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THE NATURAL DEATH ACT: PROTECTION FOR THE RIGHT TO DIE

Thomas H. Schimke, M.D.*

I. INTRODUCTION

We consciously and intellectually acknowledge the inevitability of our own deaths but unconsciously and emotionally find it difficult to accept and discuss. However, in recent times the subject of death and dying has received wide public debate. Approximately thirty-six states have passed a natural death act during the past decade, rendering death a public matter and the subject of frank and open discussion. Public officials are making statements which were previously almost unthinkable.

Elderly people who are terminally ill have a duty to die . . . . Like leaves which fall off a tree forming the humus in which other plants can grow, we've got a duty to die and get out of the way with all of our machines and artificial hearts, so that our kids can build a reasonable life.¹

The public has also become more involved as death and dying frequently occur under medical supervision. Approximately 80% of deaths in the United States now occur in hospitals and nursing homes.² The traditional sources of patient support, the family and church, have been replaced or heavily supplemented by doctors, nurses, hospitals and nursing homes. As a result, we must adopt new procedures to accomplish prompt and effective communication and resolution of disagreements among the parties involved in the medical management of death and dying. New procedures will help us to solve the increasingly more complex bioethical problems which arise in the modern medical setting.

Biomedical developments of the past 20 years have made death more a matter of deliberate decision. For almost any life-threatening condition, some form of intervention can now delay the moment of death. Once within the province of fate, death is

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¹ Colorado Governor Richard Lamm addressing the Colorado Health Lawyers Association, TIME April 9, 1984, at 68.

² Zimmerman, Experience with a Hospice-Care Program for the Terminally Ill, 189 ANN. SURG. 683 (1979).

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now a matter of human choice. This development has profound ethical and legal implications. Medical technology often renders patients less able to communicate or direct the course of their treatment. Other people must usually assist in making treatment decisions or at least acquiesce in carrying them out.

While technology allows physicians to prolong life long enough to successfully treat a life-threatening disease or injury, technology also prolongs the dying process without restoring health or a functional life. The more experience we have with technology, the more we realize the need to evaluate its use and abuse. Consequently, during the past ten years medical, legal, religious and philosophy professionals have sought to clarify the goals, rights, duties, and liabilities of all concerned. Various courts and legislatures have responded to the need for rules to govern this area.

Four incompatible goals of the health care system render the evaluation and clarification process arduous. These goals are: (1) to provide the best health care to all under all circumstances, (2) to provide equal health care to all, (3) to maximize the free choice of both the patient and the health care provider, and (4) to contain cost.³

This article focuses on the rights of a terminally or hopelessly ill patient as seen through the eyes of a health care provider. It discusses the legal, moral and medical aspects of the rights of the terminally or hopelessly ill patient and promotes the legislative passage of a Montana Natural Death Act.

II. THE PROBLEM

A. Chronic Disease

Approximately two million people die each year in the United States. With the intervention of modern medicine, acute and rapidly fatal diseases are no longer the main cause of death. Chronic conditions caused 87% of all deaths in 1978.⁴ The majority of these deaths resulted from prolonged illnesses caused by heart disease (34%), malignancies (22%), and cerebrovascular disease (7%). Traumatic and usually more sudden deaths, including accidents, homicides, and suicides, accounted for only 13% of all deaths.⁵

Those facing death today are frequently patients who suffer from one or more ailments for which a potentially therapeutic in-

⁴ Somers, Long Term Care for the Elderly and Disabled, 307 NEW ENG. J. MED. 221 (1982).
⁵ DEP'T OF HEALTH EDUC. & WELFARE, FACTS OF LIFE AND DEATH 31-33 (1978).
tervention exists. With the intervention of modern drug and surgical treatments, almost no disease has a natural history.\(^6\)

Few in our society want to think seriously about aging and death. Yet both physician and layman alike must be mindful of the characteristics of chronic illnesses which result in the overwhelming majority of health care costs in the United States today. Characteristically, chronic illness has a gradual onset, an insidious development, and an episodic relapse pattern. It causes great pain and suffering, and creates serious or catastrophic financial hardship. The constant or intermittent threat of permanent disability or death causes a panoply of serious psychological consequences: bewilderment, shock, helplessness, depression, grief, demoralization, loss of self-esteem, guilt, shame, anger, resentment, and self-pity. In turn, these psychological factors affect the patient's quality of life and will to live.

**B. Spiritual Values**

Life rarely has intrinsic value for people. Rather it has instrumental value—life is good or bad because of the good or bad things it brings. However, for some, life is infinitely important and death must be opposed. For others, the inevitability of death gives life meaning or purpose. For still others, death releases the soul from its body.

The perspectives on death are as numerous as the philosophies and religions that give them birth. For each perspective, there exist complimentary values and priorities for the medical care of dying patients. A tension develops between the perspectives; it persists even though society and health care professionals agree that the avoidance of death should not always be the preeminent goal of therapy. Assisting each patient to achieve a personally appropriate death is among the professionals' obligations.\(^7\)

**C. Medical Ethics and Duties**

The practice of medicine charges the physician with a duty to cure, prevent, or ameliorate disease whenever possible, and always to comfort. The Hippocratic Oath provides in part: "I will prescribe regimen for the good of my patients according to my ability

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6. *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment* 16 (1983) [hereinafter cited as President's Commission].

