

## 13 Terminating Food and Water: Emerging Legal Rules

There is little "law"—that is, definitive determinations by courts or legislatures—on the narrow question of suspending artificial nutrition and hydration for a dying patient.

However, when mechanical nutrition and hydration may be suspended is logically a part of the larger question of when any kind of medical treatment can be withdrawn for a dying patient, which is part of the more general physician-patient relationship that determines who decides what shall be done. The doctrine of informed consent—the patient's right not to be treated without his or her knowing approval—goes a long way toward answering these questions for competent patients. For those who cannot voice their own choices, the resolutions are different but there is familiar legal terrain.

Termination of artificially provided nutrition and hydration may appear to be a new problem. It is not, once the following threshold question has been resolved: Are nutrition and hydration provided by medical means to be considered "medical treatment"? If so, decisions about initiating, withholding, or withdrawing treatment would then be subject to generally accepted rules requiring consent to medical treatment.<sup>1</sup>

### **MEDICALLY PROVIDED NUTRITION AND HYDRATION AS MEDICAL TREATMENT**

Whether mechanical nutrition and hydration procedures constitute "medical care" subject to the rules respecting the provision or termination of care to the terminally ill is a mixed question of law and fact.<sup>2</sup> How are the methods ordinarily construed: Do they constitute the practice of medicine under health insurance policies and Medicare?<sup>3</sup> Are they the practice of medicine, performed by licensed per-

sonnel,<sup>4</sup> using medical methods and procedures?<sup>5</sup> Are they typically done in settings where medical care is commonly provided?

Medical interventions treat injuries or diseases and their effects. Malnutrition and dehydration are commonly associated with many diseases and may occasion various abnormal signs and symptoms.<sup>6</sup>

If mechanical hydration and nutrition were not considered medical treatment, would they be the same as eating and drinking? While both mechanical and natural means provide nutrients and fluids, mechanical means certainly may not provide comparable emotional satisfaction for the patient, for the supporting family members, or for the caregiving staff. While all of the means may relieve hunger and thirst, a comatose, severely demented, or dying person may not experience hunger and thirst. Thirst can also be satisfied by other means, means that are more intimate, more caring—by attending the patient, wetting the lips, and keeping the mouth moist.<sup>7</sup>

Such considerations may help resolve the legal question of whether mechanical nutrition and hydration should be deemed the same as other medical treatments or procedures, or, conversely, the same as simple feeding and drinking. Feeding or putting water to the lips of a helpless person is clearly much more than medical treatment. The invasive procedures used to normalize nutrition and hydration often have all the earmarks of being medical treatments. To equate the two would be profoundly misleading.

Administering mechanical nutrition and hydration is no picnic. It is not—like feeding and offering drink ordinarily are—close, intuitive, intimate nurturing, emotionally affecting for caregiver and recipient alike. It is not done by relatives or long-time friends or intimates. Moreover, for resistant patients who must be restrained, it really can be indistinguishable from torture.

The court decisions to date hold that mechanical nutrition and hydration are medical treatment. In *Conroy*,<sup>8</sup> the New Jersey Supreme Court held that mechanical nutrition should be treated like other medical treatments in deciding whether and when to terminate. It acknowledged that feeding has "emotional significance," even in "the realm of complex, high-technology medical care." But nasogastric tubes and other mechanical feeding techniques "are significantly different from bottle-feeding [an infant] or spoonfeeding. . . ."<sup>9</sup> Like other medical procedures, they carry risks and can have side effects and complications that can be "serious and dis-

trussing" for some patients. Like other medical procedures, they require the attention of skilled health care professionals. And they do what other medical procedures such as respirators do: "they prolong life through mechanical means when the body is no longer able to perform a vital bodily function of its own."<sup>10</sup>

The California appellate court came to the same conclusion more summarily in *Barber v. Superior Court*,<sup>11</sup> rejecting a proffered distinction between mechanical nutrition and mechanical respiration. Mechanical nutrition is like feeding only as a matter of "emotional symbolism."<sup>12</sup> Normal feeding is quite different from mechanical nutrition when one examines the actions taken and their effects. Still more summarily, a New York state trial court held in *Plaza Health*<sup>13</sup> that surgery to create a gastrostomy was medical treatment within the meaning of a state statute guaranteeing patients the right to decline treatment.

