Medical ethics is one of the most popular subjects of discussion today. It is prominently featured in the medical literature, and several new journals are exclusively devoted to it. Numerous regional and national conferences concerned with various aspects of biomedical ethics occur with great regularity and high frequency. The press and media are also devoting major attention to this subject.

A whole new "medical ethics vocabulary" has arisen, some of which adds confusion where clarity is needed. Even the term medical ethics is difficult to define. One simplistic but concise approach is to say that the physician determines what is possible, the attorney decides what is permissible, and the ethicist suggests what is proper.

A classic example where confusion in terminology exists is the living will. Does anyone write a will when he/she is not alive? Is there a difference between a living will and a dying will? Even the English usage is incorrect. The will is not alive or dead. It is the person writing it who is living or dying.

The "right to die" and "death with dignity" are justifications offered for the writing of a living will. Is dying really dignified? I believe it is dignified to live. True, the dead should be treated with dignity and respect but I see nothing dignified about dying. Does a person have a "right to die?" In the Judaic-Christian tradition, people have an obligation to live rather than a right to die. The Divine Creator gives life and takes it away. Man does not possess absolute title to his life or to his body. It is given on loan to be used but not abused. Man is charged with preserving, dignifying, and hallowing his life.

The common theme of living wills or natural death statutes is the endorsement of the right of a competent patient to sign a binding directive refusing life-prolonging measures during terminal illness. I will not even attempt to define "competent" since that term usually implies a legal rather than medical connotation. But what does "life-prolonging" mean? How prolonged? One minute, one hour, one day, one week? If the value of human life is infinite, as I believe it is, one second or one hour of life is of precisely the same worth as months or years of it, just as any fraction of infinity, being indivisible, remains infinite. What is the difference between life-prolonging and death prolonging? How does one draw the distinction? What does the phrase "terminal illness" mean? How terminal? One hour, one day, one week? A small but significant fraction of patients pronounced terminally ill by their attending physicians survive a much longer period of time than predicted as exemplified by Karen Quinlan who lived many years after her respirator was withdrawn. Many living wills incorporate the terms "permanent," "irreversible," "imminently dying," "chronic vegetative state," to which one can ask: how permanent? how irreversible? how imminent? how chronic?

Another confusing catch phrase is "heroic or extraordinary measures to prolong life." Is the use of a respirator heroic or extraordinary? How about a blood transfusion? Antibiotics? Intravenous fluids? A feeding tube? Analgesics? Where does one draw the line? Even if one accepts the use of antibiotics as standard therapy for pneumonia in you or I, would such treatment be heroic or extraordinary in a dying cancer patient? I think not. The use of cardiac monitors for patients admitted to intensive care units with precordial chest pain is standard practice today. Yet, only a decade ago, such monitors were scarce, expensive and infrequently used. Thus, what is standard practice today was heroic or extraordinary only a decade ago. In many cases, extraordinary therapy may restore critically ill or even unconscious patients to a functional life.

Are we to accept undue expense or inconvenience as a definition of "heroic or extraordinary means to prolong life?" Does the inconvenience of moving to another climate or country to obtain a cure absolve a patient of making such a move knowing full well that the result of a decision not to move is the hastening of death? If the financial cost of life-preserving care "would create grave hardships for oneself or one's
family” is the patient not obligated to pay for the potentially curative treatment rather than die prematurely without benefit of that treatment?

Although the living will is an expression of the patient's autonomy, such a written document can be as much a hindrance as a help to the physicians and family faced with carrying out the wishes cited therein. Because of the lack of specificity and uncertainty of prognosis, the provisions of the living will may be activated prematurely. The existence of the will might deprive the patient of the full concern of the medical team who may not exert the maximal effort demanded by the patient's condition. During the five-year period when the living will is usually in effect, the patient may change his mind but not formally rescind the declaration, thus, leaving the will to be activated without proper informed consent. Informed consent is today a standard of good practice. But how does one approach "informed refusal" of care as dictated by the terms of the living will? Is this refusal really informed? Just as fully informed consent for medical treatment is considered by some writers to be a fairy tale, fiction, or myth, I have similar concerns about informed refusal of care.

Another response to the living will furor is the suggestion that patients write directives for maximum care, just the opposite of the so-called living will but perhaps a better interpretation of the term "living" will. Thus, the patient, while healthy and of sound mind, would declare in writing that:

I wish maximum medical care to be provided to me to prolong my life without regard to my physical or mental diagnosis, condition, or prognosis, and without regard to financial cost. In the event I subsequently become unable to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to preserve my life until the actual moment of death.

But just as a living will does not always ensure a patient's so-called "right to die," a maximum treatment declaration also poses problems in interpretation and implementation. How does one define "maximum"? How is such a declaration with the phrase "without regard to financial cost" to be enforced in this era of health care cost containment?

The legally-sanctioned living will presumes that the patient has a right to prematurely terminate his life and to impose ethical value judgments upon physicians and other members of the medical team who are instructed to assist the patient in this hastening of death under the terms of the will. Does not a living will contradict society's declared obligation to preserve and protect the health and life of its citizens? From the moral viewpoint, the living will denies the preciousness and infinite value of human life. Here is where the "slippery slope" begins.

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The Living Will and the Directive to Provide Maximum Care
The Scope of Autonomy
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The hope that inspired the enactment of living will laws in the United States is that persons, when competent, could extend their right to refuse medical treatment into a possible future period of incompetency, by incorporating their wishes into a legally binding document. To date, 35 states and the District of Columbia have enacted such laws (often called "natural death" acts), which provide guidelines for the use of living wills under certain specified medical conditions. In those states which have not enacted living will laws, courts have relied on the common law right to self-determination and the constitutionally protected right of privacy. Whether by legislative fiat or by case law principles, the purpose of these measures is to protect an individual's right to decide his or her own medical fate, and that includes the right to forego extraordinary treatment where such treatment

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