

## MINUTES

### MONTANA SENATE 54th LEGISLATURE - REGULAR SESSION

#### COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By CHAIRMAN JIM BURNETT, on February 1, 1995, at  
1:02 PM

#### ROLL CALL

##### Members Present:

Sen. James H. "Jim" Burnett, Chairman (R)  
Sen. Steve Benedict, Vice Chairman (R)  
Sen. Larry L. Baer (R)  
Sen. Sharon Estrada (R)  
Sen. Arnie A. Mohl (R)  
Sen. Mike Sprague (R)  
Sen. Dorothy Eck (D)  
Sen. Eve Franklin (D)  
Sen. Terry Klampe (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council  
Karolyn Simpson, Committee Secretary

Please Note: These are summary minutes. Testimony and  
discussion are paraphrased and condensed.

##### Committee Business Summary:

Hearing: SB 146, SB 124  
Executive Action: SB 146, SB 124

{Tape: 1; Side: 1}

#### HEARING ON SB 146

##### Opening Statement by Sponsor:

SENATOR DOROTHY ECK, SD 15, Bozeman, said SB 146 is the Uniform Health Decision Act, and was asked to submit this bill by American Association of Retired Persons. Past legislation has been Comfort One and the Living Will, but there is a need for a bill with adequate powers of attorney because it is more sensible than the Living Will. She said, SB 146 would make her more comfortable in making a decision than the Living Will Legislation. The Bar Association, working with the Hospital Association and other medical people, have been working on this, so it isn't just an issue of AARP. Frequently, there is

legislation that promotes uniform acts, and there are advantages to uniform acts. She said, it's not the legislation that we have now, but the statutes are completely inadequate. It's possible today to do everything provided in SB 146, but the problem is, an attorney who really knows the situation well is needed. For that reason, the specificity in the law and the forms could prove to be helpful in getting what is desired. Every individual has different expectations as to what they want at the end of their life. No one wants to extend their life and suffer in pain, but individuals may want to specify that they want to be conscious at the time of death. SB 146 allows an individual to tailor their directives in a way they wish and extra language, that's not in the forms, can be added.

SB 146 repeals a lot of the existing language. She said **Sharon Hoff** has gone through the bill and will be offering some amendments that address her particular concerns, and those of her church. The bill has also been reviewed by other people who have recommended amendments. **EXHIBIT 1.** She asked that serious consideration be given to these amendments and stated, it's worth while to address this issue and come up with a uniform code. There are problems with the existing codes for those who work in the health care professions, especially hospitals and nurses. SB 146 puts all the issues in one place so it won't be necessary to go from one part of the law to another to know what is legal, and makes it easier to give advance directives. It covers all health care decisions, eliminates restrictions, and addresses decision making for those who do not sign an advance directive, which is a continuing problem in the medical profession. It includes a standard of care that maximizes honoring the wishes of the patient and provides for court access when disputes arise.

**SENATOR FRANKLIN** was present at the hearing intermittently.

**Proponents' Testimony:**

**Dan McClean**, representing the State Bar of Montana, Section on Estates, Trust, Tax, and Business Law, said this was the committee of the State Bar of Montana that worked on SB 146, and was drafted by the National Commission on Uniform State Laws. This is among several uniform laws to be promulgated by that national commission, of which Montana has adopted several. AARP has been in support of this type of legislation giving health care directives. The National Commission on Uniform State Laws is a body composed of attorneys and others who do an indepth study before promulgating a law, and try to draft legislation that's uniform among states because we are a mobile society, with people moving from one place to another. People want to know that decisions they make in Montana will be applicable in other states, and vice versa.

He said there is a lot of misunderstanding as to what Health Care Power of Attorney really is. It's different than a living will. This statute includes language that deals with end of life decisions. Living wills are dealing only with situations in which there is a terminal condition and the individual doesn't have the

competency or capacity to make decisions about that care. It is a very limited application for end of life decisions. Health Care Power of Attorney is much broader and includes decisions whether or not to enter a nursing home, hospital, or consent to treatment. By signing a Health Care Power of Attorney, someone is designated as the agent to make those decisions when an individual is not competent to make those decisions for himself. An individual is competent when signing the Power of Attorney, but planning for the time when unable to make those decisions. The premise behind this bill, and the need for legislation, is that competent persons have the right to self determination and freedom from interference with their wishes on health care decisions. SB 146 does not change most existing law, but places language in a more organized form on one place, in a more organized fashion, so there is more certainty about it, and physicians and health care providers can rely on the fact that someone has signed one of these documents. Individuals have the right to make these decisions now, while they're competent, and under common law, they have the right to appoint someone else to make the decisions for them. This legislation is needed because, if a doctor gets a directive that was been made on behalf of an incapacitated person, the doctor will know he can rely on that person having the authority to make decisions, rather than having a dispute as to who is to make decisions. SB 146 covers a broad range of health care decisions that can be made, but does not provide rules to law to be applied. It provides a framework, under which people can make a decision. The form included with the bill is an optional form. He presented suggested amendments. **EXHIBIT 2.**

**Bill Olson, representing American Association of Retired Persons,** said the Uniform Health Care Decisions Act is one of their main legislative agenda items and updating the law regarding advanced health care, power of attorney and decision-making. He passed out information about the Uniform Health-Care Decisions Act. **EXHIBIT 3.** Montana does not have a Living Will Act that allows individuals to make advanced health care decisions for when they're incapacitated. There is a Terminally Ill Act, but individuals otherwise incapacitated are not covered.

**Andree Larose, Attorney for the Montana Advocacy Program, a non-profit organization which advocates the rights of persons with disabilities,** spoke from her written testimony in support of SB 146. **EXHIBIT 4.**

**Dick Brown, Senior Vice President, Montana Hospital Association,** spoke from his written testimony in Support of SB 146. **EXHIBIT 5.** He said they support the amendments that will be presented by the Montana Catholic Conference.

**REP. CARLY TUSS, HD 46, Great Falls,** testified in support of SB 146. She serves on the Ethics Committee of a local hospital. She described an instance at that hospital, where an individual did not have a Durable Power of Attorney, but her entire family was

in agreement as to her wishes. Because there was no Durable Power of Attorney, the hospital was placed in a very awkward position.

**Marty Onishuk, representing Montana Alliance for the Mentally Ill,** said they would support SB 146 if it is amended to include people with chronic and serious mental illnesses. She spoke from her written testimony. **EXHIBIT 6.**

**Sharon Anderson, Assistant General Council, Montana Deaconess Medical Center, Great Falls,** said one of her duties is to review Durable Powers of Attorney for medical care and living wills. She said this is a topic that needs to be changed and simplified because the public is confused by it. She talks with senior citizens who are concerned. They may have a wife or husband who is in a coma, and they can't legally consent to treatment, because they have no Durable Power of Attorney, including health care. She suggested an amendment to clearly indicate health care powers can be designated to another person, including withdrawal and withholding medical treatment, nutrition and hydration.

**Rose Hughes, Montana Health Care Association and representing nursing homes throughout the state of Montana,** said the provisions of SB 146 will help their facilities do the kinds of things that residents and their families wish. They make difficult decisions everyday and normally, they are in a gray area where they're listening to families, but there's nothing official so they can follow family wishes. They had some concerns about how Comfort One works, but it has nothing to do with the new provisions and should be taken into account.

**Doug Blakley, State Ombudsman, Office of Aging, Department of Family Services,** spoke from his written testimony in support of SB 146. **EXHIBIT 7.**

**Drew Dawson, Chief, Emergency Services Bureau, Department of Health and Environmental Sciences,** spoke from his written testimony in support of SB 146 and the amendments proposed by **SENATOR ECK. EXHIBIT 8.**

**Jerry Loendorf, representing the Montana Medical Association,** said they support SB 146 and are willing to work with the committee on proposed amendments. This bill does some things they like, such as putting in one place the parts of the law dealing with the decisions made about one's health care, and allows the decision to be in one document, on which a health care provider can rely, knowing the signed document is the individual's decision regarding health care, and those decisions can be carried out. SB 146 goes further in allowing a surrogate to be named. An individual can delegate authority to people to whom they would want to make decisions, in the event they become unable to do so. Because health care providers must frequently make these decisions, this bill is important so they can have something to rely on regarding the wishes of the individual.

Opponents testimony:

Sharon Hoff, Executive Director, Montana Catholic Conference, said they oppose SB 146, in its current form. She read her written testimony. EXHIBIT 9. She handed out written testimony comparing the Uniform Health-Care Decisions Act, EXHIBIT 10, and proposed amendments, EXHIBIT 11.

Arlette Randash, representing Eagle Forum, spoke briefly in opposition to SB 146. EXHIBIT 12.

Luke Keating, read her written testimony in opposition to SB 146. EXHIBIT 13.

Rick Bartos, Attorney and Elder Rights Advocate, Office of Aging, spoke briefly in opposition to SB 146. EXHIBIT 14.

Laurie Koutnik, Executive Director, Christian Coalition, spoke briefly in opposition to SB 146. EXHIBIT 15.

Tim Whalen, representing the Montana Right to Life Association, spoke briefly in opposition to SB 146, saying it's a radical departure from current law. EXHIBIT 16.

Russell Hill, representing Montana Trial Lawyers Association, said their position on SB 146 is very narrow. He referred to page 12, subsection 6, saying that subsection legally requires a provider, doesn't just permit a provider, to decline to comply with an individual's instruction or request, that would require negligent or substandard care.

{Tape: 1; Side: 2; Comments: lost first 2 seconds}

Dallas Erickson, said he opposes SB 146.

Questions From Committee Members and Responses:

SENATOR BENEDICT asked Bob Olson if he thought SB 146 could be salvaged, having heard all of the proponents and opponents testimony.

Bob Olson said yes, it could.

SENATOR SPRAGUE asked for an explanation line 23, line 12.

Russell Hill said the way MTLA interprets this bill is, there are several sections to be dealt with, but a provider has to comply with an individual's instruction or authorization, unless he declines for reason of conscience, subsection 5, or allows him to decline if the treatment would be medically ineffective or health care contrary to health care standards, subsection 6, which would be negligent care. With the wording, a provider may decline if it's negligent care, but doesn't have to. This is in the context of the substantial immunity section, page 13. He referred to page

14, subsection 14, subsection 4, NTLA believes, when it says, nothing in this bill authorizes a health care provider to provide health care contrary to generally accepted health care standards, means they may not provide negligent care even if the individual instruction or authorization requests them to do so.

SENATOR SPRAGUE asked Russell Hill if he thinks this bill is salvageable.

Russell Hill said, he assumes it is salvageable, but do not want to testify on the other merits of the bill.

Closing by Sponsor:

SENATOR ECK said, she thinks the bill is salvageable. The Attorneys Association and Sharon Hoff represent many of the concerns, have been able to come to some understanding. It's possible to go through the bill and do the consolidation making it easier to use, and maybe not amend those sections of law on which there is disagreement.

HEARING ON SB 124

Opening Statement by Sponsor:

SENATOR ARNIE MOHL, SD 39, Kalispell, said he's introducing SB 124 for SENATOR WILLIAM CRISMORE, who had another commitment. SB 124 changes the wording on inspections.

Proponents' Testimony:

Dale Taliaferro, Administrator of Health Services, Department of Health and Environmental Sciences, said SB 124 amends section 50-1-203 of Montana law. EXHIBIT 17.

Opponents' Testimony: None

Questions From Committee Members and Responses:

SENATOR BENEDICT asked when the mandatory requirement for sanitary inspection to school houses, churches, jails, theaters and other buildings, if that also includes sanitary inspections of those places that serve food.

Dale Taliaferro said it does not. They're inspected under a license requirement. This is a general provision separate from license requirement.

SENATOR BENEDICT asked if this, in no way impacts a theater, jail, or school with a hot lunch program, but they still would be inspected under license requirement.

Dale Taliaferro said it doesn't affect the food inspection.

**SENATOR SPRAGUE** asked who would institute an inspection.

**Dale Taliaferro** said the Director of the local Health department would initiate that inspection, but inspections have been done in response to citizen complaints. Sometimes a citizen will complain to the County Commissioners or to the city and those complaints will be referred to the Department of Health and Environmental Sciences.

**SENATOR ECK** asked what is involved in doing an inspection; what kind of things do they look for.

**Dale Taliaferro** deferred to the Bureau Chief in the Department of Health. She said when these inspections are done, they look at equipment, storage, location and storage of chemicals, food service, lighting and ventilation. It's a general environmental inspection. They do not have a set of administrative rules for the inspection of jails, so they use the national standards and guidelines.

**SENATOR ECK** said there is an inspection if there are complaints, then asked if there are regular inspections.

**Dale Taliaferro** said there are no regular inspections. They do not have the staff to do that, but local departments do.

**SENATOR SPRAGUE** asked if a citizen complains to a local official, that they wanted something checked or thought they got food poisoning, if SB 124 would give to the Department of Health the option of making an inspection. He asked who makes the decision to do an inspection or not.

**Dale Taliaferro** said the Health Officer. They want to change the requirement to inspect these facilities every year. In 1988, it was determined by the Legislature, that routine inspections were not really necessary, so staff was cut.

**SENATOR ECK** said she supports this action because the Department of Health does not have the resources to protect public health and safety in buildings. She asked if the Department of Health wanted to be relieved of the liability of not doing routine inspections.

**Dale Taliaferro** said they want to carry out the law, but have a choice of asking the Legislature for 2 or 3 more sanitarians, or ask to have this changed. They felt the risk is not great because they are still able to do inspections where problems are identified.

**Closing by Sponsor:**

**SENATOR MOHL** said, after listening to the testimony, questions and answers, possibly this bill should have had a fiscal note indicating the savings with the passage of the bill.

EXECUTIVE ACTION ON SB 124

Motion: SENATOR MOHL MOVED SB 124 DO P SS.

Discussion: SENATOR ECK said she was going to vote no, but objects to the state's policy of abrogating health and safety responsibilities.

SENATOR BENEDICT said he was going to vote for the bill, and takes exception to SENATOR ECK's statement. Possibly, one of the reasons for this bill is, there is a certain amount of redundancy with both county health inspections and state health inspections. Because inspections are mandatory, the staff at the state level is probably backlogged considerably trying to do non-priority inspections.

Vote: The DO PASS MOTION for SB 124 CARRIED with SENATOR ECK voting NO.

EXECUTIVE ACTION ON SB 146

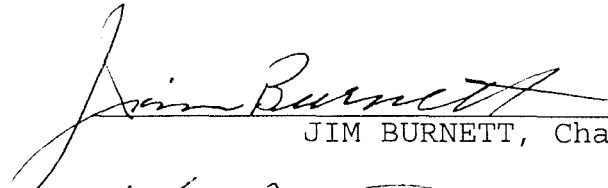
Motion: SENATOR BENEDICT MOVED to TABLE SB 146

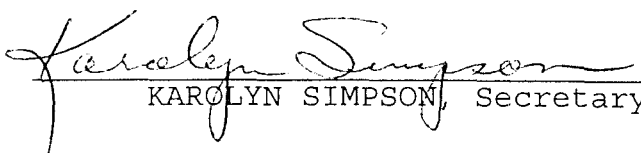
Discussion: SENATOR BENEDICT expressed concern that SB 146 needed to be amended.

Vote: The TABLE MOTION for SB 146 CARRIED UNANIMOUSLY.

ADJOURNMENT

Adjournment: 2:30 pm

  
JIM BURNETT, Chairman

  
KAROLYN SIMPSON, Secretary

JB/ks



MONTANA SENATE  
1995 LEGISLATURE  
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL

DATE \_\_\_\_\_

2/1/95

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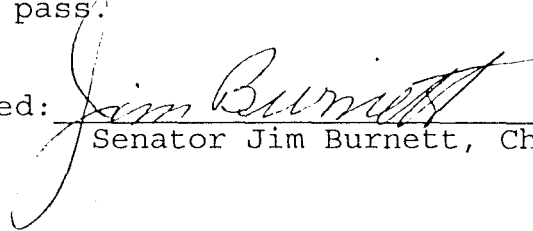
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SENATE STANDING COMMITTEE REPORT


Page 1 of 1  
February 1, 1995


MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration SB 124 (first reading copy -- white), respectfully report that SB 124 do pass.

Signed: 

Senator Jim Burnett, Chair

 Amd. Coord.

 Sec. of Senate

271546SC.SRF

Amendments to Senate Bill No. 146  
First Reading Copy

Requested by Senator Dorothy Eck  
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan Byorth Fox  
January 25, 1995

1. Title, line 9.  
Strike: ", 50-10-103,"
2. Page 2, lines 7 and 8.  
Following: "care"  
Strike: "institution" through "business" on line 8  
Insert: "facility" has the meaning provided in 50-5-101"
3. Page 2, line 9.  
Following: "individual"  
Insert: ", other than emergency medical services personnel as  
defined in 50-10-101, who is"
4. Page 2, line 11.  
Following: "(9)"  
Insert: "(a)"
5. Page 2, line 12.  
Following: "individual."  
Insert: "An individual instruction must be:  
(i) in writing and signed by the individual; or  
(ii) personally communicated by the individual to the  
supervising health care provider.  
(b) Unless the individual instruction expressly directs the  
withholding or withdrawal of life-sustaining health care during  
pregnancy, an individual instruction may not be construed to  
require that life sustaining health care be withheld or withdrawn  
from an individual known to the supervising health care provider  
to be pregnant so long as it is probable that the fetus may  
develop to the point of live birth with continued life-sustaining  
health care."
6. Page 3, line 4.  
Page 3, line 7.  
Strike: "emancipated"  
Insert: "a"  
Following: "minor"  
Insert: "authorized to consent to the provision of health care  
services under 41-1-402"
7. Page 3, line 5.  
Strike: "may be oral or written and"
8. Page 15, line 20.  
Following: "~~50-9-102.~~"

Insert: "(1) "Attending physician" means the physician who is selected by or assigned to the patient and who has the attending responsibility for the treatment and care of the patient."

Renumber: subsequent subsections

9. Page 15, lines 25 and 26.

Strike: line 25 in its entirety through "161," on line 26

Insert: "qualified patient"

Strike: "primary"

Insert: "attending"

10. Page 16, line 11.

Strike: line 11 in its entirety

11. Page 16, line 12.

Following: line 11

Insert: "(11) "Qualified patient" means a patient who is 18 years of age or older or a minor authorized to consent to the provision of health care under 41-1-402, who has executed a written individual instruction, the terms of which are determined by the attending physician to be consistent with treatment in accordance with the withholding of emergency life-sustaining procedures under the do not resuscitate protocol, and who has been determined by the attending physician to be in a terminal condition.

