on H.B. 1481 Before House Comm. on Human Ser. and Vet. Affairs*, 51st N.D. Legislative Session (Feb. 3, 1989). Testimony from both the North Dakota Catholic Conference and North Dakota Right-to-Life Committee indicated that support by these groups for the living will bill was contingent on the declaration being invalid during pregnancy. *Id.*

119. *Cf.* Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, __, 201 A.2d 537, 538 (1964). Raleigh is one of the earlier common law right to self-determination decisions which recognize the rights of innocent third persons. *Id.* at __, 201 A.2d at 537-38. In *Anderson*, the defendant, a Jehovah's Witness, was 32 weeks pregnant. *Id.* at __, 201 A.2d at 537. She required blood transfusions and had refused them based on religious beliefs, jeopardizing the life of her infant. *Id.* at __, 201 A.2d at 537-38. The court held that she could not refuse blood transfusions for religious reasons if it was determined that transfusions were necessary to save her life or the life or her child. *Id.* at __, 201 A.2d at 538.

120. N.D. CENT. CODE § 23-06.4-7(04) (Supp. 1989). When death is imminent for a pregnant woman, the physician has an affirmative duty to provide medical treatment to the woman to save a viable fetus. *Id.* Although it is not indicated either in the legislative history of the living will statute or within the statute itself, there is a presumption that a

3. *Definition of "Life-Prolonging Treatment"*

The definition of "life-prolonging treatment" in the North Dakota Living Will Act provides:

> "Life-prolonging treatment" means any medical procedure, treatment, or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying and where, in the judgment of the attending physician, death will occur whether or not the treatment is utilized. The term does not include the provision of appropriate nutrition or hydration or the performance of any medical procedure necessary to provide comfort, care, or alleviate pain.[121]

This definition of life-prolonging treatment is more easily understood when read as two separate parts. The first part of the definition is "any medical procedure, treatment, or intervention."[122] A life-prolonging medical treatment could be interpreted to include anything ordered by a physician, with the exception of nutrition, hydration, or comfort care, which are specifically excluded from the definition.[123]

The provision, withdrawal or removal of medical treatment can only apply to a "qualified patient" as defined in Section 23-06.4-02(6).[124] Further, the medical treatment is considered life-prolonging when it serves to "prolong the process of dying and where . . . death will occur whether or not the treatment is utilized."[125] Although both the Uniform Act and the North Dakota Living Will Act rely on the physician to make the final determination as to when the process of dying is being prolonged by medical treatment, the North Dakota Living Will Act contains the clause "where death will occur whether or not the treatment is utilized" which the Uniform Act does not.[126] North Dakota chose to use this language as an additional limitation on the circumstances

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declaration requesting the use of *life prolonging* procedures is valid during pregnancy. Telephone interview with Rep. Judy DeMers, prime sponsor of House Bill 1481 (March 6, 1990). Only those declarations which request the withdrawal or withholding of life prolonging procedures are invalid.

121. N.D. CENT. CODE § 23-06.4-02(04) (1989).

122. *Id.*

123. *Id.* Nutrition, hydration and comfort care are addressed specifically in section 23-06.4-07 of North Dakota's Living Will Act.

124. For a discussion of section 23-06.4-02, see *supra* notes 102-04 and accompanying text.

125. N.D. CENT. CODE § 23-06.4-02(4) (Supp. 1989).

126. *Compare* N.D. CENT. CODE § 23-06.4-02(04) (Supp. 1989) *with* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1(04), 9B U.L.A. 611 (1987).

where the declaration would be applicable.[127] Thus, the North Dakota Living Will Act does not address the withholding of medical treatment even with the existence of a valid declaration where death is not imminent.[128]

The second part of the North Dakota Living Will Act definition of life-prolonging treatment specifically excludes nutrition, hydration, and relief from pain from the definition of life-prolonging medical procedures.[129] In this regard, the North Dakota Living Will Act again differs from the Uniform Act's definition of life prolonging procedures.[130] The Uniform Act's definition of life-prolonging treatment is silent about whether nutrition or hydration are to be considered life-prolonging.[131] The North Dakota legislature has purposely chosen to exclude nutrition, hydration, and comfort care from the definition of "life prolonging treatment" because of concerns about viewing nutrition, hydration and comfort care as medical treatments.[132] However, nutrition, hydration, and comfort care are specifically addressed in North Dakota's Living Will Act.[133]

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127. *The Uniform Rights of Terminally Ill Act: Hearings on H.B. 1481 Before the House Comm. on Human Serv. and Vet. Affairs*, 51st N.D. Legislative Session (Feb. 3, 1989) (although initially opposed to the living will legislation, both the Catholic Conference and North Dakota Right to Life supported the bill based on the limiting language added to the Uniform Act's definition of "life-sustaining treatment").

128. N.D. CENT. CODE §§ 23-06.4-02, -04 (Supp. 1989).

129. N.D. CENT. CODE § 23-06.4-02(4) (Supp. 1989). Nutrition and hydration were omitted from the definition of medical treatment at the request of the North Dakota Catholic Conference, which has taken a stand *against* classifying nutrition and hydration as medical treatment. Testimony by Representative Judy DeMers, prime sponsor of North Dakota's living will. By request of the Catholic Conference, both nutrition and hydration as extraordinary measures are addressed in Section 23-06.4-07 of North Dakota's Living Will Act. *Id.*

130. *Compare Uniform Rights of the Terminally Ill Act* § 1(04), 9B U.L.A. 611 (1987) *with* N.D. CENT. CODE § 23-06.4-02 (Supp. 1989).

131. The question of whether nutrition and hydration are to be considered medical treatment has been debated in both the legal and medical arenas over the last twenty years, prompting the American Medical Association to define its position in a formal statement. Statement of the Council on Ethical and Judicial Affairs, American Medical Association, March 15, 1986. The American Medical Association expressed concern with a growing uneasiness of physicians regarding the withholding of nutrition and hydration to terminally ill patients. *Id.* The statement defines nutrition and hydration as life prolonging treatment, and ask physicians dealing with terminally ill patients to weigh the benefits of nutrition and hydration against the burdens to the patient. *Id.* The *Cruzan* Court does not differentiate artificially administered nutrition and hydration from other forms of medical treatment. *See generally* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841 (1990). Justice O'Connor states that "artificial feeding cannot be readily distinguished from other forms of medical treatment." *Id.* at 2857 (O'Connor J., concurring).

132. *The Uniform Rights of Terminally Ill Act: Hearings on H.B. 1481 Before the House Comm. on Human Serv. and Vet. Affairs*, 51st N.D. Legislative Session (Feb. 3, 1989) (the North Dakota Catholic Conference indicated that its support was dependent upon nutrition and hydration being excluded from the definition of "medical treatment").

133. N.D. CENT. CODE § 23-06.4-07(3) (Supp. 1989).

4. *The Definition of "Terminal Condition"*

As with the definition of "life-prolonging treatment," the definition of "terminal condition" is more easily understood when read in separate parts.[134] The first part of the definition is an affirmative statement that a terminal condition is "an incurable or irreversible condition that, without the administration of life-prolonging treatment, will result . . . in imminent death."[135] Thus, "terminal condition," as defined in the North Dakota Living Will Act, is limited to circumstances in which a patient's condition is incurable or irreversible, and when death is imminent.[136] Conversely, a medical condition which is not incurable or irreversible, or when death is not imminent, is not a "terminal condition" as defined by the North Dakota Living Will Act.[137]

The second part of the definition of "terminal condition" excepts the illnesses or conditions which may be incurable or irreversible, but for which death is not clearly imminent.[138] This wording is consistent with the intent of the North Dakota Legisla-

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134. N.D. CENT. CODE § 23-06.4-02(1) (Supp. 1989). For the text of section 23-06.4-02. *See supra* note 102.

