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# TERMINATION OF MEDICAL TREATMENT: IMMINENT LEGISLATIVE ISSUES

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California passed the first living will legislation in 1976. By current standards the original California act is now considered moderate to conservative, although it seemed very radical at the time.

The California act has set the standards for the thirty-five subsequent acts that have been passed and, indeed, was the model for the legislation under consideration right here now, that of the National Conference of Commissioners on Uniform State Laws.

Such acts are now described by the Legal Advisory Committee for the Society for the Right to Die as "the first generation of such legislation."

The next generation of such legislation is typified by the Hemlocks' Society revised version of the California act. Basically, the Hemlock bill would be the California act with certain additions. For example, section 7186 would be amended to add "or to request a physician to administer aid in dying," as an additional fundamental right for California citizens.

That's the nature of the debate at the present time. Two courts, *Barber* in California and *Conroy* in New Jersey, have equated nutrition and hydration with other medical procedures and have allowed them to be terminated on the same basis that sophisticated medical procedures such as respirators are terminated.

The Supreme Court of Massachusetts had the same issue pending before it right now in the *Brophy* case. There the trial court refused permission to terminate feeding, finding that nonintrusive feeding methods that cause no pain and suffering could not be withheld ethically or legally as long as they continue to be useful.

Since 1976, thirty-five states and the District of Columbia have en-

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\* Hinshaw, Culbertson, Moelmann, Hoban & Fuller.

acted living will or natural death statutes which attempt to codify the well-recognized right to refuse medical treatment. Half of those statutes—nearly all passed since 1983 when it first became an issue—expressly exclude nutrition and hydration from the life prolonging procedures that may be withdrawn under a living will.

Two of the sixteen enacted prior to that expressly exclude nutrition and hydration. Four of the seven enacted since 1984 carry out the exclusion. Twelve of the thirteen enacted since 1985 carry the exclusion, thus, of the twenty such statutes passed in 1984 and 1985, sixteen expressly exclude nutrition and hydration from the forms of life-prolonging procedures that may be omitted.

This court and legislative activity must be taken into consideration as very relevant when trying to decide whether or not someone will (a) support the Commissioner's bill, or (b) support it as amended.

Another problem in this whole debate is the form that the legal debate has taken, that is to say, the living will.

The first steps to codify a solution to the perceived problem used the will as the solution. What was forgotten, however, was that where there is no written will concerning the devolution of property, then in all cases the probate act supplies the answer. There is no statute that provides an answer to the question when and under what circumstances medical treatment may be terminated.

In other words, living will legislation is a twenty percent solution, if we assume that even twenty percent of the population will execute such wills. What happens to the other eighty percent? Presumably they are not allowed to die.

For the other eighty percent, medical ethics, morality, case law, custom and practice, common sense, and good will seem to supply the answer, and they necessarily will supply the answer into the future because under no circumstances do we foresee an incident where 100 percent of the people reaching the status of a qualified patient would have executed such a directive.

How do the National Commissioners on Uniform State Laws supply the answer? First, the Uniform Rights of the Terminally Ill Act takes the same basic approach that most states have. Their act is modeled on the original California act, but there are significant differences which I will point out.

The Uniform Act allows an individual of sound mind and 18 years of age to execute a declaration governing the withholding or withdrawal of life-sustaining treatment when he is no longer able to make such decisions.

As to the sound mind problem, there is no standard created in the statute. Presumably it would be the same as existing standards in your respective states. Section II affords some protection for the health care

providers because it states that in the absence of knowledge to the contrary, a physician or health care provider may presume that a declaration is valid and still in existence.

The declaration becomes operative when three things occur: when it has been communicated to the attending physician; and the declarant, the person who executed the declaration, is determined by the attending physician to be in a terminal condition; and, thirdly, no longer able to make decisions regarding the administration of life-sustaining treatment.

When such a declaration becomes operative, that is to say, those conditions have been met, compliance with it is *mandatory* by the health care provider. The physician and other health care providers shall act in accordance with its provisions, and if they cannot, they must comply with section 7, which allows transfer of the patient.

Section 10(f) says that no physician is required to take any action contrary to reasonable medical standards. Those two sections (sections 7 and 10) are going to conflict in the future and provide legal problems.

Terminal condition is the most important safeguard in any such legislation for those who oppose the legalization of mercy killing. If you do not, then you do not worry about it; but if you do, it is a rather significant public policy line drawing event.

Thus, it is very important how one defines "terminal condition." Often in the public policy debate those who support this kind of legislation do so on the hope that they can either minimize the impact of the definition or handle the definition with a certain amount of vagueness or looseness so that they can still reach the end they desire.

Of all safeguards in these acts this is the most important: that the triggering mechanism as to when treatment may be terminated is limited to the existence of a terminal condition. Consequently, there exists much pressure to change or loosely define "terminal condition."

For example, the New Jersey Supreme Court, when it allowed the withdrawal of nutrition in the *Conroy* case, held that such treatment could be withdrawn if the person were to die within one year from the date when this was under consideration, thus looking at terminal condition as an event that can cover a year's space of time.

The Uniform Act defines terminal condition as an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

There are four basic problems. What does "within a relatively short time" mean? When I say to my kids, if you're going out at 9:00 and I tell them to be back in a relatively short time that could mean anything from 10:00 to 3:00 in the morning.

Problem two, what is the difference between an incurable or irreversible condition and why is it disjunctive?

Problem three, what is the significance of defining the condition without the administration of life-sustaining treatment? Most of the other acts, as does the California act, define "terminal" to include the application of life-sustaining procedures. If you are not terminal when the procedures are applied, then you are not terminal, period, under that legislation.

