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TERMINATION OF MEDICAL TREATMENT: IMMINENT LEGISLATIVE ISSUES

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For generations families and physicians have been ministering to their loved ones in sickness and in death as part of the natural order. Because such a relationship, to be effective, required a special closeness, a bond of trust and dependency evolved between families and their physicians which became a generally accepted custom and practice. One's family physician played a dominant role in guiding families and their dying loved ones through the uncharted pathways to death.

In strict legal contemplation physicians had no greater authority then than they do now, but this essentially paternal and professional hand of the physician was gently extended to guide and lead the way, and it was universally accepted.

Medical technology ever on the move then created a series of veritable miracles whereby the regimen of medical special care was changed dramatically—as was the climate in which medical treatment was administered.

As technology became more sophisticated medical decisions which had heretofore been simple sometimes became very complicated. Physicians became apprehensive about their own personal liability, and the increasing degree of jeopardy facing them caused by their practice under the new technology.

There came an ever increasing demand to be relieved from jeopardy and the spectre of malpractice which has effectively bedeviled the medical profession in recent years and created a climate of apprehension and the need for greater security in the practice of medicine.

This climate was responsible in some degree for the race to obtain protective legislation and thus the surge in the late seventies and early

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eighties to introduce Natural Death Acts in ever increasing numbers of states. Some of the acts which were rushed into print and adopted in a hurry were not well drafted.

In 1976 California enacted the first Natural Death Act in this country. Being the first, it is not unusual that it contained certain flaws. Senator Keene, sponsor of the act, stated "it has served an educational purpose and affirmed the right of self-determination, especially for the dying, who are a vulnerable group, but it has not had the operational effect that I wanted it to have." Part of the problem was the 14 day rule, so-called, in which the declaration would be considered valid only if executed by an adult 14 days after diagnosis of terminal condition. This has been rejected as a fundamental flaw by most states although Idaho, Oregon and Texas required that a person be in a terminal condition before executing a declaration.

In March of 1977, Idaho enacted a Natural Death Act patterned somewhat on the California act. There was no requirement that the 14 day rule apply but Idaho would not accept a document executed in advance of a terminal condition, but at any time after the terminal condition was diagnosed. There was no requirement that a physician transfer a patient if the physician was unwilling to comply with a declaration under the Act. The original Idaho Act contained no sanctions or penalties in the event of default.

Oregon, Nevada, Texas, North Carolina, New Mexico and Arkansas also passed Natural Death Acts in 1977. Here are some aspects of the laws as enacted in these states. The Nevada and North Carolina acts did not require that the physician be bound by the declaration. They provided that the physician might consider other factors and circumstances applicable to the particular patient in making a decision whether or not to comply with the terms and provisions of the declaration. So the physician was not really bound by the act.

New Mexico would allow a person in good health to execute without the need to re-execute in the event of a terminal condition. New Mexico also made provisions for execution by a family member in behalf of a terminally ill minor using certain checks and balances and calling for court certification if the minor rejected.

Oregon's act relating to the right to die was patterned on the California act. Although passed, it did not meet with the approval of the Oregon Medical Association, which opposed the bill in committee and took the position that physicians and families could work things out without the need for further legislation. The act did not make provision for an exception in case of a pregnancy.

And finally we come to the Arkansas act. Arkansas' act is considered a Right To Die Act and provides that declarations can be made in behalf of non-competent adults and, as in New Mexico on behalf of minors. This

Act is the shortest and perhaps the most liberal of any of the acts passed. It is probably the very best reason for the need for uniform legislation and the act that is most vulnerable to abuses that might be classified as euthanasia.

It is the hope of the National Conference that the states like Arkansas, New Mexico and others will adopt the Uniform Rights of the Terminally Ill Act. There is a good chance that many states which have adopted "cut and patch" versions of the original California Natural Death Act will now review their position and adopt the Uniform Act.

The Uniform Rights of the Terminally Ill Act ("URTIA") was drafted and adopted by the National Conference of Commissioners on Uniform State Laws in August, 1985.

Its genesis in the Conference was a lengthy process which took over six years to complete, four years of monitoring the independent efforts in the several states plus two years of intensive study, research, consultation, and many, many drafts.

A Study Committee on a proposed Uniform Natural Death Act was recommended by the Scope and Program Committee at its meeting in New York City in August, 1978 after natural death acts had been passed in eight states. The Study Committee as directed met and reported its findings for the next four years, but it was not until 1982 that legislatures throughout the country seemed to become frenetic in their intent to enact some form of living will legislation without the least semblance of order or uniformity.

