The Right to Die in Montana: The Montana Uniform Rights of the Terminally Ill Act

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THE RIGHT TO DIE IN MONTANA: THE MONTANA UNIFORM RIGHTS OF THE TERMINALLY ILL ACT

William E. Hunt, Sr.*

I. INTRODUCTION

The United States Supreme Court decision in *Cruzan v. Missouri Department of Health*¹ rekindled public interest in right-to-die cases that were first prompted by the case of Karen Ann Quinlan.² Coupled with the recent cases on assisted suicide, right-to-die cases have generated a great deal of interest in the already burgeoning patient-rights movement. *Cruzan* has since drawn unprecedented media attention to both the scope of patient rights and the degree to which the state and the medical community as a whole are able to influence sustaining or terminating an individual's life, particularly if the patient is incompetent. If individuals, competent or incompetent, are effectively deprived of the right to control their bodies, comparable constitutional rights would also be jeopardized. Fortunately, courts and legislatures have intervened to prevent this from occurring.

Given the esteem our culture places on both the value of human life and the seemingly conflicting regard for privacy and

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² *See In re Quinlan*, 355 A.2d 647 (N.J.) (landmark precedent upholding the constitutional right of the terminally ill to be protected from nonconsensual bodily invasion and authorizing father's request as guardian to discontinue all extraordinary medical procedures to sustain daughter's life), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976), *and overruled in part by In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985) (holding error to disregard evidence of statements made to others "concerning artificial prolongation of the lives of others who were terminally ill").
individual autonomy, courts and state legislatures not surprisingly have been forced to deal with problems of decision-making for an incurably ill, incompetent adult. Since 1976, the federal government, District of Columbia, and most states have passed legislation confronting the issue of the rights of the terminally ill. In doing so, several states have developed the concepts of living wills and surrogate decision-makers. Both of these concepts serve to act on a patient's behalf should the patient become incapacitated. These newly-born statutes rely primarily on the right to privacy implicit in the Fourteenth Amendment and the common law principle that a person has a right to self-determination and freedom from nonconsensual touching. These principles logically extend to the core principle underlying the right-to-die cases—the right of individuals to refuse unwanted medical treatment. Legal precedent in the medical field, such as *Schloendorff v. Society of New York Hospital* and *Pratt v. Davis*, have paved an easier path for right-to-die cases. In both cases, the respective courts invoked the principle of individual autonomy in recognizing a tort cause of action against doctors who perform surgical procedures contrary to a patient's stated wishes. Likewise, the continuing administration of unsolicited life sustaining medical treatment (LSMT) is perceived as a violation of an individual's body and necessitates judicial protection.

A right-to-die case has not yet been argued before the Montana Supreme Court. In light of the activity in courtrooms across the country, however, an increase of these cases is anticipated in the near future. In exploring the broader legal and ethical issues at

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7. 105 N.E. 92 (N.Y. 1914).
8. 79 N.E. 562 (Ill. 1906).
9. *See* id. at 564; *Schloendorff*, 105 N.E. at 95.

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stake in right-to-die cases, this Article examines the provisions of the 1991 Montana Rights of the Terminally Ill Act and the Act's relation to right-to-die cases decided in other states. This Article examines two major provisions of the Act, "surrogate decision-makers"\(^1\) and "living wills,"\(^2\) for their importance in the event of court adjudication involving LSMT. Because of the sensitive nature of right-to-die cases, avoiding litigation is highly encouraged. This Article addresses how LSMT cases may be appropriately dismissed. Because some cases cannot be resolved outside the courtroom, this Article also explains the judicial process relating to right-to-die cases.