7. *Id.* at 21-23.
and my judgment and never do harm to anyone."

The old medical ethics were quite clear—only death rendered a case hopeless; ethics precisely defined death as a cessation of cardiorespiratory function. The physician functioned as a hero in the struggle against death. Developments in medical technology have made it easy to just continue treatment with little regard for the costs. However, seduced by false hopes that technology provides the key to human conquest of nature, we not only risk losing control of technology, but we also risk the prospect of becoming unwilling prisoners of devices originally created to liberate us.

Therefore, a new ethic developed with the new technology: "The social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have the discretion to resolve the conflict." Society might expect, then, for physicians to have special training or at least some resources to which they might turn when such problems arise. But society's collective refusal to make such decisions leaves physicians without resources.

At all times, of course, society expects the physician to keep his patient's interests paramount. He must confer with his patients or their next of kin, keep them fully informed, and be guided by their wishes. Serious possibilities for abuse exist when decisions are made privately between the patient's family and the physician. Neither the family nor the physician can invariably and accurately reflect the desires of the patient. Modern medical ethics no longer accept the paternalistic approach by the physician to his patient which was very common a few years ago.

Nevertheless patients and families rely heavily on the professional judgment and experience of the physician. The physician's advice is usually the decisive factor in most medical decisions. The physician generally asks the patient and family to consider the quality as well as the length of life that might result from each of the courses of action possible in a given case. There is nothing more crucial to a physician's professional role than active involvement in these decisions. A physician who fails to assist in this decision-making role fails to meet his professional responsibilities.

D. Uncertainty of Prognoses

Every physician knows that there are times when providing comfort rather than treatment clearly offers the best course of action; to do otherwise would inflict unjustifiable suffering or merely prolong the agony of a terminal or hopeless illness. In many situations the disadvantages of treatment outweigh the benefits. In others, risky choices between treatment and no treatment must be made, even though the calculus of risk, discomfort, and benefit remains unclear.\(^\text{12}\)

Medicine becomes a very inexact science when physicians prognosticate about the end of life. Except in cases involving patients who are very ill with a short prognosis of three to four months, physicians consistently underestimate survival. Actual survival coincides with predicted survival in only 16% of patients.\(^\text{13}\) This subjective nature of prognoses affects the type of treatment recommended by the physician which, in turn, affects the patient's survival.

In one study, physicians who preferred to intubate and mechanically ventilate a patient with severe chronic lung disease projected that the patient would survive about 15 months. Other physicians who decided against mechanical ventilation when presented with the same case predicted that even with artificial life support the patient had only six months to live.\(^\text{14}\)

The uncertainty about the prognosis in cases of permanent loss of consciousness or chronic vegetative state is of concern when deciding the right of the comatose patient to die. Many physicians will not make a firm prognosis in cases of this nature because they lack absolute certainty that the patient will never regain consciousness. One highly regarded expert\(^\text{15}\) in this area concluded that: (1) in cases of traumatic brain damage, if complete unconsciousness lasts for longer than six weeks, only severe disability can result from survival; (2) in cases of ischemic brain injury, no independent intellectual or motor function will return if complete unconsciousness lasts longer than four weeks; (3) in cases of dementias or brain tumors, loss of consciousness for a period lasting as long as one


\(^{15}\) Dr. Fred Plum, Professor of Neurology, Cornell University Medical College.
month dictates a hopeless prognosis. Despite reliable medical support, many physicians are averse to recommend the termination of life-sustaining treatment even after four to six weeks of coma.

E. Confusing Terminology

There is also uncertainty regarding such terms as "terminal illness," "hopeless condition," "imminent death," "ordinary and extraordinary treatment" and "reasonable medical certainty." While the majority of doctors define terminal illness as "an illness that progresses to death regardless of what is done," a substantial number choose to define a terminal illness in terms of longevity; the duration may vary from less than one month to less than one year. For purposes of this article, a terminal illness is defined as an illness likely to cause death within a timeframe which is, to the patient, very short.

A hopeless condition is distinct from a terminal condition when minor life-sustaining treatment, such as tube feedings or insulin, could prolong life for an indefinite period but no meaningful recovery can occur. The author defines a hopeless condition as a severe medical illness or injury which precludes basic bodily functions without the sustenance of life-sustaining procedures, and from which there is no reasonable chance of recovery.

Physicians variously define imminent death commonly used in the living will and natural death acts. It can mean death in less than one day or death in less than six months. The definitions of life-sustaining procedures or artificial life support are similarly varied. The term may include ventilators (by 96% of physicians), intravenous feeding (51%), and insulin (34%). There also exists a great deal of ambiguity among physicians regarding whether or not a prognosis is based on reasonable medical certainty. Physicians often expect themselves to be mathematically certain of the prognosis despite the reality that their expectation is a medical impossibility. As a result, the patient's terminal treatment, dying, and suffering can be needlessly prolonged because a physician fears possible criminal or civil liability for failure to vigorously treat all medical possibilities.