Also in 1982 the Chairman of the Study Committee reported that "[t]here is a recognized need for uniform legislation dealing with the desire of a competent adult to control the use of life sustaining procedures merely to prolong his life if he becomes terminally ill. Legislation of this nature has been adopted by at least ten states and has been introduced for adoption in 21 additional states."

The next year, in 1983, the Executive Committee of the Conference acknowledging the importance of the subject matter and the exigency being created by the lack of uniformity in the disparate Acts already adopted and the prospective Acts in the "hopper," appointed a Drafting Committee with the mandate to draft a Uniform Act.

The mandate was intended to provide an act which would satisfy the apparent need of the states and at the same time improve the quality and establish uniformity in prospective legislation. The mandate also contained specific instructions and limitations. The directive was to draft an Act which would authorize a competent adult to control the administration of life sustaining procedures that merely prolong the dying process under circumstances in which there is a terminal condition which is incurable and/or irreversible when a person is no longer able to make decisions concerning his or her own medical treatment and death will occur in

a short time.

The mandate to the Drafting Committee also contained certain restraints to be considered in that the prospective act should not apply to minors or cover treatment of the incompetent; it should not include provisions for appointment of surrogates or decisions by proxy. The act was specifically intended to accomplish a narrow, limited purpose. It was to provide a lawful means to those competent adults whose intention it was to avoid prolonging their own dying process if and when their condition became incurable or irreversible and death was expected in a short time. The method was to be a simple uncomplicated declaration executed by them directing their physician to remove those life sustaining procedures that would only prolong the period of dying when they were in a terminal condition and no longer competent.

The directive to the Drafting Committee to keep the scope narrow was purposeful and designed to produce an act that would be basic and simple and useful and one that would appeal to the several states and the adoption of which would encourage uniformity among the states. It was also important to draft an act that would pass. The matters that were not covered and specifically avoided by this act such as minority, incompetency, surrogates, proxy decision, oral declarations, and the like, were not considered by us to be trivial, but in fact, very important and to be treated either by another act or amendments to the present act once it is in place.

The Drafting Committee worked on the act for one full year and produced a draft for a first reading before the Committee of the Whole. This is the standard process in drafting uniform acts and its purpose is to enable the Committee of the Whole to read, study and react to any proposed uniform legislation that will ultimately be presented for adoption. There are always two readings of every act a year apart and sometimes more. On occasion, an act will be sent back to the Drafting Committee several times and even then, after three or four years, will fail to be adopted by the Committee of the Whole as a uniform act. After our first reading, a transcript was made of the criticism, observations, requested changes, revisions, suggestions and all proposed modifications from the floor debate of the Committee of the Whole. This transcript became the working test for the Drafting Committee as it commenced its second year of redrafting the act.

From the very beginning, in order to enable the Drafting Committee to draw from the broadest base of intelligence available, experts from the field as well as certain organizations which have specialized knowledge and register an interest in the subject of the particular act are invited to present their views during the full drafting period. The presence and participation of qualified consultants can be most valuable in a drafting effort.

In Minneapolis last August, even as late as the very day of the final debate by the Committee of the Whole, interested groups asked and received permission to be heard and to express both positive and negative views of the Act at the very last session prior to floor debate.

Some thirteen organizations were invited to attend all Drafting Committee sessions and most came and made substantial contributions to the drafting process. Among those who were present at most, if not all of the drafting sessions were:

1. The Right to Die Association
2. The Right to Life Association
3. Americans United for Life
4. Catholic Hospital Association
5. United States Catholic Conference,
Office of the General Counsel
6. The American Bar Association
7. The American Medical Association
8. American Hospital Association
9. The Association of Law and Medicine and others.

The notation here of the presence of any special interest group, expert, organization or consultant at any of our drafting sessions whether actively participating or not is not intended to indicate in any way directly or indirectly their support or approval of our act. Our reference is intended merely to show the willingness of the Drafting Committee to run an open meeting for all responsible persons who have expressed an interest and have been invited to attend. The Drafting Committee is always willing to receive the best intelligence that is available and seeks wherever possible to draw from different levels of qualified experience and expert testimony.

Although the Drafting Committee was operating under a mandate to draft according to a narrow scope there is not and never has been any limit to the expansiveness of the Committee's attitude and effort to open all channels of inquiry, intelligence and communication, without reservation or limitation, into all areas concerning the act.