II. MONTANA RIGHTS OF THE TERMINALLY ILL ACT

As a result of the national patient-rights movement, the Montana Legislature responded aggressively in 1991 by amending title 50 of the Montana Code that had, prior to the 1991 amendments and additions, been entitled "Montana Living Will Act." The new title, "Montana Rights of the Terminally Ill Act," reflects an attempt to address the recent developments associated with the patient-rights movement.\(^3\) For example, the legislature amended part 1 of the title by adding sections 50-9-105 through -108.\(^4\) The Legislature also amended sections 50-9-201 through -206.\(^5\) The law was passed with the medical community's assistance and approval during the Fifty-Second Legislature. House Bill 635\(^6\) revised the Montana Living Will Act\(^7\) to conform to the Uniform


Rights of the Terminally Ill Act as revised by the National Conference of Commissioners on Uniform State Laws in 1989.\textsuperscript{18} To date, twelve other states have also enacted rights of the terminally ill legislation modeled after the Uniform Act.\textsuperscript{19}

The general intent of the Montana Rights of the Terminally Ill Act\textsuperscript{20} (Act) is to provide competent adults with greater freedom to control decisions relating to their own medical care.\textsuperscript{21} Consistent with the constitutional right to privacy, the Act does not allow or condone euthanasia, mercy killing, or assisted suicide;\textsuperscript{22} these are separate legal issues. Nor does the Act require health care workers to violate "reasonable medical standards" in carrying out the wishes of the patient.\textsuperscript{23} Specifically, the Act affirms the common law right of a patient to refuse treatment in cases where the treatment would only prolong the natural dying process.\textsuperscript{24}

The Montana Act encompasses three significant concerns central to the right-to-die: (1) the appointment of surrogate health care decision makers for incompetent individuals, (2) the administration and interpretation of living wills or declarations, and (3) the determination of whether food and water constitute life sustaining treatment. The Montana Court has not had an opportunity to address the provisions of the Act relevant to these concerns. Nevertheless, examining the Montana Uniform Act, as well as decisions of other jurisdictions, is helpful to illustrate the scope of the Montana Act as it relates to these important issues.

\textbf{A. Surrogate Decision Makers}

Cases such as \textit{In re Quinlan}\textsuperscript{25} and \textit{In re Conroy}\textsuperscript{26} upheld and

\begin{thebibliography}{9}
\bibitem{21} MONT. CODE ANN. tit. 50, ch. 9 commissioner's comments (1991).
\bibitem{23} The American Medical Association (AMA) has, in fact, issued appropriate ethical standards and guidelines for right-to-die cases. See infra notes 63-64 and accompanying text.
\bibitem{24} See MONT. CODE ANN. tit. 50, ch. 9 commissioner's comments (1991).
\bibitem{25} 355 A.2d 647 (N.J. 1976).
\bibitem{26} 486 A.2d 1209 (N.J. 1985).
\end{thebibliography}
extended greater authority for the decisions of surrogates. Collectively, these cases hold that an incompetent patient in a chronic vegetative state has the common law right to refuse unwanted medical treatment through a substitute decision maker, even though death may not be imminent.27 Subsequent cases have gone even further. For example, the Florida District Court of Appeals progressively addressed the issue in 1986 in Corbett v. D'Alessandro.28 The significance of Corbett comes from the court's recognition of the strength of a surrogate's decision-making; the court upheld the surrogate's choice to discontinue feeding against the express wishes of the hospital.29 Although Florida's Life-Prolonging Procedure Act specifically excluded nutrition and hydration from a list of life-prolonging treatments that may be refused,30 the court in Corbett found that the constitutional right to privacy provided an independent basis for withdrawal of the tube and that the legislature did not intend the statute to limit existing common law.31

The Montana Act authorizes the designation of a proxy or attorney-in-fact to make health care decisions in the event that the patient becomes incapacitated.32 Section 50-9-10333 of the Act removed an earlier provision requiring as a prerequisite that "the declarant's condition is determined to be terminal" in order for the proxy to be valid.34 The new section now provides that there be an "irreversible condition that . . . will . . . cause . . . death within a relatively short time."35 Further, the Act defines a terminal condition as "an incurable or irreversible condition that, without the administration of life-sustaining treatment, will . . . result in death within a relatively short time,"36 and requires a physician to declare a patient to be in a terminal condition for a declaration to be operative.37

27. See Quinlan, 355 A.2d at 671; Conroy, 486 A.2d at 1241.
29. Id. at 371-72.
31. Corbett, 487 So. 2d at 371.
Another addition to section 50-9-103 of the Act specifically allows a surrogate to "make decisions governing the withholding or withdrawal of life-sustaining treatment" if the patient becomes incapacitated. This treatment would include not only a respirator, but also feeding and hydration tubes, assuming that these procedures serve as life-sustaining treatment. The decisions of surrogates granted by the Montana Act have not been tested by the courts to determine the exact degree of authority a surrogate may have over differing wishes of other persons involved in the patient's welfare. The question of how much latitude the Montana Supreme Court will bestow upon surrogate decisions in the event a surrogate decision contradicts an institution's explicit policy or another provision of the Act remains unanswered.