(12) "Terminal condition" means an incurable or irreversible condition that will, in the opinion of the attending physician, result in death within a relatively short time in the absence of the administration of treatment that will serve only to prolong the dying process."

12. Page 16, lines 13 through 20.

Strike: Section 18 in its entirety

Renumber: subsequent sections

## PROPOSED AMENDMENTS TO SENATE BILL 146

## First Reading Copy

prepared by

Daniel N. McLean,  
on behalf of the  
State Bar of Montana,  
Section on Trusts, Estates, Tax and Business law,  
for the Committee on Public Health, Welfare, and Safety

February 1, 1995

1. Page 10, line 16.  
Strike: "emancipated"  
Following: "minor"  
Insert: "authorized to consent to the provision of health  
care service under 41-1-402."
2. Page 14, lines 23 and 24.  
Following: "suicide,"  
Insert: "or"  
Following: "euthanasia"  
Strike: ", or" through "state"



SENATE HEALTH & WELFARE

EXHIBIT NO. 3

DATE 2/1/95

BILL NO. SB 146

*Bringing lifetimes of experience and leadership to serve all generations.*

**MONTANA STATE LEGISLATIVE COMMITTEE**

**ACTING CHAIR**

Mr. Lloyd Bender  
2014 S. Tracy Avenue  
Bozeman, MT 59715  
(406) 587-0069

**ACTING VICE CHAIR**

Lloyd Erickson  
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Great Falls, MT 59405  
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**SECRETARY**

Vacant

**Montana State Legislative Committee  
1995 Position Paper**

***UNIFORM HEALTH-CARE DECISIONS ACT***

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**POSITION:** Enactment of the "Uniform Health-Care Decisions Act" to update laws regarding advanced health care decisions, health care powers of attorney, and the role of guardians in health care decisions is a priority of the Montana AARP State Legislative Committee.

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**PROBLEM:** Montana has neither a living will act that allows individuals to make advanced health-care decisions when incapacitated, or a health-care power of attorney act allowing appointment of an agent to make health care decisions. Montana only has a "Terminally Ill" act. Individuals otherwise incapacitated, either temporarily or permanently, are not covered by the law. Montana's statutory short form power of attorney specifically contains the sentence, "This document does not authorize anyone to make medical and other health-care decisions for you."

**SOLUTION:** The "Uniform Health-Care Decisions Act" addresses: 1) advanced health-care directives of an incapacitated person, 2) health-care powers of attorney, and 3) the powers of guardians to make health-care decisions. This would bring Montana's statute in compliance with the Uniform Law Commissioner's model legislation as approved by the American Bar Association.

**CONTACT:** Lloyd Bender  
Acting Chairman  
2014 South Tracy Avenue  
Bozeman, MT 59715  
(406) 587-0069

# Uniform Health Care Decisions Act



Q

Why was the Uniform Health Care Decisions Act drafted?



A

The Health Care Decisions Act was approved by the Uniform Law Commissioners in August 1993, because the commissioners understood that individuals have a desire to make their own medical decisions even when they are incapacitated.



Q

Don't most states already have advance directive legislation, such as living will laws?



A

Yes, but these laws have significant limitations which create problems for incapacitated individuals and their families.



Q

Specifically, what kinds of holes exist in the various states?



A

One good example is that 20 states do not have a family or surrogate consent statute. This means that in those 20 states, if you do not have some form of medical-decision-making instrument drafted prior to your incapacity, your family cannot make the decisions for you.



Q

What other problems would the Uniform Health Care Decisions Act address?



A

One other problem is that many health care statutes, while enacted for the purpose of facilitating the making of advance directives, may actually inhibit their use. The execution requirements are often cumbersome and complex. Restrictions on the types of treatment which may be withheld or withdrawn are common. And there is little uniformity between the states. This lack of uniformity creates confusion and inconsistency between states and sometimes within the state itself.



How would the Uniform Health Care Decisions Act address these and other problems of current statutes?



The Act brings order to chaos by facilitating the making of advance directives. The Act is comprehensive, addresses decision making for those who fail to plan, and eliminates many restrictions.



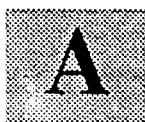
What do you mean exactly when you refer to the statute being a comprehensive act?



While most statutes have legislation recognizing living wills, powers of attorney for health care, and decision-making roles for the family, the states have addressed these topics in a piecemeal fashion. The Act addresses in one statute issues that currently are dealt with in several separate statutes.



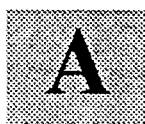
Are the cumbersome execution requirements now present in advance directive statutes part of the Uniform Health Care Decisions Act?



The drafters of the Act concluded that these cumbersome requirements did little to prevent fraud or coercion, but only served to deter the making of advance directives. Consequently, the Act keeps execution requirements to an absolute minimum.



How can I become active in supporting reform efforts in my own state?



Contact your AARP State Legislative Committee. They have actively supported advance directive legislation for years and can provide background on this issue, as well as suggest ways that you can help.

*September 1994*

**American Association of Retired Persons**  
State Legislation Consumer Issues Team  
601 E Street, N.W. • Washington, DC 20049





The Uniform Laws

# The Health-Care Decisions Act Represents A Major Advance

*While prospects for a quick and widespread enactment are uncertain, it will likely prove an influential model for many years to come*

By **DAVID M. ENGLISH**  
 University of South Dakota  
 Vermillion, SD

**P**lanning for health-care decision-making has become a significant component of the estate planning practice in recent years. This increased attention has been fueled by a variety of factors, with changing demographics perhaps being the most important. The number of individuals over age 65 is increasing each year, and the number over age 85 is increasing at an even more rapid rate. But America's population is not aging well. People are living longer but more often in a condition of chronic disability.

Some well-publicized cases also have focused attention on the issue. The widespread interest in living Wills may be traced to the seminal case of *In re Quinlan*,<sup>1</sup> and an increased interest in advance directives generally was fueled by the Supreme Court's ruling in *Cruzan*.<sup>2</sup>

This increase in public interest has led to a flurry of state legislation. *Quinlan* spurred the widespread enactment of living Will statutes, with all but three states now having such legislation on the books.<sup>3</sup> *Cruzan* led to a rapid increase in the number of power of attorney for health care statutes, a device now authorized in all but two states.<sup>4</sup> Furthermore, more than 30 states have enacted statutes allowing family members

and, in some instances, close friends to make health-care decisions for individuals who lack capacity.<sup>5</sup>

The state legislation has been a mixed blessing, however. Many of the health-care statutes, while enacted for the purpose of facilitating the making of advance directives, may actually inhibit their use. The execution requirements are often formidable. Restrictions on the types of treatment, which may be withheld or withdrawn, are common. There is little uniformity. The result is a system of legislation that is fragmented, incomplete, and often inconsistent, both among states and even within states.

The Uniform Health-Care Decisions Act, if enacted by the states, would bring order to the present chaos. The primary purpose of the Act, which was approved by the Uniform Law Commissioners in August, 1993, and by the ABA House of Delegates in February, 1994, is to facilitate the making of advance directives. The Act is comprehensive, addresses decisionmaking for those who fail to plan, and eliminates many of the restrictions. It is an Act that is congenial to estate planners, many of whom played a major role in its drafting.<sup>6</sup> Comprehensive articles on the Act will appear else-

where.<sup>7</sup> The purpose of this article is to describe the Act's innovative features as compared to the existing state legislation.

*The Act is comprehensive and addresses topics now usually dealt with by separate statute.* While most states have legislation recognizing living Wills, powers of attorney for health care, and a decisionmaking role for the family, the states have usually addressed these topics by separate statute, often in piecemeal fashion. A new approach is beginning to emerge, however. Instead of enacting separate living Will and power of attorney for health care statutes, states are beginning to move toward a combined approach. The 1991 New Jersey statute, for example, governs the creation of both living Wills (referred to as "instruction directives") and powers of attorney for health care (referred to as "proxy directives").<sup>8</sup> The more recently enacted acts in Arizona, Florida, Maryland and Virginia cover in one place not only living Wills and powers of attorney for health care but family decisionmaking as well.<sup>9</sup>

The Uniform Health-Care Decisions Act builds on this trend. Under the Act, any adult or emancipated minor may give an "advance health-care directive," which refers to

\* care" or an "individual instruction."<sup>10</sup> Like the New Jersey statute, the Uniform Act deliberately avoids the term "living Will," the drafters concluding that "individual instruction" is more accurate and less confusing.

\* Should an individual fail to execute a power of attorney for health care or should the agent not be available, the Uniform Act authorizes health-care decisions to be made by a "surrogate," to be selected from a priority list.<sup>11</sup>

The Act, while comprehensive, does not address all conceivable issues. In recent years, many states have begun to address the thorny issue of whether and under what circumstances emergency medical services personnel may recognize do-not-resuscitate orders. The Uniform Act includes do-not-resuscitate orders within the definition of "health-care decision,"<sup>12</sup> and, by extension, authorizes an individual, or his or her agent or surrogate, to give such an order. However, detailed protocols and protections are needed to guide and protect EMS personnel in withholding resuscitation. Given that state legislatures have only begun to tackle this issue, the drafters concluded that it would now be premature to attempt to codify protocols or guidelines in model legislation.<sup>13</sup>

\* The Act also does not address health-care decisionmaking for unemancipated minors. To have covered the full range of healthcare decisions for unemancipated minors, including the effect of differing parental and custodial arrangements and levels of maturity, would have made the Act unwieldy. However, the drafting committee did recommend that the Commissioners consider developing a separate uniform act on this topic.

*The Act does not attempt to legislate restrictions on the withholding or withdrawal of life-sustaining treatment.* A majority of the existing power of attorney for health care statutes permit a principal to delegate to an agent the authority to make all health-care decisions. Although held to a standard of care, the agent may act for the principal regardless of the nature of the principal's condition or the type of treatment in question.<sup>14</sup>

The living Will statutes are another matter. The complex definitions of the categories of patients for whom life-sustaining treatment may

be withheld or withdrawn, and the prohibitions against the withdrawing or withholding of certain forms of treatment, have rendered many of these statutes into virtual nullities. Prompted by *Cruzan*, a number of living Will statutes have recently been liberalized. Withdrawal or withholding of treatment is permitted not only from patients in a "terminal condition," but also from patients in conditions of "permanent unconsciousness."<sup>15</sup> But while many of the living Will statutes are now less restrictive, a major effect of the recent amendments is to add yet another layer of definitions requiring interpretation.

The drafters of the Uniform Act concluded that the attempts to statutorily prescribe the circumstances when life-sustaining treatment may be withheld or withdrawn unduly restrict, are difficult to apply in a clinical setting, and provide an appearance of precision where none is possible. Under the Act, there are no restrictions. An individual instruction and the authority which may be granted to an agent may extend to all "health-care decisions," a term which is expansively defined to include such matters as approval or disapproval of orders not to resuscitate, and directions to provide, withhold, or withdraw artificial nutrition and hydration and other forms of health care.<sup>16</sup>

While no restrictions are prescribed, certain principles of law and medical practice will impose limits, although indirectly. The Act authorizes the provision, withholding, or withdrawal of health care only to the extent not prohibited by other statutes of the state.<sup>17</sup> Furthermore, a health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards.<sup>18</sup> Finally, agents and surrogates are subject to a standard of care. An agent or surrogate may not act contrary to the principal's or patient's express wishes, and must otherwise act in the principal's or patient's best interest.<sup>19</sup>

*The Act minimizes execution requirements.* The execution requirements for an advance directive in most states are both cumbersome and confusing. A substantial major-

ity of the living Will statutes require two witnesses, but Minnesota and New Jersey permit either witnessing or acknowledgment, and South Carolina requires both witnessing and acknowledgment.<sup>20</sup> There is greater variation among the power of attorney for health care statutes. Some statutes require only the principal's signature.<sup>21</sup> Other statutes follow the living Will model by requiring two witnesses.<sup>22</sup> Finally, some statutes require that the power be either witnessed or acknowledged at the principal's option, others that it be both witnessed and acknowledged.<sup>23</sup>

A majority of the living Will and power of attorney for health care statutes also impose witness qualification rules. Some of these lists are quite lengthy. Included on the lists of various states are relatives, in-laws, intestate heirs, Will beneficiaries, creditors, the designated agent, health care providers, and nursing home operators and employees. Under some statutes, the advance directive is invalid if either witness is from one of the proscribed classes. But under other statutes, a prohibited person may act as long as the other witness is independent.<sup>24</sup>

The drafters of the Uniform Act concluded that the cumbersome execution requirements found under many state statutes have done little to deter fraud or prevent overreaching. Rather, their primary effect is to deter the making of advance directives and to invalidate defectively executed directives that otherwise would be reliable indicators of the individual's intent. Consequently, to facilitate the making of advance directives, the Act keeps execution requirements to an absolute minimum. A power of attorney for health care must be written and signed, but need not be witnessed or acknowledged.<sup>25</sup> An individual instruction may be either written or oral.<sup>26</sup>

\* The statutory recognition of an oral instruction, while relatively rare, is found in both the 1992 Virginia and 1993 Maryland acts.<sup>27</sup> Oral instructions are frequent in clinical practice. Furthermore, case law, the Uniform Act itself, and the statutes in many states require agents and surrogates to honor the principal's and patient's express wishes, which may include oral instructions. It seems nonsensical to require an agent or surrogate to honor an oral

instruction while at the same time denying statutory recognition to an oral instruction given directly to a health-care provider.

The 1993 Maryland act goes even further by authorizing an individual to orally designate an agent.<sup>28</sup> The Uniform Act does not go quite this far. But as described below, the act does allow an individual to orally designate a surrogate.<sup>29</sup>

*The Act contains one combined form.* The use of statutory forms provide a number of benefits. First, because the form is standard and widely available, individuals who might not otherwise seek professional help may be more inclined to execute an advance directive. Second, the availability of an officially sanctioned form will reduce the reluctance of health-care providers to honor a directive. Furthermore, through continued use providers will hopefully become more familiar with the form's provisions and make more informed decisions.

Nearly all living Will statutes include statutory forms,<sup>30</sup> as do a growing number of power of attorney for health care statutes.<sup>31</sup> The enactment by most states of separate living Will and power of attorney for health care statutes has, perhaps not surprisingly, resulted in the enactment of separate statutory forms. Recently, however, states have begun to enact a combined form, one that allows an individual to both designate an agent and give instructions. The 1993 Connecticut and Oregon acts are notable examples.<sup>32</sup>

The Uniform Act, like Connecticut and Oregon, includes a combined form.<sup>33</sup> Unlike Oregon,<sup>34</sup> however, *use of the form is entirely optional.* An individual is also free to omit or modify any part of the form. Making the form optional is consistent with the principle of patient autonomy, one of the driving forces behind the Act. It is also of particular importance to adherents of certain religions, such as Christian Science, whose special views would not otherwise be accommodated.

The power of attorney appears first on the form to ensure to the extent possible that it will come to the attention of a casual reader. This reflects the reality that the appointment of an agent is a more comprehensive approach to the making of health-care decisions than is the giv-

ing of an individual instruction, which cannot possibly anticipate all circumstances which might arise.

Like most well-drafted attorney forms, space is provided for the individual to designate up to two alternate agents. Furthermore, the *agent and alternate agents are automatically nominated to act as guardians, in their order of priority,* should the need for guardianship of the person arise. The purpose of this provision is not to encourage the use of guardianship, *but to prevent others from using guardianship as a device to thwart the agent's authority.* This defense is further buttressed by the Act's provision *that a guardian may not revoke an agent's authority without express approval of the appointing court.*<sup>35</sup>

More unusual is the provision providing a box to check should the individual wish the authority of the agent to become effective immediately upon execution. Under the Act, while the authority of an agent generally becomes effective only upon a determination that the principal lacks capacity, *the principal is free to provide in the power that the authority of the agent becomes effective immediately or upon the happening of some other event.*<sup>36</sup>

Because the variety of treatment decisions to which individual instructions may relate is virtually unlimited, the instructions part of the form does not attempt to be comprehensive but is directed at the types of treatment for which an individual is most likely to have special wishes. Space is provided for the individual to express special wishes regarding the provision of pain relief. In addition, *artificial nutrition and hydration is to be treated like other forms of health care unless the individual checks a box.* Most importantly and most problematical to draft, the form contains language specifying the circumstances when treatment may be withheld or withdrawn.

*Two choices are provided, a "Choice Not To Prolong Life," and a "Choice to Prolong Life."* The "Choice to Prolong Life" is designed for those wishing maximum treatment. The "Choice Not To Prolong Life" will be the option far more frequently selected. Because the concept of the living Will has become so ingrained, the drafters concluded that it was appropriate to specify in this choice that the individual's life not be pro-

longed in the event of a "terminal condition" or "condition of permanent unconsciousness," although those precise terms were not used. Limiting withdrawal or withholding of treatment to these two categories, however, would have codified in the statutory form the very restrictions which the drafters had deliberately avoided in the statutory text. Consequently, the drafters added a third more flexible option. *Treatment may also be withheld or withdrawn if "the likely risks and burdens of treatment would outweigh the expected benefits."* This test is well known to the courts and is one which was advocated in an influential 1983 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.<sup>37</sup>

*The form also includes space for an individual to express an intent to make an organ or tissue donation.* It is included here because an advance directive is far more likely to be noticed than is a donor card, which rarely comes to light when the need arises.

Finally, the form provides space for an individual to designate his or her "primary physician." The Act specifically avoids use of the term "attending physician," which could be understood to refer to the physician currently providing treatment to the individual, and not to the physician whom the individual would select. Among the functions of an individual's primary physician is the determination of whether the individual has capacity to make his or her own health-care decisions.<sup>38</sup>

*The Act contains a comprehensive provision on the authority of surrogates.* Despite the wider use of powers of attorney for health care and living Wills, families will continue to play an important role in the making of health-care decisions for an incapacitated relative. A substantial majority of individuals fail to execute advance directives. For these individuals, recourse to the family may be the only realistic method for assuring continuity in decisionmaking. Guardianship is an available option, but the appointment of a guardian is an expensive and cumbersome process that is often ill-suited to the making of health-care decisions, particularly when time may be of the essence.