In *Hier*,<sup>14</sup> a Massachusetts appellate court refused to treat gastrostomy surgery as something other than "a major surgical procedure" that was "highly intrusive"; it considered medical factors—potential complications and risk to the patient—as it would for any other medical procedure. It said *Barber* and the subsequently reversed lower court decision in *Conroy* involved termination of "ongoing nutritional support." But it rejected the argument "that nutrition should be differentiated from treatment and the right of choice confined to the latter." The distinction was not between nutrition and treatment, "but between supplying nutritional support with only modest intrusiveness and supplying it through the use of highly intrusive surgical procedures."<sup>15</sup> Degree of intrusiveness has often been a factor in determining whether a medical procedure should be authorized for an incompetent person.

To conclude that the procedures for mechanical nutrition are medical goes far toward resolving many of the questions that concern when they may be terminated. For competent patients, for patients who expressed their wishes when competent, and for patients whose wishes can be determined from how they lived their lives, the right to control medical treatment means the right to refuse medical care of all types. For incompetent patients whose will cannot be known, the inquiry does not end with the conclusion that mechanical nutrition is medical. Not all medical treatments are the same, nor should all medical treatments be analyzed as a single, homogenous

mass. Not only the intrusiveness of the treatment and the patient's prognosis—which is to say, what the effect of the treatment would be—but how common and familiar the treatment is, whether it is "ordinary" or "extraordinary," have all been considered important.

#### COMPETENT PATIENTS AND PATIENTS WHO HAVE EXPRESSED THEIR WISHES

In the past decade, courts and legislatures have required medical service providers to comply with the wishes of competent terminally ill patients to decline further treatment and have also outlined procedures for presently incompetent persons whose previous competent wishes are known.

(a) *Judicially-developed rights.* State courts have held that patients have a near-absolute right to decline unwanted medical treatment.<sup>16</sup> Even those courts which first said the patient's right was to be weighed against asserted state interests have come to conclude that state interests cannot overcome the will of a competent person where third-party rights or interests are not at issue.<sup>17</sup> The patient's right to bodily integrity and privacy generally prevails save in the special setting of prison.<sup>18</sup> This right to reject treatment rests on the common law right to be free from unconsented battery<sup>19</sup> and on the constitutional right to privacy.<sup>20</sup> Hospitals and nursing homes still often fail to comply, even where the law is well settled; and some instances of noncompliance are outrageous.<sup>21</sup>

A case whose reasoning is particularly apt to the mechanical nutrition question is *In re Osborne*.<sup>22</sup> There, an otherwise healthy man declined, for religious reasons, surgery believed to be necessary to repair injuries from a fall. While the treatment there was unquestionably "medical," the analogy to mechanical nutrition and hydration is appropriate given the common argument that maintaining artificial fluids and nutrition will maintain a life until (arguably unrelated) disease, illness, or injury brings death.<sup>23</sup> The court first considered whether the patient had "validly and knowingly chosen this course for his life. . . ." That was the first and foremost question, the *Osborne* court said, for it rejected the view<sup>24</sup>

that the state [has] a compelling interest in sustaining life. The notion that the individual exists for the good of the state is, of course, quite

antithetical to our fundamental thesis that the role of the state is to ensure a maximum of individual freedom of choice and conduct.<sup>25</sup>

Even some courts acknowledging the primacy of individual freedom have said they require consideration of factors reflecting other state interests. Whatever the ongoing validity of these factors—preserving life, protecting the interests of minor children, preventing suicide, and promoting ethical medical practice<sup>26</sup>—they have no more bearing for the patient dying of malnutrition or dehydration than they have in situations where mechanical respiration or other medical treatment is at issue.