B. The Administration of Living Wills

The Montana Act also sets forth an outline of proper administrative procedures for the creation of a living will. In order to be valid, "the declaration must be signed by the declarant, or another person at the declarant's direction, and witnessed by two individuals." Although the Act does not address the manner in which this information is communicated to the physician, section 50-9-105 specifies that "[a] declaration becomes operative when it . . . is communicated to the attending physician." The declaration becomes operative only when the attending physician determines that the patient is both terminally ill and incompetent to make medical decisions.

Furthermore, an attending physician who is furnished with a copy of a declaration must record this information in the patient's medical record. Doctors who honor declarations are protected

Act to establish a terminal condition, a "chronic vegetative state" is clearly not covered. The new Uniform Health-Care Decisions Act currently under consideration by the National Conference of Commissioners on Uniform State Laws does address patients in a chronic vegetative state. For a discussion of chronic vegetative state, see In re Jobes, 529 A.2d 434, 438 (N.J. 1987).

41. MONT. CODE ANN. § 50-9-103(1) (1991). This comports with earlier case decisions such as Conroy that specifically recognized living wills as evidence of the patient's desires and also articulated other methods for a patient to set forth advance directives regarding treatment preferences. See Conroy, 486 A.2d at 1229.
from criminal and civil liability under the Act. Section 50-9-107 provides: "In the absence of knowledge to the contrary, a physician . . . may assume that a declaration complies with this chapter and is valid."46 Physicians who comply with the Act and whose decisions are made in good faith "are not subject to civil or criminal liability or guilty of unprofessional conduct."46 A physician’s primary concern is being held criminally liable for withdrawal of medical treatment.47 Often the hospital or doctor, not the patient, seek a court order to withdraw life support for fear of unexpected and undesired retribution by the state or the patient’s family.48

Cases often arise in which the attending physician is unwilling to comply with the declaration and wishes to continue life-sustaining treatment.49 Health-care workers who are unwilling to comply with the removal of treatment must promptly take all reasonable steps to transfer care of the patient to another physician or health care facility that is willing to comply with the patient’s wishes.50 On the other hand, physicians who administer treatment against the expressed wishes of guardians may be held legally liable for a variety of remedies, including legal fees, medical expenses, and emotional distress.51 If a living will declaration is revoked, the Act requires only that the patient (or a witness) notify the attending physician that the patient wishes to revoke the living will.52 Additionally, the attending physician must make the revocation a part of the patient’s medical file.53 Should the physician fail to do so, criminal liability for the violation would attach.54


47. See Farrell, 529 A.2d at 415.

48. See id.


52. Mont. Code Ann. § 50-9-104(1) (1991) ("A declarant may revoke a declaration at any time and in any manner, without regard to mental or physical condition.").


One area left unilluminated by the Act involves identifying exactly what constitutes an individual's competent state of mind. The Act fails to provide any qualifications for determining the declarant's competency or emotional state at the time of the declaration. Absent this delineation, however, the judicial branch can generally reach a decision based on the evidence presented by the parties during litigation. The potential for discrepancy among case decisions due to a lack of judicial guidance in this area of the law should be carefully monitored.

C. The Determination of Whether Nutrition and Hydration are Life-Sustaining Treatments

The question of what constitutes "life-sustaining" treatment to a terminally ill patient is central to the right-to-die debate. A respirator considered necessary for the survival of the patient obviously would qualify as life-sustaining treatment, as would the administration of emergency treatment to a heart attack patient. The administration of food and water, however, has generated a whole new debate in right-to-die cases.

In 1986, the Massachusetts Supreme Court held in Brophy v. New England Sinai Hospital, Inc. that an artificial feeding tube could be removed from a 49-year-old stroke victim in a chronic vegetative state, in accordance with his family's desire to terminate conformance with the Act. See generally Mont. Code Ann. § 50-9-206 (1991).