135. *Id.*

136. *See* N.D. CENT. CODE § 23-06.4-07(3) (Supp. 1989). The official comments from the Uniform Act, which is the basis for North Dakota's Living Will Act offer some indication of the difficulty in attempting to limit the definition of "terminal condition." The official comment to section one of the Uniform Act states:

> The difficulty of trying to express such a [terminal] condition in precise, accurate, but not unduly restricting language is obvious. A definition must preserve the physicians' professional discretion in making such determinations. Consequently, the Act's definition of terminal condition incorporates not only selected language from various state acts, but also suggestions from medical literature in the field. . . . A number of states' statutes now use "incurable" and/or "irreversible," and the terms appear to comport with the criteria applied by physicians in terminal care situations. The phrase "incurable *or* irreversible" is to be read conjunctively when the circumstances warrant. A condition which is reversible but incurable is *not* a terminal condition.

UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1, 9B U.L.A. 612-13 comment (1987). While the comments of the drafters of the Uniform Act are not necessarily indicative of the intent of the North Dakota Legislature, absent legislative history to the contrary, they are at least some evidence of the intent of the North Dakota Legislature. *Cf.* Farmers Union Cent. Exch. v. Reliance Ins. Co., 675 F. Supp. 1534, 1537 (D.N.D. 1987).

137. *See* N.D. CENT. CODE § 23-06.4-02(7) (Supp. 1989). Although North Dakota has not provided a statutory definition of imminent death, other courts have tried to define this concept. *See* State Dept. of Human Serv. v. Northern, 563 S.W.2d 197 (Tenn. Ct. App. 1978). The Tennessee Court of Appeals found that death was imminent if death would occur sometime during a patient's hospital stay, though not necessarily immediately. *Id.* at 205, 209. *See also* 73 Op. Att'y Gen. 7 (Md. 1988)(citing Hazelton v. Powhatan Nursing Home, Inc., 6 Va. Cir. 414 (Cir. Ct. Fairfax Cty. 1986)). In *Hazelton*, a Virginia trial court suggested that the term "imminent" death might be applicable to a person within a few months of death, as opposed to a person with only a few hours to live. *Id.*

138. N.D. CENT. CODE § 23-06.4-02(7) (Supp. 1989). The definition of terminal condition in North Dakota's Living Will Act specifically excepts "any form of senility, Alzheimer's disease, mental retardation, mental illness, or chronic mental or physical impairment, including comatose conditions" which are incurable or irreversible but not terminal. *Id.*

ture to exclude those conditions that are neither curable nor reversible, but are not considered terminal conditions.[139]

There are a number of decisions which have allowed life-prolonging treatment to be discontinued where the individual was in an irreversible, persistive vegetative state but death was not imminent.[140] However, such decisions could not be based on the North Dakota Living Will Act because the definition of "terminal condition" specifically limits the scope of the Act to individuals who are very near death, with or without life-prolonging procedures.[141]

C. DECLARATIONS RELATING TO THE USE OF LIFE-PROLONGING PROCEDURES

North Dakota's Living Will Act sets forth the elements which must be present in order for a person to have the capacity to execute a living will.[142] These elements include that the declarant: 1)

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139. *The Uniform Rights of the Terminally Ill Act: Hearings on H.B. 1481 Before the Sen. Comm. on Human Serv. and Vet. Affairs*, 51st N.D. Legislative Session (March 3, 1989)(statement of Rep. Judy DeMers, primary sponsor of H.B. 1481). Rep. DeMers testified that the intent of the North Dakota Living Will Act is to clearly exclude certain conditions from the definition of terminal condition. *Id.* The conditions which are excluded include illnesses which are incurable or irreversible, but where death is not imminent. *Id.* Specifically, this would exclude individuals diagnosed with Alzheimer's disease or other similar incurable diseases, unless the disease had progressed to the point where death was imminent. *Id.*

In this regard, it is important to note that the stated legislative intent of the North Dakota Living Will is to allow the natural process of dying to occur. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989). Any affirmative or deliberate acts intended to hasten the process of dying are not allowed or condoned by the North Dakota Act. *Id.* Death must, therefore, be imminent before the provisions of North Dakota's living will may apply.

140. *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* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987), rehearing Dec. 11, 1987; Brophy v. New England Sinai Hosp., Inc. 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Colyer, 99 Wash.2d 114, 660 P.2d 738 (1983); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S. 266 (1981); Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); John F. Kennedy Mem. Hosp. v. Bludworth, 452 So.2d 921 (Fla. 1984); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987).

141. *See* N.D. CENT. CODE § 23-06.4-02(7) (Supp. 1989). In 1987 the Burleigh County court decided *In re Bayer*. *In re* Bayer, No. 4131 (N.D. Burleigh County Ct., Feb. 5, 1987), rehearing Dec. 11, 1987. Mrs. Bayer was in an irreversible, incurable persistent vegetative state, but her death was not imminent as long as she received artificial nutrition and hydration. *Id.* at 3-4. In *Bayer*, the court determined that the applicable common law doctrines allowed the Court to grant an order to remove artificial means of nutrition and hydration. *Id.* at 19-20. The scope of the North Dakota Living Will Act may have precluded a similar holding based on the Act. *See* N.D. CENT. CODE § 23-06.4-02(4) (1989). However, the court may have been able to reach its conclusion if it found section 23-06.4-07(03) of the Act applicable. *See* N.D. CENT. CODE § 23-06.4-07(03)(1989). Section 23-06.4-07(03) of the Living Will Act allows a physician to withhold nutrition and hydration where it cannot be physically assimilated or is unreasonably painful or burdensome to the patient. *Id.* Although the statute has not yet been tested, this section of the living will might have provided a means for the *Bayer* court to allow nutrition and hydration to be withheld from Mrs. Bayer.

142. N.D. CENT. CODE § 23-06.4-03 (Supp. 1989). Section 23-06.4-03(1), titled Declarations relating to use of life-prolonging treatment, provides:

1. An individual of sound mind and eighteen or more years of age may execute

be of sound mind; 2) be over the age of eighteen; and 3) sign the declaration or have another sign it at the declarant's direction and in the presence of two valid witnesses.[143] Additionally, the North Dakota Living Will Act sets forth the specific forms a valid living will declaration must take, and provides that these forms must be substantially followed if the declaration is to be valid.[144]

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at any time a declaration governing the use, withholding, or withdrawal of life-prolonging treatment. The declaration must be signed by the declarant, or another at the declarant's direction, and witnessed by two individuals who are not:

a. Related by blood or marriage;
b. Entitled to any portion of the estate of the declarant under any will of the declarant or codicil to will existing by operation of law or otherwise, at the time of the declaration;
c. Claimants against any portion of the estate of the declarant at the time of the execution of the declaration;
d. Directly financially responsible for the declarant's medical care;
e. Attending physicians of the declarant.

Id.

143. *See id.*

144. N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989). Section 23-06.4-03(3) states:

A declaration must be substantially in the form set forth in subdivision a or b, as applicable, but the declaration may include additional specific directives. The invalidity of any additional specific directives does not affect the validity of the declaration.

a. A declaration to withdraw or withhold life-prolonging treatment must be substantially in the following form:

Declaration made this __ day of _____ (month, year).

I, _____, being at least eighteen years of age and of sound mind, willfully and voluntarily make known my desire that my life must not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should have an incurable condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-prolonging treatment would serve only to artificially prolong the process of my dying and my attending physician determines that my death is imminent whether or not life-prolonging treatment is utilized, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of such life-prolonging treatment, it is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of that refusal, which is death.
3. If I have been diagnosed as pregnant and the diagnosis is known to my physician, this declaration is not effective during the course of my pregnancy.
4. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.
5. I understand that I may revoke this declaration at any time.

Signed _____

City, County and State of Residence _____

The declarant has been personally known to me and I believe the declarant to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate upon the declarant's death. I am not the declarant's attending physician, a person who has a claim against any portion of the declarant's estate upon the declarant's death, or a person directly financially responsible for the declarant's medical care.

