STATE OF MAINE
114TH LEGISLATURE
FIRST REGULAR SESSION

TERMINATION OF MEDICAL CARE STUDY

Final Report
of the Subcommittee
to the
Joint Standing Committee on Judiciary

December 1989

Staff:
Margaret J. Reinsch, Legislative Analyst

Office of Policy and Legal Analysis
Room 101, State House--Sta. 13
Augusta, Maine 04333
(207) 289-1670

Members:
Sen. Barry J. Hobbins
Sen. N. Paul Gauvreau
**Sen. Muriel D. Holloway*

***Rep. Patrick E. Paradis*
Rep. Cushman D. Anthony
Rep. Gerard P. Conley, Jr.
**Rep. Constance D. Cote*
**Rep. Susan Farnsworth*
Rep. Dana C. Hanley
**Rep. Peter G. Hastings*
**Rep. Mary H. MacBride*
Rep. John H. Richards
Rep. Patricia M. Stevens

***Denotes Subcommittee Chair*
**Denotes Subcommittee Members*

EXECUTIVE SUMMARY

The Legislative Council authorized the Joint Standing Committee on Judiciary to form a 6-member subcommittee to look at the issue of withholding and withdrawal of life-sustaining treatment. This study was conducted with the underlying purpose to recommend to the full Judiciary Committee appropriate action on LD 1010, An Act Concerning the Right to Die.

The Subcommittee decided to use the allotted study time to learn as much as possible about the entire subject of terminating or forgoing medical treatment. The members briefly reviewed general background information on the "right to die," as well as advance directives (living wills, durable powers of attorney, etc.). In addition, pertinent case law was examined.

The Subcommittee invited speakers to address the practical realities faced by health care practitioners, as well as the ethical, moral and religious aspects. Proponents of new and revised legislation on advance directives also provided useful information and materials.

Based on the information collected through the study process, the Subcommittee makes the following recommendations:

A. **PROBATE COURT JURISDICTION**
The Subcommittee recommends that, at least at this time, there be no change in the jurisdiction of the Probate Court. To that end, the Subcommittee recommends that the sponsors of L.D. 1010 be offered a Leave To Withdraw by the Judiciary Committee.

B. **EDUCATION**
The Subcommittee recommends that the Judiciary Committee help develop an educational program to communicate the fact that health care decisions can be made in advance in specific circumstances, and that it is in the best interests of every person and family to discuss the subject and clearly state their wishes.

C. **1989 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT**
The Subcommittee recommends that the Judiciary Committee consider the Uniform Rights of the Terminally Ill Act as adopted by the National Conference of Commissioners on Uniform Laws in 1989. It is important to hold a public hearing on the legislation in order to obtain a broad cross-section of responses to the proposals.

D. **MODIFICATION OF CURRENT LIVING WILL LAW**
The Subcommittee recommends that the current Living Wills law (22 MRSA c. 710-A) be amended to clearly authorize a person to specifically include artificially administered nutrition and hydration in

the category of "life-sustaining procedures" which the person can direct a physician to withhold or withdraw.

E. **CONSOLIDATION OF HEALTH CARE CONSENT LAWS**
The Subcommittee recommends that the laws concerning health care consent and the withholding or withdrawal of medical treatment be consolidated into one place, specifically the Probate Code (Title 18-A). The Subcommittee recommends consideration of the draft legislation currently being developed by a special subcommittee of the Probate Section of the Maine State Bar Association.

The Subcommittee heard testimony that there are many areas and problems concerning the withdrawal or withholding of medical treatment which are not addressed by living wills or living wills statutes. For example, the living wills statute has no application to any situation in which the person did not execute a living will; therefore, the statute provides no guidance as to who can make decisions for an incapacitated person who has no living will. Living wills also do not apply to persons who are not in a terminal condition; that is, a living will does <u>not</u> direct physicians to remove or withhold any life-sustaining procedures from a person in a persistent vegetative state or coma (if the prognosis does not indicate that death will result in a short time). Thus, living wills would not have eliminated the need for court action in any of the three Maine cases decided so far.

The Subcommittee understands that the changes recommended in this report do not address these problems; the 1989 Uniform Rights of the Terminally Ill Act also does not address any situation other than those involving terminal conditions; the draft being developed by a special subcommittee of the Probate Section of the Bar Association may provide guidance in the areas not yet covered. The Subcommittee is not prepared to make specific recommendations addressing questions other than the application of living wills to the withdrawal or withholding of artificially administered nutrition and hydration; those questions are left for further study.

PREFACE

This report is not intended to be an exhaustive or thorough discourse on the right to die or the subject of the withholding or withdrawal of medical treatment; it does, however, document one subcommittee's too-brief journey through the subject area resulting in an enlightened foundation on which to formulate and analyze proposals. We do not mean to end all discussion with our work; we prefer to see our deliberations and this report as a catalyst to help all people think about health care decision-making before there is a crisis and they are unable to make those decisions. To that end, we have included a bibliography for anyone who is interested in more information on this general subject matter.

ACKNOWLEDGEMENT

The Subcommittee would like to take this opportunity to thank all of the people who worked so diligently to help make this study as informative as possible. We greatly appreciate the assistance provided by Gordon Smith of the Maine Medical Association and Joseph Mackey of the Maine Health Care Association. The speakers who appeared before the Subcommittee were instrumental in the Study's success. We would like to take this opportunity to extend our thanks to the participants, as well as their employers and associates for making their contributions possible:

Dr. Paul M. Cox, Jr., Critical Care Medicine, Maine Medical Center, Portland

Dr. Michael T. Drouin, Women's Health Center, Central Maine Medical Center, Lewiston

Dr. Richard Gelwick, University of New England College of Osteopathic Medicine, Biddeford

Christine Gianopolis, Bureau of Elder and Adult Services, Department of Human Services, Augusta

Phyllis Foster Healey, Maine State Nurses Association, University of Southern Maine, Gorham

Sandra Homer, Maine Right to Life Committee, Hallowell

Richard P. LeBlanc, Probate Section - Maine State Bar Association; Bernstein, Shur, Sawyer and Nelson, Portland

Dr. Pat Lerwick, University of Maine School of Law, Portland

Professor Robert B. Louden, Philosophy Department, University of Southern Maine, Portland

Dr. Alexander McPhedran, Maine-Dartmouth Family Practice, Kennebec Valley Medical Center, Augusta

Linda Pearson, Nursing Resources, Maine Medical Center, Portland

Kandace Powell, Hospice of Lincoln County; Miles Hospital, Damariscotta

Cindy Quinlan, Clover Manor, Auburn

Robert C. Robinson, National Conference of Commissioners on Uniform State Laws; Robinson, Kriger, McCallum and Green, Portland

Joan Sturmthal, Long-Term Care Ombudsman, Maine Committee on Aging, Augusta

Deborah Wheaton, Bangor Convalescent Center, Bangor

Jasper S. Wyman, Christian Civic League of Maine, Augusta

The Subcommittee also thanks all the other persons who, while perhaps not as visible as those named, nevertheless provided invaluable assistance and materials, especially the members of the staff of the Law and Legislative Reference Library.

TABLE OF CONTENTS

I. INTRODUCTION

A. SOURCE OF THE STUDY

In early 1989, the Probate Court of Cumberland County was asked to rule on a mother's request to remove the nasogastric tube which was sustaining the life of her son, who had remained in a persistent vegetative state since he was stabbed over 3 years earlier. It was the second time a Probate Court had been asked to permit the withdrawal of artificial nutrition and hydration after the Maine Supreme Judicial Court's decision in 1987 allowing the removal of a nasogastric tube from a patient in a persistent vegetative state. The fact that 2 such cases had come to the Probate Courts so quickly raised concerns that the court system was not sufficiently prepared to adequately deal with such difficult decisions. Accordingly, LD 1010, AN ACT Concerning the Right to Die, was introduced into the First Regular Session of the 114th Maine Legislature. Its purpose was to ensure that the Superior Court, not the Probate Court, had jurisdiction over cases in which a court was asked to rule on the withholding or withdrawal of medical treatment, including artificial hydration and nutrition. This was proposed as a solution to two expressed concerns: 1) The Probate Code does not clearly give the Probate Court authority to act in cases involving consent to the withdrawal or withholding of life-sustaining treatment, especially nutrition and hydration; and 2) Regardless of whether the Probate Code provides explicit authority, the Probate Court is not the proper judicial forum in which these questions should be resolved.