55. The National Center for State Courts advises:

A judge is not trained to make medical decisions. Furthermore, it may subvert the ability of the court to base its decision solely and objectively on the evidence placed before it.

When the court is requested to evaluate a medical decision in an LSMT case, the court, as in all other cases where medical decisions are called into question, should confine itself to evaluating the testimony of the relevant medical professionals and other evidence as submitted by the parties to the lawsuit.

Coordinating Council on Life-Sustaining Medical Treatment Decision Making by the Courts, National Center for State Courts, Guidelines for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment 84 (1991).

56. See Bouvia v. Superior Court, 225 Cal. Rptr. at 301-04 (holding that patients have a fundamental right to refuse treatment even if it includes nutrition and hydration; the right exists even if it would severely jeopardize or create a life-threatening situation); Farrell, 529 A.2d at 411 (suicide prevention is not a separate interest, but is encompassed within the interest in preserving life). In Farrell, the court stated: "[W]e do not want to impose any restrictions or burdens on the competent patient's right to have life-sustaining treatment withdrawn if he or she is at home that would not be present if he or she were in a hospital or nursing home." Id. at 414. See also Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677, 694 (App. Div. 1987) (overturning numerous rulings of the previous year that artificial feeding could not be withdrawn).

57. 497 N.E.2d 626 (Mass. 1986).
The court ruled that "to be maintained by such artificial means over an extended period is not only intrusive but extraordinary" and further held that the patient's right to refuse treatment outweighed the state's interest in suicide prevention and preservation of life. Similarly, cases in Florida and New Jersey have reached comparable verdicts upholding the right of patients to refuse artificial nutrition and hydration. The crux of the nutrition and hydration debate centers on the notion that removing feeding devices does not preempt life but rather allows life to steer its own, natural course and permits the patient to die with dignity. Additionally, the American Medical Association's Council on Ethical and Judicial Affairs issued the following statements on bio-ethics: "It is not unethical to discontinue all means of life-prolonging medical treatment" for patients in irreversible comas (or terminally ill) and "[l]ife-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration." An emerging consensus in the medical and legal communities takes the position that artificial feeding is comparable to other forms of medical treatment and, as such, may be withdrawn at the request of the patient.

The Montana Act incorporates this prevailing attitude among physicians and health care workers, and deems artificial nutrition and hydration as life-sustaining treatment. The Act provides for withdrawal of artificial nutrition and hydration from an incompetent, terminally ill patient with one qualification in section 50-9-202. This section states that "[t]his chapter does not affect the responsibility of the attending physician or other health care provider to provide treatment, including nutrition and hydration, for

58. Id. at 639.
59. Id. at 637.
60. Id. at 638.
61. See Conray, 486 A.2d at 1236 (upholding trial court's permission to remove feeding tube from a patient struck with arteriosclerotic heart disease, hypertension, diabetes, and a gangrenous leg). The trial court's rationale focused on whether life had become permanently burdensome to the patient. In so finding, the trial court ruled that prolonging life would be "pointless and perhaps cruel." Id. at 1219. See also Corbett, 487 So. 2d at 371 ("We are unable to distinguish on a legal, scientific, or a moral basis between those artificial measures that sustain life—whether by means of 'forced' sustenance or 'forced' continuance of vital functions . . . .").
62. See Bouvia v. Superior Court, 225 Cal. Rptr. at 305.
63. See Brophy, 497 N.E.2d at 638 n.38 (quoting statement of the AMA Council on Ethical and Judicial Affairs).
64. See Bouvia v. Superior Court, 225 Cal. Rptr. at 303-04 (quoting statement of the AMA Council on Ethical and Judicial Affairs).
65. See id.
a patient's comfort care or alleviation of pain."

III. LIMITING THE NEED FOR FORMAL COURT INVOLVEMENT

The principle of personal autonomy is an unwavering constant in right-to-die cases. Fundamental under both the common law and constitutional law is the idea that competent individuals have the right to make their own LSMT decisions. Accordingly, courts discourage routine use of the judicial system to review those decisions. In landmark cases such as In re Conroy and In re Guardianship of Browning, the courts' opinions consistently emphasize the highly sensitive nature of the right-to-die issue. When no conflict exists regarding the patient's wishes, courts should not be involved. In the New Jersey Supreme Court case of In re Conroy, the court laid out both general subjective and objective tests to minimize overall court participation in the ruling and relied more on the expressed preferences of the patient. Many other courts have since followed the Conroy guidelines.