Witness _____
Witness _____

b. A declaration to direct the use of life-prolonging treatment must be substantially in the following form:

If the declarant resides in a long term care facility, the Act requires that one of the witnesses be an ombudsman.[145] This requirement that one witness to the declaration be an ombudsman reflects a growing awareness of the vulnerability of aged persons in nursing homes.[146] This awareness is also reflected in the growing body of common law decisions addressing right to die issues.[147]

Declaration made this ___ day of _____ (month, year). I, _____, being at least eighteen years of age and of sound mind, willfully and voluntarily make known my desire to extend my desire to extend my life under the circumstances set forth below, and do hereby declare:

1. If at any time I should have an incurable condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, I direct the use of life-prolonging treatment that could extend my life.
2. In the absence of my ability to give directions regarding the use of such life-prolonging treatment, it is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to direct medical and surgical treatment and accept the consequences of that directive.
3. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.
4. I understand that I may revoke this declaration at any time.

Signed _____

City, County and State of Residence _____

The declarant has been personally known to me and I believe the declarant to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate upon the declarant's death. I am not the declarant's attending physician, a person who has a claim against any portion of the declarant's estate upon the declarant's death, or a person directly financially responsible for the declarant's medical care.

4. A physician or other health care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, promptly so advise the declarant.

Id.

145. N.D. CENT. CODE § 23-06.4-03(2) (Supp. 1989). Section 23-06.4-03(2) provides:

> If the declarant is a resident of a long-term care facility, as defined in section 50-10.1-01, at the time the declaration is executed, one of the two witnesses to the declaration must be a regional long-term care ombudsman as provided in section 50-10.1-02.

Id. N.D. CENT. CODE § 50-10.1-02 (Supp. 1989). Section 50-10.1-02 defines the resident of a long-term care facility, as a "person residing in and receiving personal care from a long-term care facility." *Id.* Pursuant to the statute, the long term care Ombudsman is responsible for investigating and monitoring complaints about administrative actions that affect long-term care residents, monitoring federal, state and local laws that affect long-term care residents, providing information to the public about the problems of long-term care residents, training volunteers to assist in the ombudsman programs, and act as advocate for long-term care residents. *Id.*

146. *See* N.D. CENT. CODE § 50-10.1 (1989) (requiring the establishment of an ombudsman to monitor long term care facilities on behalf of the elderly).

147. *See In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1239 (1985). Two years after *Conroy*, the New Jersey Supreme Court decided *In re* Peter, 108 N.J. 364, 529 A.2d 419 (1987). In *Peter*, one Mr. Johanning petitioned the court to seek appointment as Hilda Peter's guardian. *Id.* at __, 529 A.2d at 422. Hilda had been in a persistent vegetative state for one year being sustained by a nasogastric tube. *Id.* Discussing the purposes of the Ombudsman, the court stated that:

> "The Ombudsman for the Institutionalized Elderly is involved in this case . . . to guard against abuse of elderly nursing home patients. Because of the particularly vulnerable nature of elderly incompetent patients in nursing homes, the Ombudsman must scrutinize all decisions to withhold or withdraw life-sustaining medical treatment from them."

D. THE FORM OF THE DECLARATION

Although the North Dakota Living Will Act requires the declaration to substantially follow the form set out in Section 23-06.4-03(3), additional specific directives may also be included.[148] Thus, although North Dakota's Living Will Act requires a specific form be used, the statute also allows for additions or personalization of the declaration by the declarant.[149]

Of the forty-one states that have drafted and passed "living will" legislation prior to North Dakota's Act, all but two states, California and Oregon, allow residents to "personalize" their living will declaration.[150] In some states, this includes naming a proxy or attorney-in-fact who is authorized to act on behalf of, or in place of the declarant.[151] This authorization is consistent with the common-law doctrines of "substituted judgment" and "informed consent."[152] Although North Dakota's Living Will Act does not specifically authorize the naming of a proxy or an attorney-in-fact within the statute, naming a proxy or attorney-in-fact may be an acceptable way to personalize a declaration.[153]

E. SUBSTITUTED JUDGMENT, INFORMED CONSENT, AND NORTH DAKOTA'S LIVING WILL

North Dakota's living will allows additional specific directives to be included in the declaration form.[154] Whether it is possible to write an effective living will naming a substitute decision maker as an additional safeguard for the right to informed consent about a

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Id. at __, 529 A.2d at 423 (footnote and citation omitted).

148. *Compare* N.D. CENT. CODE § 23-06.4-03 (Supp. 1989) *with* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9B U.L.A. 614 (1987) (Uniform Act states that the statutory declaration form *may* be followed. North Dakota chose to provide a statutory form which *must* be substantially followed, but does allow additional specific directives).

149. N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989).

150. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 9 (1987 ed.). Thirty-seven out of thirty-nine state statutes in existence prior to the enactment of North Dakota's Act allowed a provision for personalizing the living will declaration, and presumably this could include naming a proxy, agent or attorney-in-fact. *Id.* at "Checklist Chart of Living Will Laws" (Supp. 1987).

151. *Id.* at 9-10. Thirteen states specifically allow the naming of a proxy within the declaration. These include Arkansas, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Louisiana, Texas, Utah, Virginia, and Wyoming. *Id.* at 9. In addition to these states, California and Rhode Island have a separate durable power of attorney statute for medical decisions which effectively allow the holder of the power to make medical decisions in the event of the principal's incapacity. *Id.* at 9-10.

152. For a further discussion of the doctrines of substituted judgment and informed consent, *see supra* notes 41-79 and accompanying text.

153. *See* N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989) (allowing additional specific directives to be included in a declaration). For the relevant text of section 23-06.4-03, *see supra* notes 142, 144, and 145.

154. N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989). For the relevant text of section 23-06.4-03(3), *see supra* note 144.

specific medical procedure is an unanswered question at the present time.[155]

With regard to the right of a substituted decision maker to make medical decisions regarding life prolonging treatment, a developing precedent is being established through cases such as *In re Quinlan*,[156] *In re Conroy*,[157] *In re Jobes*,[158] and North Dakota's own *In re Bayer*.[159] These cases stand for a developing precedent that an individual in an incurable, irreversible persistent vegetative state has certain protected privacy rights to refuse life-prolonging treatment through a substitute decision maker, whether or not death is imminent.[160] In addition to the previously noted cases, the United States Supreme Court's *Cruzan* decision and the Florida District Court of Appeals' *Corbett* decision have recently impacted the rights of surrogates in making medical treatment decisions for an individual who is not competent.[161] In *Cruzan*, the Supreme Court held that it is not unconstitutional for a state to require "clear and convincing evidence" of the wishes of an incompetent person prior to withdrawing life-sustaining treatment from that person.[162] In 1986, the Florida District Court of Appeals decided the right of a substituted decision maker to make a determination about life prolonging treatment under Florida's Living Will Act.[163] In *Corbett*, the court addressed Florida's living will statute which specifically excluded nutrition and hydration

155. *Id.* Section 23-06.4-03(3) of North Dakota's Living Will Act states that "the declaration may include additional specific directives," but does not specifically authorize the appointment of substitute decision makers. *Id.*

156. 70 N.J. 10, 355 A.2d 647 (1976).

157. 98 N.J. 321, 486 A.2d 1209 (1985).

158. 108 N.J. 394, 529 A.2d 434 (1987).

159. No. 4131, (N.D. Burleigh County Ct. Feb. 5, 1987).

160. *See, e.g., In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976)(allowing substituted decision maker to decide the identity of treating physicians and to confer with those physicians in treatment decisions); *In re* Conroy, 98 N.J. 321, 486 A.2d. 1209 (1985) (surrogate decision makers may request withdrawal of life-prolonging procedures); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987)(surrogate decision makers may refuse life-prolonging procedures for a patient in a persistive vegetative state); *In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987) rehearing Dec. 11, 1987) (guardian's authorization to request removal of artificial feeding for wife in irreversible vegetative state affirmed at rehearing after physician refused to comply with initial order).