The courts have commonly discussed patients' rights in the context of terminal illness, and the bulk of the cases involve diseases labeled terminal.<sup>27</sup> But that would appear to be only to distinguish terminally ill patients from healthy individuals, not necessarily from patients suffering advanced chronic illness, and the broad sweep of recent decisions suggests that for competent patients, at least, any such distinctions should be of little significance.<sup>28</sup> While the distinction may be useful for some medical purposes,<sup>29</sup> the practical difference between a terminal illness and an advanced chronic illness would appear to be slight.

These principles of patient autonomy should control under the common law, whether or not a state has enacted patients' rights or natural death legislation, which typically save all existing rights.<sup>30</sup> But where there is legislative action, other questions arise.

(b) *Legislated rights.* More than thirty state legislatures have enacted "natural death" laws providing a mechanism by which patients anticipating possible incompetence can decline further care.<sup>31</sup> This mechanism is the health care declaration, popularly known as a "living will," and has precise legal effects under those laws where the statutory requirements are met.<sup>32</sup> State legislatures have also enacted various patients' rights laws further defining protections and the right to control treatment.<sup>33</sup> And durable power of attorney legislation, now almost universal, may provide a mechanism by which an individual can name the person to make his or her medical care decisions in the event of the patient's inability to act.<sup>34</sup> A recently amended Maryland statute combines these approaches in delineating the limited circumstances in which a person may be treated without his or her consent, and incorporating by reference the use of durable powers of attorney.<sup>35</sup>

Where the question arises under a patients' rights law or a living will, two related questions arise. The first is whether the legislature meant to include mechanical hydration and nutrition in the medical treatments covered by the law. The second is whether the patient who declared his or her wish not to be subjected to certain life-extending forms of medical care intended to bar medical procedures for mechanical hydration and nutrition.

Patients' rights laws and natural death laws apply to decisions respecting the provision, withholding, or termination of "medical" care.<sup>36</sup> Whether mechanical nutrition provided by doctors and nurses at medical institutions does or does not come within the term "medical treatment" as used in the statute is a question of legislative intent. Absent discussion of mechanical nutrition in the legislative reports or debates, that question would likely be resolved under general principles of statutory construction,<sup>37</sup> which would consider many of the factors detailed in the previous section.<sup>38</sup> The one court to address the precise question held that the right to reject medical treatment embodied in New York public health law entitled an ailing eighty-five-year-old man, a widower and stroke victim who elected not to eat, to decline surgery to implant a gastrostomy tube.<sup>39</sup>

Whether or not the patient with a living will meant to exclude the surgery or invasive procedures used for mechanical nutrition from the undesired medical treatment is a question of individual intent. When considered in the planning stage—when the patient is deciding whether to execute a living will—this problem is easily solved by expressly addressing whether the patient wants mechanical nutrition administered. Some model living wills now specifically refer to mechanical nutrition.<sup>40</sup> Natural death statutes often provide a form living will or "declaration," and some statutes provide that the model "may, but need not" be used, permitting variations "includ[ing] other specific directions." This invites patients to declare whether artificial hydration and nutrition are or are not to be used.<sup>41</sup> Even without such an invitation, a declaration reflecting such wishes should be dispositive as to the patient's wishes under the common law. An individual's declaration in a living will to forgo treatment should be respected by health care providers even in the absence of natural death legislation, and such respect has been judicially endorsed.<sup>42</sup>

Where the question arises only after the fact, without clear expres-

sion by the patient, intent will have to be inferred, as it often is, from circumstances and other limited available evidence.

#### INCOMPETENT PATIENTS WHOSE WISHES CANNOT BE KNOWN

Patients who are now incompetent but who expressed their views while they were able to do so should have those wishes honored. But for incompetent patients whose wishes cannot be known, courts are no longer effecting patient self-determination when they direct caregivers to follow one course of action or another. Whether medically provided nutrition and hydration are medical treatment may have substantial bearing on the rules to be applied. To conclude that mechanical hydration and nutrition are medical treatment suggests that the increasingly settled procedures for proxy decision making for incompetent individuals be followed. To conclude the contrary suggests that some other, likely less permissive, standard should be used to determine whether mechanical hydration and nutrition can or should be used.