One valuable method of avoiding LSMT litigation involves advance directives for health care that clarify a patient's desires regarding LSMT. Federal and state legislation and professional or-


68. See In re Guardianship of Browning, 568 So. 2d 4, 10 (Fla. 1990); McKay v. Bergstedt, 801 P.2d 617, 621 ( Nev. 1990); In re Conroy, 486 A.2d 1209, 1222 (N.J. 1985).

69. Conroy, 486 A.2d at 1220; Browning, 568 So. 2d at 15.


71. Conroy, 486 A.2d at 1229-32. The Conroy court laid out separate tests to handle three distinct justiciable situations where feeding may be withheld or removed when it is highly probable that a patient may die approximately within a year, even with the treatment. The first test is the "subjective test": when the evidence clearly supports that the patient would have refused the treatment under the particular circumstances. Id. at 1229. The second test is the "limited-objective test": when there is some indication of the patient's preference but no clear and convincing evidence. Id. at 1232. Finally, the third test is the "pure-objective test": when there is no evidence at all of the patient's desires but "the net burdens of the patient's life with the treatment clearly and markedly outweighs the benefits the patient derives from life." Id. Conroy died before the case was heard on appeal, but the court considered the case nonetheless and ruled that without further evidence, Conroy's case would not have satisfied any of the above three tests. Id. at 1219, 1242-43.

72. See, e.g., Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d 626, 636-37 (Mass. 1986) (agreeing with Conroy that the primary focus should be a patient's desires and the patient's experiences relating to pain and enjoyment rather than the type of treatment involved).

73. Advance directives are instructions from a competent person regarding future medical treatment decisions so that if this person is unable to make medical decisions, the advance directive (e.g., a living will) specifies the medical treatment that the person consents to or refuses, and may designate a surrogate decision maker. See, e.g., Conroy, 486
organizations, such as the American Bar Association and the American Medical Association, widely encourage the recognition and use of these advance directives by health care providers. Naturally, all practices and policies of health care institutions should be made known to the patient and guardians as soon as possible. Experience proves that health care institutions developing particular LSMT practices and policies and informing their patients of those policies help limit unnecessary and inappropriate LSMT litigation. Moreover, in the event of litigation, LSMT policies may facilitate the fair and expeditious processing of LSMT cases.

Other non-judicial alternatives for resolving LSMT matters continually emerge outside the judicial system. Organizations such as The Society For the Right to Die may be appropriate and worthy of exploration. The courts, however, retain ultimate responsibility for the fair, uniform, timely, and dignified disposition of LSMT cases that present a justiciable case or controversy. Absent contrary statutory or case law, a court generally will give careful consideration and, when appropriate, more weight to the generally accepted medical-ethical standards developed by health care, bioethical, and other interdisciplinary organizations for dealing with LSMT issues.

IV. PRETRIAL ISSUES IN LSMT CASES

The trial court should decline jurisdiction in a LSMT case unless it finds that the parties genuinely disagree about the patient's actual or probable wishes or as to the patient's competency to make treatment decisions. Otherwise, the court would merely render an advisory opinion. If the parties genuinely disagree, however, the court should not decline jurisdiction. If the patient is found to be incompetent, a proper surrogate must be legally designated to speak for the patient's best interests.

A.2d at 1229, 1229 n.5.
75. For the purposes of this article, those alternatives will not be discussed, but see the quarterly publications issued by the institute, The Society for the Right to Die.
76. See supra notes 63-64 and accompanying text discussing the AMA issuance.
77. See supra text accompanying notes 68-72.
78. Generally, this procedure occurs before the case is filed. On some occasions, however, it is done simultaneously with the filing of the case, but certainly before trial. The Montana Rights of the Terminally Ill Act specifically provides for appropriate surrogates.
A trial court presented with an LSMT case must also ascertain whether the proposed LSMT action comports with the law. If the LSMT is legally viable, and the moving party has had an opportunity to be heard, the court must make a determination before proceeding to a hearing or entertaining an order on the merits. First, the court must determine whether a genuine issue exists that requires resolution by the court, including controversies of fact or law. Second, the court must determine whether the party or parties commencing the action have a direct interest in the case; the parties must have standing to assert the claim. The exceptional nature of LSMT cases warrants the court raising these matters sua sponte. There rarely exists a genuine issue requiring judicial resolution when a competent person makes decisions regarding LSMT. The need for court intervention arises most often when the decisions regarding an incompetent person's life are in conflict.