161. *See generally* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841 (1990); Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986), *rev. denied* 492 So. 2d 1331 (Fla. 1986).

162. *Cruzan*, 110 S.Ct. at 2854. At the time of this writing, the *Cruzan* decision is less than a year old, and the scope of its impact has not yet been determined. It could be argued, however, that in deciding right-to-withhold-treatment decisions for incompetent persons, courts will require more than the "best interests" analysis. For a further discussion of surrogate decision making using a "best interests" analysis, *see supra* notes 69-73 and accompanying text.

163. Corbett v. D'Alessandro, 487 So.2d 368 (Fla. Dist. Ct. App. 1986), *rev. denied* 492 So.2d 1331 (Fla. 1986).

from the list of life prolonging treatments that could be refused.[164] Even with this restriction on the scope of the statute, the *Corbett* court upheld a surrogate decision maker's right to order the removal of a nasogastric tube.[165] The *Corbett* court found that the constitutional right to privacy provided an independent basis for withdrawing the nasogastric tube, and that the living will statute did not intend to limit existing common law and statutory rights.[166]

F. THE COMPETENCY OF THE DECLARANT AND WITNESSES TO THE DECLARATION

To make a valid declaration under North Dakota's Living Will Act, the declarant must attest to an understanding of the declaration, and have the emotional and mental competence with which to make this declaration.[167] The declarant must sign the declaration or have it signed at her request.[168] The signature must be witnessed by at least two people.[169] The purpose of these witnesses is to assure "that the declarant is mentally sound, of sufficient maturity, and is not acting under duress or fraud at the time of execution."[170] Witnesses to the declaration must not be related to the declarant either by blood or marriage, or be entitled to any portion of the declarant's estate upon the declarant's death.[171] Additionally, the declarant's physician, or anyone financially responsible for the declarant's medical care may not be a valid witness.[172] The North Dakota Living Will Act expands the witnessing requirements found in the Uniform Act, yet provides no mecha-

164. *Id.* at 370. The *Corbett* court recognized that the Florida living will statute provided an alternative means "whereby certain enumerated persons, together with the attending physician, may act on behalf of an incompetent patient who has not made a declaration in accordance with [the living will statute] when the express or implied intent of the patient can be established." *Id. But see* Cruzan v. Director, Mo. Dept. of Health 110 S.Ct. 2841 (1990) (U.S. Supreme Court upheld Missouri Supreme Court decision requiring clear and convincing evidence of an incompetent's wishes prior to the withdrawal of life-prolonging treatment).

165. *Corbett*, 487 So.2d at 370.

166. *Id.*

167. N.D. CENT. CODE § 23-06.4-03 (Supp. 1989). The need for the declarant to attest to an understanding of the living will and the need for the mental and emotional competence to make a declaration is consistent with the common law doctrine of informed consent. For discussion of the requirements of the doctrine of informed consent, *see supra* notes 41-79.

168. N.D. CENT. CODE § 23-06.4-03(1) (Supp. 1989). For the relevant text of Section 23-06.4-03(1), *see supra* note 142.

169. *Id.*

170. Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis*, 1 ISSUES IN LAW AND MED. 441, 453 (1986).

171. N.D. CENT. CODE § 23-06.4-03(1) (Supp. 1989). For the complete text of this section, *see supra* note 142.

172. *Id.*

nism to assure that those expanded requirements are met.[173]

The purpose of the witness requirements is to add validity to the declaration by having the witnesses certify that they believe the declarant is of sound mind.[174] However, like the Uniform Act, the North Dakota Living Will Act contains no provision for determining the competency of the declarant at the time of declaration.[175] It is reasonable to assume that "many declarations will be executed at or shortly after the time a patient has been diagnosed" as terminally ill.[176] This is a time when the declarant may be in considerable emotional or psychological turmoil, physical pain, and in a diminished mental capacity.[177] The legal sufficiency of a living will could be in jeopardy if the competency of the declarant is not determined accurately at the time the living will is signed.[178]

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173. *Compare* N.D. CENT. CODE § 23-06.4-03(1) (Supp. 1989) *with* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9B U.L.A. 614 (1987). The Uniform Act does not require witnesses to meet specific qualifications. *Id.* The comment to section two of the Uniform Act notes that in the interest of simplicity the witnessing procedure should be as uncomplicated as possible. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9B U.L.A. 614 comment (1987). In addition, the Uniform Act notes that the absence of a complicated witness requirement relieves physicians of the very difficult burden of determining whether the legalities of the witness requirements have been met. *Id.* Unlike the Uniform Act, North Dakota's living will requires witnesses to meet statutory requirements.

174. *See* N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989). The North Dakota Living Will Act provides statutory requirements for witnesses to verify the declarant's signature and intent. *Id.* However, the living will contains no mechanism to assure that witnesses meet the statutory witness requirements. *See id.* Without a mechanism to assure that the witnesses meet the statutory requirements, the effect of the additional requirements could be lessened because a doctor or court who has to determine whether a declaration is valid may have no means to determine whether the declaration was validly witnessed.

175. The absence in the Uniform Act of a method of determining the competency of the declarant has been critized. *See* Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis*, 1 ISSUES IN LAW AND MED. 441, 454 (1986). Marzen notes that the Uniform Act, upon which the North Dakota Living Will Act is based, provides little assurance that the declarant is competent as:

> . . .a lay witness might well believe that even a minor or mentally ill person "voluntarily" signed a declaration, and there is no duty at all imposed upon the witnesses to verify the majority, much less mental status of the declarant.
>
> [The] [u]tter failure of the Act to provide a mechanism to assure the competent mental status of the declarant at the time of execution is particularly troubling.

Id. The drafters of the North Dakota Living Will Act apparently attempted to resolve this difficulty by providing that witnesses meet additional requirements. *See* N.D. CENT. CODE § 23-06.4-03 (Supp. 1989). However, without a mechanism for enforcement of these additional requirements the legislature may have failed in this attempt.

176. Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis*, 1 ISSUES IN LAW AND MED. 441, 454 (1986).

177. *Id.*

178. *Id.* The existence of a validly executed living will does not obligate the physician to use, withhold or withdraw life prolonging procedures. *See* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989). This provision could allow a physician to refrain from acknowledging a declaration where it is reasonable to believe that the declaration was made by a minor, someone who lacked the capacity to make the declaration, or under conditions of duress. *See id.*

G. WHEN DOES THE LIVING WILL BECOME OPERATIVE?

North Dakota Century Code section 23-06.4-04 sets forth the prerequisites for the North Dakota Living Will Act to become operative.[179] One requirement for the declaration to be operative is that the declaration must be communicated to the attending physician.[180] The physician must then place the declaration in the individual's medical records.[181] The North Dakota Living Will Act does not, however specify the method in which the declaration must be communicated to the attending physician.[182] The absence of a specific method of communicating with the physician may create confusion and additional stress for both families and health care providers at an otherwise stressful time.[183] Whether the physician must actually see the declaration, or whether notice of the declaration may be communicated through other means are questions left unanswered by the statute.[184]

Once the declaration is communicated to the attending physician and placed in the medical record of the individual, both the attending physician and a second physician must determine that the declarant is in a terminal condition and unable to make deci-

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179. *See* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989). Section 23-06.4-04 provides:

> A declaration becomes operative when it is communicated to the attending physician, and the declarant is determined by the attending physician and another physician to be in a terminal condition and no longer able to make decisions regarding administration of life-prolonging treatment. A declaration made under section 23-06.4-03 does not obligate the physician to use, withhold, or withdraw life-prolonging treatment but is presumptive evidence of the declarant's desires concerning the use, withholding, or withdrawal of such treatment and must be given great weight by the physician in determining the intent of the incompetent declarant.

