



COMMENTS

*George P Smith II**

RE-THINKING EUTHANASIA AND DEATH WITH DIGNITY: A TRANSNATIONAL CHALLENGE

I

While positive euthanasia (or mercy killing) and assisted suicide for the elderly could well be recognised as the benchmark of the right of all — and especially the elderly — to control both their living and their dying, it has been cautioned that an endorsement of a special need for euthanasia for the old and infirm would be a dangerous way of legitimising the view that old age is but a special time of lost hopes, empty futures and personal pointlessness or, in other words, but a ‘tyranny of survival!’

Cautionary pronouncements of this nature miss — totally — the whole point of autonomy or self-determination in planning and executing one’s whole living experience — of which death is the ultimate reality. Fears of opening the ‘flood-gates’ or promoting a free-for-all on the ‘slippery slopes’ are an inherent caveat whenever articulation of a ‘new’ right is sought or a ‘new’ idea or ideal is postured. Fear, then, is the omnipresent watchword.

A strong, more realistic approach would be to accept the suggestion that all of us are not only bound, biologically, to die, but also — from a moral standpoint — have a *duty* to do so. The biological obligation is inarguable — for there simply can be no life without death and, obviously, no biological purpose is served ‘by insisting on staying at the table when the meal is finished’. It is certainly proper not to want to die. Yet, to take the desire to live and seek to translate it into both a science and a technological

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1 D Callahan, *Setting Limits: Medical Goals in an Aging Society*, 193-197 (1987 Simon and Schuster, New York).

feat that repudiates death as an inherent moral part of life is surely a grotesque perversion.²

II

In May 1986, the results of a Morgan Opinion Poll of Victorians regarding death found seventy-four percent of those surveyed in the state held to the view that if one is terminally ill or injured, has no chance of recovery and requests a lethal injection or other assistance in order to end life, that assistance should be given.³ And, interestingly, in a report covered in *The Age* in June, 1986, it was disclosed that seventy-three per cent of Victorians maintain that the government should act in a positive manner by legislating for a personal right to die.⁴ Thus, the rather amazing statistic emerges that three out of every four Victorians support active voluntary euthanasia.⁵ Similarly a June 1990 poll conducted by USA Today newspaper of seven hundred and twenty-four adults in America, found two-thirds of the poll were of the opinion that terminally ill individuals should be allowed to conclude their lives and — further — medical facilities should be available to assist them.⁶

On April 30 1987, the Social Development Committee in Victoria released the findings of its inquiry into 'Options for Dying with Dignity' and concluded that while the common law right to refuse medical treatment should be clarified and protected, the government should *not* legislate for active, voluntary euthanasia.⁷ While the Committee recognised the right to die with dignity should be limited to cases of passive euthanasia, it failed to address or explain why one should not be able to request active help in dying. Perhaps the most obvious argument or position against active voluntary euthanasia here could be that if a 'right to die' were understood as entailing active assistance in dying, then this would result in others — and specifically physicians or nurses — having a duty imposed upon them to kill.

As Dr Helga Kuhse of Monash University has observed:

'If a seriously ill patient requests active help in dying and if a doctor provides it, this doctor may show more compassion and respect for the patient as a person than the doctor who merely discontinues life support. This is not a travesty of a doctor's commitment to patient care; on the contrary, it can be its highest expression.'⁸

Responsive to the attitudes of the citizens of the state, on October 14 1987, the Victorian government introduced into parliament 'death with dignity' legislation which seeks to give clearer and enforceable statutory effect to the right of an individual to refuse medical treatment even if this conscious abstention hastens death. The legislative proposal would strengthen the right of people to refuse medical treatment to prolong their

2 Morris, 'Life is a Right, Death is a Duty', *The Age*, Oct 8, 1987, at p 11.

3 Kuhse, 'Death and Dignity', *The Age*, June 4, 1987. See generally, Sharma, 'Euthanasia in Australasia', 2 *J Contemp Health L & Pol'y* 181 (1986); Rieger, 'Euthanasia in The Netherlands: Distinguishing Facts from Fiction', Hastings Centre Rpt 31 (Jan, Feb 1989).