The Joint Standing Committee on Judiciary held a public hearing on April 18, 1989, on LD 1010. The witness list was long and impressive, and testimony given, both in favor of the bill and opposing the bill, was thoughtful and well reasoned. The Judiciary Committee realized that the question of which court is involved in these decisions is just a small part of a very large and complex area; it would be irresponsible to take action on the bill without looking at the entire issue of withholding and withdrawing treatment, and determining what role the Legislature should play in addressing the issue.

The Judiciary Committee therefore requested authorization from the Legislative Council to conduct an interim study of the issue of withholding and withdrawal of medical treatment. The Council authorized a 6-member study subcommittee, and approved 4 subcommittee meetings and one full-committee meeting. The deadline for submitting the study report and any suggested legislation was set as December 1, 1989. This report is the final report of the Joint Standing Committee on the Judiciary's Study of the Termination of Medical Care.

B. STUDY PROCEDURE

The 6-member Subcommittee to Study the Termination of Medical Care consisted of the following Judiciary Committee members:

Rep. Patrick E. Paradis, Chair
Rep. Constance Cote
Rep. Susan Farnsworth
Rep. Mary MacBride
Sen. Muriel Holloway
Rep. Peter Hastings

The Subcommittee held its organizational meeting on September 12, 1989. The members unanimously agreed to use the study as an opportunity to educate themselves as much as possible about the entire issue of withholding and withdrawing medical treatment, rather than spending the time debating various positions or proposals. With that in mind, the Subcommittee scheduled two days of testimony; one devoted to comments from providers of medical care, the other to explore the ethical, religious and moral aspects of withholding and withdrawing treatment.

The Subcommittee invited representatives of physicians, nurses, hospitals, nursing homes and hospice providers to address the Subcommittee on October 5, 1989. The Long-Term Care Ombudsman of the Maine Committee on Aging also spoke.

The speakers were requested to address several questions posed by the Subcommittee, as well as to add any comments that they, as practitioners, thought pertinent. In general, the Subcommittee was looking for an explanation of the current practices involving the withholding and withdrawal of medical treatment. Specifically, the Subcommittee asked the following questions:

How many cases do you know of where a conscious, deliberate decision is made about terminating medical treatment/procedures, or not initiating medical treatment/procedures, with the knowledge that death will most likely occur without the treatment/procedures?

Is there a typical case?

What is the usual decision-making process?

What triggers the usual process?

Who participates in the discussions and decisions?

How are decisions made; what factors are considered?

Do you have a DO NOT RESUSCITATE (DNR) policy? Are you satisfied with the policy and its application?

Do you perceive any problems with the current practices and procedures concerning withholding and withdrawal of medical treatment/procedures? If so, what are they? What causes them? What would you suggest as solutions?

How does patient competency affect this area?

Should courts review decisions? Should the court (or other agency of the State) have any role? If so, what?

The slate of speakers on October 5th was excellent and provided a broad range of information. The following professionals generously took time out of their busy days to participate in the study:

Phyllis Foster Healey (nurse, nursing instructor)
Dr. Alexander McPhedran (neurologist)
Dr. Paul Cox (critical care medicine)
Linda Pearson (nurse, nursing resources director)
Joan Sturmthal (Long-Term Care Ombudsman)
Kandace Powell (nurse, hospice)
Deborah Wheaton (nursing home administrator)
Cindy Quinlan (nursing home administrator)
Dr. Michael Drouin (obstetrician/gynecologist; hospital ethics committee chair)

The meeting on October 16th covered several of the ethical, moral and religious aspects to be considered when discussing the withholding or withdrawal of medical treatment. The speakers included representatives of groups who often participate in legislative activities, as well as persons from the more academic realm. The following speakers addressed the Subcommittee on October 16th:

Christine Gianopolis (Director, Bureau of Elder and Adult Services)
Dr. Richard Gelwick (theologian)
Jasper S. Wyman (Christian Civic League of Maine)
Robert B. Louden (philosophy professor)
Sandra Home (Maine Right to Life Committee)
Dr. Pat Lerwick (physician, 3rd-year law student)

In the afternoon, the Subcommittee also heard from Robert C. Robinson, Esq., and Richard P. LeBlanc, Esq., on the new Uniform Rights of the Terminally Ill Act, the Uniform Health Care Consent Act and advance directives in general.

The Subcommittee held its final meeting on November 6, 1989, during which the members discussed recommendations to be made to the full Judiciary Committee.

II. WITHHOLDING AND WITHDRAWING MEDICAL TREATMENT - GENERAL BACKGROUND

A. "RIGHT TO DIE"

"The Right to Die" is the often-used shorthand term describing the generally-recognized, but not necessarily universally-accepted, concept that each person is the ultimate decision-maker when it comes to refusing life-sustaining medical treatment for himself or herself. This concept has its roots in the common law theory of battery. The law of battery recognizes an individual's right to be free from nonconsensual bodily contact, including unauthorized medical procedures. Through time, the concept has incorporated threads of negligence law, resulting in the right to give informed consent before being treated. The "right to die" results from the evolving recognition of the affirmative right to refuse treatment, or the right to "informed refusal."[1]

Although the exact construct of "informed consent" is somewhat amorphous and constantly evolving, a brief look at the generally-accepted elements may be useful. Ideally, "informed consent is a process requiring a high degree of interaction between the physician and the patient. The threshold element on which the process is based is patient competency: A patient cannot consent or refuse consent if he or she is not capable of making the health care decision. The next two elements concern information about the diagnosis, the physician-recommended method of treatment, alternatives and the risks and benefits associated with each, including no treatment. The second element is the physician's duty to disclose the information; the third element is the patient's understanding of the information the physician discloses. Free interaction is necessary here to ensure that the patient has the necessary information and comprehends what the physician discusses. Fourth, the patient should be free to consent or refuse consent; there should be no reduction of the patient's voluntariness from coercion by threats or misrepresentation. Fifth is the step of actual consent or withholding of consent. This is the patient's actual decision about whether to proceed with a particular treatment procedure.[2]

---

[1] Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying. 7 (1987).

[2] Beauchamp, Tom L., and James F. Childress, Principles of Biomedical Ethics, third edition, Oxford University Press (1989), pp. 78 - 113. As mentioned, the issue of informed consent is not static and is subject to much disagreement and discussion. For one of many thorough discourses on informed consent, see President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions, volumes 1 - 3, October 1982.

There is support for the assertion that the "right to die" is also a constitutional right, relying on specific provisions of state constitutions providing a right of privacy (e.g., N.J. Const., Art. I, par. 1, cited in Matter of Quinlan, 355 A2d 647 at 633 (N.J. 1976), cert. denied, sub nom Garzer v. New Jersey, 429 U.S. 922 (1976); Fla. Const., Art. I, Sec. 23, cited in Corbett v. D'Alessandro, 487 So.2d 368 at 370 (Fla. App. 2 Dist. 1986)), and the penumbral right of personal privacy recognized by the Supreme Court to exist in the Bill of Rights of the U.S. Constitution. Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Stanley v. Georgia, 394 U.S. 557 (1969); Griswold v. Connecticut, 381 U.S. 479 (1965). "Presumably, this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." Quinlan 355 A.2d at 663. The question of whether an incompetent person has a right, protected by the Constitution, to reject medical treatment is now squarely before the U.S. Supreme Court. Cruzan v. Director, Missouri Department of Health, 760 S.W.2d 408 (Mo. 1988), cert. granted 58 USLW 3046 (8/1/89). Not before the Court, however, is the question of limitations on a competent person's right to refuse treatment, although the decision in Cruzan may provide some guidance.