16. President's Commission, supra note 6, at 459-60.
18. President's Commission, supra note 6, at 26.
19. Id. at 933.
20. Id. at 932.
F. Passive Euthanasia Liability

Physicians are ambivalent about serving as the ultimate decision-makers and about the public's perception of them as "playing God." Omitting treatment of patients whose hearts are still beating represents a radical departure from two thousand years of medical tradition.21

When a physician omits treatment, the resulting death is called passive euthanasia.22 This omission may be regarded by the law as an affirmative action which lead to the same result. "A material element of every offense is a voluntary act, which includes an omission to perform a duty which the law imposes on the offender and which he is physically capable of performing."23 Approximately 20 states including Montana have statutes which uphold the common law prohibiting assisting, advising, or otherwise aiding another to commit suicide.24 Despite the lack of judicial action against physicians who practice passive euthanasia, the physician remains ill at ease due to our laws and our litigious society.

"[W]hat [precedent] there is suggests that the doctor will be protected if he acts on a good faith judgment that is not grievously unreasonable by medical standards."25 Despite this assurance, physicians' concern about possible criminal liability for deliberate omissions became a reality with the indictment in 1983 of two physicians on charges of murder and conspiracy to commit murder in *Barber v. California*.26 The deceased patient underwent surgery for closure of an ileostomy. In the recovery room the patient suffered a cardiac arrest. Three days later the physician diagnosed diffuse severe anoxic encephalopathy27 causing a chronic vegetative state (brain death criteria were not present) with no likelihood of recovery. The doctors complied with a written request from the family to remove the ventilator. Two days later, at the family's request, the doctors stopped intravenous fluids. The patient died soon thereafter; a third party sought a state action against the physicians.28

The magistrate court dismissed the charges against the doctors and the State of California appealed to the Superior Court of

27. Brain disease caused by an absence of oxygen.
28. *Barber* at 1010, 195 Cal. Rptr. at 486.
Los Angeles. The superior court ruled that the doctors' intentional conduct lacked authorization since the patient had not previously executed a written directive or living will. Viewing the family's request as a nullity, the state court reinstated the criminal charge of murder against the doctors.

On appeal by the doctors, the court of appeal stated that legislation offers the only long-term solution to this problem. The court found that few people have living wills and attributed this to the typically human characteristics of procrastination and reluctance to contemplate the need for a living will. Further, the court ruled that:

1. A diagnosis of brain death is not a condition precedent to the cessation of life-sustaining treatment;
2. The disconnecting of mechanical devices can be compared to withholding medications or intravenous fluids;
3. The benefits and burdens of nutrition and hydration may not always provide net benefits to patients and ought to be evaluated in the same manner as any other medical procedure;
4. A physician has no duty to continue treatments proven to be ineffective; and
5. The standards of medical practice authorize a physician to discontinue a form of therapy which, in his judgment, is useless.

The court concluded that the doctors' omission to continue treatment under the circumstances, though intentional and with knowledge that the patient would die, was not an unlawful failure to perform a legal duty.

III. Changing Medical Ethics and Jurisprudence

A. In re Quinlan

Prior to the celebrated Karen Ann Quinlan case, the patient's family and physician or the physician alone commonly made the decision to withdraw artificial life-sustaining procedures from a patient who would never regain consciousness or was terminally ill. Undoubtedly, members of the medical profession practiced euthanasia prior to 1976 by withholding or withdrawing life-sustaining procedures from the terminally ill. But, it became imperative to some physicians that there be legal rules to regulate this discretionary euthanasia. They argued that discretionary eu-

29. Id. at 1011, 195 Cal. Rptr. at 487.
30. Id.
31. Id. at 1014, 195 Cal. Rptr. at 488.
32. Id. at 1016-19, 195 Cal. Rptr. at 490-91.
33. Id. at 1022, 195 Cal. Rptr. at 493.
35. As many as 80% of doctors practiced medicine this way. 21B(1) J. A.M.A. 249 (1971).
thanasi placed patients treated by different doctors in inequitable positions and subjected physicians to the risk of civil or criminal liability.

B. Informed Consent

Since Judge Cardozo espoused the concept of informed consent in Schloendorff v. Society of New York Hospital, courts have found that patients possess the moral, ethical, and legal right to be informed of all aspects of their health and should have the right to participate in all decisions which may affect their health. The elements of an informed consent are: (1) the diagnosis; (2) the nature and purpose of the proposed treatment or procedure; (3) the risks, consequences, and side effects; (4) the probability of success; (5) reasonably available alternatives; and (6) result to be anticipated if nothing is done.

The right of an individual to determine when bodily invasion in the form of medical treatment will occur is not a new concept in the law.

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference by others, unless by clear and unquestionable authority of law.

Under the doctrine of informed consent and absent an emergency, no medical procedure or treatment may be performed by a physician without the patient’s consent. Absent an informed consent, medical treatment may be variously expressed as assault, battery, negligence, malpractice, or even trespass. The underlying concept—protection of bodily integrity—remains the crux of informed consent.