4 *Ibid.*

5 *Ibid.*

6 Haj, 'Poll: Suicide Option Up to Terminally Ill', *USA Today*, June 8-10, 1990 at 1, col 1.

7 *Ibid.*

8 *Ibid.*

lives artificially if they are terminally ill or have suffered severe and irreversible injury. It will also allow healthy people to make statements that they do not consent to their lives being prolonged artificially in such circumstances. These statements would have a legal force similar to that of wills and would apply when a gravely ill person is no longer able to express consent.⁹

A point of controversy for the Australian Medical Association is the guarantee in the legislation that if an individual's wishes are frustrated in this regard, the physicians and attendants may well be guilty of the new offence of 'medical trespass'.¹⁰ Other provisions provide for safeguards to ensure that refusal of consent is voluntary, informed and executed by a mentally competent person.¹¹ Surely, recognising and then structuring a right to die with dignity by refusing life-sustaining treatment has but an exceedingly limited value unless it can be enforced. As the Editor of *The Age* put it:

'Doctors should also realise that the legislation would protect them in circumstances where they might otherwise face even more serious criminal charges by agreeing to withhold treatment. The potential danger of doctors 'undertreating' patients for fear of prosecution is much less real than the present risk of costly over-treatment to prolong a life painfully or distressingly approaching its inevitable end.'¹²

Advance statements authorising doctors to withhold treatment of the terminally ill are not new in Australia; for in 1983, the South Australian Parliament enacted a Natural Death Act which enables the terminally ill to direct that no extraordinary measures be undertaken to prolong their lives.¹³

A recent survey of British general practitioners found thirty-five percent of those contacted would practice active voluntary euthanasia *if* it were legal — with ten percent saying they *might* do so!¹⁴ Justice Michael Kirby has called for greater honesty in dealing with this painful topic and has observed that there is a striking contrast between public standards and private action in this area of concern.¹⁵

If one wished to commit suicide in Australia, all that is required is a mere eighty-three cents to purchase a copy of the 'barefoot doctor's' procedure for voluntary euthanasia contained in the Annual Report of the Voluntary Euthanasia Society of Scotland now available throughout the Continent. Scottish law allows the Edinburgh based society to distribute to its members advice on methods of suicide that is otherwise an offence south of the English-Scottish border!¹⁶ The publication and distribution of such material may well be an offence in Australia where all States and Territories provide significant penalties for those *convicted* of aiding, abetting or counselling persons attempting suicide!¹⁷

9 Editorial Opinion, 'The Right to Die with Dignity', *The Age*, Oct 14, 1987.

10 Ibid.

11 Ibid.

12 Ibid.

13 Ward, 'New Life in the Death-with-Dignity Debate', *The Australian*, Oct 14, 1987.

14 Kuhse, *supra* n 3.

15 Kirby, 'Dilemma of Death', *The Age*, May 12, 1987.

16 Ward, *supra* n 13.

17 Ibid.

On February 8 1984, Judge John H. Hews of the Superior Court of California for Riverside County determined that a twenty-six year old competent woman disabled with cerebral palsy, with no functional use of her limbs except for some limited use of one hand, was not entitled to starve herself in a hospital.¹⁸ While recognizing Elizabeth Bouvia's competency, sincerity and rationality, the fact that she was not terminal and could live anywhere from fifteen to twenty years was of controlling significance. This fact had to be balanced against her right of privacy together with the feelings of other members of society who would be offended by her act of self determination. Particular recognition was given to the physicians, nurses and other patients at the Riverside General Hospital where Ms Bouvia was confined, as well as other physically handicapped persons throughout the nation. The Judge acknowledged that, 'She does have the right to terminate her existence but not while she is non-terminal with the assistance of society'.¹⁹

Two years later, on February 21 1986, Judge Warren Deering of the Los Angeles County Superior Court ruled that Ms Bouvia's efforts to obtain an injunction to prohibit the High Desert Hospital, a county facility where she was then a patient, from maintaining a nasogastric tube through her nostril for the purposes of increasing her nutritional intake were improper.²⁰ In denying Ms Bouvia's petition, the Court ruled that the hospital's determination of the need for the use of the nasogastric tube was made in the exercise of reasonable medical judgment to avoid the plaintiff being placed in a life-threatening situation.²¹

On appeal to the California Court of Appeal, the Court held that Ms Bouvia had a fundamental right to refuse medical treatment and force-feeding.²² Stating that if it were found that Ms Bouvia's condition was 'irreversible', there being no cure for her palsy or arthritis and that she faced fifteen to twenty years of painful existence made endurable only with the constant administration of morphine, the court concluded that to maintain her as she was presently in the hospital would abridge her right to privacy, remove her freedom of choice and invade her right to self determination.²³

The Bouvia Court of Appeal likened its judicial task of decision making with the case of *Bartling v Superior Court of California* which was factually similar in that it involved the central issues of whether a patient could ever refuse life continuing treatment.²⁴ There it was determined that the lower trial court was incorrect in its conclusion that so long as there was some potential for restoring Mr Bartling to a 'cognitive, sapient life', it was improper to allow him to refuse a proper course of medical treatment. The lower court held, specifically, that the right to have life-support equipment

18 *Bouvia v County of Riverside, et al*, trial transcript reprinted in 1 *Issues in Law & Med* 485 (1986).