B. ADVANCE DIRECTIVES

An "advance directive" is a document executed by a competent person to indicate what his or her health care wishes are should certain circumstances exist in the future when he or she is not then able to communicate those wishes. There are two main types of advance directives, "instruction" or "treatment" directives and "proxy" directives. Instruction directives explain what medical care the person would like provided or withheld should the person be unable to express those instructions when appropriate. The most common instruction directive is a "living will," or a directive made pursuant to a "natural death statute." Proxy directives designate another individual who will make health care decisions for the person executing the directive if and when the person is no longer able to make those decisions for himself or herself. A durable power of attorney is a proxy directive and can be general, giving the proxy a broad range of authority over many aspects of the person's life, including health care; or it can be limited solely to health care. It is assumed that the person serving as the proxy will be well aware of the person's wishes concerning his or her health care so that the proxy's decisions will be the same as the person would have made could he or she have done so at the time.

1. Living Wills

A living will allows a person to declare in advance that, in the event of a terminal condition,

life-sustaining procedures are to be withheld or withdrawn. Some living wills are very specific, referring to specific procedures which are acceptable or unacceptable; others are more general, instead referring to the removal or non-initiation of medical procedures which serve only to prolong the dying process. The effect of living wills in the absence of statutory acceptance is unclear. Without a statute explicitly authorizing the execution and recognition of living wills, it an be argued that a physician is not obligated to follow those instructions, although a living will in such circumstances is, at the very least, evidence of the person's wishes regarding health care. In 1976, California enacted the first "natural death act," giving legal status to directives to physicians which meet certain requirements.[3] Since then, 40 states and the District of Columbia have enacted statutes which, in one form or another, give formal recognition and legal effect to living wills.[4] Nine of those are at least partially based on the Uniform Rights of the Terminally Ill Act of 1985, adopted by the National Conference of Commissioners on Uniform State Laws in 1985.[5] All of these laws apply to declarations, signed by competent adults, to express medical treatment choices in the event that the person is in a terminal condition and unable to participate in treatment decision-making.

The Maine Living Will Act (22 MRSA c. 710-A) was enacted in 1985, and is based on the Uniform Rights of the Terminally Ill Act adopted by the Uniform Law Commissioners in 1985. Maine was the first state to base its statute on the model law, but the Legislature chose to deviate from the uniform language in an important way. The Judiciary Committee of the 112th

[3]1976 Cal. Stat., C. 1439, Health and Safety §§7185-7195.

[4]The 41 jurisdictions are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. Handbook of Living Will Laws, 1987, 1987 Edition, Society for the Right to Die (1987), p. 5, and Society for the Right to Die Chart Updates (1989).

[5]Alaska, Arkansas, Hawaii, Iowa, Maine, Maryland, Missouri, Montana and Oklahoma, Handbook of Living Will Laws, pp. 5-6.

Maine Legislature specifically excluded from the definition of "life-sustaining procedure" the provision of nutrition and hydration. 22 MRSA §2921, sub-§4. The one clear result of this definitional change is that artificially administered nutrition and hydration cannot be terminated on the basis of a living will which refers only to the withholding or withdrawal of "life-sustaining procedures." A declarant can specifically state in a living will that artificial nutrition and hydration should be withdrawn or withheld, but it is unclear what legal effect this would have since it lacks statutory support. The majority of the Maine Supreme Judicial Court ruling in the In re Gardner case (See D) would have (two of the justices have left the Court since the Gardner decision) apparently given legal effect to the written instructions.

2. Model Health Care Consent Act

The National Conference of Commissioners on Uniform State Laws approved a Model Health Care Consent Act in 1982. The Uniform Act consists of five basic concepts. First, the Uniform Act establishes who may consent to health care for themselves. Second, the Uniform Act provides a triggering mechanism to determine when a person is incapable of consenting to health care. Third, the Uniform Act establishes a scheme for determining who may make health care decisions for a person incapable of consenting (if the person has not already designated a proxy). Fourth, the Uniform Act provides a method for family members authorized to consent for another to delegate their authority to make health-care decisions. Fifth, the Uniform Act authorizes a person to designate another person to serve as a health care representative and to make health care decisions on his or her behalf.

3. Durable power of attorney; Health care agents

A power of attorney is a document by which the person executing the document (the principal) gives another person (the agent) the legally-recognized authority to act in the principal's behalf. Unless the document specifically provides otherwise, the agent's authority to act on the principal's behalf terminates if and when the principal becomes incompetent. A "durable power of attorney" explicitly continues the agent's authority despite the principal's incompetency. In fact, some durable powers of attorney do not take effect until the principal is incompetent. Twenty-one states and the District of Columbia have durable power of attorney

statutes which either explicitly authorize, or which have been interpreted to authorize, the agent to make medical decisions for the principal.[6]

The Maine durable power of attorney law has been criticized because, although it does specifically include consent to medical treatment, the language is buried in the midst of property and business authorizations. Critics argue that the power to make medical decisions on behalf of a principal is unique and important enough to have the authorization set out separately in the statute, and perhaps in more detail.

C. PROBATE COURT JURISDICTION

The impetus for this study was LD 1010, AN ACT Concerning the Right to Die. The bill is currently pending in the Judiciary Committee, and requires action during the Second Regular Session.

LD 1010 would remove from the Probate Court jurisdiction that it currently has (and there is some dispute) over cases involving the withholding or withdrawal of medical treatment. The question of jurisdiction is problematic for at least two major reasons. First, not all decisions about withholding or withdrawing medical treatment are ever submitted to any court for resolution. Where an effective living will exists (a very small percentage of cases), there seems to be no problem in carrying out its instructions without resorting to the power of a court. Where another person has been designated to make health care decisions for the patient through a power of attorney or health care proxy, at least where the patient's wishes are known, there has been no need to ask the court to interpret the terms of the directive or the extent of the proxy's power. In probably the greatest number of cases, there has been no advance directive executed, but the family and the physicians are able to discuss the circumstances and reach an agreement about whether medical treatment, including nutrition and hydration, should be withheld or withdrawn.

Second, the Probate Court's jurisdiction is limited. One limitation is the fact that the Probate Court has no authority to rule on the criminal or civil liability of any

[6]Alaska, Arizona, California, Colorado, Hawaii, Illinois, Iowa, Maine, Maryland, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Vermont and Washington. Ten additional states authorize proxy appointments through their living will or natural death statutes: Arkansas, Delaware, Florida, Idaho, Indiana, Louisiana, Minnesota, Utah, Virginia and Wyoming. Society for the Right to Die: State Law Governing Durable Power of Attorney; Health Care Agents; Proxy Appointments. October 1, 1989.

person, regardless of whether the person is a party and therefore before the court. This means that persons carrying out Probate Court orders or exercising powers granted by the Probate Court are not immune from prosecution, for example, for violating a criminal statute by terminating a ward's medical treatment.[7]

Another possible limitation of the Probate Court's jurisdiction is found in the language of the Probate Code authorizing a guardian (once appointed) to "give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service." 18-A MRSA §5-312, sub-§(a), ¶(3). The concern, although not held by all involved, is that the statute gives the guardian power to consent to the provision of treatment, but it does not specifically authorize refusal of consent, or consent to the withholding or withdrawal of treatment.[8]

There have been a total of three cases that were resolved by the courts in Maine.[9] All of the cases were decided since December, 1987, and are summarized below.

D. CASES

Living wills and durable powers of attorney appear to work extremely well when they are used. Unfortunately, not everyone takes the formal step of putting their health care wishes in writing. The courts in numerous states have been asked to rule in cases because the patient has not executed an advance directive and a conflict exists between the physician and the family of the patient, or between family members, or because a clarification is needed concerning the guardian's authority or the physician's legal duty.

---

[7]Kennebec County Probate Judge James E. Mitchell specifically addressed this question in his order In re Robert F. Hallock, docket no. 88-381, issued September 26, 1988.