Id.

180. *Id.*

181. *See* N.D. CENT. CODE § 23-06.4-06 (Supp. 1989) (requiring the attending physician who knows of a declaration of a terminally ill patient to record the declaration in the patient's medical records).

182. *See* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989) (requiring the declaration to be communicated to the attending physician for the declaration to be operative).

183. *Cf.* Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis*, 1 ISSUES IN LAW AND MED. 441, 454 (1986). Marzen notes that many declarations will be considered, and perhaps executed immediately following a terminal diagnosis. *Id.* This is often a time of confusion and turmoil for both the patient and family. *Id.* Thus, clear channels of communication are especially important at this time, and a lack of clarity in the Uniform Act about how the physician should be informed could jeopardize the exercise of the declaration.

184. *Id.* at 457. In communicating the existence of a living will declaration to the physician, Marzen notes that under the wording of the Uniform Act, "a telephone call by a mere acquaintance representing that such a document exists would seem to be sufficient." *Id.* The North Dakota Living Will Act, like the Uniform Act, does not specify the manner in which the declaration must be communicated to the physician. *Compare* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989) *with* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 3, 9B U.L.A. 615 (1987).

sions for herself.[185] When this has been done, the declaration becomes operative.[186]

When a declaration becomes operative, the North Dakota Living Will Act does not *require* the physician to initiate or withhold life-prolonging measures pursuant to the statute.[187] The operative declaration is to be considered by the physician as "presumptive evidence of the declarant's desires concerning the use, withholding, or withdrawal of such treatment."[188] If, however, the attending physician is unwilling to comply with the declaration, the statute requires the physician to transfer the patient as quickly as possible to a physician who is willing to comply with the declaration.[189]

Although North Dakota's Living Will Act does not provide any affirmative guidance for physicians who believe that a declaration was made under conditions that would invalidate the operation of the living will,[190] the Act does, however, allow the physician the freedom to exercise professional judgment.[191] Thus, under the North Dakota Living Will Act, the physician could refrain from action even after existence of the living will is communicated to the physician if there is reason to believe that the declarant was a minor or lacking in the mental capacity to make a

185. *See* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989).

186. *See id.*

187. N.D. CENT. CODE § 23-06.4-04 (Supp. 1989). For the relevant text of section 23-06.4-04, *see supra* note 179.

188. *Id.*

189. N.D. CENT. CODE § 23-06.4-08 (Supp. 1989). Section 23-06.4-08 may acknowledge the differing moral and ethical principles which exist between physicians and allow a physician to graciously exit a situation which is contrary to his or her personal ethical obligations toward a patient. Following the December 11, 1987 decision authorizing the discontinuance of artificial nutrition and hydration, Mrs. Ione Bayer's physician reported to Mrs. Bayer's family that he had spent three sleepless nights, unable to reconcile his personal beliefs as an individual with the court order. Telephone interview with Ruth Sharp, Mrs. Bayer's daughter (May 11, 1990). Consequently, Mrs. Bayer continued to be fed artificially until the family could locate a physician who would agree to treat her in compliance with the court order. *Id.*

190. *Cf.* Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis* 1 ISSUES IN LAW AND MED. 441, 457 (1986). Marzen notes that the problem of a physician who believes that a declaration was not validly executed is not addressed in the Uniform Act, stating:

> [W]hat if the attending physician has reasonable cause to believe that the declarant was a minor, was mentally unsound, or had acted under duress, fraud, or undue influence at the time the declaration was executed? . . . There is no exception in the Act that permits the physician to simply disregard these obligations [to honor the declaration or transfer the patient] even in the face of known evidence of irregularities at the time of execution.

Id. at 453, 457. The North Dakota Living Will Act, like the Uniform Act, fails to address this problem. *Compare* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989) *with* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 3, 9B U.L.A. 615 (1987).

191. *See* N.D. CENT. CODE § 23-06.4-04 (Supp. 1989). For the relevant text of section 23-06.4-04, *see supra* note 179.

valid declaration.[192]

The essential purpose of North Dakota's Living Will Act is to provide the right to control decisions relating to one's own medical care, specifically where life-prolonging treatment is considered.[193] It seems inconsistent with the intent of the Act to provide that the physician is not obligated to either provide, withhold or withdraw life-prolonging procedures when a facially valid declaration is present.[194] Allowing physicians discretion to enforce the terms of a declaration may require them to become the ultimate authority as to whether life-prolonging treatment will be provided, withheld, or withdrawn.[195]

A physician with questions about the validity of a declaration may enlist the assistance, advice, or counsel of family members.[196] The doctrine of substituted judgment, discussed in the majority of right to die cases, states that the physician, informed family, and loved ones who have the ability to make decisions for an individual who is incompetent.[197] Substituted judgment could be an additional safeguard employed by a physician where the intent or circumstances surrounding the drafting of a declaration is questioned.

H. REVOCATION OF A DECLARATION UNDER THE NORTH DAKOTA LIVING WILL ACT

The North Dakota Living Will Act provides that a declaration can be revoked at any time and in any manner if the declarant is competent.[198] The statute states that "revocation in any manner" includes: 1) a dated writing, signed by the declarant; or 2) a physical cancellation or destruction by the declarant, or by another by request and in the presence of the declarant or 3) the declarant

192. *See id.* A valid operative declaration under the North Dakota Living Will Act does not require a physician to follow the directives in a living will, but is merely "presumptive evidence of the declarant's desires concerning" medical treatment. *Id.*

193. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989).

194. *Id. See* Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis*, 1 ISSUES IN LAW AND MED. 441, 444 (1986) (noting that allowing a physician discretion to render a valid declaration inoperative is inconsistent with an intent to allow an individual the right to control his or her own medical treatment).

195. *Id.*

196. Under the doctrine of substituted judgment, family members or others may have the right to make medical decisions for an incompetent patient. *See e.g., In re* Quinlan, 70 N.J. 10, __, 355 A.2d 647, __ (1976). For a complete discussion of the doctrine of substituted judgment, *see supra* notes 46-68 and accompanying text.

197. For a further discussion of substituted judgment, *see supra* notes 46-68 and accompanying text.

198. N.D. CENT. CODE § 23-06.4-05 (Supp. 1989).

may express an intent to revoke orally.[199]

Given the stress and emotion involved in a situation where an individual is afflicted with a serious or terminal illness, it is not unlikely that a declarant will experience periodic wavering in his or her decision to have life prolonging procedures either provided, withheld, or withdrawn.[200] The intent behind living will statutes is to provide the means by which the right of self determination may be exercised where death is imminent.[201] Periodic vacillation or a waiver of decision must be distinguished from a sincere oral expression of the intent to revoke as provided in the statute.[202] Given this distinction, it follows that the declaration of an individual who later waivers in the desire to abide by the declaration may not automatically be voided because of temporary or fleeting wavering.[203]

The revocation of a living will becomes operative when that revocation is communicated to the physician or other health care provider by the declarant or a witness to the revocation.[204] If the health care provider is someone other than the physician, (for example, a charge nurse) the health care provider may have an

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199. *Id.* Section 23-06.4-05 provides:

1. A declaration may be revoked at any time and in any manner by the declarant, provided the declarant is competent, including by:
   a. A signed dated writing;
   b. Physical cancellation or destruction of the declaration by the declarant or another in the declarant's presence and at the declarant's direction; or
   c. An oral expression of intent to revoke.
2. A revocation is effective upon communication to the attending physician or other health care provider by the declarant or a witness to the revocation.
3. The attending physician or other health care provider shall make the revocation a part of the declarant's medical record.

Id.