The traditional reliance of health

providers on the family, however, is often based on little more than medical custom. While there is a recent and growing body of judicial precedent validating a role for the family,<sup>39</sup> many states have no decision on point, and few of the cases address the issue of priority. Perhaps due to these uncertainties, a growing number of states — over 30 to date — have enacted statutes to validate a role for the family.<sup>40</sup>

Most of the statutes tend to be quite limited in scope. The New York statute, for example, applies only to decisions to administer or withhold cardiopulmonary resuscitation.<sup>41</sup> Many others address only the withdrawal or withholding of lifesustaining treatment.<sup>42</sup> Other statutes empower the family to consent to treatment and apply to decision-making from the onset of incapacity but fail to specifically address withdrawal or withholding of lifesustaining treatment.<sup>43</sup>

### Priority

A substantial majority of the statutes, however, do address the issue of priority. The better and growing approach is to recognize that the family may act only if no guardian or agent has been appointed or is available.<sup>44</sup> Should no agent or guardian be available, the statutes empower the spouse to make the decision. Adult children come next, usually followed by parents. Non-traditional relationships are not generally recognized, but this is beginning to change. Many recent statutes place "close friends" on the list, although normally at the bottom.<sup>45</sup> More significantly, Arizona grants a "domestic partner" a fourth priority, although it failed to define the term.<sup>46</sup>

\* Section 5 of the Uniform Act, the surrogacy provision, addresses the role of the family and close friends, and responds at least in part to the concerns of those in non-traditional relationships. The section is comprehensive. A surrogate is empowered to make all "health-care decisions" for the affected individual. The right of a surrogate to act is triggered by a determination that the patient lacks capacity to make his or her own health-care decisions. Not all patients are covered, however. A surrogate may make a health-care decision only for an adult or emancipated minor for whom no agent or

guardian has been appointed or whose agent or guardian is not reasonably available.<sup>47</sup>

### Controversy Developed

The Act, like a majority of the state statutes, prescribes a priority list for who may act as surrogate. Developing the list proved to be quite controversial, however. A majority of the drafting committee concluded that the priority list should consist of specified family members, with the patient's close friends trailing at the end. A majority of the Commissioners thought otherwise, however, and overruled the drafting committee.

The commissioners concluded that a priority list based primarily on closeness of family relationship does not necessarily reflect reality. Unmarried individuals in cohabiting relationships, for example, are much more likely to prefer that their companions act on their behalf. For this reason, appearing first on the priority list is a new type of decision-maker, the orally designated surrogate. This is to be distinguished from an agent, who can only be appointed in writing signed by the principal.

but the function is largely the same. But because of the risk of miscommunication of an individual's oral statement, some reliability of proof is required. An individual may designate a surrogate only by personally informing his or her supervising health-care provider.<sup>48</sup> The health-care provider is then in turn obligated to record the designation in the individual's health-care record.<sup>49</sup> While the Commissioners recognized that written powers of attorney are preferred, they also recognized that many individuals will quite simply fail to prepare the necessary document. Furthermore, oral designations of decisionmakers occur with some frequency in clinical practice.

If an individual has not designated a surrogate, or if the designee is not reasonably available, a rather standard family list is followed: the spouse, followed by an adult child, followed by a parent, followed by an adult brother or sister.<sup>50</sup> Should all classes of family members decline to act or otherwise not be reasonably available, a health-care decision may be made by another relative or friend who has exhibited special care and

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concern for the patient and who is familiar with the patient's personal values.<sup>51</sup>

The Uniform Act is in general to be effectuated without litigation, and the surrogacy provision is no exception. A healthcare decision made by a surrogate is effective without judicial approval.<sup>52</sup> Because a surrogate is not usually selected by the patient, however, there has been no consent, expressed or implied, to this informality. Some system of review is appropriate. The Act relies on notice. Upon his or her assumption of authority, a surrogate must communicate that fact to the members of the patient's family who might otherwise be eligible to act as surrogate.<sup>53</sup> Notice to the family will enable them to follow health-care developments with respect to their now incapacitated relative. It also will alert them to take appropriate action should the need arise.

### Conclusion

The Uniform Health-Care Decisions Act is not the Commissioners' first venture into the field of health-care decisionmaking. But the previous acts were quite limited in scope. The 1982 Commissioners' Model Health-Care Consent Act<sup>54</sup> focused primarily on the authority of the family to make health-care decisions. The Uniform Rights of the Terminally Ill Act, in both its 1985<sup>55</sup> and 1989 versions,<sup>56</sup> focused exclusively on the withdrawal or withholding of life-sustaining treatment.

The Health-Care Decisions Act represents a major advance over existing law and the prior uniform acts. It is comprehensive; it facilitates the giving of advance health-care directives; it addresses decisionmaking for those who have failed to plan; and it eliminates many of the restrictions. While its prospects for quick and widespread enactment are uncertain, it will likely prove an influential model for many years to come.

### FOOTNOTES

1. 355 A.2d 647 (N.J. 1976).
2. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261 (1990).
3. For a list, see Alan Meisel, *The Right to Die Table 11-1* (Supp. 1993) [hereinafter *The Right to Die*]. The exceptions are Massachusetts, Michigan, and New York.
4. *The Right to Die Table 10A-1*. The exceptions are Alabama and Montana.
5. *The Right to Die Table 8-1*.

6. Willard H. Pedrick, of Tempe, Arizona, served as Reporter from August, 1991 to August, 1992. I served as reporter from August, 1992, until completion. James N. Zartman, of Chicago, Illinois, served as ABA Co-Advisor. Francis J. Collin, Jr., of Napa, California, served as Advisor from the ABA Section of Real Property, Probate and Trust Law. Harley J. Spitler, of San Francisco, California, served as Observer for the State Bar of California, Section of Estate Planning, Trust and Probate Law. The Act was unanimously endorsed by the Supervisory Council of the ABA Section of Real Property, Probate and Trust Law, at its October, 1993, meeting.

7. See David M. English & Alan Meisel, *The Uniform Health-Care Decisions Act*, 21 Est. Plan. (forthcoming 1994).

8. See generally N.J. Stat. Ann. Secs. 26:2H-53 to 26:2H-78 (West Supp. 1993).

9. See generally Ariz. Rev. Stat. Ann. Secs. 36-3201 to 36-3262 (1993); Fla. Stat. Ann. Secs. 765.101 to 765.401 (West Supp. 1993); Md. Health-Gen. Code Ann. Secs. 5-601 to 5-618 (1994); Va. Code Ann. Secs. 54.1-2981 to 54.1-2993 (Michie Supp. 1993).

10. Unif. Health-Care Decisions Act ("UHCDA") Sec. 1(f).

11. See UHCDA Sec. 5, and *infra* notes 39-53 and accompanying text.

12. UHCDA Sec. 1(i).

13. The first state statutes addressing the honoring of do-not-resuscitate orders by EMS personnel were enacted in 1991 in Illinois and New York. See 210 Ill. Comp. Stat. Ann. 50/10.8 (Smith-Hurd 1993); N.Y. Pub. Health Law Secs. 2960 to 2979 (McKinney 1993). As of January, 1994, 17 states have enacted legislation on this topic, most frequently authorizing a state agency such as the department of health to develop protocols. See *Choice in Dying, Statutes Authorizing Surrogate Decisionmaking*, Right-to-Die Law Digest (Dec. 1993).

14. For a discussion, see David M. English, *The UPC and the New Durable Powers*, 27 R. Prop. Prob. & Tr. J. 333, 395-400 (1992).

15. See, e.g., Cal. Health & Safety Code Sec. 7186(e) (West Supp. 1994) ("permanent unconscious condition"); Haw. Rev. Stat. Sec. 327D-2 (1991) ("persistent vegetative state ... deep coma"); La. Rev. Stat. Ann. Sec. 40:1299.58.2(10) ("profound comatose state") (West 1992); Tenn. Code Ann. Sec. 32-11-103.9 (Supp. 1993) ("coma or persistent vegetative state").

16. UHCDA Sec. 1(i).

17. UHCDA Sec. 13(c).

18. UHCDA Sec. 7(f).

19. UHCDA Sec. 2(e), 5(f).

20. Minn. Stat. Ann. Sec. 145B.03(2)(a) (West Supp. 1994); N.J. Stat. Ann. Sec. 26:2H-56 (West Supp. 1993); S.C. Code Ann. Sec. 44-77-40 (Law. Co-Op. Supp. 1993).

21. See, e.g., 755 Ill. Comp. Stat. Ann. 45/4-10 (Smith-Hurd 1992).

22. See, e.g., N.Y. Pub. Health Law Sec. 2981(2) (McKinney 1993).

23. See, e.g., Nev. Rev. Stat. Sec. 449.840(1) (1991) ("witnessing or acknowledgment"); N.C. Gen. Stat. Sec. 32A-16(3) (1993) ("witnessing and acknowledgment").

24. For the witness disqualification rules, see David M. English, *supra* note 14, at 369-72 ("power of attorney for health care statutes"); *The Right to Die Sec. 11.9* (1989 & Supp. 1993) (living will statutes).

25. UHCDA Sec. 2(b).

26. UHCDA Sec. 2(a).

27. See Va. Code Ann. Sec. 54.1-2983 (Michie Supp. 1993); Md. Health-Gen. Code Ann. Sec. 5-602(d) (1994).

28. Md. Health-Gen. Code Ann. Sec. 5-602(d) (1994).

29. See UHCDA Sec. 5(b), and *infra* notes 39-53 and accompanying text.

30. The exceptions include Delaware, New Mexico and Ohio.

31. According to research conducted by Charles P. Sabatino, Assistant Director of the ABA Commission on Legal Problems of the Elderly, 36 states and the District of Columbia as of 1/1/94

had statutory forms in their power of attorney for health care statutes.

32. Act approved June 29, 1993, P.A. 93-407, 1993 Conn. Legis. Serv. 1323 (West); Act approved Aug. 31, 1993, ch. 767, 1993 Or. Laws.

33. UHCDA Sec. 4.

34. Use of the Oregon form is mandatory.

35. UHCDA Sec. 6(a).

36. UHCDA Sec. 2(c).

37. For a discussion of the cases and the President's Commission report, see *The Right to Die Secs. 4.17, 9.27-9.32* (1989 & Supp. 1993). The following is the relevant portion of the form:

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

[ ] (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[ ] (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

38. UHCDA Secs. 2(d), 5(a).

39. See Judith Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. Am. Med. Ass'n 229 (1987).

40. For a list, see *The Right to Die Table 8-1* (Supp. 1993).

41. N.Y. Pub. Health Law Sec. 2965(2) (McKinney 1993).

42. See, e.g., Unif. Rights of the Terminally Ill Act (1989) Sec. 7, 9B U.L.A. 122 (1993 Supp.).

43. See, e.g., S.D. Codified Laws Sec. 34-12C (Supp. 1993).

44. See, e.g., 755 Ill. Comp. Stat. Ann. 40/25(a) (Smith-Hurd 1992).

45. See, e.g., Fla. Stat. Ann. Sec. 765.401(1)(g) (West Supp. 1993); 755 Ill. Comp. Stat. Ann. 40/25(a)(7) (Smith-Hurd 1992).

46. See Ariz. Rev. Stat. Ann. Sec. 36-3231(A)(4) (1993).

47. UHCDA Sec. 5(a).

48. UHCDA Sec. 5(b).

49. UHCDA Sec. 7(b).

50. UHCDA Sec. 5(b).

51. UHCDA Sec. 5(c).

52. UHCDA Sec. 5(g).

53. UHCDA Sec. 5(d).

54. 9 U.L.A. (Pt. I) 453 (1988).

55. 9B U.L.A. 609 (1987).

56. 9B U.L.A. 109 (1993 supp.).

David M. English, a professor of law at the University of South Dakota, served as a Reporter to the drafting committee on the Uniform Health-Care Decisions Act. He currently serves as Chair of the Section on Aging and the Law of the Association of American Law Schools and as Chair of the Special Committee on Organ and Tissue Donation of the ABA Section of Real Property, Probate and Trust Law.

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*Rescued!*

*Leaders in a rural Vermont town thought they were simply ending someone's suffering, until a pro-life pastor jumped in.*

by Wesley J. Smith

**J**une 21, 1993. For 30-year-old drifter Ronald Comeau, the day seemed to mark the end of the road. Under arrest in the small community of Bennington, Vt., accused of robbing another homeless man, Ron was alone, seemingly with no one to turn to. It had been a long time since he had seen his father, and their relationship had never been good. His mother had no phone. He hadn't seen his brothers for nearly seven years. Even the police didn't care enough to watch him in the holding cell.

Minutes after being locked up, police say, he was found hanging from a noose he had made out of the trim of a cheap jail blanket.

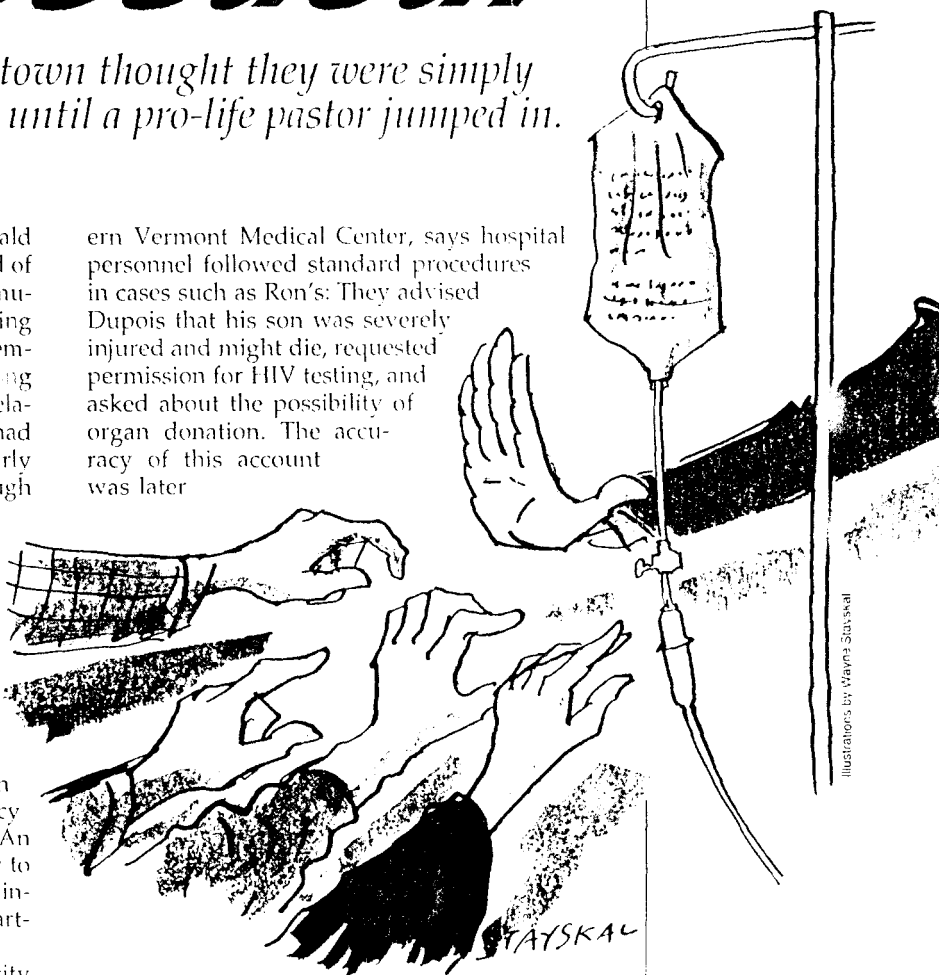
The police cut him down. They found no pulse. He didn't appear to be breathing. Paramedics were called, CPR administered. Then, a weak pulse—maybe.

The paramedics arrived. More CPR. A wailing ambulance ride to the Southwestern Vermont Medical Center. In the emergency room, Ron was given advanced life support. An injection of atropine. Two shots of electricity to restart the heart. It worked. After about 15 minutes without a pulse, Ron had a steady heartbeat.

Nothing unusual here. Go to any big-city hospital or any small-town medical center and you will find the unwanted, suffering through their last hours, helped as much as possible and then soon forgotten. But few would forget Ronald Comeau. Not the staff of the Southwestern Vermont Medical Center, and certainly not people such as clergyman Mike McHugh, retired teacher Joseph Schaaf, psychiatrist Peter Zorach, attorney Stephen Saltonstall and Bennington Probate Court Judge Doris Buchanan. None of them knew it yet, but Ronald Comeau was about to become the center of a legal and emotional maelstrom.

The hospital located Ron's father, Renald Dupois of Maine, within hours. Amy Swisher,

ern Vermont Medical Center, says hospital personnel followed standard procedures in cases such as Ron's: They advised Dupois that his son was severely injured and might die, requested permission for HIV testing, and asked about the possibility of organ donation. The accuracy of this account was later



Illustrations by Wayne Stayskal

disputed, but Dupois did not come to his son's bedside, and, soon afterward, his phone was disconnected.

### Hopeless?

It was decided that Ron needed a guardian to make decisions on his behalf. Enter Joseph Schaaf, well-known in the local legal community because of his volunteer work as a guardian *ad litem* (a temporary representative during a court case) in child-custody matters. He agreed to serve as Ron's permanent guardian without pay and was so appointed by Judge Buchanan on July 23.

By all accounts, Schaaf took his responsi-



EXHIBIT 3  
DATE 2-1-95  
SB 146

## RIGHT TO DIE (continued from page 1)

bilities very seriously, visiting Ron at least five days a week and discussing Ron's case with doctors and staff. By mid-August, he had come to a difficult decision. Ron had been diagnosed as being in an irreversible persistent vegetative state. He was now awake and had reflexes, but he appeared to have no cognitive ability whatsoever. Schaaf instructed Saltonstall, who was his pro-bono attorney in the Comeau matter, to seek permission from the Probate Court to remove the ventilator that aided Ron's breathing. This was expected to lead to the young man's death.

On August 17, a hearing was held before Judge Buchanan. Based on the testimony of attending physician Michael Albus and consulting neurologist Keith Edwards, Judge Buchanan ruled that Ron was "unaware" of what was happening "around him and to him," and that there was "no reasonable possibility of recovery or improvement." Convinced it was in Ron's best interests, she signed the order permitting the ventilator to be withdrawn.

But Ron didn't die. Not only that, he began to improve. By the middle of September, he had emerged from his persistent vegetative state. He was now aware. But that was not a cause for joy. Schaaf was horrified by Ron's condition. "I saw a person who could register some feelings, but those feelings were pain, agony and fear. His hands were bent in toward his wrists. It appeared he was trying to remove his feeding tube. Whether it was a conscious act, I couldn't tell."

Speech pathologist Juanita J. Cook saw a different Ronald Comeau.

"Seems to recognize personnel—favorite nurses," Cook noted in Ron's medical records. "On 9/21, definitely responded with recognition today when I went in and said my name, reminding him that I was the person who came in to talk—not to do any direct care, etc.—Big smile, with overall body movement. Very different from the grimace at having hands restrained."

Other notes in the file show a man who was aware, sometimes grimacing, often seemingly in pain, at other times intently concentrating on discussions about his future care.