[8]In contrast, the durable power of attorney statute specifically allows the power of attorney to authorize the attorney-in-fact or agent "to consent to, **withhold consent to** or approve on behalf of the principal any medical or other professional care, counsel, treatment or service of or to the principal by a licensed or certified professional person or institution engaged in the practice of, or providing, a healing art." (emphasis added) 18-A MRSA §5-501, 2nd paragraph.

[9]In re Gardner, in Superior Court; In re Hallock, in Probate Court; and In re Weaver, in Probate Court. There is a contested guardianship case pending in Cumberland County and another case pending in Superior Court in Androscoggin County.

The three court rulings in Maine to date resulted from situations in which the patient had not executed any advance directive.

In re Gardner. Joseph V. Gardner, 22 years old, suffered severe, permanent and disabling head injuries when he fall from the back of a moving pick up truck on May 11, 1985. All available medical, surgical and rehabilitative care and treatment were applied, but Gardner, the Superior Court found,[10] remained in a "'chronic and persistent vegetative state without hope of regaining any cognitive of voluntary bodily functions by any known or anticipated medical procedures.'"[11] Before the accident, Gardner had on several occasions informally mentioned that he would not want to be kept alive in a vegetative state.

During the summer of 1986, Gardner's mother, his legal guardian, requested that the artificial nutrition and hydration be withdrawn. The physicians and administrators at the facility in which Gardner was being cared for, were unclear about their rights and responsibilities and therefore brought a an action for a declaratory judgment in Superior Court. On August 14, 1987, Justice Delahanty ruled that it was legally proper for the guardian to have artificially administered nutrition and hydration discontinued, allowing the guardian to use Gardner's informal statements on which to base the guardian's substituted judgment as to what Gardner would have chosen for himself had he been able to. The District Attorney, representing the State's interest in preserving life as well as the State's interest in preserving the integrity of the medical profession,[12] appealed.

[10]The District Attorney, arguing for the appellant state, disputed the assertion that Gardner had never gained consciousness, and included excerpts from the medical records to support that argument.

[11]In re Gardner, 534 A.2d 947, 949, (Me. 1987), quoting the Superior Court decision.

[12]The other two commonly-expressed state interests of preventing suicide and protecting innocent third parties, such as dependents, were not seen as applicable.

The Supreme Judicial Court, in a 4-3 decision, ruled that Gardner's statements were sufficient evidence in and of themselves to assert Gardner's choice regarding termination of the artificially administered nutrition and hydration. The Court affirmed the Superior Court's determination that no civil or criminal liability applied to any person carrying out the guardian's instructions in compliance with Gardner's choice to discontinue the treatment. The Courts ruling was based on a recognition of Gardner's common law right to refuse life-sustaining treatment. In re Gardner, 534 A.2d 947 (Me. 1987).

In re Hallock. In January of 1988, Robert F. Hallock, 59, suffered a cardio-pulmonary arrest as a result of choking on a piece of food while a resident of the Augusta Mental Health Institute, resulting in brain damage. Prognosis for recovery was determined to be very poor. With the consent of Hallock's family, the guardian (appointed for Hallock before the incident because of Hallock's mental competence) petitioned the Kennebec County Probate Court for instructions concerning a guardian's authority to consent to the withdrawal of artificially administered nutrition and hydration and the withholding of antibiotics when the ward has never made any statements regarding the termination of life-sustaining treatment.

Probate Court Judge James E. Mitchell issued an order in September of 1988 based on the facts of that particular case. Judge Mitchell ruled that the guardian had authority to accept and act on the advice of the medical experts that it "appears appropriate to withdraw food and liquids and antibiotic treatment" from Hallock. The Court ruled that the general authority of guardians, provided in 18-A MRSA §5-312, sub-§a,¶(3), includes the authority to consent to the withdrawal and withholding of medical treatment, including artificially administered nutrition and hydration. The Court clearly stated that it was not "establishing or enunciating broad and generalized concepts or procedures for other parties in other cases." In re Robert F. Hallock, Kennebec County Probate Court, docket no. 88-381, issued September 26, 1988.

In re Weaver. Mark Weaver, 22, was left with severe brain damage when, in May, 1985, he was stabbed in the throat. In early 1989, Weaver's mother petitioned the Probate Court of Cumberland County to have the feeding tube removed. Probate Judge Dana W. Childs ruled on February 27, 1989, that the tube could be removed. The case draw media coverage because the person who stabbed Weaver, and who had already served a term of

imprisonment for the assault, petitioned the Probate Court to intervene. His concern was that if Weaver were to die after the removal of the feeding tube, he could be prosecuted for murder. Judge Childs refused to allow the intervention, based on the fact that the intervention had nothing to do with Weaver's best interests. In re Weaver, Cumberland County Probate Court, docket no. 89-177, February 27, 1989.

Citations to several of the most instructive of the over 60 reported cases in other jurisdictions are included in the appendix.

III. TESTIMONY

A. HEALTH CARE

The materials and comments that have been provided to the Subcommittee have been extremely informative. The Subcommittee recognizes that the opinions and perceptions expressed by the speakers and commentators are not necessarily representative of anyone other than the person who addressed the Subcommittee. The members are also aware that not all viewpoints were expressed to the Subcommittee during the two days of testimony. Because of the quality and the breadth of the knowledge of those that did attend, however, the Subcommittee is confident that it has a fairly good understanding of the subject matter of withholding and withdrawing medical treatment.

All the speakers agreed that deciding whether to forego or to terminate medical treatment can be a very weighty ethical dilemma. Opinions do differ concerning to what extent nurses, on whom the greatest burden of 24-hour care falls, are being consulted and involved in the decision-making process, although all agreed that communication, at the very least, is important. At least one nurse was reported as mentioning that some physicians believe that writing a DO NOT RESUSCITATE (DNR) order indicates failure, and are thus reluctant to do so.

There was also no consensus on the establishment and use of "ethics committees" at hospitals. At best, they serve as an interdisciplinary forum where the best experts the facility has to offer can consult with each other, thoroughly discuss the case and reach a combined conclusion with its attendant recommendations. At worst, they may undermine the doctor-patient relationship and remove the ultimate decision-making authority far from the patient himself or herself.

The "typical" case, it was explained, is one in which the person was previously well, cared for himself or herself and never made any formal statement of their health care wishes. A sudden illness or accident occurs, usually cutting off oxygen to the brain, resulting in brain damage. In about half of these cases, Dr. Alexander McPhedran estimated, extraordinary support of respiration is necessary; in the other half, no respiratory support is needed, but other medical support is necessary: artificial nutrition and hydration, turning to avoid bedsores, etc.

There was general agreement by the speakers that addressed it that provision of artificial nutrition and hydration should be considered a "medical procedure," and that if a line is drawn allowing termination of "extraordinary," as opposed to "ordinary," procedures, provision of artificial food and nutrition should fall on the "extraordinary" side, at least partly because it exposes the patient to additional risks.

Dr. Paul Cox described how he views artificial nutrition and hydration, dismissing the provision of nutrition as imbued with special symbolic meaning in all circumstances. "When [food] becomes blenderized, sterilized, and in a plastic bag that looks like a bag of IV solution and goes into someone through a tube without being tasted, then I think it is a therapeutic agent. That therapeutic agent has real risks for harm as well as potential for good. If it is used in a patient who has a temporary inability to eat or a permanent inability to eat but ability to decide whether he wants to continue that tube feeding, then I think that it is an appropriate therapeutic agent. If it is used to keep a patient alive in a chronic vegetative state with no hope for improvement, I think that is an inappropriate use of a therapeutic agent and should be stopped when the family is ready for that step." Dr. Cox went on to say that people do not die of hunger when the artificial feedings are stopped, they die of starvation. There is no indication that there is any pain or discomfort resulting from lack of food for the patient in a persistent vegetative state once the feeding tubes are removed. (There are, however, certain palliative measures that are usually necessary to keep the patient comfortable.) In fact, provision of artificial nutrition and hydration is not without side effects. Dr. Cox stated that he believes it is more ethical to withdraw therapy than to withhold therapy. In other words, medical science should be free to try all methods of aggressive therapy and, if it is not successful, not be saddled with any disapproval for discontinuing the procedures that do not effect the desired result.[13]

---

[13]The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research agrees:

> Ironically, if there is any call to draw a moral distinction between withholding and withdrawing, it generally cuts the opposite way from the usual formulation: greater justification ought to be required to withhold than to withdraw treatment. Whether a particular treatment will have positive effects is often highly uncertain before the therapy has been tried. If a trial of therapy makes clear that it is not helpful to the patient, this is actual evidence (rather than mere surmise) to support stopping because the therapeutic benefit that earlier was a possibility has been found to be clearly unobtainable.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on Treatment Decisions (1983), p.76 (1983).