If mechanical hydration and nutrition are medical care, then the case law and statutes on when care may be terminated provide guidance. For once-healthy adults now rendered incompetent, whether or not permanently comatose or vegetative, the substituted-judgment test requires a proxy or court to ascertain what the person would have elected for himself or herself.<sup>43</sup> For those who were never competent, the best-interests test may require a subtle and difficult weighing of the great imponderable: death versus an existence that can barely be called life.<sup>44</sup> Natural death acts in some states authorize family members or other proxies to terminate care (other than for comfort or palliation) where death is imminent and where further treatment will only "prolong the dying process."<sup>45</sup>

The decision to terminate life-sustaining care for another person should always be difficult. But many sane, competent, loved, and loving people have chosen death in the face of such life; this fact and the familiar procedural framework should render the task feasible.

Feasible but troubling. There is more than a touch of irony in the way our values lead to opposite results. Where the patient is least likely to be suffering in the present, where he or she is comatose or

vegetative, the decision to terminate is, relatively, easy. But where the patient is conscious and aware, even if incompetent and uncommunicative, he or she may be suffering greatly. While that suffering might tend to encourage making choices that allow a shorter life, the decision to forgo treatments to sustain life will also curtail conscious life, something one should be reluctant to do. These decisions with conscious patients are therefore most difficult.

Three courts have dealt with these problems, and their decisions reflect three distinctive approaches.

In *Storar*,<sup>46</sup> a severely retarded man suffered from bladder cancer. The cancer was expected to kill him within six months in any event, but it also caused bleeding that would be fatal sooner if he did not undergo regular blood transfusions. Because the transfusions were painful and debilitating, the man resisted them and had to be restrained; his mother, unquestionably loving, opposed the transfusions because they terrified her son. Following a best-interests test, the court held that the transfusions should nonetheless be administered. It relied on an expert's argument that the "transfusions were analogous to food—they would not cure the cancer, but they would eliminate the risk of death from another treatable cause."<sup>47</sup> The result was to impose on health care providers a duty to treat in a wide variety of situations of doubtful wisdom, leaving little room for judgment or discretion in the treatment of incompetent patients.<sup>48</sup>

In *Hier*,<sup>49</sup> the patient had suffered severe mental illness for the last fifty-eight of her ninety-two years, and required a gastrostomy tube for nutrition because of other medical conditions not otherwise debilitating. She had pulled out gastrostomy tubes before and vigorously resisted surgery. She had no relatives, her court-appointed proxies favored treatment, and while the doctors were of different views as to the wisdom of surgery, the physicians opposing surgery did not do so on medical grounds.<sup>50</sup> Following earlier Massachusetts decisions<sup>51</sup> applying a substituted-judgment rather than best-interests test,<sup>52</sup> the court gave substantial weight to Mrs. Hier's opposition, notwithstanding her incompetence. It read her resistance to tubes and surgery as "a plea for privacy and personal dignity by a ninety-two-year-old person who is seriously ill and for whom life has little left to offer."<sup>53</sup>

In the most recent decision, *Conroy*,<sup>54</sup> the patient suffered from severe and permanent mental and physical infirmities—organic

brain syndrome, heart disease, diabetes, gangrene. She was not comatose, but could not converse or move from her semifetal position; she was incontinent and, even if spoon-fed all day, was unable to take enough food and water by mouth to maintain herself. She followed people with her eyes, would moan occasionally or smile, and her facial expressions varied, but she was otherwise uncommunicative. Her nephew, who was the court-appointed guardian and only living relative, sought permission to terminate mechanical tube-feeding; medical opinion was divided. The New Jersey Supreme Court rejected as naive the use of a substituted-judgment test—whose theoretical linchpin is self-determination—where a previously competent patient had failed to express his or her wishes in more than "general or casual terms."<sup>55</sup> It crafted a kind of intermediate best-interests where there was trustworthy evidence the patient would have refused treatment. In that case, treatment could be terminated where the net burdens outweighed the benefits of continued life.<sup>56</sup> Absent such evidence, however, treatment could be terminated only where the burdens "clearly and markedly outweigh the benefits"; where treatment would probably engender such "recurring, unavoidable and severe pain . . . that the effect of administering life-sustaining treatment would be inhumane."<sup>57</sup>