### Out of his misery

But Ron remained profoundly disabled. Schaaf recalls, "I thought that if it were me there, lying helpless in a bed, I hope to God that someone would help me move on from my misery to whatever comes next, because whatever comes next can't be worse than that." He decided to raise the question of withholding food and fluids from Ron.

Apparently with that in mind, Dr. Edwards wrote a report stating in part, "Although I would have no ethical or moral problems in letting . . . a medical complication go untreated, it

is difficult to support withdrawing nutrition in a patient who is demonstrating some neurological function."

One day in October, the Medical Center ethics committee convened to consider Schaaf's plan to starve and dehydrate Ron Comeau to death. Of course, the issue was not defined in such stark terms. Ron was being fed through a feeding tube. Some in the medical community consider such "artificial feeding" to be a form of medical treatment no different from other life-saving interventions such as using a respirator. Others regard it as humane care. This is a distinction with a profound difference: Medical treatment can be ethically withheld; humane care cannot be, according to the American Medical Association.

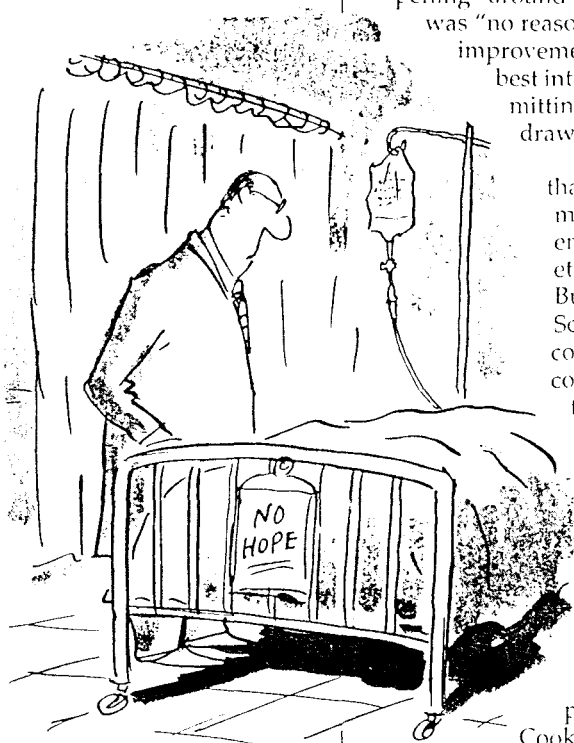
Ron was neither terminally ill nor in an irreversible coma. He was awake and aware, if profoundly brain-damaged and disabled. But that did not seem to concern the ethics committee. Psychiatrist Peter Zorach, the chairman of the ethics committee, recalls: "We had a discussion. We weren't going to take a vote, but Mr. Schaaf felt it would be helpful to him if he knew whether people would support his position. There were people in the discussion who had taken part in Mr. Comeau's care and who were able to express observations about what could be done. We imagined that his being in a hospital bed, not able to move, might be a frustrating experience. If being in jail made him so unhappy that he wanted to kill himself, then being in a hospital partially paralyzed would also make him unhappy. People felt that he was not happy and that there was not much likelihood that he would ever be happy. His emotions usually looked like fear, anger, rage and sometimes sadness." The vote was 10 to 3 to support whatever decision Schaaf might make.

On Nov. 9, Schaaf and Saltonstall, along with Ron's guardian *ad litem* and his attorney, appeared before Judge Buchanan to determine whether Ron's feeding tube should be removed. The guardian *ad litem* took no position. Doctors Albus and Zorach testified in support of removing nutritional care. No one argued against removal. Dr. Edwards' report recommending against this course was not mentioned to the judge. (Saltonstall says he was unaware of Dr. Edwards' opinion.) It was disclosed that Ron was no longer in a persistent vegetative state, but the information was couched in terms of unbearable suffering with no hope of further improvement. Judge Buchanan granted the motion, ruling that Ron would "beyond any reasonable doubt . . . ask that artificial nutrition and hydration be terminated." If all had gone as planned, Ron Comeau would have been dead within a week.

### To the rescue

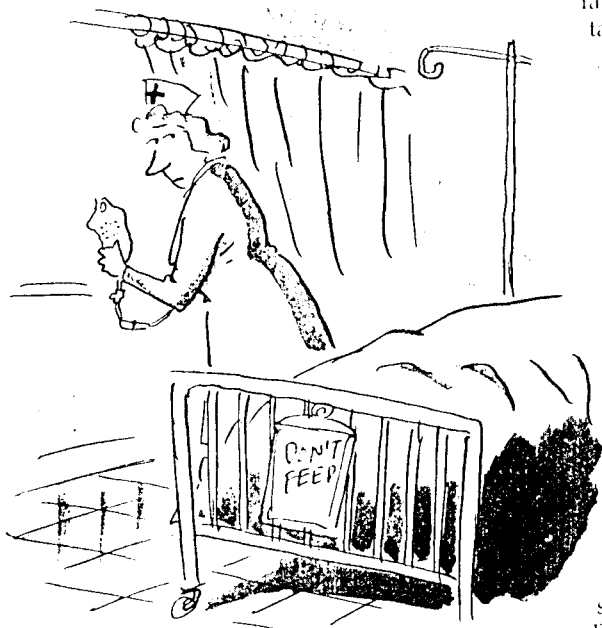
The Rev. Mike McHugh, minister of Grace Christian Church in Essex Junction, Vt., is accustomed to the maelstrom. Founder of the Vermont chapter of Operation Rescue, McHugh sees it as his Christian duty to seek to preserve life. To say that McHugh is a controversial figure in Vermont is an understatement.

Two days after Judge Buchanan's ruling, McHugh got a phone call from a fellow believer. Local media had reported that a young man was



going to be legally starved to death. Was there anything McHugh could do?

McHugh obtained a copy of the *Bennington Banner's* story on the case. He knew he had to step in. He called on his network of pro-life



attorneys and then went to a prayer meeting of local pastors. He came away from these discussions and prayers determined to be bold.

McHugh called Judge Buchanan at her home and told her he wanted to petition the court to become Ron's guardian. She agreed to convene an immediate hearing. McHugh then went high profile, issuing a press release announcing that he was going to fight to save Ron's life.

A hearing was held at 8 p.m. on Nov. 11. Among those present were Schaaf, Saltonstall and McHugh. Also present were representatives of much of Vermont's media. The Comeau case was about to become an event.

McHugh asked Judge Buchanan to stay the order removing Ron's feeding tube and to name him Ron's new guardian. Under cross-examination, he admitted to having willfully violated a federal judge's restraining order and to having been arrested 20 times in connection with his Operation Rescue activities. He also admitted that he had never met Ron and that Ron was not part of his congregation. Judge Buchanan ruled that she could not stay her own order. Moreover, she ruled that, under Vermont law, McHugh had no standing to enter the case.

The next day, McHugh, along with a less controversial pastor named John Goyette, filed an appeal in the Bennington Superior Court. A stay was granted pending a hearing to be held Nov. 16. The order was served on the hospital, and Ron's food and fluids were restored.

But the stay was only a temporary reprieve. McHugh was likely to lose on the standing issue in the emergency hearing, and if he did, Ron Comeau's death would proceed as planned.

## In search of a family

McHugh had one last card to play: Ron's family. He first tried to find Ron's mother. He drove to Rhode Island, where he had heard she

lived, and found several women answering to the name of Mary Comeau, but none of the women was the right Mary.

Growing desperate, he decided to appeal to Ron's father, even though the media had depicted the man as uncaring about his son's fate. He made some phone calls to police contacts and headed north toward Maine. Making another call along the way, he was told that Ron's father had been found and that "he doesn't want his son to die."

McHugh finally met Ron's father, Renald Dupois, and his brother, Raymond. McHugh showed them news clippings and said to Renald, "I am told you don't have an interest in this."

"That's not true," Renald insisted. Raymond thought the hospital said Ron was dying; he had no idea Ron was still alive.

McHugh offered to pay all expenses if the two men would go back to Vermont with him and appear at the Nov. 16 hearing. They agreed. With his own money and contributions from other pro-life supporters, McHugh soon had the Dupois brothers installed in a hotel in Bennington.

Whether or not McHugh was seeking publicity for himself, as some have alleged, he surely got it. With the dramatic appearance of Renald and Raymond Dupois, Ron's case became a front-page sensation. The court continued the hearing until the Dupois brothers could visit Ron and determine if he was indeed their son and nephew. McHugh held a news conference, which descended into an ugly shouting match when he refused to allow reporters to question the brothers.

An angry debate was on. Many were glad that Ron's family had become involved at last, but highly resented McHugh's intrusion and the turning of the young man's tragedy into a media circus. McHugh pulled no punches either, stating that those who wanted Ron to die were executioners, an allegation that Saltonstall particularly resented since he was the lawyer who had convinced the Supreme Court of Massachusetts to throw out that state's death-penalty law.

Editorials were flying. A *Rutland Herald* editorial opened, "It is too bad that the sanctity of life should have as its defender a religious freebooter such as McHugh." A newspaper commentator named Jack Hoffman was furious that the press had allowed "Michael McHugh, the anti-abortion fanatic," to dictate "the terms of staging his own publicity stunts."

Amidst the media uproar, the Dupois brothers visited Ron. They came away convinced he should live. Renald Dupois told the press, "I said, 'This is Dad.' When he heard that, he had a smile on his face and started to move all

(continued on page 4)





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## RIGHT TO DIE (continued from page 3)

over the place. That made me happy."

Raymond added, "If he's in a coma, it's the funniest coma I ever saw."

### A lot of life

The case was about to take another twist. In Worcester, Mass., Renald Comeau, Ron's brother, heard a news report about the brouhaha in Vermont. He and his wife, Patricia, immediately left for Bennington, where they were joined by his and Ron's half-brother, Robert DesRosiers.

The family gathered at Ron's bedside, the first such reunion in a very long time. Ron delighted at being shown a shirt with the Harley Davidson logo on it. His brothers came away from the reunion quite upset at what had almost happened to Ron. "Imagine, they were going to kill this guy," DesRosiers said later. "There's a lot of life there."

Meanwhile, Joe Schaaf believed the family should take control now that they were involved. He met with Renald Comeau, and they agreed that Renald would take over as his brother's guardian. Any thought of starving Ron was abandoned.

In the months since his life was saved, Ron Comeau's condition has slowly improved. According to Renald, Ron recognizes family, listens to music, can sit up, roll over, use the television remote control, clumsily push himself in a wheelchair and eat foods such as soup and pudding. He even flirts with pretty nurses, summoning them with his call button and blowing them kisses. He was recently transferred to a rehabilitation facility in Massachusetts. Renald reports that Ron has his good days and his bad days; one very good day was the day he was reunited with his mother, whom he had not seen for years.

### It could happen anywhere

This happy ending raises disturbing questions. In an editorial entitled "What Went Wrong?" the *Burlington Free Press* stated: "Vermonters remain puzzled and upset. Institutions they trust sanctioned the death of a man still able to smile, recognize people, move his arms, blink purposely."

Vermonters aren't the only ones who should be puzzled and upset. What happened to Ron Comeau could happen anywhere. The legal and medical systems almost permitted Ron to be killed because a retired educator believed that the quality of his life was not worth living.

One fundamental problem was the way the court decided to withdraw Ron's nutrition. The hearing took place in a kangaroo-court atmosphere with a predictable, almost predestined, conclusion. The only opinions Judge Buchanan heard were those favoring Ron's death. No one argued to maintain Ron's life, not even the

guardian *ad litem*, appointed to represent Ron in the hearing. Moreover, the judge knew, but apparently did not take into account, that Ron had improved since the August hearing.

In hindsight, would the principals have acted differently? Schaaf still believes he made the right choice. He says, "I saw somebody who was not getting better. We talked about it in the ethics committee for more than an hour. My role was to act as a family would. If a member of my family was in the same position, I would have made the same decision. It's horrible to see someone suffering like that."

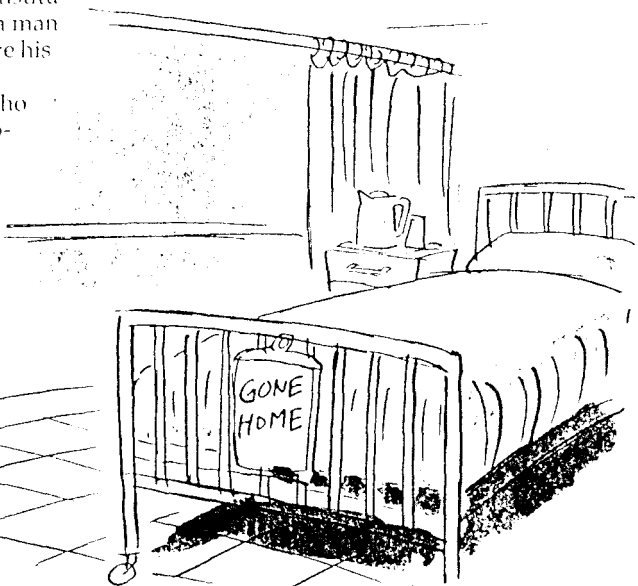
Saltonstall agrees. "I would not want to live in that situation. I would hope my family would pull the plug."

It is clear that those who advocated Ron's death did not do so out of malice but in the sincere belief that dying would be better than living in such a profoundly disabled state. But, does anyone have the *moral right* to starve and dehydrate another human being to death? If this case teaches us anything, it is that once acts designed to *cause death* are allowed, so-called "protective guidelines" are easily broken or ignored.

Ronald Comeau is alive and reunited with his family, not because the system worked, but because an unpopular, in-your-face, pro-life radical threw a monkey wrench into its gears. And despite the widespread disdain for his zealotry and the suspicion of his motives, *he* was the one who had it right: not the doctors, who said Ron would never improve; not the guardian, who essentially chose to kill his ward; not the medical ethics committee, which gave the guardian its blessing; and not the judge, who acted like a rubber stamp.

Renald Comeau wonders, "How many more Ronnie Comeaus are out there?"—an important question, especially since the next Ron Comeau might not have a Mike McHugh. [ ]

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**The legal and medical systems almost permitted Ron to be killed because a retired educator believed that the quality of his life was not worth living.**

**MONTANA ADVOCACY PROGRAM, Inc.**

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February 1, 1995

Senator Jim Burnett, Chairperson  
Senate Public Health, Welfare & Safety Committee  
State Capitol  
Helena, Montana 59620

Re: SB 146

Mr. Chairman and Members of the Committee:

For the record, my name is Andree Larose and I am a staff attorney for the Montana Advocacy Program. Montana Advocacy Program is a non-profit organization which advocates the rights of individuals with disabilities. We are here to testify in support of SB 146, with some proposed changes. Actually the comments I present to you are those of another staff attorney, Lonnie Olson, who could not be here today.

1. In general, we support this bill and think it is a great step forward in clarifying and enhancing the rights of Montanans with regard to health care decisionmaking. However, the bill as presently drafted creates a conflict in the statutes between the rights accorded individuals seeking treatment because of mental impairment under Title 53, Chapters 20 and 21 and some provisions of the Uniform Health Care Decisions Act. For example, Section 53-21-165(6) requires the appointment of a guardian for an incompetent patient, in comparison to Section 6 of the HCDA which allows the designation of a "surrogate" decisionmaker. The bill leaves unclear which is controlling.

2. Provisions of this bill allow the appointment of a "surrogate" to make decisions for individuals who may be lacking in the capacity to act, without judicial process. The determination of competency is made by a physician, yet competency is both a medical and a legal concept. With the surrogacy provision, this bill is in conflict with the due process rights of patients to make decisions concerning a person's own health care. These rights are constitutionally protected under Cruzan v. Missouri Dept. of Health, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990). Unless the provisions concerning surrogacy are changed, or additional language as I suggest below is included, the entire statute may be found unconstitutional as it deprives a patient of constitutionally protected due process.

3. To deal with these conflicts, at least as they apply to mentally impaired individuals, we propose the following clarifying language. We propose to amend Section 14(6) to delete the currently proposed language and insert instead the following:

Nothing in this Act shall affect any of the rights of an individual under Title 53,

Chapters 20 and 21.

4. In closing, Mr. Olson has spoken with the State Bar Subcommittee Chair Dan McClean and does not believe the committee would have any objection to the inclusion of this language in the bill. Mr. Olson and I would be happy to work with this committee in further revision or drafting of any amendments if you decide it is necessary.

We urge you to make the amendment we propose and to pass this bill. Thank you for your time.

Sincerely,

A handwritten signature in cursive script, appearing to read "Andree Larose".

Andree Larose

**Senate Public Health, Welfare, and Safety  
Chairman Senator Jim Burnett**

**Senate Bill 146**

**The Uniform Health Care Decisions Act**

Mr. Chairman and members of the committee, I am Dick Brown, Sr. Vice President of the Montana Hospital Association (MHA). The MHA represents 55 Montana hospitals and medical assistance facilities, and the forty-five long terms care facilities located with those hospitals. I am here on behalf of those facilities to offer the associations support of Senate Bill 146.

Hospitals, long term care facilities, and other health care providers make decisions daily about the care of patients they are serving. In an increasing number of situations either the patient or an agent of the patient has specific instruction regarding their care which they would like followed.

Senate Bill 146 establishes a procedure for the designation of a power of attorney to see that an individual's instruction are carried out when they are no longer able to give that direction themselves. This bill provides the authority for all health care decisions regarding an individual. Third, and key to the legislation is the fact that it is based on uniformity in the decision making process. These points are all viewed as enhancements to current statutes on health care decision making authority.

The MHA has worked on legislation regarding the Living Will Act and the Montana

Rights of the Terminally Ill Act, and subsequently the Comfort One statutes. Comfort One as you may recall is a program which provides non-hospital patients an opportunity to limit their treatment in a medical emergency. MHA administers the Montana Comfort One program.

MHA supports Senate Bill 146 and the amendments offered by Senator Eck. In addition to clarification of definitions and other provisions in the bill, the amendments will provide for the continuation of the Comfort One program.

On behalf of MHA I thank you for the opportunity to speak in support of this bill and encourage your support as well.



MonAMI

SENATE HEALTH & WELFARE

EXHIBIT NO. 6

DATE 2/1/95

BILL NO. SB 146

## Montana Alliance for the Mentally Ill

To Public Health, Welfare and Safety Committee

SUPPORT SB 146 IF AMENDED TO INCLUDE PEOPLE WITH  
SERIOUS MENTAL ILLNESSES

MonAMI is an advocacy and support group for consumers with mental illnesses and their families. We have eight chapters in Montana. I'm Marty Onishuk, state vice president.