As to all of these problems, the Commissioners give a very lengthy comment, and that comment really sums up the legal debates that have surrounded these statutes. I recommend it for your reading.

In my opinion, the net effect of the definition of "terminal condition" used by the Commissioners and as explained in their commentary will do three things. It will broaden the category of patients who qualify as terminal. It will loosen the medical standards as to the physician's judgment as to when such patients qualify, that is to say that broader group of patients may qualify earlier than under many other statutes and certainly under the cases that have been decided.

Three, it will create ambiguity when applied to patients in a coma or persistent vegetative state since such patients have both an irreversible and incurable condition and it seems that under this Act, section 14, any medical treatment can be withheld from them including food and water, since the argument goes, "they feel no pain, and need neither food nor comfort care." Nonetheless, even as broad, it is significant and very important that the termination of medical care be limited to a terminal state, and this the Act does.

The fourth significant problem: what does "no longer able to make decisions" mean? Many of the states require legal incompetency. This does not. The Commissioners, oddly enough, offer no comment on this, and no definitions in the statute pertaining to this problem.

Is it a legal standard? Is it a medical standard? Is it a common sense standard? Is it a probate standard? It's fraught with difficulty for a lawyer who is trying to give advice to a client. The Act is silent also about the role of the family in giving or withholding consent once the qualified patient reaches this state. Presumably they have no role in the face of such an executed directive.

The Act, thus, excludes the family from the decision-making process once the qualified patient no longer can make a decisions. Qualified patient is one who is eighteen and has executed the declaration and is in a terminal condition.

The Act excludes all persons who are able to make such a decision. In other words, regardless of the fact that a patient has such a document, if the patient is able to make such decisions, then the document is not involved in the decision-making process; so the Act applies only to those who cannot make such decisions and again brings up the significance of that standard. What does it mean and who decides as to when a patient is

unable to make such a decision? Presumably the physician and the health care provider do so because they are the ones who have the onus of acting under the directive.

Now one of the key sections—section 6—says “The Act does not affect the responsibility of physicians to provide treatment, including nutrition and hydration, for a patient’s comfort, care or alleviation of pain.”

This section is significant because it has the property of being deceptive. What does it mean? Under current law, physicians have such a responsibility according to accepted medical standards, but these standards are in great debate in the cases, and we will see one day where that comes out.

That responsibility, in any event, runs beyond just comfort care and alleviation of pain. Presumably, the Act does not affect nutrition and hydration in those cases which do not involve their use as means of comfort care or alleviation of pain.

Are there such cases? Yes. The comatose or persistent vegetative state may be classified as such cases. This will be an area of debate. The argument will be that a comatose patient or patient in a persistent vegetative state is one who does not need nutrition and hydration from comfort care or alleviation of pain, and therefore *must have* nutrition and hydration omitted pursuant to this declaration under the Act, regardless of the ethical position of the health care provider. If a physician is involved with the declaration under the Uniform Act, he must follow the standards of the Act or transfer the patient.

Thus, the Commissioners have taken the position contrary to sixteen of the twenty acts passed since 1983 which have excluded nutrition and hydration from the forms of life-prolonging procedures that may be omitted.

They have attempted to take a more nuanced position, but their position, nonetheless, is that unless necessary to alleviate pain or provide comfort care, nutrition and hydration *must be omitted* under the declarations made pursuant to the Act.

Even in those cases the Act does not *mandate* the giving of nutrition and hydration. It *allows* the physician to exercise his or her discretion according to his or her medical judgment, whether or not nutrition and hydration are necessary and will be provided only where relief from paid for comfort care is at issue.

It allows him no such discretion otherwise. That is to say, where, in his moral judgment, nutrition and hydration are obligatory to preserve life even if not needed only or solely to relieve pain or give comfort care, the physician would be bound to follow the terms of the directive and omit nutrition and hydration. If some accreditation body said as a matter of creating medical standards that those patients do not need nutrition and hydration for comfort care, then he would be deviating from the

standards of his profession if, in fact, there was such a declaration, he did not follow it, and he did not refuse to treat the patient.

The Commissioners point out that the only conscience clause available to him is transfer under section 7. He then can transfer the patient to someone else. I suggest it's not altogether practical because who is going to take the patient under the situation of a problem existing like that?

If he fails to transfer the patient, he's guilty of a misdemeanor. There is no conscience clause in the Act other than transfer. Immunities in section 8 are ambiguous, nor does section 10 supply the answer—transfer is the only safeguard. A Catholic physician can take the position that comfort care and alleviation of pain are medically necessary for a comatose patient, and, therefore, exercising his discretion, continue to feed. Under that scenario, our parade of horrors is a nonproblem.

True. That may be a scenario that will solve this situation if such acts become law. However, the scenario that would make this situation even more difficult is cost containment. Where, for example, the DRGs come down with a position that these kinds of patients do not need nutrition and hydration as you indicated, and, therefore, if they have executed such a declaration, it will not be available to them or you will not be paid under the DRG.

Of course, to we professional people, not getting paid for providing a humane service is irrelevant, so maybe it's a nonproblem.

On balance, when one decides whether to support the Act or not because, even though we may all be Catholics, putting our principles into place in public policy just does not work; and on deciding whether or not to support such an Act, one has to take all of these various elements into consideration.

The nutrition and hydration element is a very significant one because it continues the process that began in the whole abortion debate, that is today we find our Catholic medicine being "ghettoized" because we can't practice medicine the same way everybody else does. We're being pushed into a corner and maybe that's all right too, because maybe that makes us stand up and be something and say something on behalf of something.