All three courts view surgery or procedures to administer mechanical nutrition and hydration as they view other medical treatments. The courts considered such factors as the burdens and benefits of each treatment, the risks and possible effect of complications, as well as the effects of not treating. The differences between the decisions concern not nutrition versus treatment, but each court's attitudes toward treatment.

The New Jersey Supreme Court in *Conroy* attempts to steer a middle ground between *Storar*, which imposes a rigid requirement of treatment, and the Massachusetts case, which follows a looser rule in relying heavily on incompetent patients' noncomprehending resistance to treatment.<sup>58</sup> It repudiates the lingering suggestion in earlier cases that competent patients may have to succumb to unwanted treatments for the good of the state or society. But in explaining when to apply its subjective substituted-judgment test, it says that a lifetime aversion to doctors and hospitals<sup>59</sup> is not adequate to show that Miss Conroy "clearly" would have rejected mechanical feeding, and seems to require that the patient evidence something like a philosophical analysis of her wants and prefer-

ences.<sup>60</sup> To be sure, it is correct to treat lightly preferences stated only abstractly and casually; but a lifetime of active disregard of medical care is neither abstract, nor casual, nor general. And the court suggests that the principal medical fact to consider is pain. For the objective test, to be used where there is no evidence of the patient's preference respecting treatment, pain must be "recurring, unavoidable and severe," so much so that treatment is "inhumane." For the limited-objective test, to be used where there is "trustworthy" but not compelling evidence of the patient's preference for no treatment, the court may be read to say that pain (alone) must "outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life."<sup>61</sup>

Despite their differences, the courts are consistent on their view of mechanical hydration and nutrition as medical treatment. Faced with the hard facts of what the surgery or procedure required, none stepped away from the conclusion that surgery or procedures to supplant or compensate for inability to take fluids and food are medical treatment every bit as much as are procedures to supplant or compensate for inability to breathe or to dialyze blood.

To require mechanical nutrition and hydration in all circumstances to the greatest extent medically possible and without regard to the benefits for the patient must rest largely on the symbolic significance of feeding.<sup>62</sup> To rely upon the symbolism of a treatment in requiring it is to acknowledge that the welfare of the individual being treated is irrelevant: it is a symbol not to the incompetent, likely comatose, or at least uncomprehending patient, but to others—perhaps other patients, perhaps healthy people who will someday be patients. Perhaps it is a symbol to caregivers that they should not come to accept death, not because that attitude will enable them yet to do this patient any good, but because it may affect how they respond to another patient in different conditions some time in the future.<sup>63</sup>

These are all reasonable arguments, but they turn on the interests of people other than the patient whose welfare is at issue; as such, a court which dismissed them as not addressing the real issue before it would, I think, be on solid ground. If the symbolic point is to honor the sanctity of life, then respecting self-determination, not subjecting it to medical institutions or state power, is the more powerful symbol. If self-determination is not at issue, as with in-

competents, the problem remains that treatments conceived for one set of medical problems are being used in wholly new circumstances. It is perhaps too obvious to say that the difficulty derives from the severity as well as the finality of the choices: death as the only alternative to a life in pain and suffering, with few observable rewards. For some, this will be a terrible, tragic choice: withdraw mechanical hydration and nutrition and "kill" the patient, or impose it and "torture" her. That may sound harsh, yet the fact remains that much done in the name of medical care is hard to distinguish from torture.