Mental illnesses are neurobiological brain diseases. The chemical processes of the brain do not work as they should. The neurotransmitters between the neuron cells malfunction. The cause(s) is not known, but family history (genetics) plays a part as well as events in the womb and viruses are believed to contribute. No prevention is known. But treatment works--medications are becoming more targeted with research information.

Other diseases of the brain are Alzheimer's, Parkinson's, epilepsy and multiple sclerosis. All brain diseases are physical diseases.

In serious mental illnesses--schizophrenia, bipolar disorder (manic-depression), and major depression--the physical brain disorder may disrupt thought patterns, cause auditory and visual hallucinations, cause delusions or warp emotions. This can result in bizarre behaviors and impaired judgement--talking to voices, not caring for self, not handling money.

Mental illnesses can be cyclical diseases with good days and bad days. Diabetes is another cyclical physical diseases.

We support SB146 if it is amended to include people with serious mental illnesses. They know what medications work and do not work for them. An advanced medical directive would give them to have a say in their treatment.

We question if excluding an illness isn't a violation of the American with Disabilities Act.

Amendments we would like:

1. Add People with serious mental illnesses to DD and older persons
2. Add mental illnesses and name at least three--schizophrenia, bipolar disorder and major depression
3. Add Montana State Hospital to "long term facility".

OFFICE ON AGING  
DEPARTMENT OF FAMILY SERVICESEXHIBIT NO. 7DATE 2/1/95BILL NO. SB 146

MARC RACICOT, GOVERNOR

(406) 444-5900



STATE OF MONTANA

PO BOX 8005  
HELENA, MONTANA 59604-8005

February 1, 1995

TO: Senate Public Welfare Committee

FROM: Doug Blakley, State ombudsman

RE: In support of SB 146 - Uniform Health Care Decision Act

The primary responsibility of the Ombudsman Program is to serve as an advocate for residents of nursing homes, personal care homes and other similar facilities. In this capacity, ombudsmen are in facilities on a regular basis, assisting residents and consumers to resolve complaints at the local level.

Issues related to health care decision making are the largest single complaint area we deal with as ombudsmen. It is an extremely complex issue for all concerned: residents, families, providers and advocates. Complaints fall into two major categories: impediments to residents being able to exercise self determination and decision making in facilities; and problems for surrogates in exercising decision making, especially in the absence of any advanced directives.

SB 146 has many noteworthy features that maximize health care decision making.

- It simplifies the process of developing an advanced directive by combining living will, durable power of attorney and do-not-resuscitate decisions into a single form. This eliminates the possibility of having conflicting forms.
- The statutory form is comprehensive, with minimal execution requirements.
- It provides statutory authority for families to exercise surrogate decision making when residents have not executed an advance directive.

Surrogate decision making is a major problem in long term care facilities. In spite of legislative efforts and public education, the majority of residents, like the rest of us, have not executed an advanced directive. Most seniors avoid making an advanced directive because it means dealing with issues of mortality and death. They assume their family members will be able to step in and make decisions for them when they are no longer able to do so. Usually family members are permitted to do this. Problems sometimes occur when decisions have to be made regarding major crises, such as operations or living will type decisions. Problems also arise when family decisions conflict with providers decisions or when the quality of provider services is questioned. By legitimizing surrogate decision making, families will have an easier time exercising decision making.



Unfortunately, the simplicity of surrogate decision making also poses the greatest potential drawback of the bill. We frequently run into the problem of residents who are in conflict with their families or doctors over decision making. In such cases if a doctor feels the decision making is in question and concluded the resident is not competent, the Act allows the doctor to designate a surrogate. While many doctors have the skills to make such a determination, some doctors succumb to family pressures or do not have the skills to make an accurate determination of competence.

An inappropriate decision about competence by a doctor shifts the current burden of proving competence from those who challenge it to the resident. This is a huge shift. Under the Act as it is written, there is no remedy for a competent resident misdiagnosed by their doctor short of going to court to establish their competence.

I feel a competent resident should not be subjected to such a situation. I would recommend a couple of possible solutions if such a situation should arise:

- insert a clause in Section 6 stating that if a person disagrees with the doctors determination, that such determination be non-binding and the current practice of going to court to establish incapacity be followed; or
- some form of dispute resolution be established to determine if the doctors assessment was appropriate. Dispute resolution could take the form of an ethics committee (where they exist) or some form of mediation through the ombudsman program.

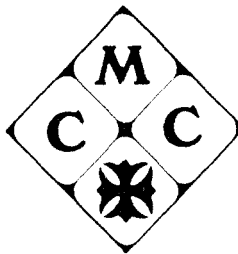
Because of my concerns over this issue, I contacted Professor David English, Reporter for the Committee of the Uniform Code Commissioners and a law professor at the University of South Dakota. He indicated that this issue had come up in developing the bill, but could not be resolved during the Committee's deliberations because of the lack of uniform options such as those offered above. He felt that both of the proposed options would be acceptable within the framework of the model law.

**SENATE BILL 146**  
**Testimony of Drew Dawson, Chief**  
**Emergency Medical Services Bureau**  
**Department of Health and Environmental Sciences**

Mr. Chairman and members of the committee. I am Drew Dawson, Chief of the Emergency Medical Services Bureau in the Department of Health and Environmental Sciences.

I am pleased to support Senate Bill 146. This bill clarifies the rights of persons to have more control over their own health care. We have worked closely with Senator Eck and are pleased to support the amendments she has proposed. Among other things, these amendments would assure the coordination of the existing prehospital, emergency medical services Do-Not-Resuscitate program with the new legislation. The amendments are necessary to preserve the integrity of this very successful program which was enacted by several previous legislatures.

I would be happy to answer your questions.



# Montana Catholic Conference

SENATE HEALTH & WELFARE  
EXHIBIT NO. 9  
DATE 2/1/95  
BILL NO. SB 146

February 1, 1995

PUBLIC TESTIMONY - SB 146  
UNIFORM HEALTH CARE DECISIONS ACT

CHAIRMAN BURNETT, MEMBERS OF THE COMMITTEE, FOR THE RECORD, I AM SHARON HOFF, EXECUTIVE DIRECTOR, MONTANA CATHOLIC CONFERENCE. IN THAT CAPACITY, I REPRESENT MONTANA'S TWO ROMAN CATHOLIC BISHOPS ON MATTERS OF PUBLIC POLICY. WE OPPOSE SB 146 IN ITS CURRENT FORM.

WITH ALL THE RECENT ADVANCES IN MEDICAL TECHNOLOGY, MOST OF US WILL BE FACED WITH DECISIONS AND QUESTIONS REGARDING OUR HEALTH CARE WHICH WERE UNHEARD OF A FEW YEARS AGO. NEW METHODS OF PROLONGING LIFE, DELAYING DEATH, AND CURING DISEASES OFFER US WONDERFUL ALTERNATIVES IN MEDICINE THAT EARLIER GENERATIONS COULD ONLY DREAM OF. ALONG WITH THE OBVIOUS ADVANTAGES OF THESE NEW TECHNOLOGIES COME CERTAIN DISADVANTAGES.

THE CATHOLIC CHURCH HAS DEVELOPED A LARGE BODY OF THOUGHT ON THESE ISSUES OVER THE CENTURIES. THIS THOUGHT REFLECTS OUR BELIEF IN LIFE AFTER DEATH AND OUR DEEP AND ABIDING RESPECT FOR LIFE. WHILE TECHNOLOGY ADVANCES RAPIDLY IN THE MEDICAL ARENA, RELIGIOUS TEACHING IS CONSTANTLY DEVELOPING TO MEET THE EVER INCREASING

DEMANDS FOR INFORMATION AND POSITIONS ON SPECIFIC TREATMENTS. WE OFFER OUR CONCERNS TO AID IN **YOUR** SEARCH.

SB 146 REPLACES MONTANA'S HEALTH AND SAFETY CODES, CHAPTER 9, COVERING THE RIGHTS OF THE TERMINALLY ILL (50-9-101 - 206) AND CHAPTER 10, DO NOT RESUSCITATE - NOTIFICATION (50-10-101 - 107). SB 146 ATTEMPTS TO CREATE A UNIFORM CODE FOR HEALTH CARE DECISIONS AND COMBINES FEATURES OF A DURABLE POWER OF ATTORNEY FOR HEALTH CARE, THE RIGHTS OF THE TERMINALLY ILL, ALL ADVANCED HEALTH CARE DECISIONS, AND DO NOT RESUSCITATE PROVISIONS. PUTTING ALL THESE PIECES TOGETHER IS EXTREMELY COMPLEX. I HAVE SPENT MANY MONTHS WORKING WITH THE UNIFORM HEALTH CARE DECISIONS ACT DRAFTED BY THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS AFTER WHICH SB 146 IS MODELED. I DO NOT ENVY THIS COMMITTEE'S RESPONSIBILITY IN REVIEWING AND DECIDING ON LEGISLATION THAT HAS SUCH FAR-REACHING IMPLICATIONS. YOU TRULY HOLD THE LIVES OF MANY IN YOUR HANDS.

WHILE WE SEE THE UNIFORM HEALTH CARE DECISIONS ACT AS ESSENTIALLY FLAWED, WE ARE WILLING TO WORK WITH THE COMMITTEE TO HELP CREATE LAW WHICH PROTECTS MONTANA'S MOST VULNERABLE PEOPLE, THE SICK, THE ELDERLY, AND THE DYING, FROM A LAW WHICH IS CRAFTED TO SERVE WHAT IS EXPEDIENT RATHER WHAT IS BEST. I HAVE PREPARED SEVERAL PROPOSED AMENDMENTS TO SB 146 AND WOULD LIKE TO REVIEW THESE AMENDMENTS WITH THE COMMITTEE. I HAVE ALSO PREPARED A COMPARISON BETWEEN CURRENT LAW AND THE PROPOSED LAW AND OFFER THAT COMPARISON TO THE COMMITTEE TO AID IN YOUR DELIBERATION.

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THE FIRST PROPOSAL IS FOUND ON PAGE 2, LINE 11, **INDIVIDUAL INSTRUCTION**, CONCERNING A PROPOSED AMENDMENT, (9) (b). WHILE THIS AMENDMENT ADDRESSES SOME OF OUR CONCERNS, THIS AMENDMENT DOES NOT SERVE OUR BELIEF THAT VULNERABLE LIFE MUST BE PROTECTED. IT SEEMS TO US THAT IF A WOMAN CHOOSES TO BECOME PREGNANT AND CARRY A CHILD TO TERM, THAT CHOICE SHOULD SUPERSEDE THE PREVIOUS CHOICE AS INDICATED BY THE LANGUAGE "**UNLESS THE INDIVIDUAL INSTRUCTION EXPRESSLY DIRECTS THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING HEALTH CARE DURING PREGNANCY...**" PAST EXPRESSIONS OF INDIVIDUAL WISHES WILL NOT NECESSARILY REFLECT WHAT A PERSON WOULD HAVE WANTED IN THE PRESENT CIRCUMSTANCES WERE THE INDIVIDUAL FULLY INFORMED AND COMPETENT.

WE ALSO ENCOURAGE ADDING (9) (c) REGARDING THE WITHDRAWAL OF NUTRITION AND HYDRATION. CURRENT LAW AT 50-9-202, **TREATMENT OF QUALIFIED PATIENTS**, COVERS THE ABORTION ISSUE AND THE NUTRITION AND HYDRATION ISSUE IN LANGUAGE SIMILAR TO THAT SUGGESTED IN THESE TWO AMENDMENTS.

ONE OF THE STRENGTHS OF SB 146 IS THE EXPANDED DEFINITIONS SECTION. WE SUGGEST ADDING TWO ADDITIONAL DEFINITIONS, "LIFE PROLONGING TREATMENT" AND "TERMINAL CONDITION." WE BELIEVE BOTH DEFINITIONS ADD CLARITY TO THE ACT'S INTENT.

ONE CONCERN FREQUENTLY EXPRESSED TO ME IS THE ABSENCE OF WITNESSES ON THE POWER OF ATTORNEY. WE SUGGEST THAT HAVING A HEALTH CARE POWER OF ATTORNEY WITNESSED BY INDIVIDUALS WHO HAVE NOTHING TO GAIN FROM THE PATIENT'S INCAPACITATION, IS PRUDENT.

THIS CONCERN IS ADDRESSED ON BOTH PAGE 3, LINE 9 AND 10, AND ON PAGE 5, LINE 21.

THE LANGUAGE OF THE ACT IS VERY BROAD AND ALLOWS THE AGENT OR SURROGATE TO MAKE UNREVIEWABLE DECISIONS. WE SUGGEST ADDING LANGUAGE TO AT LEAST INCLUDE CONSULTATION WITH THE ATTENDING PHYSICIAN PRIOR TO THE AGENT'S OR SURROGATE'S DECISIONS AND THAT THOSE DECISIONS BE BASED ON THE AGENT'S OR SURROGATE'S KNOWLEDGE OF THE PRINCIPAL'S WISHES AND RELIGIOUS OR MORAL BELIEFS, AS STATED ORALLY, OR AS CONTAINED IN THE POWER OF ATTORNEY FOR HEALTH CARE.

WE ARE CONCERNED ABOUT THE DESIRE FOR COMPLETE AUTONOMY. THE SUGGESTED CHANGE TO PAGE 4, LINE 25, STRIKES LANGUAGE ALLOWING AN AGENT TO MAKE HEALTH CARE DECISIONS EVEN THOUGH THE PATIENT IS STILL CAPABLE. A COMPETENT INDIVIDUAL SHOULD EXERCISE A ROLE IN DECISIONS ABOUT THEIR OWN MEDICAL CARE. THIS SAME CONCERN IS AGAIN ADDRESSED ON PAGE 7, LINE 5.

PART 2, **INSTRUCTIONS FOR HEALTH CARE**, INCLUDED IN THE ADVANCED HEALTH CARE DIRECTIVE HAS SEVERAL DIFFICULTIES. FIRST, THE FORM ALLOWS TWO CHOICES, **TO NOT** PROLONG LIFE OR **TO** PROLONG LIFE. WE'RE SUGGESTING LANGUAGE TO PROVIDE WHAT WE BELIEVE IS BETTER PROTECTION FOR THOSE ENTERING INTO AN ADVANCED HEALTH CARE DIRECTIVE.

ON PAGE 7, LINE 24, WE SUGGEST LANGUAGE CONNECTING BACK TO THE DEFINITION OFFERED FOR "TERMINAL CONDITION" RATHER THAN "AN **INCURABLE AND IRREVERSIBLE** CONDITION THAT WILL RESULT IN MY DEATH

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WITHIN A RELATIVELY SHORT TIME." DIABETES IS INCURABLE AND  
IRREVERSIBLE AND COULD BE ACCOMPANIED BY A COMATOSE CONDITION.  
WITH TREATMENT, DIABETICS CAN LIVE LONG AND SATISFYING LIVES.

REGARDING NUTRITION AND HYDRATION, IF THE INDIVIDUAL CHOOSES  
TO NOT PROLONG LIFE, IT APPEARS THAT NUTRITION AND HYDRATION ARE  
IMMEDIATELY WITHDRAWN, SINCE THEY ARE NOT ADDRESSED. NUTRITION  
AND HYDRATION ARE INCLUDED IN THE CHOICE TO PROLONG LIFE; HOWEVER,  
THEY ARE TREATED TOGETHER RATHER THAN SEPARATELY AND THE PATIENT  
HAS NO CHOICE EXCEPT TO ACCEPT NUTRITION AND HYDRATION **"REGARDLESS  
OF MY CONDITION AND REGARDLESS OF THE CHOICE I HAVE MADE..."** WE  
SUGGEST REPLACING THE CURRENT LANGUAGE WITH THREE CHOICES AND  
INSURING THAT NUTRITION AND HYDRATION ARE NOT WITHDRAWN IN ORDER  
TO CAUSE DEATH AS INDICATED IN OUR AMENDMENT TO **"INDIVIDUAL  
INSTRUCTIONS"** COVERED EARLIER.

SECTION 6 COVERS THE DESIGNATION OF SURROGATE. WE HAVE  
NUMEROUS CONCERNS THAT THIS SECTION CONCENTRATES LIFE AND DEATH  
DECISION-MAKING WITH A SINGLE INDIVIDUAL. THERE IS ONLY ONE  
STATUTORY LIMITATION FOR THE SURROGATE--HE OR SHE CANNOT COMMIT  
THE PATIENT TO A MENTAL INSTITUTION. THE SURROGATE CAN, HOWEVER,  
COMMIT THE PATIENT TO CONVULSIVE TREATMENT, PSYCHOSURGERY,  
STERILIZATION, AND ABORTION, TO NAME A FEW, AND THE SURROGATE CAN  
WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENT. OUR SUGGESTED  
AMENDMENTS TO PAGES 11, 14, AND 15 ATTEMPT TO PUT SOME PROTECTIONS  
IN THE LAW BY INCLUDING CONSULTATION WITH THE ATTENDING PHYSICIAN

AND ALLOWING PHYSICIAN DISCRETION REGARDING NUTRITION AND  
HYDRATION.

THE SUGGESTION FOR PAGE 14, LINE 23 DROPS THE LANGUAGE "TO  
THE EXTENT PROHIBITED BY OTHER STATUTES OF THIS STATE" TO ASSURE  
THAT THIS ACT INDEED DOES NOT AUTHORIZE MERCY KILLING, ASSISTED  
SUICIDE, OR EUTHANASIA.

ADVANCE DIRECTIVES AND LIVING WILLS ARE NOT SIMPLE SUBJECTS.  
IT WOULD BE EASY IF CERTAIN TREATMENTS WERE ALWAYS CONSIDERED  
EXTRAORDINARY AND OTHERS WERE ALWAYS ORDINARY. THERE WOULD BE  
CLEAR LINES AND, PERHAPS, EASY DECISIONS. HEALTH CARE DECISIONS  
HAVE A SUBJECTIVE QUALITY TO THEM. THE BURDENS OF ANY TREATMENT  
MAY VARY WITH EACH INDIVIDUAL. OUR SUGGESTIONS HERE ARE AN  
ATTEMPT TO AID IN THIS CRITICAL DECISION-MAKING AND ARE OFFERED AS  
A SAFEGUARD FOR VULNERABLE PEOPLE AND THOSE WHO MAY HAVE TO MAKE  
DECISIONS FOR THEM.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY. AGAIN, I OFFER YOU  
THE SERVICES OF THE MONTANA CATHOLIC CONFERENCE AS YOU DELIBERATE  
AND WORK TO PROVIDE GOOD HEALTH CARE DIRECTIVES FOR MONTANANS.