C. Right to Refuse Treatment

The patient’s right to refuse treatment and to withdraw consent at any time logically extends the informed consent doctrine.

The patient’s right to informed consent makes no sense without a right to an informed refusal. The right to refuse should be extended to the dying patient, for his decision on preferred treat-

36. 211 N.Y. 125, 105 N.E. 92 (1914).
ment is no different from that involved in any other medical situation. The individual continues to know best his own value preferences, capacity for pain and suffering, and uncompleted business and social obligations. He remains the optimal cost avoider.  

The primary goal of health care, in general, is to maximize each patient's well-being. However, a physician merely acting in a patient's best interests, without recognizing the individual as the pivotal decision-maker, fails to respect each patient's interest in self-determination—the capacity to form, revise and pursue his own plans for life.

D. The Best Interests Standard

During the past twenty years, conflicts between a physician's and the patient's determination of the patient's best interest have been resolved in different ways. In a 1964 Jehovah's Witness transfusion case, the court favored the ethics of the physician and the "best interests" of the patient. The court ordered the blood transfusions despite the patient's religious beliefs and first amendment rights to religious freedom.

[T]he doctor's conscience and professional oath must also be respected. In the present case the patient voluntarily submitted himself to and insisted upon medical care. Simultaneously he sought to dictate to treating physicians a course of treatment amounting to medical malpractice. To require these doctors to ignore the mandates of their own conscience, even in the name of free religious exercise, cannot be justified under these circumstances. The patient may knowingly decline treatment, but he may not demand mistreatment.

E. The Subjective Standard

Recent court decisions, however, have been less utilitarian in their approach toward a patient's desires. They have instead adopted a deontological jurisprudence based on the rights of the "individual as a person." One of the major principles of this jurisprudence provides that each person enjoys an equal right to the most extensive basic individual liberty compatible with a similar liberty for others. Individual autonomy protects the inherent, in-

41. President's Commission, supra note 6, at 26.
trinsic worth of an individual. The equal right of freedom to decide to live or die can be based on the principle that "to respect persons is to recognize that they possess an inviolability founded on justice that even the welfare of society as a whole cannot override."3

While individual liberties usually concern an approach to life, they also involve an approach to death. The respect of a person’s autonomy implies that a person is rational, adequately informed and can freely give consent. It implies that he alone has both the equal moral right to be free to live, and, ultimately, the equal right to be free to decide to die.4

In other words, individual autonomy requires the application of a subjective standard. Under this standard, the subjective values of the individual outweigh the values of the medical or legal paternalistic approach to determining the patient’s best interest, whether the subjective values are in the patient’s best interest. The President’s Commission advocates this standard: “[A] competent patient’s self-determination is and usually should be given greater weight than other people’s views on that individual’s well-being.”5

“[T]he value of life . . . is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.”6

Because medical-legal ethics are changing, the old professional interests or ethics of the physician will not usually prevail over the common law and constitutional (religious and privacy) rights of the individual. In a more recent Jehovah’s Witness case,7 the court upheld the patient’s right to refuse blood transfusions despite the risk of death. The court found that although the interests or ethics of the medical profession should be considered, they cannot override an individual’s constitutional right to refuse medical treatment even when the refusal may result in death. However, the right to decline life-sustaining medical treatment is not absolute. When coupled with the state’s interest in the preservation and sanctity of life, the protection of innocent third parties, and the prevention of suicide, the state’s interests become compelling and may at least temporarily override the patient’s right to die. In In re Conroy,8 the court held that the guardian of an eighty-four year old incompetent, nursing home patient could not have a nasogas-

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44. M. Kohl, Beneficent Euthanasia 84 (1975).
45. President’s Commission, supra note 6, at 27.

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tric feeding tube removed until incompetency was properly determined and the ombudsman for the institutionalized elderly was notified.

IV. DEVELOPMENT OF A PROCEDURE TO SOLVE THE PROBLEM

A. Goal

This issue is complex because of conflicts between the varied interests, both public and private, and the widely divergent and deeply held values of the parties involved. This complexity necessitates the adoption of a predominately procedural policy to guide patients, families, clergy, surrogates, health care providers and the judiciary in the resolution of conflicts surrounding the patient's right to die.

The goal should be to advance the type of medical treatment that best promotes a patient's health and well-being, based on that particular patient's values and goals. No uniform, objective determination is adequate—whether defined by society or by health professionals.

Medical cases of this type are usually in court because the hospitals and physicians, fearing civil or criminal liability, are reluctant to follow modern ethical principles. In actuality, treatment of patients poses more risks than non-treatment since very few cases involving the omission of treatment have been litigated by surviving family members.

Although a natural death act neither establishes a right to die nor guarantees a natural death, it does assure the patient's right to refuse medical treatment based on the principle of individual autonomy and it protects the health care providers from legal liability for an omission. While the Montana Living Will Act protects those patients who make the proper declaration, the majority of the terminally or hopelessly ill do not have a living will or a durable power of attorney. Moreover, they frequently lack competence to make such a declaration when it is needed. A natural death act protects the autonomy of terminally or hopelessly ill incompetent persons.