We have created tools with immense potential for good. We must now decide when not to use them. The slope for making such decisions is, as they say, slippery. But that is the point of every slippery slope argument: the position at the summit is untenable. To maintain every person for as long as possible would be to cause suffering on a massive scale. We have no choice but to move along the slope, always testing our footing in the search for secure ground.

One feature of the cases is unmistakably clear. Competent patients and incompetent patients who have previously expressed their wishes are treated differently than are incompetent patients whose wants are unknown. This was presaged four years ago in the companion leading New York cases, *Storar* and *Brother Fox*.<sup>64</sup> The lesson is that advance planning for the aging and seriously ill is essential for those who want to control the course of their lives. Careful documentation is advisable—the courts in *Conroy*<sup>65</sup> and *Bludworth*<sup>66</sup> encourage the use of living wills—if not always required. Sometimes the courts will act on the strength of oral statements. But unless the patient is a Catholic priest and the proxy is another Catholic priest—as was the case in *Brother Fox*—it would be prudent, to say the least, for the patient's wishes to be expressed carefully and in writing, with appropriate documentation concerning competence.

## NOTES

1. I would like to acknowledge the thoughtful comments and criticisms of my partner, John Laster, and of Prof. Carol Sanger of the University of Santa Clara Law School. They contributed significantly to this discussion, although I remain responsible for errors and judgments in the final product.

2. See chapter 2; see also *In the Matter of Mary Hier*, 18 Mass. App. 200, 464 N.E.2d 959, 961-962, *app. den.*, 392 Mass. 1102 (1984) (methods for mechanical nutrition discussed), and Joanne Lynn and James Childress, "Must Patients Always Be Given Food and Water?" *Hastings Cent. Rep.* 13:17-21 (October 1983) reprinted as chapter 5 *supra* (description of the different methods of treatment and some of the medical indications relating their use).

3. They are typically treated as medical services under medical and health and accident policies, 10 *Couch on Insurance* 2d 41:452 (1984 Supp.), save where specific policy language warrants exclusion, 10 *Couch on Insurance* 2d (rev. ed.) 41A:56 (1982). Earlier Medicare regulations defined the provision of mechanical nutrition as skilled nursing care. 42 C.F.R. 405.127 (c) (2) (i) and (ii) (skilled nursing care includes "hypodermoclysis or intravenous feeding . . . Levin [large NG] tube and gastrostomy feedings . . .") (1982). Current regulations are less precise, but I understand the practice to be to cover all procedures to insert NG (nasogastric) tubes and IV (intravenous) lines and all surgical procedures to introduce mechanical nutrition into the body.

4. The question would likely come up if at all in an enforcement proceeding involving someone who had provided mechanical nutrition without a license and not under the supervision of a physician or nurse. The practicalities of mechanical nutrition are such that it would always be provided under a physician's supervision, so that a narrow licensing decision would be unlikely.

5. See chapter 2 and the authorities cited in note 2 above on the techniques and requirements for mechanical nutrition.

6. See Lynn and Childress, note 2 above ("In the past, malnutrition and dehydration must have accompanied nearly every death that followed an illness of more than a few days.").

7. See chapter 3.

8. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

9. *Id.* at 1236.

10. *Id.*

11. *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Cal. App. 2 Dist. 1983).

12. *Id.* at 488.

13. *In re Plaza Health and Rehabilitation Center*, (N.Y. Super. Ct., Onandaga County, February 2, 1984).

14. *In the Matter of Mary Hier*, 18 Mass. App. 200, 464 N.E.2d 959, *app. den.*, 392 Mass. 1102 (1984).

15. *Id.* at 964.

16. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1221-1226 (1985), *Eichner v. Dillon* (Brother Fox), 52 N.Y.2d 363, 420 N.E.2d 64 (1981).