Should a right-to-die case reach trial, additional procedures become necessary to ensure early control and an expeditious outcome. A trial court should establish and facilitate procedures designed to identify LSMT cases immediately when they are filed with the court. The movement of the case on the court docket must be closely supervised and controlled from filing through final disposition in order to avoid costly delays; where appropriate, the court should make available all pretrial procedures in LSMT cases to narrow the issues and facilitate prompt and fair resolution. In addition, in LSMT cases, the court should have expert and investigatory services immediately available to facilitate an expeditious, efficient, and just performance of the court's adjudicative, supervisory, and administrative duties. The court should contract for these invaluable services when they are not readily available. The results compiled by expert and investigatory services should be presented promptly to the court and made available to all involved parties.

Parties having a direct interest in the patient's welfare are en-

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79. Determinations of whether genuine issues and standing exist are generally governed by state civil procedure.

80. But see McKay v. Bergstedt, 801 P.2d 617, 620 (Nev. 1990) (patient was competent quadriplegic when he requested the removal of his ventilator system because he could not imagine life without his father, his lifelong care provider, who had a terminal illness).

81. See supra note 71 and accompanying text.

82. These services may be provided by organizations such as the AMA, Free Speech Advocates, the Society for the Right to Die, Ethics and Advocacy Task Force of the Nursing Home Action Group, American United for Life Legal Defense Fund, or American Academy of Medical Ethics.
titled to notice regarding LSMT proceedings. Therefore, in addition to the patient, notice must be delivered to the patient’s attending physician and the health care facility or agency under whose auspices the LSMT is maintained, proposed to be withheld, or provided. An attorney-in-fact under a durable power of attorney, or the patient’s spouse, next of kin, close friend, or an associate must also be given notice. In the case of an incompetent person, the patient’s guardian or guardian ad litem (GAL) must also receive notice.

Those individuals and organizations without standing to formally join an LSMT case may only be heard as amicus curiae. The trial court, however, has sole discretion to permit an individual or organization to file an amicus curiae brief or to testify. In determining whether to allow amicus curiae, a court should consider the uniqueness or complexity of the factual and legal issues, and the ability of the parties to adequately present the issues. The contributions of those seeking to be heard as amicus curiae should be weighed against the potential delay caused by participation, the potential expense to the patient or family, and the potential physical suffering or emotional distress to the patient or family. Other pertinent factors that courts should consider include the interest of those seeking amicus curiae status and the privacy rights of the patient and family.

As stated above, LSMT decisions made by, or on behalf of, competent patients generally should not require court review. Even when the patient is not competent, however, the court should take reasonable steps to ascertain the current or previously-expressed wishes and views of the patient and keep the patient apprised of the proceedings. A court may consider conversations the patient engaged in regarding life support while still competent to ascertain proof of the patient’s LSMT wishes. If the patient is

83. See generally In re Farrell, 529 A.2d 404, 416 (N.J. 1987) (holding that the patient, the patient’s loved ones, and doctors are most properly involved in the patient’s medical decisions).

84. “Associate” in this context means an associate of a significant period of time who seeks to speak on the patient’s behalf and is known to the court.

85. See Farrell, 529 A.2d at 416.


87. See, e.g., In re Estate of Greenspan, 558 N.E.2d 1194, 1197 (Ill. 1990) (AMA filed an amicus curiae brief that concurred with the court’s opinion, but the American Academy of Medical Ethics and other physicians as amici differed from the AMA’s holding).