A natural death act does not, however, include a procedure for those patients who are brain dead. Because these patients already meet the statutory definition of death, existing law makes it easier to deal with their cases. This existing codification of the Uniform

Determination of Death Act uses the following medical guidelines for brain death: (1) cerebral function is absent;\textsuperscript{52} (2) brainstem reflexes are absent;\textsuperscript{53} (3) the cause of coma is established and sufficient to account for the loss of brain function; (4) reversible causes of brain dysfunction have been ruled out;\textsuperscript{54} (5) an adequate period of observation has elapsed; (6) confirmation of the clinical diagnosis of brain death by electroencephalography is desirable.\textsuperscript{55}

B. Competency

The patients of primary concern are adults or minors who are comatose, or medically adjudged to be permanently incompetent and in a terminal or hopeless condition. This group includes critically ill or injured patients being kept alive by artificial means. It also includes senile nursing home patients who require treatment for an acute illness.

An assessment of the patient's competency is of major importance at the onset of the decision-making process. This determination allows all competent persons to direct their own treatment and protects incompetents from the harmful effects of their own decisions. The concept of competency, like the concept of dangerousness, is vague and involves both medical and legal principles. The test for competency varies from one context to another. Further, there is little legal guidance to illuminate the concept of competency to consent to, or refuse, medical treatment. Medical specialists use five general tests for competency: (1) simple ability to make a choice; (2) the ability to make a choice with a reasonable outcome; (3) ability to make a choice based on rational reasons; (4) the simple ability to understand; (5) actual understanding.\textsuperscript{56} None of these tests is specifically approved for life and death decisions. However, choices 3 and 5 provide more clear and convincing evidence of competency, and apply more directly to the issue at hand.

Ultimately, decision-making incapacity or incompetency is not a medical or a psychiatric diagnostic category. Rather, it rests on a judgment of the type that an informed lay person might make: that a patient lacks sufficient ability to understand a situation and

\begin{itemize}
  \item \textsuperscript{52} Coma with cerebral unreceptivity and unresponsivity evidences an absence of cerebral function.
  \item \textsuperscript{53} Brainstem reflexes include pupillary light, corneal, oculovestibular, oropharyngeal, and respiratory reflexes.
  \item \textsuperscript{54} Reversible causes of brain dysfunction include sedation, hypothermia, neuromuscular blockade, and shock.
  \item \textsuperscript{55} President's Commission, Defining Death 162-65 (1981).
  \item \textsuperscript{56} Roth, Tests of Competency to Consent to Treatment, 134:4 Am. J. Psych. 279 (1977).
\end{itemize}
to make a choice in light of that understanding. Indeed, when judges make legal determinations of patients' competence, they consider the situation not as medical experts but as lay persons examining the data provided by health care personnel and others.

A simple mental status examination commonly used by physicians should be sufficient to establish competency: orientation, mood and affect, cognitive function, the presence or absence of hallucinations or delusions, recent and remote memory, logical sequencing, and comprehension of abstract ideas. The determination of competency is routinely within the province of physicians dealing with medical problems and the patient's competency to make a decision to die should not be an exception. Routine recourse to the courts for this purpose is not necessary.

C. Roles of Participants

To promote the respect for patients as individuals and to reduce health care provider liability for purposeful omissions in treatment, the parties must frankly discuss the decision to be made in a hopeless or terminal illness situation. The Montana Natural Death Act will facilitate that process.

The competent adult patient should be the decision-maker unless he knowingly transfers his authority to another. On the one hand, the health care provider maintains a predisposition for sustaining life and discourages the patient's acquiescence to death. On the other hand, the primary physician must recommend a medically sound course of action and assist the patient in the making of an informed decision about treatment. While the grieving family members may support the patient's wishes, they cannot be expected to be dispassionate; their grief and anxiety are often greater than the patient's. The clergy can attend especially to religious questions and rituals that affirm the spiritual and temporal meaning of the patient and his family.

A major obstacle to an equitable resolution of the incompetent patient's right to die arises when the patient's family disagrees with the health care provider's proposed course of action. One party may wish to terminate treatment while the other may favor the status quo. Uncounted millions of health care dollars are spent each year because of this impasse. The Montana Natural Death Act will function to promote the development of a process wherein

57. President's Commission, supra note 6, at 123.
58. Id. at 126.
59. Id. at 41-52.
this conflict can be resolved.

Although the court need not play a role in every substantive decision to withhold treatment, there will be instances when the discrete and disinterested opinion of the judiciary will be required to resolve legal matters. While the court should not arbitrate disagreements on moral matters, it should be involved in the simultaneous appointment of a guardian and guardian ad litem. The guardian will usually be a family member who will exercise the incompetent’s right to refuse treatment by using the subjective standard of the patient: If competent, would the patient choose to have the life-sustaining treatment removed?