200. *See* Bartling v. Glendale Adventist Med. Center, 163 Cal.App.3d 186, 209 Cal. Rptr. 220 (Cal.Ct.App. 1984). Mr. Bartling petitioned the court to have his ventilator disconnected. *Id.* 189, 209 Cal. Rptr. at 221. Mr. Bartling was aware that approval of his request to disconnect his respirator would result in his death. *Id.* 191, 209 Cal. Rptr. at 222. From time to time, Mr. Bartling had occasionally wavered in his desire to be free of the respirator. *Id.* 192, 209 Cal. Rptr. at 223. In addressing the periodic wavering, the *Bartling* court stated: "The fact that Mr. Bartling periodically wavered from this posture because of severe depression or for any other reason does not justify the conclusion . . . that his capacity to make such a decision was impaired. . . ." *Id.* 193, 209 Cal. Rptr. at 223-224.

201. *See* N.D. CENT. CODE § 23-06.4-01 (Supp. 1989) (stating the intent of the North Dakota Living Will Act is to provide individuals the means to control their own medical decisions in the face of terminal illness).

202. *Cf.*, Lane v. Candura, 6 Mass. App. Ct. 377, __, 376 N.E.2d 1232, 1236 (1978) (a terminally ill patient who vacillates in the decision to refuse medical treatment where death is inevitable does not justify the conclusion that the patient lacks the capacity to make medical decisions).

203. *Id. See also*, Bartling v. Glendale Adventist Med. Center, 163 Cal.App.3d 186, 209 Cal. Rptr. 220, 223-224 (Cal. Ct. App. 1984) (periodic wavering from the decision to seek removal of a life sustaining respirator does not indicate the lack of capacity to make medical decisions).

204. N.D. CENT. CODE § 23-06.4-05(2) (Supp. 1989).

implied duty to inform the physician of the revocation if informed first.[205] As stated earlier, the Act requires either the physician or the health care provider to make the revocation a part of the declarant's medical record.[206] During a medical emergency (such as a cardiac arrest) where the patient's medical record may not be consulted immediately or readily available, a reciprocal duty of the health care provider and the physician to disclose the existence of a revocation could be an important safeguard.[207] The duty to disclose the existence of a declaration would arise from the fact that under emergency situations, the physician or health care provider with knowledge of the revocation may be the only one to ensure that the revocation is honored. This duty is consistent with the purposes of North Dakota's Living Will Act, which is to provide a vehicle for an individual's informed consent to be expressed and followed regardless of competency.[208]

I. COMFORT CARE AND PAIN RELIEF

Life-prolonging treatment notwithstanding, North Dakota's Living Will Act does not alter the responsibility of physicians and health care providers to ease the pain and suffering of the dying patient.[209] Recent cases addressing the right to die have recognized that prevailing medical practice does not require that all efforts be made to prolong the life of an individual.[210] It has long been recognized that the dying are more often in need of comfort than of treatment.[211] Unfortunately, the line between comfort

205. *Id.* Because North Dakota Living Will Act declaration is only operative where death is imminent, an argument can be made that an implied duty to inform the physician of the revocation exists. *See* N.D. CENT. CODE § 23-06.4-02(7) (Supp. 1987). If death is imminent, time could be of the essence and steps to ensure that the revocation is communicated to the physician would be crucial.

206. N.D. CENT. CODE § 23-06.4-05(3) (Supp. 1989). Once a declarant revokes a living will, the physician or health care provider must make it a part of the patient's medical record. *Id.* In an emergency situation, if the physician is familiar with the patient's medical history and condition, the medical record may be unavailable or not be consulted immediately. A valid revocation to a living will could under those circumstances go unnoticed by the physician. *Id.*

207. *Cf. id.*

208. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989).

209. N.D. CENT. CODE § 23-06.4-07 (Supp. 1989). Section 23-06.4-07 provides: "This chapter does not affect the responsibility of the attending physician or other health care provider to provide treatment for a patient's comfort care or alleviation of pain." *Id.*

210. *See In re* Quinlan, 70 N.J. 10, __, 355 A.2d 647, 667, (1976).

211. Satz v. Perlmutter, 362 So.2d 160, 163 (Fla. Dist. Ct. App. 1978). In *Satz*, the court addressed the distinction between providing treatment and providing comfort noting:

> Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of

care and treatment is not always clearly drawn. In an effort to clarify the distinction between comfort care and treatment, the North Dakota Living Will Act specifically excludes comfort care provided to ease the process of dying from the definition of "life prolonging treatment."[212]

J. NUTRITION AND HYDRATION

North Dakota's Living Will Act does not affect the responsibility of the physician to provide nutrition or hydration except where it cannot be physically assimilated, or is physically harmful.[213] Based on testimony from the North Dakota Catholic Conference, nutrition and hydration are not considered medical treatment.[214] In this respect, North Dakota's Living Will Act directly conflicts with the prevailing attitude among physicians that life prolonging medical treatment does include nutrition and hydration.[215] North

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> the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same.

Id.

212. *The Uniform Rights of the Terminally Ill Act: Hearings on H.B. 1481 before Sen. Comm. on Human Serv. and Vet. Affairs*, 51st N.D. Legislative Session (March 3, 1989)(statement of Judy DeMers, prime sponsor of House Bill 1481). The North Dakota Living Will Act was amended prior to its approval by the legislature to clarify the difference between treatment which was life-prolonging and treatment that was comfort care provided to an individual very close to death. *Id.* To distinguish the life-prolonging treatment from the care provided to an individual whose death is imminent, nutrition, hydration and comfort care were separated from the definition of life-prolonging procedures. *Id.* Thus, under the North Dakota Living Will Act as enacted, nutrition, hydration and comfort care are clearly not life prolonging treatment. *See* N.D. CENT. CODE § 23-06.4-02(04) (Supp. 1989).

213. N.D. CENT. CODE § 23-06.4-07 (Supp. 1989). Section 23-06.4-07 provides in part:

> This chapter does not affect the responsibility of the attending physician or other health care provider to provide nutrition and hydration. Nutrition and hydration may be withheld from a patient with a terminal condition if the nutrition and hydration could not be physically assimilated by the patient or would be physically harmful or unreasonably painful to the patient.

Id.

214. *Id.* The legislative history of Section 23-06.4 indicates that the provision regarding nutrition and hydration was added as an accommodation to the North Dakota Catholic Conference which indicated that it would not oppose the Act if nutrition and hydration were removed from the definition of "medical treatment." *The Uniform Rights of the Terminally Ill Act: Hearings on H.B 1481 before the Sen. Comm. on Human Serv. and Vet. Affairs*, 51st N.D. Legislative Session (March 3, 1989) (testimony by Sr. Paula Ringuette, North Dakota Catholic Conference).

215. Statement of the Council on Ethical and Judicial Affairs, American Medical Association, March 15, 1986. The Statement of the Council provides, in part:

> Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, *nutrition or hydration*. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained. (Emphasis added).

Id.

Dakota's Living Will Act does, however, reflect the fact that it "is hard to shed the emotional symbolism of food."[216] Respecting the "emotional symbolism" of the food in dealing with right to die issues, the common-law has attempted to draw the distinction between nutrition and hydration given as "ordinary care" as distinguished from nutrition and hydration given as "extraordinary care."[217] Although no definitive test exists to differentiate "ordinary" from "extraordinary" care, it can be said that the individual's total circumstances must be considered,[218] and evaluated in light of available life prolonging technology.[219] Additionally, aside from the differences in whether nutrition and hydration is ordinary care or extraordinary care, it must be noted that there are circumstances where nutrition and hydration are actually harmful to a terminally ill patient.[220] Nasogastric tubes, a very common form of artificial feeding, may cause the incompetent patient

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216. *In re* Conroy, 98 N.J. 321, __, 486 A.2d 1209, 1236 (1985)(quoting Barber v. Superior Ct., 147 Cal.App. 3d 1006, 1-16, 195 Cal. Rptr. 484, 490 (1983)).