17. Compare *Conroy*, note 8 *supra*, with *In re Quinlan*, 70 N.J. 10, 335 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

18. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *Satz v. Perlmutter*, 362 So.2d 160 (Fla. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980). The exceptions are for patients who are prisoners in state penal institutions, *e.g.*, *Hall v. Myers*, 399 N.E.2d 452 (Mass. App. 1979) (the state interest in orderly prison administration must also be considered), and where the patient is the parent of a minor child who might otherwise become a ward of the state, *Application of President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*,

377 U.S. 978 (1964), *but cf. In re Osborne*, 294 A.2d 372 (D.C. 1972) (surgery would not be required where minor children were financially provided for).

19. *Eichner v. Dillon*, note 16 *supra*; *Foody v. Manchester Memorial Hospital*, 40 Conn. Supp. 127, 482 A.2d 713 (1984); *In re Bartling*, 209 Cal. Rptr. 220 (1984); *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Cal. App. 2 Dist. 1983).

20. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *In re Colyer*, 99 Wash.2d 114, 660 P. 2d 738 (1983); *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *In re Bartling*, 209 Cal. Rptr. 220 (1984); *In re Guardianship of Barry*, Memorial Hospital, 40 Conn. Supp. 127, 482 A.2d 713 (1984); *In re L.H.R.*,—Ga.—(No. 41065, decided October 16, 1984).

21. *Leach v. Shapiro*, 13 Ohio App.3d 393 (1984); *In the Matter of Lydia E. Hall Hospital*, 455 N.Y.S.2d 706 (1982).

22. 294 A.2d 372 (D.C. App. 1972).

23. See, *e.g.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981), and the intermediate court opinion in *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985).

24. Reflected in *John F. Kennedy Memorial Hospital v. Heston*, 279 A.2d 670 (N.J. 1971).

25. 294 A.2d at 375, n. 5.

26. See *Saikewicz*, note 18 *supra*, 370 N.E.2d at 424-428.

27. The others are largely Jehovah's Witness cases. In the typical case, an otherwise healthy young person requires surgery because of injuries sustained in an accident but declines it because he or she reads the biblical proscription against "drinking blood" as proscribing blood transfusions. See, *e.g.*, *In re Estate of Brooks*, 32 Ill.2d 361, 205 N.E.2d 435 (1965).

28. *Conroy*, note 8 *supra*; *Bartling*, note 19 *supra*.

29. Department of Health and Human Services, Health Care Financing Administration, "Medicare Program, Hospice Care, Final Rule," Federal Register 48:56008-56036.

30. West's Ann. Cal. Health & Safety Code 7193 (1984 Supp.); D.C. Code 6-2429 (a) (1981); Kan.Stat. Ann. 65-28, 108 (d); Nev.Rev.Stat. 449.680; N.M.Stat. Ann. 24-7-9; Ore.Rev.Stat. 97.085 (2); Tex.Rev. Civ.Stat. Ann. art. 4590h, 11, Va.Stat. Ann. 54-325.8:12.

31. The fifteen statutes enacted as of 1983 are reprinted in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment*, Appendix D, pp. 310-387 (1983). Florida, Georgia, Illinois, Louisiana, Maryland, Mississippi, West Virginia, Wisconsin, and Wyoming have since enacted statutes, and bills are pending in more than a dozen other states. See Society for the Right to Die, Newsletter, Fall, 1984, p. 8.

32. The most common requirement is that death be "imminent" and the effect of further care only to "prolong the dying process," but there are others, in addition to elaborate procedural requirements. They are summarized in Ron Landsman, "Legal Planning of Health Care for the Critically Ill," in Callahan, et al., *Estate and Financial Planning for the Aging and Incapacitated Client* (PLI 1984), pp. 149-152.

33. *E.g.*, Minn.Stat. Ann. 144.651 (12) (1984 Supp.); Rev.Code Wash. 7.70.050 (1984 Supp.); Md.Stat. Ann. Health Gen., 19-344 (d) (i) (ii) and (iii) (1982); N.Y. Pub.H.Law 2803-c (3) (3) (1977).