The two years of drafting and many hours of detailed analysis of each word and phrase have accomplished a certain simplicity and economy of language in an act that hopefully will express fully the purposes intended and provide patients the finest care, protection and relief and physicians satisfaction and security.

Four critical terms in this act are essential and powerful and sometimes provocative, and they are used with grace and precision to create a simple, direct, useful law.

First: *LIFE SUSTAINING TREATMENT* is a medical intervention or treatment - it does include nutrition and hydration in the Uniform Act and there is much controversy that surrounds this term. It is felt by many

that nutrition and hydration are fundamental and should be left as rights of the patient and not to the discretion of the physician. Others hold that feeding by nasogastric tube or intravenous infusion is equivalent to artificial breathing by a respirator. They hold that this is a medical procedure and should be provided or withheld according to the criteria applicable to medical procedures. In section 6B of the Uniform Act, the Drafting Committee placed the burden of comfort, care and alleviation of pain to the physician, calling for whatever is necessary, including nutrition and hydration, for the comfort of the patient and the alleviation of pain. If not needed for comfort and care or alleviation of pain, nutrition and hydration are to be treated as any other life sustaining procedure and may be withdrawn by the physician.

Second: *TERMINAL CONDITION* is a precise medical term of art used by physicians to convey the concept that the illness, disease or condition is incurable or irreversible. This phrase does not mean any terminal disease or illness, but only one that is incurable and/or irreversible. Some states include the "and/or" language in their acts. The commentary points out that "incurable or irreversible" is to be used conjunctively when circumstances warrant.

A medical disease that is incurable and reversible is not a terminal condition. An opinion of the attending physician is essential to establish that a terminal condition exists. Diabetes and some kidney diseases may be incurable, but reversible and therefore in that instance do not constitute a terminal condition under the act.

Some acts have used the language "no possibility of recovery." The Drafting Committee finds this language as well as the word "imminent normal," etc., unacceptable because of latent ambiguity.

Third: *QUALIFIED PATIENT* is another term of art under the act. It means a patient that has been determined by the attending physician to be in a terminal condition. He or she must be 18 years of age and have executed a declaration. Section 6 of the act makes use of this phrase with regard to a patient's ability to make his or her own decisions concerning medical treatment. Of greater significance, however, is the interrelationship of these three terms as used in the Uniform Act. "Life sustaining treatment" applies only to a "qualified patient" who must by definition have a "terminal condition" which is incurable or irreversible. This was carefully designed to avoid repetition and possible confusion.

The Drafting Committee labored long and hard on the question of how to treat the pregnancy question in the act. There was some early limited support for a pro-abortion position which was resisted by a majority of the Committee. The Committee articulated its guiding policy throughout the act as being in support of life and determined to draft a pregnancy section that was reasonably calculated to be acceptable to almost everyone. At the last minute and after long and heated debate and

close to the end of debate, a motion was quietly and calmly made by a very articulate, persuasive young woman commissioner who moved to add just five words to the beginning of the otherwise reasonable pregnancy section as follows: "Unless the declaration otherwise provides" and you have before you in section 6C the result of that calm, quiet motion. It passed. The section is now not as acceptable to everyone. In fact, it is not the language or the concept supported by the Drafting Committee. There is relief, however in the knowledge that the individual declaration can redact the section to accommodate the specific wishes of the declarant.

We now come to the form and execution of the declaration. The declaration may be custom made, but the form recommended is simple and uncomplicated. It must be signed by the declarant and witnessed by any two individuals. It is almost simplistic. The avoidance of technical requirements in the execution was purposeful. There will be times and places when certain technical requirements would be most difficult to accomplish and might prevent the effective execution of the declaration.

Fourth, *REVOCATION*: The philosophy of the Drafting Committee in favor of life is nowhere found as graphically as in section 4 of the act. Revocation can be effected by the slightest sign of any kind made known to the attending physician or health care provider. The Committee insisted that the many technical requirements of wills and other documents should not be the guiding principle in this act. We chose to allow almost anything whatsoever that could be construed as revocation to be one. A revocation that would, under other circumstances be denied is intended to be accepted under the act if there is even the slightest basis for it.

This act, as do all uniform acts, contains commentary which reflects much of the thought, expression and dialogue of the Drafting Committee that cannot or should not be included in language of the statute itself for one reason or another. However, there are times when statements or paragraphs are inserted in the commentary with the express purpose of guiding and directing courts and lawyers in achieving the precise meaning intended by the draftsmen.

Many times an objection to a particular phrase, clause, sentence or concept in an act will be overcome by the willingness of the Drafting Committee to add to a comment in clarification.