> Once one enters the realm of complex, high technology medical care, it is hard to shed the "emotional symbolism" of food. However, artificial feedings . . . are medical procedures with inherent risks and possible side effects, instituted by skilled healthcare providers to compensate for impaired physical functioning.

Id. (citation omitted).

217. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, __, 497 N.E.2d 626, 637 (1986). In assessing whether plaintiff Paul Brophy could have his artificial feeding tube removed, the *Brophy* court looked at the distinction between ordinary and extraordinary care. *Id.* In this regard the court noted that Mr. Brophy had received more than seven hours of nursing care per day, he had no ability to care for himself in any way, and he had been maintained by a nasogastric tube, which provided his nutrition and hydration. *Id.* The court recognized that maintenance on a nasogastric tube might be considered ordinary for a specific, defined period of time, but reasoned that "to state that the maintenance of nutrition and hydration by the use of the existing . . . tube is only ordinary is to ignore the total circumstances of Brophy's situation . . . to be maintained by such artificial means over an extended period of time is not only intrusive, it is extraordinary." *Id.*

218. *Id.*

219. *Id.* In addition to the question of whether a coma is reversible, it must be acknowledged that the advent of new life-prolonging techniques might change what is today considered an extraordinary measure, into one that is ordinary. *Id.* at __, 497 N.E.2d at 637.

220. Telephone interview with Ruth Sharp, Mrs. Ione Bayer's daughter (May 11, 1990) (after the cuffed tracheostomy was inserted, Mrs. Bayer had continuous sores in and around her mouth from being force fed several times a day). *In re* Conroy, 98 N.J. 321, 372-374, __, 486 A.2d 1209, 1236 (1985) (quoting *In re* Caulk, 480 A.2d 93, 99 (N.H. 1984) (Douglas, J. dissenting)).

> Furthermore, while nasogastric feeding and other medical procedures to ensure nutrition and hydration are usually well tolerated, they are not free from risks or burdens; they have complications that are sometimes serious and distressing to the patient.

Id. In re Conroy, 486 A.2d at 1236 (quoting Lo and Dornband *Sounding Board, Guiding the Hand That Feeds: Caring For The Demented Elderly*, 311 NEW ENG. J. MED. 402, 403(1984)).

> Nasogastric tubes may lead to pneumonia, cause irritation and discomfort, and require arm restraints for an incompetent patient.

Id.

greater discomfort than the inability to ingest food.[221] Thus, while issue of nutrition and hydration for the individual whose death is imminent is an emotional one, it can neither be assumed that nutrition will always be beneficial to a patient whose death is imminent, nor always harmful when withheld.[222]

K. IMMUNITIES

The North Dakota Living Will Act provides that any person who acts pursuant to the requirements of the living will chapter is immune from criminal, civil, and disciplinary action.[223] The scope of immunity from liability is limited to non-grossly negligent acts.[224] The North Dakota Living Will Act addresses liability in section 23-06.4-11.[225] Subsection (1) of section 23-06.4-11 states that death occurring under this Act is neither homicide or suicide.[226] Similarly, the common law recognizes that a physician has "no duty to continue treatment once it has been proved to be ineffective."[227] In some circumstances, after a specified length of time, physicians consider the chances of recovery by an incompe-

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221. *Id.*

222. *Id.* at 1236 (citing Lynn and Childress *Must Patients Always Be Given Food And Water* 13 HASTINGS CENTER REP. 17, 19-20 (1983); Paris & Fletcher, *Infant Doe Regulations and The Absolute Requirement To Use Nourishment and Fluids for the Dying Infant*, 11 LAW, MED. AND HEALTH CARE 210, 211-13 (1983). Dehydration may not be painful or uncomfortable for a dying patient. *Id.* Where patients have lost the ability to sense hunger or thirst, withholding of food which must be artificially forced upon the individual may be no more painful than the termination of any other medical treatment. *Id. See generally* The Right to Forego Medical Treatments, What Are the Legal Limits? 73 Op.Att'y Gen. 18 (Md. 1988) at —, n.22.

223. N.D. CENT. CODE § 23-06.4-09 (Supp. 1989).

224. *Id.*

225. N.D. CENT. CODE § 23-06.4-11 (Supp. 1989). Section 23-06.4-11 contains several miscellaneous provisions regarding the North Dakota Living Will Act. *Id.*

> Subsection (1) of section 23-06.4-11 provides:
> 1. Death resulting from the withholding or withdrawal of life-prolonging treatment pursuant to a declaration and in accordance with this chapter does not constitute, for any purpose, a suicide or homicide.

Id.

226. N.D. CENT. CODE § 23-06.4-11(1) (Supp. 1989). Subsection 1 which provides that death resulting from removal of life prolonging treatment is not homicide or suicide is in accord with the common law. *See, e.g.*, Bartling v. Superior Ct., 163 Cal.App.3d 186, 209 Cal. Rptr 220, 226 (Cal.Ct.App. 1984). The *Conroy* court noted:

> Declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.

In re Conroy, 98 N.J. 321, —, 486 A.2d 1209, 1224 (1985).

227. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 491 (Cal. Ct. App. 1983). The *Barber* court, addressing a physicians duty to continue medical treatment noted:

> A physician has no duty to continue treatment once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in

tent individual to be very doubtful.[228] Section 23-06.4-11 of North Dakota's Living Will Act which provides for immunity, gives healthcare providers statutory protection to carry out a living will declaration without fear of liability.[229]

L. THE VALIDITY OF DECLARATIONS MADE IN ANOTHER STATE OR DECLARATIONS EXECUTED BEFORE JULY 10, 1989

Section 23-06.4-13 of the North Dakota Living Will Act provides that a declaration executed in another state by a resident of that state in compliance with the law of that state is validly executed for the purposes of the North Dakota Act.[230] Courts have recognized the need to accept declarations from residents of other states, even if the state itself has not yet passed "living will" legislation.[231] A declaration from an out-of-state citizen can be considered as best evidence of their intentions regarding life-prolonging medical treatment, and be recognized without time-consuming and expensive court proceedings.[232]

The North Dakota Living Will Act additionally recognizes living will declarations executed prior to July 10, 1989.[233] The

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the immediate aftermath of (a heart attack), there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.

Id.

228. *See In re* Bayer, No. 4131 (N.D. Burleigh County Ct.) December 11, 1987 at 7.

229. N.D. CENT. CODE § 23-06.4-11 (Supp. 1989).

230. N.D. CENT. CODE § 23-06.4-13 (Supp. 1989).

231. *See* Saunders v. State, 129 Misc. 2d 45, 492 N.Y.S.2d 510, 512 (Sup.Ct. 1985). In *Saunders*, Thelma Saunders executed a living will while living in Pennsylvania. *Id.* She became ill after moving to New York. *Id.* Although New York did not have living will legislation at the time, the Court recognized her living will as an "Informed Medical Consent Statement," and the best evidence of her decisions regarding life-prolonging treatment. *Id.* at 516.

232. *Id* at 516. The court in *Saunders* recognized that

> The living will . . . authorizing the refusal or discontinuance of further medical treatment in petitioner's case by artificial means and devices . . . the petitioner's wishes are entitled to be fulfilled without need for additional . . . time-consuming and traumatic court proceedings. . . .

Id.

233. N.D. CENT. CODE § 23-06.4-14 (Supp. 1989). Section 23-06.4-14 provides:

> An instrument executed before July 10, 1989, which basically complies with the intent of subsection 1 of section 23-06.4-03, must be given effect pursuant to this chapter. A previously executed instrument that purports to comply with the intent of this chapter is valid for five years from July 19, 1989, unless the declarant becomes incompetent within five years after the execution of the declaration and remains incompetent at the time of the determination of a terminal condition under section 23-6.4-04, in which case the declaration continues in effect. When the declaration expires, a new declaration must be executed if the declarant wishes to make a written declaration under this chapter.