19 *Ibid* 491. See Annas, 'When Suicide Prevention Becomes Brutality: The Case of Elizabeth Bouvia', *Hastings Centre Rpt* 20 April (1984).

20 *Bouvia v High Desert Hospital et al*, trial transcript reprinted in 1 *Issues in Law & Med* 493 (1986).

21 *Ibid* 193.

22 *Bouvia v High Desert Hospital et al*. Slip Opinion.

23 *Ibid*. See generally, Brown & Thompson, 'Nontreatment of Fever in Extended Care Facilities', 300 *New Eng J Med* 1246 (May 31, 1979).

24 163 *Cal App 3d* 186 (1984).

disconnected was limited to comatose, terminally ill patients or representatives acting on their behalf.²⁵

In rendering its reversal of the lower Bartling Court *after* Mr Bartling died, the Court of Appeal for the Second District held that a competent adult with a serious illness (here emphysema, chronic respiratory failure, arteriosclerosis, an abdominal aneurysm, a malignant tumor of the lung, suffering from alcoholism and chronic/acute anxiety depression) had the right to order the hospital to withdraw life supports. This action was warranted even though the patient, Mr Bartling, was not diagnosed as terminal, but was regarded as 'probably incurable' but with a possible potential to live a year *if* weaned from the respirator.²⁶ With its holding, the *Bartling Court* has aligned itself with the sophisticated majority of courts that uphold a patient's right to refuse medical treatment even at the risk to that patient's health or very life.²⁷

The real tragedy of the *Bartling case* is that it was forced upon the courts for ultimate decision making. Mr Bartling had done everything conceivable to establish legal structures designed to assure the maintenance of his right of self determination. He had executed a living will and a separate declaration that he did not want artificial life supports. He had executed a durable power of attorney in his wife directing the withdrawal of artificial supports and a release was given by the Bartling family to the Glendale Adventist Hospital and its physicians from civil *liability*. The hospital argued the case had to be presented to a court of law because it was not only unethical for it to disconnect life supports but that it was subject to criminal prosecution for murder if it acted according to Mr Bartling's wishes and those of his family.²⁸ Regarding the issue of criminal liability for their actions, the court stated that based on the authority of *Barber v Superior Court of California*²⁹ and the Florida case of *Staz v Perlmutter*,³⁰ a hospital no longer should have concerns for its actions when such were based on similar circumstances and directions as those set out in *Barber* and *Bartling*.

On June 25 1989, the United States Supreme Court held in the case of *Cruzan v Director of the Missouri Department of Health*, that it was proper for the state of Missouri to apply a clear and convincing standard of evidentiary proof in determining the extent of an incompetent patient's right (here, a thirty-two-year-old woman named Nancy Cruzan) — exercised through her parental guardians — to discontinue nutrition and hydration when 'living' in a persistent vegetative state.³¹ Ms Cruzan has, since a 1983 automobile collision, been surviving in a coma and provided artificially with food and water. She is capable of living, with artificial assistance, for some thirty or more years and the state of Missouri is paying presently

25 Ibid 193.

26 Ibid.

27 See *Schloendorff v Soc of NY Hosp*, 211 NY 125, 105 NE 92, (1914); *Matter of Spring*, 405 NE 2d 115 (Mass 1980); *Lane v Candura*, 376 NE 2d 1232 (Mass App 1978); *Matter of Quackenbush*, 383 A 2d 785 (NJ Morris County Ct 1978); *Matter of Conroy*, 486 A 2d 1209 (NJ 1985); *Satz v Perlmutter*, 362 So 2d 160, 379 So 2d 359 (1980); *In re Osborne* 295 A 2d 372 (DC 1972); *Supt of Belchertown State School v Saikewicz*, 370 NE 2d 417 (Mass 1977).

28 Supra n 24.

29 147 Cal App 3d 1006 (1983).