The guardian ought to be guided in his decisions by available knowledge of the patient’s own desires and feelings, to the extent that they were expressed before the patient became incompetent. If the guardian cannot ascertain the choice the patient would have made, he ought to be guided by the patient’s best interests. Under this standard such factors as the relief of suffering, the preservation or restoration of functioning, the quality as well as the extent of life sustained, and the impact of the decision on those people closest to the patient may be considered. 60

The guardian ad litem should be appointed simultaneously with the guardian. He will represent the legal interests of the incompetent in any judicial proceeding, including a review of the guardian’s decision concerning the ward. The guardian ad litem will realize the inherent subjective nature of the guardian’s decisions and will advocate the patient’s desires from a more disinterested position.

D. Passive Euthanasia Is Not Suicide

The death rights of a terminally or hopelessly ill, competent, adult patient are clear. Medical ethics and legal rules prohibit treatment administered against the patient’s will. Various state supreme courts have ruled that declining life-sustaining medical treatment may not be viewed as an attempt to commit suicide: “Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur it would be the result, primarily, of the underlying disease and not the result of a self-inflicted injury.” 61

60. Id. at 132-35.
61. Conroy, 98 N.J. at 351, 486 A.2d at 1224.
E. Proportionate v. Disproportionate Treatment

The terms ordinary and extraordinary treatment must be elucidated so that health care providers can perform their duties in a confident and competent manner. These terms cause much confusion and provide little guidance. A better approach involves the determination of whether the proposed treatment is proportionate or disproportionate vis-a-vis benefits or burdens for the patient. A proportionate treatment has, in the view of the patient, at least a reasonable chance of providing benefits which outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, such as a surgical operation, the treatment may still be proportionate if the prognosis is for complete cure or significant improvement in the patient’s condition. On the other hand, a minimally painful or intrusive treatment such as the use of a nasogastric tube for feeding, may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement of the condition.62

The benefit-burden standard assumes that: (1) a determination has been carefully made by qualified medical personnel; (2) the patient’s spouse or appropriate surrogate concurs with the proposed withdrawal of life-sustaining procedures; and (3) the decision is consistent either with the expressed desires of the patient or what the spouse/surrogate believes the patient would have wanted under the circumstances.

Under the proportionate-disproportionate or benefit-burden analysis, surgical operations and mechanical devices such as ventilators, pacemakers, and hemodialysis machines may be extraordinary treatment. Intravenous feeding,63 antibiotics, and nasogastric tube feedings64 also might be extraordinary under this analysis.

62. President's Commission, supra note 6, at 82-90; Barber, 147 Cal. App. 3d at 1019, 195 Cal. Rptr. at 491.

"[O]ne would have to think that the use of the same respirator or life support could be considered ordinary in the context of the possibly curable patient but extraordinary in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient." Quinlan, 70 N.J. at 48, 355 A.2d at 668.

"[T]he focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence . . . ." Id. at 51, 355 A.2d at 669.


63. Barber, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484.

64. Conroy, 98 N.J. 331, 486 A.2d 1209; In re Severn, 425 A.2d 156 (Del. Ch. 1980).
"As recently as five years ago . . . the idea that fluids and nutrient might be withdrawn, with moral and perhaps legal impunity, from dying patients, was a notion that would have been repudiated, if not condemned, by most health professionals." 65 Although many arguments can be raised for continuation of nourishment, in certain cases the patient would neither expect nor desire continued nourishment if he could competently express himself. In some cases, nourishment may actually detract from the patient's dying with dignity. 66

F. Prognosis Committee

The primary physician should be responsible for confirming the diagnosis and prognosis of an incompetent, terminally or hopelessly ill patient. This can be accomplished by consulting a second physician, preferably one with special expertise in treatment of the disease or condition in question. If there is disagreement between physicians or between the physicians and the family regarding the diagnosis and prognosis, the matter should be referred to a "prognosis committee" within the medical institution for a second opinion. This ad hoc committee, composed of the patient's physician and at least two other physicians with relevant qualifications, would be selected on a case-by-case basis. If these physicians unanimously agree that there is no reasonable medical probability that the patient will return to a rational and functional state, they should enter that opinion in the patient's medical record. 67 Selection of prognosis committee members should be made by the medical staff president and would include only physicians. The prognosis committee would function only to confirm the diagnosis and prognosis. It would not have the duties of a multidisciplinary ethics committee which may establish bioethical policies for the institution. The prognosis committee, rather than the court, should determine the time at which it can be said there is no reasonable probability that a patient will recover from his terminal or hopeless condition. 68

V. Proposal for Legislative Action

The following is the author's proposal. The general form is

68. Id. at 135, 660 P.2d at 750.
taken from statutes in California and Virginia. Unique provisions within this proposed statute incorporate recent rulings of the Washington Supreme Court. 69

Section
1. Short title.
2. Statement of purpose.
3. Legislative findings.
4. Definitions.
5. Procedure for declaration by competent patient.
7. Revocation of declaration.
9. Conflicts among the parties.
10. Sanctions; immunities; burden of proof; presumption.
11. Mercy killing or euthanasia prohibited.
12. Effect of declaration; suicide; insurance.

1. Short title. This chapter shall be known and may be cited as the "Montana Natural Death Act."

2. Statement of purpose. The legislature of Montana desires to affirm that persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal or hopeless condition. Through the Natural Death Act, the legislature seeks to minimize differences between those who execute living will declarations and those who do not, and to guarantee each the right to choose appropriate medical treatment for themselves.