COMPARISON-UNIFORM HEALTH CARE DECISIONS ACT AND MONTANA'S RIGHTS  
OF THE TERMINALLY ILL ACT (50-9-102-206) PREPARED BY SHARON HOFF,  
EXECUTIVE DIRECTOR OF THE MONTANA CATHOLIC CONFERENCE ON 1/15/95.

DEFINITIONS

The Uniform Act contains numerous new definitions for terms not contained in the current Montana's code. The uniform code committee<sup>1</sup> recommends expanding the definition of (7) "health care institution." and the definition of (9) "Individual instruction." They also recommend deleting the language, i.e. "(or osteopathy)" from (11) "Physician" and have included the appropriate state statute which defines "Physician."

WHO MAY ACT AS PRINCIPAL

The present law indicates "The declarant may designate another individual of sound mind and 18 or more years of age to make decisions..." The original Uniform Act includes emancipated minors; however, the uniform code committee is suggesting a change to "An adult or minor *authorized to consent to the provision of health care services under 41-1-402...*" 4-1-402 refers to validity of consent of minor for health services. The committee suggests eliminating the word "emancipated."

WHO MAY ACT AS AGENT

Present law indicates "declarant may designate another individual of sound mind and 18 or more years of age..." (50-9-103). The Uniform Act only prohibits the principal's long-term care provider and its employees from acting as an agent, unless related to the principal by blood, marriage, or adoption.

MEANS OF GIVING INSTRUCTION

The present law permits a person to give an instruction by a written and witnessed living will. It also allows for a revocation (50-9-104) "at any time in any manner." The

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<sup>1</sup> Refers to Trusts, Estates, Tax and Business Law Section of the State Bar of Montana.

declaration that designates another individual to make decisions is also signed and witnessed. Under the Uniform Act, such a direction could be oral, with no witnessing needed. The uniform code committee is suggesting a change to include (a) in writing and signed by the individual; or (b) personally communicated by the individual to the supervising health-care provider. .

#### **MEANS OF GRANTING POWER OF ATTORNEY FOR HEALTH CARE**

Under the present law a person may grant a power of attorney for health care by a written and witnessed document. Montana Code 72-5-501, Durable Power of Attorney, allows a principal to appoint another as attorney in fact. Under the Uniform Act the grant must be in writing, but need not be witnessed. The sample form included with the Uniform Act does have spaces for witnesses to the entire document, but witnesses do not seem to be a requirement.

#### **WHEN DOES DIRECTIVE BECOME EFFECTIVE**

Current law 50-9-105 indicates the declaration does not become effective until the person lacks capacity. Under the Uniform Act a person could specify that an agent would become effective immediately or upon the happening of a specific event other than loss of capacity, (Section 3(3)).

#### **RECORDING OF LOSS OF CAPACITY**

Current law, 50-9-201 requires the attending physician, upon determining that a declarant is in a terminal condition, to record that determination and the terms of the declaration in the declarant's medical record. Although the primary physician must make such a determination under the Uniform Act, documentation of that determination is not required. Section 3(4) states that determinations of capacity are to be made by the patient's physician--unless otherwise specified in the written advance

directive. The comments<sup>2</sup> make clear that the patient can appoint anyone, including a non-physician agent to make that determination.

#### CONSTRUCTION OF MULTIPLE DIRECTIVES

The present law does not address conflicting durable powers of attorney for health care; however, 50-9-108 indicates that a declaration in existence prior to 10-1-91 is effective if it complies with 50-9-103(1). The Uniform Act permits multiple directives, living wills, and durable powers of attorney for health care, to be construed together to determine the person's intent. See Section 3(5).

#### DIRECTIVE FORM

In current law, the Declaration for both treatment and designation of agent, are both very vague and broad, focusing on an "incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relative short period of time..." Within the Uniform Act, there is no indication regarding whether death within a "relatively short time" is expected "with out without treatment". The form within the Uniform Act permits the declarant to separately make choices for "life prolonging" treatment, hydration, and nutrition. The Uniform Act permits a choice to "not prolong life" or "prolong Life." Nutrition and hydration are treated together rather than with a separate box to be checked for each.

#### EUTHANASIA AND ASSISTED SUICIDE

Section 50-9-205(7) of the Montana law does not "condone, authorize, or approve mercy killing or euthanasia. The Uniform Act contains language that only "prohibited mercy killing, assisted suicide, euthanasia or the provision, withholding or

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<sup>2</sup> Refers to comments included in the Uniform HealthCare Decisions Act Drafted by the National Conference of Commissioners on Uniform State Laws.

withdrawal of health care, to the extent prohibited by other statutes of this State." The uniform code committee is suggesting the language. "This ACT does not authorize mercy killing, assisted suicide, or euthanasia" and dropping the reference to other statutes.

#### **NUTRITION/HYDRATION**

Regarding nutrition and hydration, current law, 50-9-202(2)...does not affect the responsibility of the attending physician or other health care provider to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain." In the proposed ACT, the individual will have to indicate on the form whether to seek "artificial nutrition and hydration as well as provision of pain relief." There is no definition of "artificial nutrition and hydration" in the proposed ACT.

#### **GUIDELINES FOR AGENT**

Current law allows no provision for release of information or any guide to the agent as to what information he/she should consult before making decisions. The Uniform Act permits the agent to have the same rights to information as the principal.

#### **PREGNANCY**

Current law; 50-9-106(6) AND 50-9-201(3) indicates that "Life-sustaining treatment cannot be withheld or withdrawn pursuant to this section from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment." The Uniform Act does not contain such a provision. The uniform code committee is suggesting a change to provide for pregnancy. Their suggested change broadens current law which now does not allow the withdrawal of life-sustaining treatment and allows the woman to indicate a preference. The suggested language reads: "Unless the individual

instruction expressly directs the withholding or withdrawal of life- sustaining health care during pregnancy," and continuing with current language indicated above.

#### NOTICE OF RIGHT TO REVOKE

50-9-104 allows a declarant to revoke a declaration at any time and in any manner. The language is similar to that proposed by the Uniform Act. The proposed Uniform Act has a section on revocation, Section 4(1)-"individual may revoke designation of agent only by a signed writing or personally informing the supervising health-care provider;" and (2) "may revoke any or all...other than the designation of an agent, at any time and in any manner that communicates an intent to revoke."

#### SURROGATES

The Uniform Act permits the designation of a a surrogate who can make health care decisions for the patient if the patient has not designated an agent or a guardian has not been appointed, Section 6. If the patient does not designate a surrogate, a certain family member becomes a surrogate by default. The Uniform Act permits "an adult who has exhibited special care and concern for the patient," to act as a surrogate. This process is mostly consistent with current law. However, the term "surrogate" is not used in current law.

The purpose of the surrogate provision is to provide for the situation where no agent or guardian has been appointed. Its effect, however, is to eliminate the formalities of designating a durable power or attorney for health care in writing or the judicial appointment of a guardian. This result is probably intentional since it is consistent with the ACT's emphasis on having decisions made with the least amount of formality.

#### SCOPE OF AGENT OR SURROGATE'S POWER

The surrogate has considerable authority. Under the ACT, there is only one statutory limitation on the agent's authority.

He/she cannot consent to commit the patient to a mental institution. The agent can consent to convulsive treatment, psychosurgery, sterilization, abortion and withholding or withdrawing life-sustaining treatment under any circumstance, even when the patient is pregnant and continued treatment would benefit the unborn child. (See Pregnancy for further information..)

Current Montana law under "Rights of the Terminally Ill" is not specific regarding the scope of power. The agent is appointed "to make decisions regarding my medical treatment...". 72-5-501, Durable Power of Attorney, allows the attorney in fact to make decisions should the principal be disabled or incapacitated. This section is not specific either. The uniform code committee suggests adding language to 72-5-501(2) "Nothing in this section affects the Uniform Health-Care Decisions Act or affects powers of attorney for health care executed in conformance with that Act."

#### OBLIGATION OF PROVIDER

Current law, Part 2, 50-9-201 and 50-9-202 covers treatment of qualified patients. Section 50-9-202(2) and (3) are covered above regarding the physician's responsibility to provide treatment, including nutrition/hydration and alleviation of pain and that life-sustaining treatment cannot be withheld when the individual is pregnant. Under the Uniform Act, the physician is obligated to use, withhold, or withdraw life-prolonging treatment when there is presumptive evidence of the patient's wishes. The physician is also obligated to follow the directives of a durable power of attorney for health care.

#### CONSCIENCE CLAUSES

Present law, 50-9-203, indicates that an attending physician or other health care provider who is "unwilling to comply" must provide transfer of care to another physician or health care provider. This appears to be a conscience clause, although it is somewhat vague.

The Uniform Act excuses individual from compliance, but excuses institutions only if the instruction is "contrary to a policy of the institution which is based expressly on reasons of conscience and if the policy was timely communicated to the patient or to a person authorized to make health care decisions for the patient."

**MEDICAL STANDARDS**

Montana law, 50-9-205(6) states "This chapter does not require a physician or other health care provider to take action contrary to reasonable medical standards. Although the two statutory schemes use different language, both provide that a provider need not comply with instructions contrary to accepted medical practice. The provision in the Uniform Act, however, becomes unacceptable in light of the strict requirements of its conscience clause. Catholic institutions may be increasingly unable to rely on the argument that something is contrary to accepted standards when society's standards become unacceptable from a Catholic perspective. There is, therefore, a need for broader conscience clauses.

**PENALTIES**

The present law expressly provides civil and criminal penalties for certain acts. The Uniform Act provides for civil money damages for providers who fail to comply with a direction.

PROPOSED AMENDMENTS - SB146 - SUBMITTED BY SHARON HOFF, EXECUTIVE DIRECTOR, MONTANA CATHOLIC CONFERENCE

DEFINITIONS

PAGE 2, LINE 11 "Individual Instruction"

**strike from Amendments to Senate Bill No. 146, First Reading Copy**

(9) (b) Unless the individual instruction expressly directs the withholding or withdrawal of life-sustaining health care during pregnancy, ... **Replace with** (b) An individual instruction may not be construed to require that life sustaining health care be withheld or withdrawn from an individual known to the supervising health care provider to be pregnant so long as it is probable that the fetus may develop to the point of live birth with continued life-sustaining health care.

**ADD** (c) Medically administered nutrition and hydration must not be withdrawn in order to cause death. They may be withdrawn if they offer no reasonable hope of maintaining life or if they pose excessive risks or burdens.

PAGE 2, LINE 13 - (Definitions) INSERT:

(10) "Life Prolonging Treatment" means any medical procedure, treatment, or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying and where, in the judgment of the attending physician, death will occur whether or not the treatment is utilized. The term does not include the provision of appropriate nutrition and hydration or the performance of any medical procedure to provide comfort care or alleviate pain; or medical procedures, treatment, or intervention performed in an emergency, pre-hospital situation.

(19) "Terminal condition" means an incurable or irreversible condition that, without the administration of life-prolonging treatment, will result, in the opinion of the attending physician, in imminent death. The term does not include any form of senility, Alzheimer's disease, mental retardation, mental illness, or chronic mental or physical impairment, including comatose conditions that will not result in imminent death.

PAGE 3, LINE 9 AND 10 INSERT

The power of attorney for health care must be in writing, must be signed by the principal **in the presence of at least two or more subscribing witnesses**, remains in effect notwithstanding the principal's later incapacity, and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent, may not be an owner, operator, or employee of **the principal's health care provider or the principal's long-term care facility**, as defined in 50-5-101.



PAGE 3, LINE 19

(5) **(Replace current language)** After consultation with the attending physician and other health care providers, the agent shall make health care decisions:

(a) In accordance with the agent's knowledge of the principal's wishes and religious or moral beliefs, as stated orally, or as contained in the power of attorney for health care.

(b) If the principal's wishes are unknown, in accordance with the agent's assessment of the principal's best interests.

PAGE 4, LINE 25

...decisions. **strike** "or if you want someone else to make those decisions for you now even though you are still capable."

PAGE 5, LINE 21

(5) ...sign and date the form at the end **in the presence of two witnesses** (other language could be added to indicate who cannot witness).

PAGE 7, LINE 5

own health care decisions. **(delete through line 6).**

PAGE 7, LINE 24

(A) I have a **terminal condition** that will result in my death within a relatively short time.

PAGE 8, LINE 3

**Replace current language with:**(g) NUTRITION AND HYDRATION: Nutrition or hydration or both must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (f) unless I mark one of the following boxes: [ ] nutrition, [ ] hydration, or [ ] both must be provided regardless...**continue with current language.**

PAGE 11, LINE 5

**Replace (6) with** (6) After consultation with the attending physician and other health care providers, the surrogate shall make health care decisions:

(a) In accordance with the patient's individual instructions, if any, and to the extent known to the surrogate in consideration of the principal's wishes and religious or moral beliefs.

(b) If the principal's wishes are unknown, in accordance with the surrogate's assessment of the principal's best interests.

PAGE 14, LINE 24

**Strike** "or the provision, withholding or withdrawal of health care, to the extent prohibited by other statutes of this state."

PAGE 14, LINE 29

EXHIBIT 11  
DATE 2-1-95  
1 SB 146

an individual to a mental health care institution, (Add) or to psychosurgery, or sterilization, unless the procedure is first approved by court order.

PAGE 15, LINE 1

NEW (6) Nothing in sections 1 through 16) requires a physician to withhold, withdraw, or administer nutrition or hydration, or both, from or to a person in a terminal condition in the absence of circumstances or directives described in this section. However, the administration of nutrition or hydration or both, is presumed to be in the best interests of the patient and nutrition or hydration appropriately administered is not life-prolonging treatment. In the absence of a written statement concerning nutrition or hydration, nutrition or hydration or both, may be withdrawn or withheld if the attending physician has determined that the administration of nutrition or hydration is inappropriate because the nutrition or hydration cannot be physically assimilated by the patient or would be physically harmful or would cause unreasonable physical pain to the patient.

(7) Formerly (6)

February 1, 1995

Senate Public Health

Arlette Randash

SB 146 Uniform Health Care Decisions Act

I rise in opposition to SB 146 for the numerous and compelling reasons given here and more which I have enumerated in a handout I will give to you at the end of my testimony. I will speak to 3 compelling reasons this bill should be defeated.

1) Under current Montana law, MCA 50-9-202 (2) it reads "This chapter does not affect the responsibility of the attending physician or other health care provider to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain." SB 146 would permit an agent, guardian, or surrogate to direct the withholding or withdrawal of artificial nutrition and hydration and all other forms of health care. (Line 5, page 2). For the first time food and water could be legally withheld from a patient in Montana. Is that a threshold the families of Montana who sent you to represent them here would want you to cross today? Many patients near the end of their death do not choose to eat or drink. However, *to permit a surrogate to withhold food and water is a vast digression from an individual making that choice.....* and obviously patients are making that choice without legal hindrance under current law because the public has not seen headlines reporting otherwise. So what necessitates this law? I submit nothing does.

In truth, food and water are not commonly considered part of the healing process, they are seen as the sustenance of life. When I go to McDonald I don't order a Big Nutrition and a Cold Hydration! Or when my babies were young no one who saw me feeding them or giving them a bottle ever asked me about artificially nutritating and hydrating them! Had I withdrawn that artificial application of food my babies would have died and I would have been charged with homicide. They were dependent upon me at that end of life, as my Mom and Dad may be dependent on me or someone else at the other end of life.

Incidentally, on page 16, line 22, "'Abuse' means the infliction of physical or mental injury or the deprivation of food, shelter, clothing, or services necessary to maintain the physical or mental health of an older person ....." It defies logic that we could define abuse on page 16 as the deprivation of food and on page 5 line 9 we permit a surrogate to designate the withdrawal of food calling it 'nutrition' for a patient.....a patient that not even a second doctor's opinion was deemed necessary to determine was incapacitated!

2) The ability for surrogates to withhold food and water is more seriously complicated by a flaw in the definition of "capacity" in line 24, page 1. SB 146 defines "'Capacity' [as] an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision," however, incapacity is not defined as being temporary or permanent. Because of this flaw in SB 146 agents, guardians, and surrogates are authorized to make life and death decisions that are *permanent* for patients who might be only *temporarily* incapacitated. Furthermore, because the capacity definition is flawed life and death decisions would be permitted by surrogates for the entire spectrum of the population who might find themselves temporarily

incapacitated by a tragic accident rather than just the so-called terminally ill. Montana should legally favor a presumption of life for its citizens.

A May 4 Wall Street Journal underscored that fatal flaws are being made in the application of Living Wills. "There is a growing body of evidence that living wills are being misapplied so as to deny care to people with treatable medical conditions. For example, there is the tragic case of the 73 year old woman in the Midwest who, upon entering a hospital for hip replacement surgery, was given a living will to sign along with the other admission forms. She tolerated the surgery well and was on the road to recovery. Then, she suffered a cardiac arrest. Rather than attempt to save her (remember, the woman was not otherwise terminally ill), it was assumed that because she had signed a living will, she wanted to die if faced with a grave medical condition. Thus, the woman was given no medical assistance whatsoever and died--a process that took some 20 minutes. The woman's daughter was not even notified of the problem or asked for permission to "do nothing." The first the daughter found out about the crisis was when she was informed of her mother's passing." SB 146 could permit just such a fatal flaw: the designation of permanent decision for a patient who is only temporarily incapacitated. SB 146 would certainly not be good policy, good law, *or for the soon to be deceased*, good public health.

3) I have already demonstrated that SB 146 is not a uniform health care decisions because we have that under current law, it is a euthanasia **bill**. And it is also a **surrogacy bill**, giving authorization to surrogates without legal safeguards to make life and death decisions. (Section 6) What this bill attempts is to remove formalities in obtaining DPA's. The current protections codified in Montana law are there for a purpose: to protect patients at a vulnerable time in their life from coercion. Some health care providers and facilities would prefer quick simple avenues, short cuts in end of life decisions. (Mention the IR article December 13, 1994) **And it is a doctor's immunity bill**. (Section 10) Doctors want immunities codified into law. In truth, I have not heard of one attempted prosecution of a doctor for the withholding of medical care for a dying person. So this bill is absolutely unnecessary because there is no evidence of a liability problem for doctors in this area of medical care. In truth, families do not sue over end of death decisions because they are relieved of the financial burden of the dying person and because they were all too often not able to enjoy the person's companionship anyway due to a comatose condition etc. ....so they do not seek relief for compensatory damages.

Please note the further considerations I have prepared for your attention in the handout. If there is to be a withdrawal of nutrition and hydration please let it be from SB 146 by giving it a "**Do not Pass.**"

# Couple's suicide saves fortune.

## Would rather money went to charity

MINNEAPOLIS (AP) — The day Richard and Helen Brown were found dead in their garage, letters of explanation began arriving in their friends' mailboxes.