Id.

requirements for recognition include compliance with the intent of North Dakota's Living Will Act.[234] The recognized declaration executed prior to the effective date will remain effective for a five year period beginning July 10, 1989, unless the declarant becomes and remains incompetent and terminally ill during that five year period.[235] When a living will declaration executed prior to July 10, 1989 expires, a new one must be executed if the declarant wishes to retain a living will.[236] Section 23-06.4-14 is the only section of North Dakota's living will requiring a re-execution after a specific period of time has passed.[237] Anyone who has executed a recognized living will prior to July 10, 1989 might alleviate the possibility of missing the five year deadline by simply re-executing a new declaration as soon as possible using the statutory format of North Dakota's living will.[238]

IV. CONCLUSION

The "right to die," the history of "living wills" and living will statutes are still in the infancy stages of development. 1976 was a hallmark year for the right to die issue, marked by the seminal *Quinlan* decision,[239] which was a major step in the right to die movement, and the passage of the first state "living will" statute.[240] Since those early years, nearly all of the states have recognized the need for living will legislation, in an effort to encourage citizens to exercise their right and responsibility to control decisions relating to medical care.[241]

As stated earlier, the scope of the North Dakota Living Will Act is narrow: applicable only in those cases where the patient is

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234. *Id.*

235. *Id.*

236. *Id.*

237. *The Uniform Rights of Terminally Ill Act: Hearings on H.B. 1481 Before the Sen. Comm. on Human Serv. and Vet. Affairs*, 51st N.D. Legislative Session (March 3, 1989) (statement by Sr. Paula Ringuette). The North Dakota Catholic Conference asked the legislature to include a provision in the living will statute requiring re-execution of a declaration every five years, unless the declarant would become incompetent prior to the five year period. *Id.* This request was considered by the Senate committee, but limited to declarations executed prior to July 10, 1989. *Id.* Determining the date of a declarant's incompetence could be difficult, and a blanket five year re-execution requirement might invalidate a declaration on a procedural technicality. *Id.*

238. *See* N.D. CENT. CODE § 23-06.4-14 (Supp. 1989).

239. *See In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

240. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS (1987 ed.). California was the first state to pass "living will" legislation in 1976. Arkansas, Nevada, North Carolina, New Mexico, Oregon, and Texas passed legislation the following year. *Id.* at "Checklist Chart of Living Will Laws" (Supp. 1987).

241. *See, e.g.*, N.D. CENT. CODE § 23-06.4-01 (Supp. 1989) (intent behind North Dakota's living will is to allow adults to control decisions relating to their medical care).

diagnosed with a terminal illness and death is imminent.[242] Consistent with the precedent set forth in *Cruzan*, North Dakota's Living Will Act is but one method for providing "clear and convincing evidence" of a patient's desire for withdrawal of life-sustaining procedures.[243] Additional ways to provide clear and convincing evidence of one's wishes upon incapacity could include naming a surrogate decision maker in the Living Will declaration itself, through appointment of a proxy, or by executing a durable power of attorney to be exercised in conjunction with the living will.[244] These kinds of additions could safeguard the constitutional rights to privacy and liberty and common law rights of self determination not protected by the Living Will Act itself.[245] Additionally, as the legislative intent of the North Dakota Living Will Act recognizes the right of competent adults to control decisions relating to medical care and encourages communication between an individual, the family and health care providers,[246] it would seem that the stated intent of the North Dakota Living Will Act, at least implicitly, would favor the ability of a declarant to name a surrogate decision maker under the Act.[247]

This Note began with a discussion of *In re Bayer*, the first right to die case in North Dakota.[248] Whether a validly executed living will would have enabled Ione Bayer to forego unwanted life prolonging treatment is an unanswered question at this time. However, a valid living will could have provided her physician with "clear and convincing evidence" of her feelings against being kept alive in a persistent vegetative state.[249] The evidence of Mrs. Bayer's wishes in the form of a valid living will may have allowed

242. See N.D. CENT. CODE § 23-06.4-03 (Supp. 1989).

243. *See* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841 (1990).

244. For a further discussion of surrogate decisionmaking, *see supra* notes 46-79 and accompanying text.

245. *Cf.* Corbett v. D'Alessandro, 487 So.2d 368, 372 (Fla. Dist. Ct. App. 1986), *rev. denied* 492 So.2d 1331 (1986) (noting that the Florida living will did not preclude common law rights).

246. N.D. CENT. CODE § 23-06.4-01 (Supp. 1989).

247. *See* N.D. CENT. CODE § 30.1-30 (Supp. 1989) (in addition to the required statutory format, North Dakota Living Will Act allows for additional specific directives). Under North Dakota's Durable Power of Attorney Act, it is possible to execute a durable power of attorney for medical decisions. It could be argued that the durable power of attorney could be incorporated into the living will declaration, and take the form of a specific directive. *Cf.* N.D. CENT. CODE § 23-06.4-03(3) (Supp. 1989). The living will statutes of several other states allow for the appointment of a proxy decision maker. For a complete list of those states, *see supra* note 150.

248. *See In re* Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 1987).

249. Saunders v. State, 129 Misc.2d 45, 492 N.Y.S.2d 510, 512 (Sup. Ct. 1985). The *Saunders* court noted the Amicus Curiae brief filed by the Society for the Right to Die on behalf of Thelma Saunders. *Id.* The Society "urged the court to find that a Living Will . . . is clear and convincing evidence of a patient's wishes, which may be acted upon when the patient is incompetent and without hope of recovery." *Id.*

her physician to work *with* her family, to abide by those wishes.[250]

The North Dakota Living Will Act is a first step for the North Dakota legislature in dealing with the right to refuse medical treatment — an issue which courts such as the *Bayer* court, have acknowledged and requested legislative direction with.[251] Compared to some other states, the North Dakota Living Will Act is a relatively conservative act; nutrition and hydration and comfort care are excluded from the definition of "life-prolonging treatment,"[252] the declarations of pregnant individuals are invalid during their pregnancy with the exception of very limited circumstances,[253] and the attending physician is neither obligated to follow the declaration,[254] nor required to take any action "contrary to reasonable medical standards."[255]

The cases that involve "living wills" are very few in number, and generally concern the interplay between the constitutional and common law rights to self determination, and the restrictions on those rights as defined by a living will statute.[256] The majority of the amendments to the living will statutes in states which have enacted such laws are not a result of changes in the common law, but a result of advances in medicine, and rapid changes in attitudes about the rights of the terminally ill to refuse or prolong treatment which will artificially prolong their life.[257]

North Dakota's Living Will Act has only been effective since July 19, 1989. Questions about its validity, its effectiveness, and the extent of its usage will likely remain unanswered for some time. At this point, however, the Living Will Act is a first step in recognizing the right of an individual to have a voice in medical

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250. For a discussion of the doctrine of substituted judgment, and a doctrine of informed consent, *see supra* notes 41-79 and accompanying text.

251. *See also* Cruzan v. Director, Mo. Dept. of Health, 110 S.Ct. 2841, 2859 (1990)(Scalia, J., concurring):

> I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field (right to die cases) . . . (and) it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish (to refuse appropriate measures necessary to preserve one's life) will be honored.

Id.

252. N.D. CENT. CODE § 23-06.4-02.4 (Supp. 1989).

253. N.D. CENT. CODE § 23-06.4-07.4 (Supp. 1989).

254. N.D. CENT. CODE § 23-06.4-04 (Supp. 1989).

255. N.D. CENT. CODE § 23-06.4-11.6 (Supp. 1989).

256. *See* Corbett v. D'Alessandro, 487 So.2d. 368, 372 (Fla. Ct. App. 1986) (a state living will statute must be read cumulatively with existing law, and cannot impair or restrict the constitutional right to refuse treatment).

257. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS (1987) at 6.

treatment decisions until the moment of death, and the statutory mechanism to assert that right.

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