3. Legislative findings. The legislature finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits; however, the changing standards of medical care have resulted in the recognition that it may not always be appropriate to use therapy to sustain the life of a terminally ill patient, or one who has no hope for a meaningful recovery.

The legislature further finds that society is searching for ways to re-humanize the dying process and solve the conflict between modern technology and human needs of the dying.

The legislature further finds that in the interest of protecting individual autonomy, prolongation of life for such persons may cause loss of personal dignity and unnecessary pain and suffering.

while providing nothing medically necessary or beneficial to the patient.

The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the propriety of terminating the use or application of life-sustaining procedures when the patient has not executed a valid living will but has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which persons have a right to expect, the legislature hereby declares that the laws of the state of Montana shall recognize (i) the right of a competent adult person to make an oral or written declaration instructing such person’s physician to withhold or withdraw life-sustaining procedures in the event of a terminal or hopeless medical condition and (ii) the right of a minor or incompetent adult to have a surrogate exercise these rights by proxy.

4. Definitions. As used in this chapter, the following definitions apply:

(1) “Primary physician” means a person licensed to practice medicine in the State of Montana who has primary responsibility for the treatment and care of the patient.

(2) “Declaration” means either (i) a witnessed document in writing, or (ii) a witnessed oral statement, made by the declarant prior to, or subsequent to, the time the patient is diagnosed as suffering from a terminal or hopeless condition and in accordance with the provisions of section 5. This declaration shall be binding upon the physician and nurse and all other health care providers including hospitals and nursing homes. Failure to abide by this declaration shall result in sanctions in accordance with the provisions of section 10.

(3) “Life-sustaining procedure” means any medical procedure, treatment or intervention which: (i) utilizes mechanical or other artificial means including but not limited to ventilators, oxygen, hemodialysis, resuscitation, nasogastric or intravenous feeding tubes, blood transfusions, antibiotics, chemotherapy and insulin to sustain, restore or supplant a spontaneous vital function and is of such a nature as to afford a patient no significant benefit nor reasonable expectation of recovery from the terminal or hopeless condition; (ii) when applied to a patient in a terminal or hopeless condition, would be useless in promoting recovery, would add excessive pain or burden to the patient, and would serve only to prolong the dying process; however, nothing in this section shall reduce the duty to administer medications or perform acts deemed
necessary to provide comfort or alleviate pain.

(4) "Qualified patient" means (i) any competent adult patient who has made a declaration in accordance with this chapter and who is terminally or hopelessly ill or (ii) any permanently incompetent adult patient or minor patient who is medically adjudged to be in a terminal or hopeless condition in accord with the definitions provided herein.

(5) "Hopeless condition" means a severe disease or injury from which, to a reasonable degree of medical probability (i) there can be no meaningful recovery and (ii) basic bodily functions require the continuous sustenance of life-sustaining procedures.

(6) "Terminal condition" means a condition caused by injury or disease from which, to a reasonable degree of medical probability: (i) there can be no meaningful recovery and (ii) death will occur within a relatively short time without the application of a life-sustaining procedure.

(7) "Prognosis Committee" means a hospital or nursing home ad hoc committee formed to offer a formal medical opinion on the terminal or hopeless condition of an incompetent patient when a disagreement about future medical treatment arises between the health care providers and the family or surrogate of the patient. Any of the involved parties can request this opinion. The committee shall be appointed by the medical staff president and be composed of the primary physician and two other physicians. The only function of the committee is to ascertain the terminal or hopeless condition of the patient. The opinion of the prognosis committee shall be made part of the patient's medical record.

5. Procedure for declaration by competent patient; effect. Any competent adult may, at any time, make a written declaration directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a terminal or hopeless condition. A written declaration shall be signed by the declarant in the presence of two disinterested subscribing witnesses. An oral declaration may be made by a competent adult in the presence of a physician and two disinterested witnesses by any nonwritten means of communication at any time subsequent to the diagnosis of a terminal or hopeless condition.

It shall be the responsibility of the declarant to provide notification to his primary physician that a written declaration has been made. In the event the declarant is comatose, incompetent or otherwise mentally or physically incapable, any other person may notify the physician of the existence of a declaration. The primary physician who is so notified shall promptly make the declaration,
or a copy of the declaration, a part of the declarant's medical records. If the declaration is oral, the physician shall likewise promptly make the fact of such declaration a part of the patient's medical record.

A proper declaration shall become effective immediately and shall be binding on the primary physician and other health care provider.

6. **Suggested form of a written declaration.** A declaration executed pursuant to this chapter may but need not be in the following form, and may include other specific directions including, but not limited to, a designation of another person to make the treatment decision for the declarant should he be (i) diagnosed as suffering from a terminal or hopeless condition and (ii) be comatose, incompetent or otherwise mentally or physically incapable of communication. Should any other specific directions be held to be invalid, such invalidity shall not affect the declaration.