The ailing, elderly couple had chosen suicide so they could leave their entire \$10 million fortune to charity, rather than spend some of it on medical treatment.

"They were taking the high road to death," their former pastor, Charles Heuser, said Monday.

The Browns, married 53 years, had made their money in radio stations and from a broadcasting school they founded.

In recent months, Richard Brown, 79, had to use a wheelchair because of arthritis and asthma. Helen Brown, 76, had Alzheimer's disease. Both had polio as children.

The Browns' bodies were found Dec. 5 in their Cadillac Eldorado in the garage of their Fort Lauderdale, Fla., re-

tirement home. Both died of carbon monoxide poisoning.

Their will specified their money should go to United Church of Christ organizations.

"We have the means to afford the best doctors, hospitals and around-the-clock home care to the end of our lives, but neither of us wants that kind of life," the Browns wrote in letters that began arriving Dec. 5. "It would also consume a substantial part of our money, which through our will and through the mission work of our church is destined to help many young people throughout the world who may one day be able to help many more.

"We have no immediate family or heirs. In a sense, this legacy represents the final purpose of our lives."

"To them, it would be a poor use of money" to spend it on care for their deteriorating bodies, said Heuser, who had advised them to leave their wealth to United Church of Christ missions.

Heuser, of Gold Beach, Ore., said that he didn't know they would commit suicide but that he can't fault them for doing so.

The Rev. Dave Hohmann, who will preside at a memorial service Thursday, said their religion teaches against passing judgment on people who commit suicide. "Our job is to remember the good," Hohmann said.

And there are many who recalled the Browns' kindnesses. Connie Wester, a secretary at the broadcasting school, recalled Brown's reaction when she and her husband adopted a baby.

"Mr. B wanted me to determine whether I wanted to be a full-time mother," she said. "So he gave me a month off with pay and said I was welcome to come back but said he would understand if I wanted to be home full time. I think that was pretty special that he would do that."

Mrs. Wester, who still works at the National Education Center-Brown Institute campus, was among several people who received the farewell note from the Browns.



Richard and Helen Brown, shown in a family photo, chose suicide last week so they could leave their money to charity.

# The Living Will's Fatal Flaw

By WESLEY J. SMITH

This week's news that a Michigan jury acquitted Jack Kevorkian raises old questions of euthanasia once again. A related and less publicized issue is the push for people to sign living wills. The death of Richard Nixon, who was not put on a ventilator because he had signed a living will, is being used by advocates to tout the document. Accounts of Mr. Nixon's decision have claimed that living wills permit patients to retain control even while incapacitated, since the document is said to require "doctors and families" to execute patients' pre-stated desires regarding their own care.

That sounds good. There's only one problem: It isn't true. Living wills do permit doctors to decide issues of life and death for their patients. But they do not permit families to exercise any power at all.

That is an important distinction. In our health care delivery system patients make health care decisions, not doctors. This is known as the law of informed consent, under which the doctor is charged with fully advising the patient of the pros and cons of treatment or non-treatment, testing and the like, as well as making recommendations. The patient is then free to accept or refuse the doctor's recommendations, and to get a second opinion or even a different doctor if that is what the patient desires. This provides a valuable fail-safe system, since doctors sometimes make mistakes.

The living will changes this balance of power. Once a living will is signed, the patient gives up the protections of informed consent, leaving all health care decisions in the hands of the medical profession. The power to decide whether the time has come for the living will to go into effect belongs to the doctor, as does the power to decide the type and extent of medical intervention that is to be withheld. And this power isn't restricted to "extraordinary care," such as ventilators to assist with breath-

ing, but to any medical intervention—from not treating a curable bacterial infection to withdrawing food and fluids so that the patient starves and dehydrates to death.

There is a growing body of evidence that living wills are being misapplied so as to deny care to people with treatable medical conditions. For example, there is the tragic case of the 73-year-old woman in the Midwest who, upon entering a hospital for hip replacement surgery, was given a living will to sign along with the other admission forms. She tolerated the surgery well and was on the road to recovery. Then, she suffered a cardiac arrest.

Rather than attempt to save her (remember, the woman was not otherwise terminally ill), it was assumed that because she had signed a living will, she wanted to die if faced with a grave medical condition. Thus, the woman was given no medical assistance whatsoever and died—a process that took some 20 minutes. The woman's daughter was not even notified of the problem or asked for permission to "do nothing." The first the daughter found out about the crisis was when she was informed of her mother's passing.

Then there is the case of the nursing home resident from Washington state who was accidentally given the wrong medication by a staff nurse. The mistake was quickly discovered. However, the patient was not advised of the mishap even though mentally competent. Why? She had signed a living will that instructed that she not be resuscitated if she suffered a cardiac arrest. It was thus assumed she would not want to be treated for a condition that could (and did) lead to her death, even though she was capable of making that decision herself.

Happily, there is an advanced medical directive that receives far less publicity than the living will, that allows patients to decide ahead of time on the level of care they want while retaining the important protection of informed consent. It is the

endurable power of attorney for health care, which is valid even in the three states—New York, Massachusetts and Michigan—that do not recognize the living will by statute. (Alaska and Alabama authorize only living wills by statute.)

In a durable power of attorney for health care, the patient appoints a designated agent as his health care decision maker. The agent will generally be a family member or close friend—someone who knows the patient intimately and who will have a true understanding of the patient's attitudes, having discussed the matter at length with the person granting the power. The durable power also permits people to opt in favor of life-prolonging care, an option often unavailable to the signers of living wills.

In such circumstances, the doctor will have to justify his or her recommendation to either provide care or withhold it. Second opinions can be sought. The chances for a tragic misapplication of the advanced directive that can occur with a living will are greatly reduced. For example, in the case of the woman allowed to die when she suffered a cardiac arrest, a call to her agent (presumably her daughter) might have brought instructions to intervene and the woman could well be with us today, enjoying the mobility accorded by her new hip. At least it would have been worth the try.

In a world where assembly-line medicine is becoming the norm, would it not be better to eschew doctor-empowering living wills in favor of the "real people"-empowering durable power of attorney? It's not as catchy a name, but it is a much better document that more fully protects patients who can't make decisions for themselves.

Mr. Smith, a consumer advocate and lawyer, is the author of "The Doctor Book," "The Senior Citizens' Handbook" and co-author with Ralph Nader of "Winning the Insurance Game."

EXHIBIT 12  
DATE 2-1-95  
SB 146

February 1, 1995

Senate Public Health and Welfare  
Arlette Randash  
Eagle Forum

Points of consideration concerning SB 146

Line 28, page 1

"Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition."

*This definition is overly broad permitting an agent, guardian, or surrogate a license to choose medical procedures providing no medical benefit to an individual, i.e. sterilization or abortion.*

Line 5, page 2

Artificial nutrition and hydration are not defined and are considered a form of health care. They can be provided, withheld, or withdrawn, by the agent, guardian or surrogate.

*When my children were babies they could not feed nor give themselves water. I fed them fluids with a bottle and food with a spoon. Was I artificially nutrating and hydrating them? Had I not fed them and they had died I would have been charged with homicide. How is this vulnerable patient any different than a baby dependent upon an adult for care?*

Line 1, page 3

*The definition of "Surrogate" provides no protection that the person is mature, capable, or knowledgeable of the individual's wishes, values, or of standard medical procedures, and does not have a conflict of interest that would compromise his discernment in rendering decisions of the individuals best medical interest, (benefactor of an estate.)*

Line 5, page 3

"The individual instruction may be oral or written....." Under current law 50-9-103 the declaration must be made by an individual of sound mind, must be signed by the declarant, or another at the declarant's direction, and witnessed by two individuals.

*SB 146 removes the safeguards of protecting the individual. If the individual instruction may be merely oral what protects the individual from an ill advised decision during depression, extreme loneliness, fear, suicidal thoughts, mental instability or from acting out of desperation brought on by wanting to preserve the family from suffering or financial deprivation.*

*The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia, in fact, it is almost always a case of an anguished plea for help and love.*

*A 12 member, government-backed panel has concluded that most Americans who suffer from depression go undiagnosed and untreated. The panel, which studied the issue for more than*

*3 years, reviewed more than 3,500 cases, and developed treatment guidelines for doctors and health care workers, said that only one-third of patients who go to a primary-care doctor with depressive disorders are appropriately diagnosed and treated. The panel, convened by the Agency for Health Care Policy and Research (Part of the Public Health Service), also found that women are 2 times more likely to suffer from a major depressive disorder than men. Depression when linked with serious illness would even be more prevalent. "Doctors are Urged to Look for Signs of Depression," NYT 4/21/93:B8)*

Line 26, page 3

"An advance health care directive is valid for purposes if it complies with section 1 through 16, regardless of when or where executed or communicated."

*Health care technology has advanced with quantum leaps. Techniques commonly used today were unheard of 15 years ago. Most human beings tend to draw up provisions and then not reconsider them for a long time. What one might think would be his medical decision today might make very different decisions given new medical treatment options. One might make very different decisions at a different age in life. And few of us can foresee the medical complexities we might face, nor the location where we might find ourselves seriously ill. What is available medically in a remote part Nevada would be very different if an accident occurred while traveling in New York.*

Line 3, 9, page 5

"If you choose not to limit the authority of your agent, your agent will have the right to, (d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

*All patients should be kept as free of pain as possible so that they may die comfortably and with dignity. However, a person has the right to prepare for his or her death while fully conscious, and should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person even if this therapy may indirectly shortening the person's life so long as the intent is not to hasten death. Would SB 146 permit a surrogate to demand the administration of medicine that is intended to hasten death nor its being withheld to alleviate pain?*

In current law 50-9-202 (2) says "This chapter does not affect the responsibility of the attending physician or other health care provided to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain. [Note line 4, page 8 where no presumption would remain in SB 146 since if the box is not marked nutrition and hydration would be withdrawn.

*There should be a presumption in favor of providing nutrition and hydration as there is in current law to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient. In SB146 a precedent would be set that food and water could be withheld or withdrawn, disregarding comfort care and alleviation of pain to the patient. Furthermore, no information is given to the individual or his agent in the model form provided as to the realistic effect that withholding or withdrawing food and water has on a patient. Dehydration can cause spasmodic*



*jerking and the slow atrophying of the body into a fetal position results. Death by starvation and dehydration can be painful and horrible for both the individual and attending family members.*

*Furthermore euthanasia is an action or omission which of itself or by intention causes death in order to alleviate suffering. Passage of SB 146 would usher in the condone and participating in euthanasia and assisted suicide, and what is particularly disturbing is that SB 146 would permit for the withholding of painkillers to alleviate the suffering which is the primary premise given for euthanasia in the first place.*

Line 23, page 7

*"I have an incurable and irreversible condition that will result in my death within a relatively short period of time " is ambiguous because it does not clarify if this condition exists with treatment or without treatment.*

Line 23, page 7

*"a relatively short period of time" is not defined in the proposed law or in current law. A benefactor to an estate might have a much different view of a 'relatively short period' of time than an elderly person wishing to live long enough to experience a grandchild's wedding or the birth of a great grandchild.*

Line 27, page 7

*"the likely risks of burdens of treatment would outweigh the expected benefits."*

*Again a benefactor of an estate might weigh the likely risks and burdens very different than an incapacitated person.*

Line 12, page 10

*"A surrogate may make a health care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and an agent or guardian has not been designated or appointed or is not reasonably available."*

*Section 6 permits surrogates to be designated to make health care decision if an agent or guardian has not been appointed by the court. If the individual has not designated a surrogate a member or members of the family may by default become surrogates. In reality, all formalities may be dispensed with, protections originally provided to protect the interests of the individual by law, and doctors and health care facilities are removed from liabilities. Those liabilities provided the accountability that keeps health care providers and institutions adhering to high qualities of health care and ethical standards.*

Line 12, page 10

*"if the patient has been determined by the primary physician to lack capacity....."*

*SB 146 which is calling for dispensing with formalities also makes no provisions that a second opinion is of a qualified physician is required to determine that an individual is indeed incapacitated.*

*No provision is made once again in Section 6 that the surrogate has no conflict of interest that would compromise his judgement in determining what is in the best interest of the patient.*

Line 2-4, page 11

"If the class is evenly divided concerning the health care decision and the supervising health care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision"

*After outlining this condition, SB 146 does not then delineate what the procedure shall be.*

Line 17, page 11

"A supervising health care provider may require an individual who claims the right to as a surrogate to provide,.....

*The provider may require.....but is not obligated to require proof sufficient to establish claimed authority to act as a surrogate.*

Line 29, page 11

"if possible,"

*Creates vagueness removing liability for physicians and health care facilities.*

Line 18, page 12

*This is a conscience clause because provisions of SB 146 may create problems for health care providers who may object on moral grounds to "directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care." (line 5, page 2) However, health care institutions may find it impossible to meet the requirements of line 21, page 12 which stipulate that "a health care institution may decline to comply with an individual instruction or health care decision if it is contrary to a policy of the health care institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient."*

Line 8, [age 13

This is an improvement over current law because "unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information."

*However, there is no provision for an ethics committee or some alternative form of ethical consultation which could be made available to assist by advising on particular ethical situations, or by offering educational opportunities, and by reviewing and recommending options to an agent, guardian, or surrogate, charged with making health care decisions.*

Line 18, page 14

"Death resulting from the withholding or withdrawal of health care in accordance with [sections 1 through 16] does not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary"

*Word games are being played in SB 146. If a deliberate directives given by an agent or guardian results in death being hastened and if the law has predetermined that is not homicide or suicide what shall protect the individual from unscrupulous and amoral coercion? What will prevent benefactors from withholding treatments to preserve estates which, when probated, they are the recipient of?*

Line 22, page 14

[Sections 1 through 16] do not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this state.

*This is an erosion of the presumption to protect human life from current statutes under 50-9-205 (7) that says, "This chapter does not condone, authorize, or approve mercy killing or euthanasia.*

Line 27, page 14

"[Sections 1 through 16] do not authorize an agent or surrogate to consent to the admission of an individual to a mental health care institution unless the individual's written advance health care directive expressly so provides."

*This is the only prohibition of an agent in directing choices for an individual's health care provision. Under current MCA 50-9-106 (6) and 50-9-201 (3) the life of an unborn child is protected by the law that reads, "Life-sustaining treatment cannot be withheld or withdrawn pursuant to this section from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment." I understand the an amendment is being suggested which would add, "unless the individual instruction expressly directs the withholding or withdrawal of life-sustaining health care during pregnancy."*

Line 22, page 16

"'Abuse' means the infliction of physical or mental injury or the deprivation of food, shelter, clothing, or services necessary to maintain the physical or mental health ....."

*Why is the deprivation of food or services called 'abuse' in current code 52-3-803 which SB 146 is not repealing; however, earlier on line 5, page 2 it would permit the withholding or withdrawal of artificial nutrition and hydration. Word games are being played again with no provision for the protection of the individual.*

February 1, 1995

Senate Public Health  
Luke Keating / SB 146

I am very much opposed to SB 146 because of my own personal experience. We all have a right to die in comfort. This bill does not in any way cover "to die in comfort."

I had my mother for eight years in a nursing home located in Billings. I spent a great deal of time at the home so I was well aware of all that happened there. The last couple of years, I would go twice a day and feed my mother.

I am not here to discuss nursing homes. I will testify about removing food, water, and medication when one is dying.

I had two sisters. My sister, who is a nurse, called about two years before my mother passed away. She thought we three should discuss and decide the type of care Mother would have at the end. Also she wanted me to be reassured so that I would not have tough decisions to make. She explained to us that dehydration was a very painful death, in fact, *she said dehydration was one of the most painful deaths.*

We three decided we wanted food, water, medication and comfort for our mother at the end. We then wrote the nursing home and the doctor of our wishes. I do know the home was not too happy.

About a year later the lady in the next room to my mother was dying. All food and water was being withheld from her. She was dying from dehydration. She was rolled into a ball in a fetal position and she was so very dry. Her lips and mouth were dry with sores. She dried up and died. She deserved to die in comfort.

The last few days for my mother included IVS, nourishment, medication and warmth. She was not dry and was pain free and very comfortable. The doctor explained there would be no point in surgery. That was not what we wanted anyway.

We wanted our mother to die comfortably, warm, and with loving care. We all have this right to die with dignity. We also have the right to die with comfort, medication and nourishment and not suffer. I hope you will defeat this bill. I have never been so shocked that this was taking place and will never forget the pains we had to go through to vigilantly protect Mother from a horrible death.

Mr. Chairman, Committee members my name is Rick Bartos. I am the Elder Rights Advocate from the Office on Aging. I am an attorney and have been involved in issues of guardianships, advanced directives, health care decision making and protection of Montana's elderly population.

I rise as an opponent to Senate Bill 146. There are several serious policy and practical issues regarding Senate Bill 146 and its affect on Montanan's ability to make determinations concerning their health care and quality of life.

Historically, the Montanan legislature has enacted statutes relating to last will and advanced directives, such as the Montana Rights of the Terminally Ill Act. It has been effectively utilized by Montanans. During the 1991 session, the legislature expanded the terminally ill act to allow decisions to withhold or withdraw medical treatment by a proxy or surrogate.

Today our law allows adults to declare that in the event a person suffers an incurable or irreversible medical condition which will result in death in a short period of time, that person may instruct the attending health care physician to withhold or withdraw medical treatment. This declaration can be evidenced in writing or can be made by a surrogate or proxy decision maker and family members.

The crucial legal prerequisite, prior to withholding or withdrawal of medical treatment, is the underlying determination made by a physician that a person has an irreversible or incurable disease or illness which will result in death in a relatively short period of time. At any time, the patient may revoke this declaration, either orally or in writing and require the continuation of medical treatment.

Currently Montanans may prepare power of attorney and delegate medical care decisions to other individuals including family members, yet retain the fundamental right to determine the nature and course of medical treatment.

Senate Bill 146 significantly alters this policy and legal declaration and remove several very important and fundamental protections. It also shifts what we currently have as self-determination to unilateral decisions made by physicians and health care facilities.

1. Senate Bill 146 proposes a determination of whether we have the capacity to make a health care decision shall be made by the primary physician. The primary physician can unilaterally decide you no longer have the capacity to make a decision.

Your right to decide is eliminated. This applies to all of us whether we have executed a health care power of attorney or not. This is a major policy shift from the present law. Our constitution extends protection for our right to determine our own destiny. Issues of competency, and capacity has achieved highest respect and protection in the law.