Dr. Michael Drouin discussed a persistent vegetative state, or permanent coma, in some detail. A patient in such a state[14] has no cognitive function. The functions performed by the cortical brain centers - thinking, eating, feeling pain, awareness of self and environment - are absent. In contrast, the involuntary, reflexive functions governed by the brain stem continue. In Joseph Gardner's situation, his eyes would follow activity around the room, but such apparent signs of cognitive function were simply reflexes. A person in such a state usually cannot swallow, and has no control over bowels or urinary function. Dr. Drouin was confident that keeping someone alive in this state interferes with the natural process of dying.

Other speakers presented anecdotal and informal survey information about nursing homes, and the role of hospice in withholding or withdrawal of medical treatment cases. The rights and wishes of the patient should receive the greatest respect, was the conclusion. Joan Sturmthal, the Long-Term Care Ombudsman, suggested the establishment of a "super ethics committee" that would serve at least all the nursing homes, which must often deal with these patients without families and without personal involvement of physicians.

B. ETHICAL, MORAL AND RELIGIOUS ASPECTS

As much as the testimony of the health care providers helped the Subcommittee to understand the pertinent medical and technical facts of withholding and withdrawing medical treatment, the speakers on October 16th emphasized how these complex issues require much thought to frame and, if possible, resolve the ethical/moral questions raised by the fast advance of technology.

The Subcommittee was interested in a comparison of how the various major religions of the world view the withholding or withdrawal of medical treatment. Dr. Richard Gelwick compiled comparative information, and presented the Subcommittee with a simple chart for brief review. Dr. Gelwick cautioned that the summary was not exhaustive and should not be considered definitive. The Subcommittee, however, found the following information provided by Dr. Gelwick very useful.

[14](referred to as "permanent loss of consciousness" in Deciding to Forego Live Sustaining Treatment, p. 174, fn. 9)

- The following is an explanation of some basic differences in religious outlook between Eastern and Western religions.

  (1) Eastern religions generally do not claim there is a personal, all knowing, and all powerful loving deity. Without such theory, the "God's Will" argument against or for termination of life does not make sense.

  (2) Eastern religions generally do not hold that there is a moral law given in commands that humans must obey. The Western settlement of termination of life by appeal to a commandment ("Thou shalt not kill") does not follow.

  (3) Eastern religions generally do not focus on history as linear but have a cyclical sense of reality. The Western anxiety about life after death has no role.

  (4) Where Western religions have generally sought to align the individual's behavior with the will of the personal and supreme God, Eastern religions have sought to ground the individual in a selfless sense of reality. The Western concern to preserve or to guide an immortal soul is not relevant.

- The lack of medical technology in the native land of the Eastern traditions has delayed their facing the dilemmas of heroic life-saving measures. Extensive deliberations are yet to occur.

- The consideration of religious outlooks in a global perspective is appropriate to the practice of medicine in America since all of the major world religions are now a significant part of our society. Major academic texts on religion in America now include Eastern religions as part of the picture of religion here.

- A very over simplified comparison of Western and Eastern religions may be shown as follows:

[15]RELIGION	ULTIMATE SYMBOL	SUICIDE	EUTHANASIA
Judaism	Yahweh	yes/no	active, no passive, yes/no
Christianity	Triune God		
Roman Catholic		no	active, no passive, yes
Orthodox		no	active, no passive, yes
Episcopal		no	active, no passive, yes/no
Methodist		no	active, no passive, yes
Baptist		no	active, no passive, yes
United Church of Christ		no	active, no passive, yes
Evangelical		no	active, no passive, no
Islam		no	no
Hinduism	Brahman	yes	yes/no
Buddhism	No-self	yes	yes/no
Taoism	Balance	no	no

[15]Chart prepared and presented by Dr. Richard Gelwick, University of New England College of Osteopathic Medicine.

Robert B. Louden provided a helpful bibliography as well as a discussion of the role of "experts" when value judgments are involved, and particular case studies. Specific questions which should be considered in varying situations were raised. His conclusion: "Those who believe that termination of medical care for "living" (i.e., not "brain-dead") patients is [a] "slippery slope" fear that such policies will lead to a gradual disrespect for the sanctity of human life. Any policy developed in this area needs to build in as many safeguards as is practically feasible against the danger of abuse due to the risk of an incorrect diagnosis, the difficulty of ascertaining [a] patient's true wishes (and of determining whether such wishes are rational), problems involved with allowing proxies to speak on behalf of [a] patient, the risk of administering euthanasia to a person who could later have been cured by new medical developments, etc. At the same time, a balance needs to be struck between concern over possibilities of abuse on the one hand and an overly bureaucratic, lawyers' paradise on the other."

The persons most at risk, one advocate asserted, are not those who are terminally ill, but those who do not die soon enough. Sandra Homer presented the position of the Maine Right to Life Committee that if death is imminent, withdrawal of useless treatment is not unethical if the treatment simply prolongs dying. The administration of nutrition and hydration is not totally "artificial" (it is satisfying a basic need of life, which need is not related to the illness), and should not be considered a medical treatment. The Oklahomans for Life were apparently instrumental in enacting the "Hydration and Nutrition for Incompetent Patients Act," passed in Oklahoma in 1987. The Act establishes a presumption that "every incompetent patient has directed his health care providers to provide him with hydration and nutrition to a degree that is sufficient to sustain life." Okla. Stat. 63 §3080.3. There are three exceptions to this presumption: 1) The physician knows by clear and convincing evidence that the patient, when competent, made an informed decision that artificial administered hydration or nutrition should be withheld or withdrawn from that person (no requirement that it be made in writing); 2) The attending physician and one consulting physician agree that artificially administered hydration or nutrition will itself cause "severe, intractable, and long-lasting pain" or that it is not medically possible to administer; or 3) The attending physician and one consulting physician determine that the incompetent patient is chronically and irreversibly incompetent, in the final stage of a terminal illness or injury, and death is imminent. Okla. Stat. 63 §3080.4. The conclusion reached by the Maine Right to Life Committee is that artificially administered nutrition and hydration should not be withdrawn unless the patient has consented to such termination.

Jasper S. Wyman of the Christian Civic League of Maine, reiterated that the problem exists where no living will or other advance directive has been executed. He urged action with caution, and that whatever course taken must provide flexibility to accommodate individual beliefs.

Also discussed at the October 16th meeting was the role of the State as the public guardian for incompetent persons with no other available person to serve as guardian. Christine Gianopolis, Director of the Bureau of Elder and Adult Services, explained that the State serves as guardian for over 400 persons, and estimated that there are probably 4-5,000 persons in Maine with private guardians. The Bureau strongly encourages the execution of living wills and durable powers of attorney, and provides information and sample forms to that end.

The Subcommittee also heard a brief summary of the legal basis for the existence of the right to refuse and to terminate treatment (See I, A, above). The summary was compiled by Dr. Pat Lerwick, currently in her third year at the University of Maine School of Law.