34. All states have enacted or have pending durable power laws. Those enacted as of 1983 are reprinted in *Deciding to Forego Life-Sustaining Treatment*, note 31 *supra*, Appendix E, pp. 390-422.
35. Maryland Code Health-Gen. 20-107 (1984 Cum.Supp.).
36. E.g., "medical procedure, treatment or intervention," Va.Stat. Ann. 54-325.8:2 ("medical procedure, treatment or intervention," Va.Stat. Ann. 54-325.8:2 [P3]; but see also N.M.Stat. Ann. 24-7-2 (a), 24-7-3 (a) and *passim* ("maintenance medical treatment, defined as "medical treatment designed solely to sustain the life processes").
37. Among the guidelines for statutory construction are the rules that remedial social legislation—such as laws that confer or promote rights relating to health and safety—be liberally construed, Sands, 2 *Sutherland Statutory Construction* 60.01, 60.02 (1974). Such statutes do not derogate common law rights or natural or common right, for which there is a rule of strict construction, so that by negative implication a policy of liberal construction is again pointed to 2 *id.* 61.01, 61.06 (1981 Supp.).
38. See the text accompanying notes 1-7 *supra*.
39. See *In re Plaza Health and Rehabilitation Center*, note 13 *supra*, citing N.Y. Pub.H.Law 2803-c (3) (c).
40. Society for the Right to Die "Living Will Declaration" (no date).
41. Moreover, some laws provide that the invalidity of a specific direction "shall not affect the [validity of the] declaration," so that adding such specifics does not expose the patient to the risk that their entire effort might be undone. Va.Stat. Ann. 54-325.8:4. See also D.C. Code 6-2422 (c). But cf. Ore.Rev.Stat. 97.055 (1) ("The directive shall be in the following form . . ."); Nev.Rev.Stat. 449.610 ("The declaration shall be in substantially the following form . . .").
42. *Conroy*, note 8 *supra*; *John F. Kennedy Memorial Hospital v. Bludworth*, 452 So.2d 921 (Fla. 1984).
43. *Deciding to Forego Life-Sustaining Treatment*, note 31 *supra*, pp. 132-134; *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980).
44. *Deciding to Forego Life-Sustaining Treatment*, note 31 *supra*, pp. 134-136.
45. See note 32 *supra*.
46. See note 23 *supra*.
47. 420 N.E.2d at 73.
48. See chapter 14.
49. See note 2 *supra*.
50. See George J. Annas, "The Case of Mary Hier: When Substituted Judgment Becomes Sleight of Hand," *Hastings Cent. Rep.* 14:23-24 (August 1984).
51. *Saikewicz*, note 18 *supra*.
52. This was inappropriate. See Alexander M. Capron, "Ironies and Tensions in Feeding the Dying," *Hastings Cent. Rep.* 14:32-34 (October 1984); Annas, note 50 *supra*, at 25.
53. *In the Matter of Mary Hier*, 18 Mass. App. 200, 464 N.E.2d 959, 965, *app. den.* 392 Mass. 1102 (1984).
54. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).
55. *Id.* at 1231.
56. *Id.* at 1231-32.
57. *Id.* at 1232.
58. Capron, note 52 *supra*, p. 34 ("it seems questionable to equate Mrs.

- Hier's removal of the feeding tubes with a competent choice to reject this form of treatment, . . . although [her actions] could not simply be ignored . . .").
59. *In re Conroy*, 98 N.J. 321, 339-40, 486 A.2d 1209, 1218 (1985).
60. *Id.* at 1242-43.
61. *Id.* at 1232. The concurring and dissenting opinions read the majority to "too narrowly define the interests of people like Miss Conroy [because] significant pain in effect becomes the sole measure of such a person's best interests." *Id.* at 1247.
62. Daniel Callahan, "On Feeding the Dying," *Hastings Cent. Rep.* 13:22 (October 1983); cf. chapters 19 and 8.
63. See chapter 8.
64. See notes 16, 23 *supra*.
65. See note 8 *supra*.
66. See note 42 *supra*.