88. See Mont. R. Civ. P. 24(b).

89. See, e.g., Farrell, 529 A.2d at 415.

90. See supra text accompanying notes 68-72.

absent from the proceedings, the court should appoint legal counsel, a GAL, or a guardian for a patient if the court determines that an appointment is necessary to protect the patient’s interests. The roles, duties, and standards of performance of legal counsel, a GAL, and a guardian should be clearly defined and communicated prior to appointment.

V. AT TRIAL: JUDICIAL HEARINGS

Once pretrial procedures are satisfied and the court determines that it has jurisdiction over a justiciable issue, the court should hold a formal hearing. Although a presumption exists in favor of open hearings and public records, the court may take steps to protect the privacy and minimize the anguish of the individuals involved in LSMT cases by limiting public access to the proceedings.

In the initial stages of the decision-making process, the first issue the court may have to resolve is whether the patient currently possesses the requisite mental capacity to make an LSMT decision. If the patient has sufficient capacity, the patient’s wishes usually control and, absent an overriding state interest, the court’s role is limited to enforcing the patient’s wishes. The statements (oral or written) of the competent patient control as evidence regarding patient’s intent. If a patient currently lacks the capacity to make an LSMT decision, the court must determine whether the patient, while competent, either appointed (where authorized by state law) a health care agent (either via a durable power of attorney, a living will, or some other mechanism) or executed a living will without an authorized designation of a health care agent. If a health care agent was duly appointed, the agent should exercise the authority vested by the appointment, according to state law. The court ordinarily has no further role in making the LSMT decision. If a health care agent has not been appointed but the patient otherwise expressed wishes regarding LSMT while competent (either by a living will, orally, or otherwise), these wishes should control, absent an overriding state interest. If the patient was never

92. See Conroy, 486 A.2d at 1232 (holding that if a patient’s preferences were to be kept alive despite pain, life support should never be removed). See also supra note 71 and accompanying text.

93. See Conroy, 486 A.2d at 1229-30.

94. The burden of proof is clear and convincing evidence. See In re Swan, 569 A.2d 1202, 1205 (Me. 1990) (following In re Gardner, 534 A.2d 947, 953 (Me. 1987) (general oral statements regarding vegetative conditions were sufficient to provide clear and convincing evidence)). But see In re Beth Israel Medical Ctr., 519 N.Y.S.2d 511, 515-17 (Sup. Ct. 1987) (medical treatment was withheld for an incompetent patient where no evidence was availa-
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competent, did not appoint a health care agent, or did not express wishes regarding LSMT while competent, the court must determine who, if anyone, will make decisions for the patient and what standards will guide these decisions. 95

Under statutory and common law in many states, the patient's next of kin 96 have the power to make decisions on behalf of an incompetent patient who fails to appoint a health care agent or express wishes regarding LSMT while competent. 97 If the surrogate's LSMT decisions are challenged, the court must determine whether grounds exist to dismiss or override the surrogate for failing to execute decisions in accordance with the standards established by state law. 98 In states that do not recognize "next of kin" surrogates, the court must either appoint someone to speak on behalf of the incompetent patient or make the LSMT decision itself. 99 In either case, the appointed surrogate, or the court acting as the surrogate for the patient, must make decisions within the standards established by state law.

If the patient, while competent, did not express explicit wishes, or if the patient was never competent, then LSMT may be withheld or withdrawn, absent an overriding state interest to continue LSMT, according to the standards for surrogate decision making followed in the particular jurisdiction. 100 These decision-making standards may vary widely. The surrogate may conclude that LSMT represents what the patient would have desired, based on what is known about the patient's preferences and general values regarding health care, life-extension, and overall manner of living. 101 If the surrogate lacks sufficient information to reach a judgment or the surrogate's decision is precluded by the law of the jurisdiction, the surrogate then may turn to the court for a deter-

95. See, e.g., Beth Israel Medical Ctr., 519 N.Y.S.2d at 515-17.
96. In some unusual circumstances, non-relatives are also or otherwise deemed fit.
97. See, e.g., In re Jobes, 529 A.2d 434, 447 (N.J. 1987) (family members close enough to make substituted judgment include a spouse, parents, adult children or siblings).
98. See Conroy, 486 A.2d at 1229-30.
99. This option is seldom exercised and falls under the "pure-objective test" articulated in Conroy. See supra note 71. See also supra text accompanying notes 32-39 on surrogate decision making under the Montana Rights of the Terminally Ill Act.
100. See Conroy, 486 A.2d at 1232 (stating that, regardless of the degree of pain inflicted on the patient, if the patient expressed her desire, while competent, to be kept alive on life-support, under no circumstances should life support be withdrawn).
101. Most courts will require at least some evidence, if not clear and convincing evidence, to support the surrogate's determination of the patient's intent.
mination of the best interest of the patient.