C. ADVANCE DIRECTIVES - PROPOSALS

Robert C. Robinson is the Maine representative to the National Conference of Commissioners on Uniform State Laws. In that role, he presented the Uniform Rights of the Terminally Ill Act approved by the Uniform Law Commissioners in 1989 for the Subcommittee's consideration. The 1989 Uniform Act updates the 1985 Uniform Act which Maine adopted in substantially the form approved by the Uniform Law Commissioners. The 1989 Uniform Act includes three fundamental changes. First, it specifically provides for a declarant to appoint a person who will act as his or her proxy to make medical decisions, including the withdrawal or withholding of treatment, if and when the declarant is incompetent. Second, the 1989 Uniform Act provides for a hierarchy of family members who may consent to the withdrawal or withholding of life-sustaining treatment for an incompetent person. Third, the 1989 Uniform Act specifically provides that life-sustaining treatment may not be withdrawn or withheld under the law if the attending physician knows that the person is pregnant if it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

Richard P. LeBlanc, representing the Probate Section of the Maine State Bar Association, recommended a modification in the wording of the 1989 Uniform Act. He also proposed that the living wills statute be moved into the Probate Code and that the durable power of attorney statutes be revised to more clearly cover treatment decisions. This restructuring would consolidate all the statutes on this subject in one place, assisting persons in effectively using them.

D. PROBATE COURT JURISDICTION

Although the Subcommittee sought a much broader range of information than LD 1010 directly addressed, the members still solicited comments on the question of appropriate jurisdiction from all the speakers. A few had no opinion, and preferred to leave the question to the legislative and legal experts; others were happy to provide their thoughts on the issue.

Most of the health care providers favored as little court involvement as possible, and saw the Probate Court as better able to meet that requirement because of its informality and less rigorous docket and procedures. The informality seemed to some an important factor in easing the situation for families who find themselves in the devastating position of making a decision about withholding or withdrawing treatment for a loved one; introducing a court into such a possibly emotionally-charged situation can prove quite daunting for the participants. The proponents of the Probate Court retaining jurisdiction were satisfied that the Probate Judges in the State have sufficient expertise, and capacity to learn where the specific expertise is lacking, to adequately handle the subject matter. In addition, supporters emphasized the experience that the Probate Courts have in appointing guardians and establishing and reviewing their authority. The Probate Court should retain jurisdiction, it was argued, once the Court has accumulated such a wealth of knowledge about the particular case through the various stages of incompetency and guardianship proceedings.

Other speakers expressed the opinion that the Superior Court was a more appropriate forum, if only because its docket and standard procedure would require more time between filing and judgment than would be applicable in the Probate Court. The more time there is for careful deliberation and thorough analysis of the facts as well as the legal and ethical issues involved, the speakers argued, the better the chance that an inappropriate decision will be avoided. Except in the case where the patient is suffering excruciating pain, there is no compelling reason to rush these cases to judgment through the Probate Court. As for patients in persistent vegetative states, enough time should pass in order to ensure that the diagnosis and poor prognosis are correct; no quick resolution is required for the patient.

The Subcommittee received testimony arguing that the Superior Court is a better forum because it has vast experience in issuing injunctions and other expedited relief. It is a fact-finding court with expertise in answering questions of law and fact in very serious life-or-death cases. Perhaps most important, the Superior Court has the power to grant full relief and to litigate the rights and liabilities of all persons concerned, including physicians, medical facilities and other health care providers.

IV. FINDINGS AND RECOMMENDATIONS

The Subcommittee's purpose in undertaking this study was to learn as much as possible about the subject of withholding and withdrawal of medical treatment, and not necessarily to recommend any action by the full Judiciary Committee. Through the course of this study, however, the Subcommittee has determined that certain changes are not only appropriate but necessary to carry out the State's role in respecting and honoring competent persons' decisions regarding their own health care. The Subcommittee therefore makes the following recommendations to the full Judiciary Committee.

A. PROBATE COURT JURISDICTION

The Subcommittee recommends that, at least at this time, there be no change in the jurisdiction of the Probate Court. To that end, the Subcommittee recommends that the sponsors of L.D. 1010 be offered a Leave To Withdraw by the Judiciary Committee.

The Subcommittee reviewed the question of jurisdiction over withholding and withdrawing treatment. The number of cases in which a court is involved still appears rather small; most cases are resolved through the proper resort to living wills, powers of attorney and health care consent directives, or through discussion and consensus of family and physician. The number of cases ending up in court, while increasing (there is a contested guardianship case pending in Cumberland County, and a Superior Court case pending in Androscoggin County), is not at a crisis state. There are excellent arguments for retaining Probate Court jurisdiction, just as there are strong, defensible arguments for vesting all the decision-making authority in the Superior Court. The members wrestled with the issue and determined that they were simply not ready to cut off access to the Probate Court. Parties who believe that Superior Court provides a better or more deliberate forum have the opportunity to bring an action for declaratory judgment (establishing the proper bounds of a guardian's authority, for example) in Superior Court. The Subcommittee was not prepared, however, to eliminate the viable and adequate option offered by the Probate Court at this time. The Subcommittee therefore recommends no change in the jurisdictional statutes, and recommends that the Judiciary Committee offer the sponsors of LD 1010 a Leave To Withdraw.

B. **EDUCATION**

The Subcommittee recommends that the Judiciary Committee help develop an educational program to communicate the fact that health care decisions can be made in advance in specific circumstances, and that it is in the best interests of every person and family to discuss the subject and clearly state their wishes.

The Subcommittee agrees that each person has the right to decide whether to have life-sustaining treatment, including nutrition and hydration, withheld or withdrawn. Unfortunately, when the majority of people are in a position where making such a decision is appropriate, they are no longer competent to make the decision because of the disease or injury which placed them in that position. In most cases, the family could be spared the difficult task of determining and proving the patient's desires regarding life-sustaining treatment if the patient had executed a living will, a health care proxy, a durable power of attorney, or otherwise expressly made his or her intentions known. No court involvement would be needed to carry out the patient's wishes that are adequately expressed and legal (as long as those wishes are within the realm of medically acceptable procedures). The Subcommittee therefore recommends that the Judiciary Committee review ways to educate people better about advance directives and their uses. This recommendation is not to be construed to mean that the Subcommittee encourages all people to execute an advance directive; the Subcommittee is cognizant that each person may have a different view about his or her health care and what procedures are appropriate for that person. Such very personal decisions call into play many more concepts than medicine alone. Rather, the Subcommittee encourages persons to think about those future situations and make it clear, ideally in writing, what medical or other treatments should be appropriately pursued, and which should be withheld or withdrawn. In this way we can know, and therefore respect and honor, each other's choices in the most personal matter of all - life and death.

The Subcommittee encourages all interest groups, agencies and individuals to participate in this education process. Various organizations and agencies currently provide information on advance directives on request, and we applaud their efforts. Anyone with additional ideas is encouraged to make suggestions to the Judiciary Committee for further legislative action. The Judiciary Committee should then consider the relevant suggestions and follow up on those deemed appropriate.

C. MODIFICATION OF CURRENT LIVING WILLS LAW

The Subcommittee recommends that the current Living Wills law (22 MRSA c. 710-A) be amended to clearly authorize a person to specifically include artificially administered nutrition and hydration in the category of "life-sustaining procedures" which the person can direct a physician to withhold or withdraw.

The Subcommittee recognizes the right of each person to make his or her choices with regard to health care. To the extent that a person is competent when making those choices, the Subcommittee believes that the statute should clearly support that person's choice to have life-sustaining procedures withheld or withdrawn if the person is in a terminal condition. The Subcommittee believes that this support should extend to the choice to include artificially administered nutrition and hydration as any other life-sustaining procedure which may be withheld or withdrawn. The Subcommittee therefore recommends that the Maine Living Wills Statute (22 MRSA c. 710-A) be amended to clearly authorize any person executing a living will to specifically direct the attending physician to withhold or withdraw artificially administered nutrition and hydration consistent with the terms of the living will. By the use of the phrase "artificially administered nutrition and hydration," the Subcommittee means to include all tube and intravenous methods of providing nutrients and liquids. The focus is on the inability of the person to receive nourishment through spoon feedings or any other method considered by most people as "ordinary." Any method which, under standard circumstances, requires the actions of a physician or other licensed health care professional to initiate or maintain (such as inserting a nasogastric tube) is, in the Subcommittee's view, not "ordinary" and should be considered a method of artificial administration of nutrition and hydration.