30 379 So 2d 359 (Fla 1980).

31 58 *USL Week* 4916 (June 25, 1990).

\$130,000.00 a month to maintain her tragic existence. Perhaps the only option open presently for Ms Cruzan's guardians to effect her death with dignity is to move her to another state where the right to refuse food and water, as medical treatment, is recognized.³²

The practical effect of this 'sad' and 'devastating' decision by the Supreme Court is that it may prompt very ill people to consider suicide before they lose physical and mental control of their faculties. A salutary effect of the decision, however, on the ninety-five percent of those Americans who do not have living wills will be to force them to deal with the eventuality of their own death and to think through very carefully the manner in which they wish to die under controlled medical conditions.³³ Hopefully, such thoughtful re-evaluations will in turn prompt more citizens to execute living wills and, when appropriate, durable powers of attorney authorising surrogate decision makers to implement final life-threatening medical decisions for them.

IV

There is an inherent paradox within any analysis of death control. For by attempting blindly to preserve the mere quantity of one's life, we may in fact degrade the very quality of life, dying and final death. But, in appropriate cases, by allowing one to die (or indirectly hastening death by use of a pain killer that has the perhaps undesired although expected effect of hastening death), we may augment the quality of life, dying, and death — though we admittedly sacrifice some *measure* of quantitative living.³⁴

The controlling principles for decision making in health issues should be the 'best interest' principle. Stated otherwise, the physician should always endeavour to both protect and maximise the patient's best interest.³⁵ Inextricably related to this principle is an economic evaluation of the costs (economic, social, psychological) versus the benefits of pursuing or not pursuing a modality of treatment when major medical treatment is mandated or a response to a catastrophic or terminal illness must be made.³⁶ This consideration obviously expands the focus of interest to include the patient's immediate family or, in other words, those responsible for maintaining the rehabilitative process; it would also admit of a societal interest regarding the effective utilization of scarce or limited medical resources to competing patient needs. Here, I of course, refer to the doctrine of *triage*.³⁷

Sadly, all too often, in issues of death management and control, the 'best interests' principle is no longer considered efficacious.³⁸ Supported by professional associations fearful of incurring blanket criminal liability for

32 Okie, 'Medical Groups Criticise Court Interfering in Life-or-Death Designs', *Wash Post*, June 26, 1990, at A8, col 1.

33 *Ibid*.

34 M Shapiro, R Spece, Jr, *Cases Materials and Problems on Bioethics and Law* 574 (1981 West Pub Co, St Paul).

35 Statement of the World Medical Assembly, 140 *Med J Aust* 431 (Oct 1983); President's Commission for The Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment* 88-89, 97, 134-136 (1983).

36 Pellegrino, 'Rationing Health Care: The Ethics of Medical Gatekeeping', 2 *J Contemp Health L & Pol'y* 23 (1986); Smith, 'Triage: Endgame Realities', 1 *J Contemp Health L & Pol'y* 143 (1985).

37 Smith, *supra*.

38 Kuhse, 'Euthanasia - Again' 142 *Med J Aust* 610 (May 27, 1985). See Sharma, *supra* n 3.

their members as a consequence of outdated and unresponsive laws prohibiting euthanasia and uncompromisingly defining murder, physicians often follow procedures *not* in the best interests of their patients.³⁹ Added to this professional inhibition and indeed miring it are obtuse philosophical, jurisprudential and ethical rambling regarding the differences between ordinary and extraordinary means of sustaining life, intention and foreseeability of medical acts and distinctions between acts and omissions or between killing and letting die. Reasonable actions tied to basic degrees of common sense are either obfuscated by these concerns or totally precluded from use.

Dr Helga Kuhse of the Centre for Human Bioethics at Monash University in Melbourne, an eloquent spokesperson and often lone dissenter to the lock-step ideology of traditionalism, has cited a glaring example of a case where letting die (or passive euthanasia) runs counter to the best interests of a patient.