Under present law, competency and capacity status to make personal decisions, including health care, is made by the district courts of this state. The court establishes its decision on a number of factors examined in open court and on the evidence.

Senate Bill 146 would allow primary physicians to make a unilateral decision regarding our legal capacity to make health care decisions. The bill shifts these fundamental self determination rights from the patient to an attending physician.

If a patient or family member disagrees with the primary physician, the only recourse for the patient is to seek court intervention. The patient would be required to petition the district court to reverse the decision of the primary physician and restore his/her right to decide. The legal burden would be one the patient to overcome the presumption of incapacity.

There are many factors which influence an attending physician in determining capacity. There are countless individualized cases, no two are identical. Unless the primary physician determines you have regained your capacity, legally you no longer are in a position to declare your own destiny or make decisions affecting your body.

What is the standard test to be applied in determining capacity? What safeguards are developed to assure that a patient's fundamental right of self determination is fully protected. What assurances are there that the physician will not routinely make these decisions an individual indeed can make his/her own decisions without arbitrary determination of lack of capacity? Capacity and competency issues are complex, detailed and are not within the decision making of a single person.

Will the test or measurement be:

Appearance and behavior?  
Stream of talk (thought process)?  
Thought content?  
Perceptual abnormalities?  
Affect?  
Cognitive functions?  
Attainment of a certain age?

Historically, our laws have continually declared that our competency is presumed, as a matter of law no matter, regardless of what standard is utilized or in what forum the case is heard.

In legal guardianship proceedings, the legislature has give this mandate to our district courts when they adopted our guardianship and conservatorship laws. Section 72-5-306, MCA provides:

Purpose and basis for guardianship. Guardianship for an incapacitated person may be used only as is necessary to promote and protect the well-being of the person. The guardianship must be designed to encourage the development of maximum self-reliance and independence in the person and may be ordered only to the extent that the person's actual mental and physical limitations require it. An incapacitated person for who a guardian has been appointed is not presumed to be incompetent and retains all legal and civil rights except those that have been expressly limited by court order or have been specifically granted to the guardian by the court.

The legislature has repeatedly protected the right of self-determination. There is a legal presumption of competency, or capacity to make decisions. If competency is challenged, the district court is required to strictly scrutinize any substitute decision making for the ward.

Senate Bill 146 completely abandons this policy and declaration. It abandons the concept of encouraging the development of maximum self-reliance and independence in decision making.

2. The present Montana Rights of the Terminally Ill Act allows the withholding or withdrawal of health care if there has been a determination that the patient has an incurable or irreversible condition which will result in death in a relatively short period of time.

Senate Bill 146 eliminates any need for a health care provider to make the legal prerequisite determinations of irreversible or incurable illness or disease. Once a patient is determined to have lacked the capacity to make a decision and a surrogate is appointed, the surrogate may in fact order and direct the withholding or withdrawal of medical treatment. The patient may not have an incurable or irreversible disease or illness, yet face the probability of loss of medical treatment. This withdrawal or withholding of medical treatment includes artificial hydration and nutrition (food and water).

There are no controls. There are no effective protections or checks in this critical stage. The continuation of life of a patient is left to the discretion of a physician and a surrogate.

This legislation is no longer a right to the terminally ill statute. It is shifting tremendous authority of deciding whether a person lives or a person dies. It shifts authority to another to make a determination if a person enjoys a quality of life that is different or less than what we enjoy or whether a person dies.

3. The legislation transfers enormous authority from the patient and allows health care providers and health care institutions to determine whether they will even honor the request of a patient, surrogate or family member to provide health care to a patient.

Section 8 paragraph (6) reads in part:

**A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or health care institution.**

These terms are broad, undefined and invite varying interpretations. A health care provider will be in a position to discontinue health care and medical treatment if he/she believes such treatment or health care is contrary to "accepted health care standards." What are those standards? Who creates these standards? How are they monitored? Quite frankly, there are no accepted health care standards that are readily available. More importantly, the bill allows the physician or health care facility to create standards as you go and are interpreted and decided by the health care provider or health care institution at that time.

The standards will be dependent upon the philosophy, and policy of an individual health care provider and physician.

Does this mean once a physician determines that the quality of life is not desirable, the physician may withhold treatment?

Does it mean the physician can apply cost/benefit analysis to the treatment of a patient?

Does it mean once a patient reaches a certain age, the treatment requested such as bone or knee replacement is no longer acceptable and therefore the medical treatment is denied?

Does this mean that any elective treatment is now a discretionary determination made by the health care provider and subject to market influences, insurance concerns and arbitrary policy decisions?

Crucial decisions are being made while time is short. A physician who withdraws medical treatment and causes the patient to be transferred to another facility or physician may ultimately reduce the patient's ability to recover. The patient is then faced with the prospect of petitioning the court for judicial intervention. This is not a level playing field.

4. Section 10 of the legislation provides broad and sweeping immunity from civil and criminal liability to health care providers and health care institutions. These individuals will not be subject to civil or criminal liability or to discipline for unprofessional conduct for :

--- declining to comply with a health care decision of a person on a belief that the person then lacked authority.



Once a health care physician determines you lack the capacity to make health care decision and your request to continue medical treatment is declined, you have no legal recourse to hold the physician accountable for these decisions.

These legal obstacles are unfair to people who do not have the sophistication or energy to engage in a legal battle with the gatekeepers of medical care. Medical care is not a monopoly that should be controlled by health care providers.

5. If a family member is not readily available "an adult exhibiting special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as a surrogate." This could include anyone. More importantly the decision of the surrogate is effective without judicial approval. The only exclusion is a person who is the owner, operator or employee of a long term care facility. There are countless patients who not only face the prospect of being denied the ability to decide their own health care, they simultaneously now face the prospect that another individual will determine their fate.

There are several serious more, philosophical and ethical problems with Senate Bill 146. At the time a person is most vulnerable and frail, is when the person becomes legally helpless and subject to uncertainty and loss of self control.

We eliminate the presumption of capacity to make our own decisions by unilaterally transferring this authority for all of us to a primary physician.

We shift the burden to prove capacity upon the patient and direct that if the patient disagrees with the health care provider's decision, the patient must petition and seek judicial intervention at a time when full energy and concentration is on getting well.

We allow the withholding and withdrawal of all medical treatment, including hydration and nutrition even if the person does not have an irreversible or incurable condition or disease which will result in death in a relatively short period of time.

We allow surrogates and the health care industry to establish standards of what is a proper quality of life and unilateral decisions of life and death.

We allow the physician to determine whether a medical treatment or services is medically acceptable, based upon that physician or medical institution's discretion of what is acceptable.

We create the beginning of the gatekeeper of health care and allow rationing of health care.

For those who choose to execute the health care power of attorney provided in the bill, we allow the hastening of death, by not only withholding of medical treatment but the

affirmative action of injecting or providing "pain medication," which will hasten one's death, and simultaneously excuse this action as not being assisted suicide, mercy killing or euthanasia.

Montana presently has sufficient statutory options for individuals to determine their own destiny. The protections have been time tested and applied. There is no demonstrated public need for such drastic changes to the way we conduct these life and death decisions.

February 1, 1995 - Senate Public Health

In 1983, the Montana code Annotated had no law pertaining to the rights of the terminally ill. However, health care in the United States has undergone some extraordinary changes. Not only are there changes in clinical practices due to technological advances, but the health care system is being challenged by both institutional and social factors as well. Increased financial pressure has mounted as 30% of all Medicare funds are spent taking care of the elderly. Dr. Kevorkian has made a name for himself in assisting in over 20 deaths in spite of a prohibition of assisted suicide, the suspension of his license to practice medicine, and the unwillingness of prosecutors to bring him to justice. Erik Humphrey, founder of the Hemlock Society, has made the best sellers list with his "how to commit suicide manual," Final Exit.

Yet amidst the social questioning of ethics, the debate on "right to die", and the high cost of medical care, we need to be rigorously honest on what we are advocating here. SB 146 is an euthanasia bill. The compassionate sounding title, "The Uniform Health Care Decisions Act", sounds innocuous and masks what is truly being discussed here. A death contract with a compassionate sounding name is still a death contract. Permitting an individual, an agent, guardian, or surrogate to withhold or withdraw nutrition and hydration, in spite of the euphemisms, is the legal granting for removal of food and water. It is starvation. It is killing.

If someone is lost in the wilderness, dies from lack of food or water, we say he or she died from dehydration, or literally they starved to death. What is the difference in what is proposed here?

IN 1990, a Dutch official reported that in his country where assisted suicide is illegal but tolerated, doctors killed about 5,400 patients with their consent. But what is most alarming is that another 5,900 were killed without giving consent. And of that number, nearly a quarter of these patients were reportedly "competent," but were never asked about their own choice in this matter. Can you see the mischief we invite in this legislation? Moreover, in June of 1994, the Dutch Supreme Court refused to punish a doctor who supplied a fatal dose of sleeping pills to a severely depressed, but otherwise healthy, woman, thus broadening that country's euthanasia guidelines to include the mentally or emotionally ill. Perhaps, that's why Oregon's Measure 16 which was narrowly approved by a 51% - 49% margin, has not been permitted to go into effect under a court injunction that appears to be permanent. American citizens, as well as the courts, are questioning if this slippery slope hastening death, merits the journey some would want us to take. In fact a Gallop Poll conducted in December of 1993, show a rapid decline in support for euthanasia as a 64% approval from the previous year, fell to a 48% approval with a 47% disapproval rating.

Just ten years ago New York Governor Mario Cuomo set up a task force to make public - policy recommendations on issues raised by medical advances. This diverse group comprised of not only traditional religious institutions but also the "Choice in Dying" organization, and the N.Y. Civil Liberties Union, looked into euthanasia and assisted suicide, and recommended unanimously against it's legalization. Citing a "pervasive failure" by American medicine to treat pain and to diagnose and treat depression, the report concluded that, "legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable." It

said that risks would be greatest for the elderly, the poor, and socially disadvantaged, and those lacking access to good medical care.

Common sense and long held tradition tells us that people have an inherent right to three things as they approach death... warmth, food, and water. These are the things that are fundamental to life. Can it be good public policy, good public health law, or a sign of charity to give favorable consideration to this measure which denies two out of three necessary sustainers of life at a most vulnerable time? Can we ever assert that promoting death is a health care solution? It is my belief that the state has a compelling interest to protect and promote the health and well-being of it's citizens. As a representative of families who care deeply on this issue, I urge you a representative of the citizens of this state to vote "no" on SB 146.

Laurie Koutnik  
Christian Coalition of Montana



RIGHT TO LIFE ASSOCIATION

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SENATE HEALTH & WELFARE

EXHIBIT NO. 16

DATE 2/1/95

BILL NO. SB 146

MONTANA RIGHT TO LIFE TESTIMONY ON SENATE BILL 146  
BEFORE THE SENATE PUBLIC HEALTH COMMITTEE  
FEBRUARY 1, 1995

Mr. Chairman, Members of the Committee:

For the record my name is Tim Whalen, representing the Montana Right To Life Association. Montana Right To Life is a state affiliate of the National Right To Life Committee, the oldest and largest organization of its kind in the United States. The Montana Right To Life Association wishes to go on record as opposed to Senate Bill 146 introduced by Senator Eck.

Under current Montana Law patients have a right to give instructions to Health Care Providers about the type and level of treatment they wish to receive in the event of illness or accident should they become incompetent to act on their own behalf. Durable Powers of Attorney allow a patient to give authority to third persons who can then work directly with Health Care Providers in seeing that a patient's wishes are honored in the rendering or withdrawal of treatment. Living Wills allow a patient to directly communicate in advance to Health Care Providers the level and types of treatment desired.

Do not let anyone tell you that patients in Montana do not have the right to make decisions about their health care should they be rendered incompetent by accident or illness.

Senate Bill 146 is a giant leap towards denying patients input into their own health care decisions whether competent or incompetent and takes us a long way down the road towards involuntary euthanasia. Although Senate Bill 146 is presented to you as a Uniform Law, please know that not a single State in the Union has adopted it.

Senate Bill 146 does not fully protect a patient's own choices and in some cases undermines patient responsibility for decision making by allowing patients to appoint an agent to make decisions for the patient even while the patient is competent. Competent adults should make their own health care decisions.

The State should not legislatively create an environment in which "agents" or others than the patient, acquire the power to intimidate and prey on those of weak will.

Senate Bill 146 discards that protection in current law that the delegation of authority must be in writing and be witnessed. Senate Bill 146 elevates Surrogates claiming to have authority to make

health care decisions for incompetent patients to the status of "King". They can call for the discontinuation of reasonable non-burdensome life saving measures, even over the objections of family and physician. And, from a practical point of view, once those decisions have been made, no one, including family, doctor, or a judge can override them.

Again as a practical matter, because the delegation may be oral and without witnesses, a surrogate cannot be effectively challenged even if the decisions he or she makes renders the patient dead.

Section 6 of the bill provides that a surrogate may be designated, by an adult or emancipated minor, to make health care decisions on behalf of a patient who has chosen not to create an advance health care directive who subsequently is rendered incompetent. The net result is that even if a patient chooses not to establish an advance directive, believing that medical personnel will make professional medical judgments on his or her behalf, this bill makes possible the likely event that an unintended non-medically trained individual will be making health care decisions on the patient's behalf that do not reflect the patient's desires once he or she is rendered incompetent.

Finally, Senate Bill 146 allows treatment to be withdrawn that a patient specifically requested should medical personnel decide that the requested treatment is medically ineffective or contrary to generally accepted health care standards. One study based on physician interviews found that most often when arguments about medical effectiveness were invoked, quality of life considerations were used to justify their position rather than which treatments were medically efficacious.

Senate Bill 146 if implemented would radically alter who decides when important Health Care decisions are made. Please don't take those rights away from patients. Please vote to kill Senate Bill 146.

Thank you.

## Department of Health &amp; Environmental Sciences

## Testimony on Senate Bill 124

Submitted to: Senate Public Health Committee

By: Dale Taliaferro, Administrator of Health Services

February 1, 1995

Mr. Chairman and members of the Committee, the Department of Health & Environmental Sciences (DHES) supports the proposed amended language to §50-1-203, MCA. This section has been in place for 21 years and the proposed amended language updates it to be consistent with current needs and resources.

The primary purpose of this bill is to modify required inspections of schoolhouses, churches, theaters, jails, and other buildings or facilities where people may assemble from mandatory to discretionary by changing the "shall" in line 13 to "may." The language is modified from mandatory to discretionary to remove a requirement for inspections that are not needed. Neither Local or State Public Health has staff to inspect all of the facilities named, but are able to inspect those that are requested by local public officials or are the subject of complaints.

The DHES or local boards of health need to retain the flexibility and authority to conduct public health inspections in public places where persons may assemble. These inspections are to investigate complaints, prevent communicable disease epidemics, and address a variety of public health issues especially for vulnerable populations such as children or inmates. Broad language needs to be retained to maintain the ability to address changing community public health issues on an as-needed basis.

In §50-1-203(1), MCA, the language requiring the department to conduct "sanitary" inspections is technically updated to "public health" inspections with deficiencies identified during the inspection re-identified by language modification from "unsanitary" to "public health".

Also in Section 1, the language is removed which automatically classifies a facility as a public nuisance when deficiencies are found. Most inspected facilities, when notified of deficiencies, willingly make corrections and do not require action as a declared public nuisance. The DHES or a local health board may still petition a court to declare a facility as a public nuisance and requires abatement of a deficiency.

Section 2 broadens the language to include injunctive relief to be certain the DHES or a local health board can seek closure of a facility immediately if there is sufficient risk to the health of the public and there is a rare instance where the facility does not agree to voluntarily close. It is not anticipated this situation would occur with any frequency, however, the ability to act if necessary should be provided.

This bill reduces unnecessary regulatory requirements, but retains sufficient safeguards to protect the health of the public using public facilities.

DATE

2/1/95

SENATE COMMITTEE ON

Public Health

BILLS BEING HEARD TODAY:

SB 124, SB 146

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PLEASE PRINT

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Check One

| Name                  | Representing                | Bill No.    | Support         | Oppose |
|-----------------------|-----------------------------|-------------|-----------------|--------|
| Arlette Mandash       | EAGLE Forum                 | SB 146      |                 | ✓      |
| Katharine Donnelly    | MHA                         | SB 146      | ✓               |        |
| Marty Onishak         | Mon AMI                     | SB 146      | W/ Amnd.        |        |
| Tim Whalen            | MT Right to Life            | SB 146      |                 | ✓      |
| Dick Brown            | MT. HOSPITAL ASSN           | SB 146      | X               |        |
| Stacey Benefield      | MT Hosp. Assn               | SB 146      | X               |        |
| Bill Olson            | AARP                        | SB 146      | X               |        |
| Doug Blackley         | Office on Aging (DB)        | SB 146      | X               |        |
| Daniel N. McLean      | State Bar of Montana        | SB 146      | X               |        |
| Rick Barros           | Elder Rights Advocates of A |             |                 | ✓      |
| Ana L. "Duke" Keating | self                        |             |                 | ✓      |
| Lynne Kachnik         | Christian Coalition of MT   |             |                 | ✓      |
| Denny Moore           | Board of Visitors           | SB 146 with | X with amnd.    |        |
| Tom Ebbert            | St Vincent Hosp             | SB 146      | SUPP. with best |        |

Amendments

## VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY



DATE

2/1/95

SENATE COMMITTEE ON

Public Health

BILLS BEING HEARD TODAY:

SB 146, 129

&lt; ■ &gt;

PLEASE PRINT

&lt; ■ &gt;

Check One

| Name                     | Representing         | Bill No. | Support | Oppose |
|--------------------------|----------------------|----------|---------|--------|
| Drew Dawson              | Dept Health          | 146      | ✓       |        |
| <del>Art. Med Assn</del> | /                    |          |         |        |
| Terone T Loendorf        | Art. Med Assn        | 146      | ✓       |        |
| <del>W. J. O'Keefe</del> |                      | 146      |         | ✓      |
| David Danaher            | Division of Health   | 146      | Arrived |        |
| Andree Larose            | Montana Advocacy     | 146      | ✓       |        |
| SHARON HOFF              | MT CATH CONF         | 146      |         | X      |
| Dallas Erickson          | Self                 | 146      |         | X      |
| SHARON M. ANDERSON       | MT. DEACONESS        | 146      | X       |        |
| DALE TALIAFERRO          | MDILES               | 124      | ✓       |        |
| Rae Hughes               | MT Health Care Assn. | SB 146   | ✓       |        |
| Mitzi Schwab             | MDILES               | 124      | ✓       |        |
|                          |                      |          |         |        |
|                          |                      |          |         |        |

## VISITOR REGISTER

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