(Should the Judiciary Committee approve the 1989 Uniform Rights of the Terminally Ill Act, the Subcommittee recommends that the new language be retained which makes clear the authority for declarants to include nutrition and hydration as a life-sustaining treatment which can be withheld or withdrawn. If fact, the 1989 language, because it does not exclude nutrition and hydration as Maine law does, will cover that situation without amendment. The 1989 Uniform Act is being introduced into the Second Regular Session of the 14th Legislature by an individual legislator rather than by the Subcommittee.)

D. 1989 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT
The Subcommittee recommends that the Judiciary Committee consider the Uniform Rights of the Terminally Ill Act as adopted by the National Conference of Commissioners on Uniform Laws in 1989. It is important to hold a public hearing on the legislation in order to obtain a broad cross-section of responses to the proposals.

The Subcommittee is interested in the 1989 Uniform Rights of the Terminally Ill Act adopted by the Uniform Law Commissioners this past summer. The modifications of the 1985 model law (on which the Maine living wills law is based) were designed to cover more situations and to provide increased guidance. Those modifications are novel, and the Subcommittee did not have the opportunity to fully explore the new provisions. The new model law deserves a comprehensive public hearing before the full Judiciary Committee. Therefore, although the Subcommittee is not prepared at this time to recommend passage of the 1989 model law, the Subcommittee does recommend that the Judiciary Committee consider the new uniform law to determine if its adoption is appropriate.

E. CONSOLIDATION OF HEALTH CARE CONSENT LAWS
The Subcommittee recommends that the laws concerning health care consent and the withholding or withdrawal of medical treatment be consolidated into one place, specifically the Probate Code (Title 18-A). The Subcommittee recommends consideration of the draft legislation currently being developed by a special subcommittee of the Probate Section of the Maine State Bar Association.

The Subcommittee recognizes the difficulties that all those, except the most experienced practitioners, have in finding and reconciling all the various statutes governing the exercise of the right to refuse life-sustaining treatment. The Subcommittee therefore recommends that the full Judiciary Committee consider consolidating the living will and appropriate Probate Code sections governing health care decision-making. A special subcommittee of the Probate Section of the Maine State Bar Association is drafting legislation which will do just that; it will clarify and expand Part 5 of Article V of the Probate Code to deal with:

1. Powers of Attorney, which would include:

   (a) Durable powers of attorney;
   (b) Non-durable powers of attorney; and
   (c) Medical powers of attorney and health care consents; and

2. Declarations Relating to Use of Life-Sustaining Treatment, which would be a revised and coordinated version of the Uniform Rights of the Terminally Ill Act (1989). The current living wills statute in Title 22 would be repealed.

The special subcommittee of the Probate section will present the draft to the Judiciary Committee in time to be included in the Committee's deliberations involving the recommended legislation included in this report.

#223LHS

APPENDIX A

114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document **No. 1010**

H.P. 733 House of Representatives, April 3, 1989

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 27.

Reference to the Committee on Judiciary suggested and ordered printed.

EDWIN H. PERT, Clerk

Presented by Representative PARADIS of Augusta.

Cosponsored by Speaker MARTIN of Eagle Lake.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

An Act Concerning the Right to Die.

(AFTER DEADLINE)

(EMERGENCY)

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, Probate Courts have been ruling on the rights of guardians to consent to the termination or withholding of medical treatment, hydration or nourishment for the wards of the guardians; and

Whereas, Probate Courts do not have the resources to handle cases of this magnitude; and

Whereas, the Superior Court is a more appropriate forum for such actions to be heard and decided; and

Whereas, the rights of wards who are patients may not be adequately protected under the current law; and

Whereas, in the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 18-A MRSA §5-102, sub-§(c) is enacted to read:

(c) The Superior Court has exclusive jurisdiction over proceedings concerning a guardian's request for or consent to termination or withholding of medical treatment, hydration or nourishment for the guardian's ward.

Sec. 2. 18-A MRSA §5-209, sub-§(c), as enacted by PL 1979, c. 540, §1, is amended to read:

(c) The guardian is empowered to facilitate the ward's education, social, or other activities and to authorize medical or other professional care, treatment, or advice. A guardian is not liable by reason of this consent for injury to the ward resulting from the negligence or acts of 3rd persons unless it would have been illegal for a parent to have consented. A guardian may consent to the marriage or adoption of ~~his~~ the ward. A guardian may not request or consent to the termination or withholding of medical treatment, hydration or nourishment until the Superior Court has determined that the guardian may do so.

Sec. 3. 18-A MRSA §5-312, sub-§(a), as enacted by PL 1979, c. 540, §1, is amended to read:

(a) A guardian of an incapacitated person has the same powers, rights and duties respecting ~~his~~ that guardian's ward that a parent has respecting ~~his~~ that parent's unemancipated minor child, except that a guardian is not legally obligated to provide from ~~his~~ the guardian's own funds for the ward and is not liable to 3rd persons for acts of the ward solely by reason of the parental relationship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court~~:~~ .

(1) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, ~~he~~ the guardian is entitled to custody of the person of ~~his~~ the ward and may establish the ward's place of abode within or without this State, and may place the ward in any hospital or other institution for care in the same manner as otherwise provided by law.

(2) If entitled to custody of ~~his~~ the ward, ~~he~~ the guardian shall make provision for the care, comfort and maintenance of ~~his~~ the ward and, whenever appropriate, arrange for ~~his~~ the ward's training and education. Without regard to custodial rights of the ward's person, ~~he~~ the guardian shall take reasonable care of ~~his~~ the ward's clothing, furniture, vehicles and other personal effects and commence protective proceedings if other property of ~~his~~ the ward is in need of protection.

(3) A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service. A guardian may not request or consent to the termination or withholding of medical treatment, hydration or nourishment until the Superior Court has determined that the guardian may do so.

(4) If no conservator for the estate of the ward has been appointed, ~~he~~ the guardian may:

(i) Institute proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform ~~his~~ that duty;

(ii) Receive money and tangible property deliverable to the ward and apply the money and property for support, care and education of the ward; but, ~~he~~ the guardian may not use funds from ~~his~~ the ward's estate for room and board which ~~he~~ the guardian, ~~his~~ the guardian's spouse, parent, or child have furnished the ward unless a charge for the service is approved by order of the court made upon notice to at least one of

the next of kin of the ward, if notice is possible. ~~He~~ The guardian must exercise care to conserve any excess for the ward's needs.

(5) A guardian is required to report the condition of ~~his~~ the ward and of the estate which has been subject to ~~his~~ the guardian's possession or control, as specified by the court at the time of the initial order or at the time of a subsequent order or as provided by court rule.

The court on its own motion, or on the petition of any interested person, may appoint a visitor to review the guardian's report and determine if appropriate provisions for the care, comfort and maintenance of ~~his~~ the ward and for the care and protection of ~~his~~ the ward's property have been made. The visitor shall report ~~his~~ the visitor's findings to the court in writing.

(6) If a conservator has been appointed, all of the ward's estate received by the guardian in excess of those funds expended to meet current expenses for support, care, and education of the ward must be paid to the conservator for management as provided in this code, and the guardian must account to the conservator for funds expended.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

STATEMENT OF FACT

This bill provides that only the Superior Court, not the Probate Court, has jurisdiction to determine whether a guardian may request or consent to the termination or withholding of medical services, hydration or nourishment of a minor or other ward of the guardian.

APPENDIX B

STATE OF MAINE
ONE HUNDRED AND FOURTEENTH LEGISLATURE
COMMITTEE ON JUDICIARY

June 12, 1989

Honorable Charles P. Pray, President of the Senate
Honorable John L. Martin, Speaker of the House
114th Legislature
Maine State Legislature

Re: Judiciary Committee Study Request

Dear President Pray and Speaker Martin:

The Joint Standing Committee on Judiciary is submitting the attached study request for Legislative Council approval.