'A woman is dying of terminal cancer of the throat. She is no longer able to take food and fluids by mouth and is suffering considerable distress. She would be able to live for a few more weeks if medical feeding by way of a nasogastric tube were continued. However, the woman does not want the extra two or three weeks of life because life has become a burden which she no longer wishes to bear. She asks the doctor to help her die. The doctor agrees to discontinue medical feeding, removes the nasogastric tube, and the woman dies a few days later.'⁴⁰

Obviously, here, a painless, noble or dignified (to that degree possible) *death* was in the patient's best interest. Yet, the *method* of bringing it about was not. The patient could have died less painfully (and, indeed, mercifully) had she been given a lethal injection.⁴¹

Another poignant example of a terminally ill individual who was refused the right to order doctors to cease a prolongation of his life is to be found in the case of John McEwan — a former Australian water-ski champion trapped, tragically, in an inert body. A diving accident in 1985 on Australia Day left him a quadriplegic. In July of that year, he decided that he could no longer endure and executed a document which he gave to his solicitor acknowledging that if he were to become comatic, he should not be revived. Subsequently, McEwan went on a hunger strike in Melbourne's Austin Hospital and was promptly certified by the attending physicians as insane. Not until he agreed to end his fast, take antidepressant drugs and accept counselling was the certification revoked. Ten painful months later McEwan died at home.⁴²

39 Ibid.

40 Kuhse, *supra* n 38 at 611. See generally, Smith 'Recognising Personhood and The Right to Die with Dignity', 6 *J Palliative Care* 24 (1990).

41 Ibid. Janet Adkins, a fifty-four year old victim of Alzheimer's disease, committed suicide with the help of a retired Detroit-area physician who attached her to a machine (dubbed a suicide machine) that released intravenous solutions containing lethal drugs that allowed her to kill herself in an unusual case in America of medically assisted suicide. Galdwell & Booth, 'Doctor Helps Woman Commit Suicide', *Wash Post*, June 6, 1990, at A3, col 1.

42 Ward, *supra* n 13.

V

On March 15 1987, the Council on Ethical and Judicial Affairs of the American Medical Association articulated a new policy whereby a physician can ethically withdraw 'all means of life prolonging medical treatment' including food and water, from a patient in an irreversible coma. This policy goes far beyond previous AMA determinations in two major respects: 1) it specifically mentions nutrition and hydration — food and water — as a form of artificial life support and furthermore, 2) it applies not only to terminally ill patients but to those in an irreversible coma, as well.⁴³ Although nothing in the policy actually encourages physicians to withhold food and water, the Chairman of the AMA Council acknowledged that, 'there are times, even outside terminal illness when physicians can ethically withdraw life-supporting measures, including food and water'.⁴⁴ Although some critics suggest that withdrawing nutritional support from a dying or comatose patient is dangerously close to murder, the AMA statement declares that 'the physician should not intentionally cause death'.⁴⁵

The President of the American Association of Neurological Surgeons has observed that withdrawing extraordinary technological support from patients who have no hope of regaining consciousness can be the most humane course of treatment to follow. He continued by stating that, 'After a while — maybe weeks or months of seeing the patient with no concept of the present, no memory of the past and no hope for the future — a lot of families say, 'Why does this have to go on?' What's the purpose?''⁴⁶

I suggest that what is seen here with this AMA policy is what traditionally has been recognised as passive euthanasia. In order to be promotive of wider acceptance here, the better position would be to consider these actions of withdrawal as but complements to basic notions of autonomy or self determination.

Present American Criminal Law complicates the whole area of the non-treatment of critically or terminally ill persons. Although actual prosecutions of physicians for terminating life support in hopeless cases are quite rare,⁴⁷ still the very possibility of criminal prosecution has a chilling effect on a physician's actions which might otherwise be promotive of patient autonomy and dignity. It can be hoped earnestly that the new AMA policies on withdrawal of medical treatment will have a salutary effect on law reform in this area.

Absent extraordinary circumstances (eg, if a physician knew a patient's medical condition was curable) the disconnection of life support systems by physicians acting at the behest of families should not be considered a

43 Statement of the Council on Ethical and Judicial Affairs, American Medical Association, March 15, 1986, Chicago, Illinois.

44 Colburn, 'AMA Ethics Panel Revise Rules on Withholding Food', *Wash Post Health Mag* 9, April 2, 1986. See also *Guides to the Evaluation of Permanent Impairment* (A Engelberg ed 1988).

45 *Supra* n 43.

46 *Supra* n 44.