Declaration made this _____ day of _______ (month, year). I, ________________, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

(a) If at any time I should have a terminal or hopeless condition and my primary physician has determined that there can be no meaningful recovery from such condition or my death is likely to occur within a very short time, where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort or to alleviate pain.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment. I accept the consequences of such a refusal.

(c) It is my intention that this declaration shall be valid until revoked by me ____________________________ (signature and date).

(d) The declarant is known to me and voluntarily signed this document in my presence ________________________ (signed by two disinterested witnesses).

7. **Revocation of declaration.** A declaration shall be effective until revoked by the declarant according to this section. A declaration may be revoked at any time and in any manner by the declar-
ant. Any revocation shall be effective when communicated to the primary physician. No civil or criminal liability shall be imposed upon any person for a failure to act upon a revocation unless that person has actual knowledge of such revocation.

8. Procedure for incompetent patient. (1) Life-sustaining procedures may be withheld or withdrawn from an adult or minor patient with a terminal or hopeless condition who (i) is comatose, or medically adjudged to be permanently incompetent and (ii) has not made a declaration in accordance with this chapter, provided there is consultation and agreement for the withholding or the withdrawal of life-sustaining procedures between the primary physician and a second physician with expertise in the diagnosis and treatment of the patient’s illness, and any of the following surrogate individuals, in the following order of priority if no individual in a prior class is reasonably available, willing, and competent to act:

(a) The person or persons designated by the patient in writing to make the treatment decision for him should he be diagnosed as suffering from a terminal or hopeless condition;

(b) The person holding the durable power of attorney for the patient;

(c) The patient’s spouse;

(d) An adult child of the patient or, if the patient has more than one adult child, by a majority of the children who are reasonably available for consultation;

(e) The parents of the patient;

(f) The nearest living relative of the patient;

(g) The judicially appointed guardian and guardian ad litem.

(2) The proper surrogate has a duty to the incompetent patient to exercise by proxy the patient’s right to die under appropriate medical circumstances.

(3) In any case where the treatment decision is made by a family member, there shall be at least one non-party witness present.

(4) In the absence of family members, designated person, or durable power of attorney, anyone of the involved parties may initiate judicial action for appointment of a guardian and guardian ad litem in order to ensure that the qualified patient’s right to choose appropriate medical treatment is not forfeited.

(5) The absence of a declaration by an adult patient shall not give rise to any presumption as to his intent to allow or refuse life-sustaining procedures.

(6) Proxy decisions will be made only when, to a reasonable
degree of medical probability, the lack of decision-making capacity is permanent. If the patient regains his competency, the proxy decision is void.

(7) The surrogate's proxy decision should use the subjective standard of the patient by which the surrogate attempts to reach the decision that the incapacitated person would make if he or she were able to choose. If the surrogate is unaware of the patient's desires, the surrogate will make the decision based on the patient's best interests.

(8) The guardian ad litem will represent the legal interests of the incompetent in any judicial proceeding including a review of the guardian's decision concerning the ward.

9. Conflicts among the parties. The responsibility for ensuring that surrogate decisionmaking practices are of high quality falls first to the attending physician. Routine judicial oversight is neither necessary nor appropriate. In the event of conflict among the physicians and patient-designated surrogate or family members, the parties shall first informally and without judicial action seek the opinion of the hospital prognosis committee. Upon failure of the parties to resolve the disagreement after the prognosis committee has given its opinion, any of the parties can request the court to appoint a guardian and guardian ad litem and oversee the eventual resolution of the disagreement.

10. Sanctions; immunity; burden of proof; presumption. Failure by the primary physician to effectuate the directive of a qualified patient pursuant to this chapter shall constitute unprofessional conduct unless the primary physician transfers the patient to another physician who will accomplish the directive. A health care facility, physician or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the withholding or the withdrawal of life-sustaining procedures from a patient with a terminal or hopeless condition in accordance with this chapter. A person who authorizes the withholding or withdrawal of life-sustaining procedures from a patient with a terminal or hopeless condition in accordance with a qualified patient's declaration or as provided in section 8 shall not be subject to criminal prosecution or civil liability for such action.

The provisions of this chapter shall be presumed to apply unless it is shown by clear and convincing evidence that the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures did not, in good faith, comply with the provisions of this chapter. A declaration made in accordance with this
article shall be presumed to have been made voluntarily.

11. *Mercy killing or active euthanasia prohibited.* Nothing in this chapter shall be construed to condone, authorize or approve mercy killing or active euthanasia, or permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

12. *Effect of declaration; suicide; insurance.* The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not constitute a suicide. Nor shall the making of a declaration pursuant to this article affect the sale, procurement or issuance of any policy of life insurance. No policy of life insurance shall be legally impaired or invalidated by the withholding or withdrawal of lifesustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary. A person shall not be required to make a declaration as a condition for being insured for, or receiving, health care services.

**VI. CONCLUSION**

To protect the dignity and autonomy of its citizens, the legislature should pass the Montana Natural Death Act. This Act will expand the Living Will Act by protecting all patients' rights to refuse disproportionate medical treatment. Further, the Act will shield the providers of health care from criminal and civil liability for passive euthanasia. Significant emotional and pecuniary savings will result.