While determining the patient's wishes based on a written document (e.g., a living will, durable health care power of attorney), the court should determine whether the document meets the legal requirements to be considered as evidence, but failure to meet the legal requirements (e.g., a letter to a friend) will not preclude the court from accepting the document as evidence of the patient's wishes. Admission of the document is discretionary with the court. 102

Other useful evidence of a patient's wishes that the court may consider are oral statements made by the patient, or substantially equivalent expressions by a patient who cannot speak. These statements or expressions, however, ordinarily will not outweigh the wishes expressed in a validly executed written document. 103 In determining the wishes of a currently incompetent patient from oral statements made by the patient when the patient was competent, the court may find it necessary to relax the hearsay rule. Additionally, the court may consider the patient's lifestyle or other expressive conduct as evidence of the patient intent in the absence of other evidence or to supplement any written or oral evidence of a patient's intent. 104

Courts generally find it unnecessary to visit the patient outside the courtroom during the course of an LSMT trial except when a dispute arises concerning the competency of the patient, the patient's contemporaneous wishes, or a question of fact that can be readily resolved by direct observation. It may be desirable to obtain the testimony of an outside physician in addition to the treating physician's testimony, if the patient's medical condition or prognosis under proposed alternative treatments raise an issue. Weight should also be given to generally accepted medical-ethical standards. 105

Once the court reaches a decision, this decision should be promptly communicated in clear, unambiguous language, along with specific instructions. 106 The court, in fashioning its order, should consider those individuals and health care providers re-

104. See, e.g., id. at 1230 (religious beliefs or tenants).
105. See, e.g., In re Estate of Greenspan, 558 N.E.2d 1194, 1197 (Ill. 1990).
sponsible for carrying out the order. On post-hearing matters, expedited appeals are often required where the exigencies of the patient's circumstances so dictate. The court should take steps permitted by law to expedite the case. A court may extend its jurisdiction even though a patient has died of other causes before the appeal is ever heard. 107 Furthermore, where appropriate, the court should retain jurisdiction over an LSMT disposition because litigants may later seek clarifications relating to the court's procedural orders.

VI. CONCLUSION

As a result of the national patient-rights movement, the Montana Living Will Act was amended in 1991 to conform to the Uniform Rights of the Terminally Ill Act of 1989. In essence, this Act affirms the common law right that a patient may refuse treatment in cases where treatment would only serve to prolong the death process.

Many issues surrounding the Montana Rights of the Terminally Ill Act require clarification. For example, the degree of authority to be granted a surrogate is, as of yet, undetermined because the "decision of surrogates" has never been tested by the courts. Additionally, in the area of living wills, the issue of what constitutes an individual's competent state of mind at the time of declaration remains unanswered. Lack of judicial guidance encourages discrepancy among case decisions.

Although an LSMT case has yet to reach the Montana Supreme Court, some of the right-to-die controversy has subsided due to a nationwide consensus. A wide majority of states are now willing to recognize a right to privacy against bodily invasion in light of the growing consensus that supports avoiding extraordinary life sustaining measures. At present, there is hope that the Montana Code Commissioners will recommend that Montana adopt, in the 1995 legislative session, the new Uniform Health-Care Decisions Act that the National Conference of Commissioners on Uniform State Laws is presently drafting. This adoption would address, among other issues, the health care decisions pertaining to a person in a chronic vegetative state. If Montana chooses to adopt the Uniform Health-Care Decisions Act, it will be a positive step.

107. See Farrell, 529 A.2d at 410 (patient died before case reached the New Jersey Supreme Court, but the court retained jurisdiction at the urging of the patient's family despite her death because of the importance of the issue and the inevitability of similar cases arising).
toward clarifying important right-to-die issues that, up to this point, remain unaddressed.