47 Ginnex, 'A Prosecution's View on Criminal Liability for Withholding Medical Care: The Myth and the Reality' in *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients* (E Doudera & W Peters eds 1982). See Smith, 'All's Well That Ends Well: Toward A Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?' 22 *U Cal Davis L Rev* 275 (1989).

criminal act.⁴⁸ Disconnection is not homicide for the very same reason a request for cessation of treatment by a competent patient is not suicide. Rejecting the notion that a patient's refusal of lifesaving treatment was suicide, the Supreme Judicial Court of Massachusetts stated:

'(1) in refusing treatment the patient may not have the specific intent to die and (2) even if he did, to the extent that the cause of death was from natural causes, the patient did not set the death producing agent in motion with the intent of causing his own death.'⁴⁹

VI

The judicial system is ill qualified and, indeed, has no special competence to consider or to make decisions regarding treatment or non-treatment of critically and terminally ill individuals.⁵⁰ A constant resort to the courts in this area of concern is perhaps the counterpart to medicine's tendency to overtreat.⁵¹

The family unit has traditionally exhibited the greatest degree of concern regarding the welfare of ailing family members. The competent patient is aided by family members when critical health decisions must be made. In fact, family members often act as advocates for those members confined to a hospital.⁵² It is the family unit, again, that makes decisions for its incompetent members.⁵³ Absent a showing of improper motives or a judgment that would have a significant deleterious effect on the incompetent, the courts will not impose their evaluation of what is in the patient's best interests upon the family. And this is as it should be.⁵⁴

Resort to the courts should only be available as a last resort and only under very limited circumstances; or more specifically when irreconcilable conflict among family members arises, there is unambiguous evidence of wrongful motives or a strong basis for believing that the modality of treatment or non-treatment is beyond the standard of reasonableness.⁵⁵ A hospital ethics committee or ethical tribunal should be utilized when irreconcilable differences of opinion result between the attending physician and the patient's family — this is an additional safeguard to the maintenance of self-determination without judicial interference.⁵⁶

Law reform activity has been significant with the passage of right-to-die or living will legislation. At present, thirty-five American states have enacted living will legislation that, in essence, means that in terms of overall United States population two out of every three citizens have access

48 Newman, 'Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for The Family, The Physicians and The State', 3 *NY Law Sch Human Rights Annual* 35 (1985). See also the Hastings Centre Guidelines on *The Termination of Life Sustaining Treatment and the Care of the Dying* (1987).

49 *Supt of Belchertown State School v Saikewicz*, 373 Mass 728, 743 n 11, 370 NE 2d 417, 426 n 11 (1977).

50 *Supra* n 48 at 76.

51 *Ibid* 79.

52 *Ibid* 44.

53 *Ibid*.

54 *Ibid* 46. See Smith, 'Quality of Life, Sanctity of Creation: Palliative or Apotheosis?', 63 *Neb L Rev* 709 (1984).

55 *Ibid* 79.

56 Dagi, 'The Ethical Tribunal in Medicine' in 1 *Ethical, Legal & Social Challenges to a Brave New World* at Ch 7 (G Smith ed 1982). See also Smith, 'The Ethics of Ethics Committees' 6 *J Contempt Health L & Pol'y* 157 (1990).

to a recognised means of refusing to maintain futile prolongation of dying if they become terminally ill with no hope of recovery.⁵⁷

Additional support for legislative reform was seen in August 1985, when the National Conference of Commissioners on Uniform State Laws promulgated a model statute entitled, Uniform Rights of the Terminally Ill Act. The statute strengthens living will enactments by authorising an adult person to control decisions regarding administration of life sustaining treatment by executing a declaration instructing a physician to withhold or withdraw life-sustaining treatment in the event the person is in a terminal condition and is unable to participate in medical treatment decisions.

Wider acceptance by the states of The Uniform Determination of Death Act would be another strong effort to decrease if not eliminate judicial interference within this area of death management simply because of the definite posture that the legislation takes and thereby provides a framework for subsequent decision making. Under the Act,

‘An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brain stem is dead. A determination of death must be made in accordance with accepted medical standards.’⁵⁸

As Professor Bede Morris of the Australian National University has observed so eloquently, ‘... something as splendid, exhilarating, demoralising, romantic, painful, frustrating and unpredictable as life itself deserves a glorious and dignified end, if that can be arranged. Medicine must aim to help an individual to go out with the sort of style which befits the selfless morality we all see.’⁵⁹

57 *Handbook of 1985 Living Will Laws* 5 (1986). See also G Smith, *Final Choices: Autonomy in Health Care Decisions* 84, n 39 (1989).

58 12 *Unif Laws Ann Ss* 1 (1985 Supp). See also, Smith, ‘Legal Recognition of Neocortical Death’, 71 *Cornell L Rev* 850 (1986).

59 *Supra* n 2.