The Council approved our request to carry over LD 1010, AN ACT Concerning the Right to Die so that we may spend more time on and involve experts while we examine the issue of termination of medical treatment, hydration and nutrition.

Please contact us if the attached study request does not provide all the information you need.

Thank you for your consideration.

Sincerely,

Sen. Barry J. Hobbins
Senate Chair

Rep. Patrick E. Paradis
House Chair

attachment

3566m

COMMITTEE: JUDICIARY

STUDY REQUEST: Termination of Life Support Services

SOURCE: This study will provide recommendations on which the Judiciary Committee can base its deliberations on LD 1010, AN ACT Concerning the Right to Die.

STUDY GROUP: Full Judiciary Committee

FIRST MEETING: To be held no later than 9/1/89.

STUDY SUBJECT: The central issue the Committee will examine is the appropriate forum in which to make decisions concerning the termination of medical treatment, extraordinary or otherwise, hydration and nutrition for incapacitated persons.

SPECIFIC QUESTIONS TO BE EXAMINED:

1. Is the Probate Court the appropriate forum to make termination decisions? Is the Superior Court a better forum?

2. Does the Probate Code need revision to adequately address the issue of termination of medical treatment, hydration and nutrition?

3. Does the "living wills" legislation require revision to adequately address the issue of termination of hydration and nutrition?

SPECIAL TASKS TO BE UNDERTAKEN: The Committee may:

1. Review current statutes and case law to determine current status of who may make termination decisions; which decisions may be made; and under what circumstances;

2. Hold 4 public hearings in Augusta;

3. Hold informational sessions for discussions with:

   A. Probate judges
   B. Probate attorneys
   C. Legal experts in the fields of guardianship, living wills, and termination of medical treatment, hydration or nutrition;

4. Conduct, summarize and analyze the results of a literature search on termination of medical treatment, hydration and nutrition; and

5. Determine and summarize the statutes and case law in selected states.

STAFFING: The Committee shall request staffing assistance from the Legislative Council.

COMPENSATION: The Committee members shall receive reimbursement for travel and other necessary expenses and the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2, for each day's attendance at the Committee meetings.

REPORT: The Committee may produce a written report of findings and recommendations, including any suggested legislation, to be submitted to the full Judiciary Committee no later than December 1, 1989.

#293LHS

STATE OF MAINE

114th LEGISLATURE

LEGISLATIVE COUNCIL

May 26, 1989

Honorable Barry J. Hobbins, Senate Chair
Honorable Patrick E. Paradis, House Chair
Joint Standing Committee on Judiciary
114th Maine Legislature
Augusta, Maine 04333

Dear Senator Hobbins and Representative Paradis:

The Legislative Council considered requests from Committees to carry over legislation to the Second Regular Session at its meeting Wednesday. The Council took the following action on your requests:

LD 232	Denied
LD 627	Approved
LD 671	Approved
LD 881	Approved
LD 1010	Approved
LD 1064	Approved

A complete list of the Council's actions is enclosed for your information. I would be happy to answer any questions you may have about the Council's action.

Sincerely,

John L. Martin, Chair
Legislative Council

STATE OF MAINE

114th LEGISLATURE

LEGISLATIVE COUNCIL

June 19, 1989

Honorable Barry J. Hobbins, Senate Chair
Honorable Patrick E. Paradis, House Chair
Joint Standing Committee on Judiciary
State House
Augusta, Maine 04333

Dear Senator Hobbins and Representative Paradis:

The Legislative Council met last night to review requests from Committees to conduct interim studies and took the following action on your requests:

Right to Die Approved

A complete list of the Council's action on study requests is enclosed.

The Council will allocate funds for each study at its next meeting, which will probably occur the day after the Legislature adjourns. Your original request to the Council included the information we need to make that decision, including the size of the study subcommittee and the number of meetings you are proposing. We will base our decisions on that information unless we hear from you by 5:00 p.m. today.

In the meantime, it would facilitate the process if you would appoint the members of the subcommittee including the designation of chair, and forward this information to Sally Diamond's Office.

Thank you for your cooperations.

Sincerely,

John L. Martin, Chair
Legislative Council

Enclosure
cc: Martha Freeman, Director, Office of Policy and Legal Analysis

APPENDIX C

SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT Concerning Living Wills

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §2921, sub-§4 is amended to read:

4. Life-sustaining procedure. "Life-sustaining procedure" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process ~~and shall not include nutrition and hydration~~. "Life-sustaining procedure" shall not include artificially administered nutrition and hydration unless the individual elects in the declaration to include artificially administered nutrition and hydration in the definition of life-sustaining procedure.

Sec. 2. 22 MRSA §2921, sub-§9 is enacted to read:

9. Artificially administered of nutrition and hydration. "Artificially administered nutrition and hydration" means the provision of nutrients and liquids through the use of tubes or intravenous procedures.

Sec. 3. 22 MRSA §2922, sub-§4 is amended to read:

4. Suggested form. A declaration may, but need not, be in the following form:

DECLARATION

If I should have an incurable or irreversible condition that will cause my death within a short time, and if I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

☐ yes ☐ no I elect to have the term "life-sustaining procedure" include artificially administered nutrition and hydration.

I understand that if I do not make the election to include artificially administered nutrition and hydration, the law does not include artificially administered nutrition and hydration in the definition of "life-sustaining procedure" which may be withheld or withdrawn according to this declaration.

Signed this _____ day of _____.
date month year

Signature

City, County and

State of Residence _____
city county state

The declarant is known to me and voluntarily signed this document in my presence.

Witness _____ Address _____

Witness _____ Address _____

STATEMENT OF FACT

This bill is a recommendation of the Subcommittee of the Judiciary Committee studying the Termination of Medical Care.

This bill amends the current living wills statute with regard to the artificial administration of nutrition and hydration. The current law allows competent persons to execute a document directing the attending physician to withhold or withdraw life-sustaining procedures should the patient be in a terminal condition and not be competent to make treatment decisions at that time. The definition of "life-sustaining treatment" does not currently include the artificial administration of nutrition and hydration.

This bill amends the definition of "life-sustaining procedure" to allow persons to specifically provide in their living wills that artificially administered nutrition and hydration should be withheld or withdrawn if they are in a terminal condition and the other terms of the living will apply. This change will not preclude a person who has executed a living will but who is still competent (so the living will is not effective) to direct the withholding or withdrawal of artificially administered nutrition and hydration.

"Artificially administered nutrition and hydration" is intended to include all tube and intravenous methods of providing nutrients and liquids. The focus is on the inability of the person to receive nourishment through spoon feedings or any other method considered by most people as "ordinary." Any method which, under standard circumstances, requires the actions of a physician or other licensed health care professional to initiate or maintain (such as inserting a nasogastric tube) is not "ordinary" and should be considered a method of artificial administration of nutrition and hydration.

This bill is not intended to affect the provision of care necessary for the patient's comfort or freedom from pain.

APPENDIX D

MAINE REVISED STATUTES ANNOTATED
Title 22
Chapter 710-A

LIVING WILLS

§2921. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Attending physician.** "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.

2. **Declaration.** "Declaration" means a document executed in accordance with the requirements of section 2922.

3. **Health care provider.** "Health care provider" means a person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

4. **Life-sustaining procedure.** "Life-sustaining procedure" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process and shall not include nutrition and hydration.

5. **Person.** "Person" means an individual, corporation, business trust, estate, trust, partnership, association, government, government subdivision or agency or any other legal entity.

6. **Physician.** "Physician" means an individual licensed to practice medicine in this State.

7. **Qualified patient.** "Qualified patient" means a patient who has executed a declaration in accordance with this chapter.

8. **Terminal condition.** "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a short time.

§2922. Declaration relating to use of life-sustaining procedures

1. Declaration; execution. A competent individual 18 years of age or older may execute a declaration at any time directing that life-sustaining procedures be withheld or withdrawn. The declaration must be signed by the declarant, or another at the declarant's direction, in the presence of 2 subscribing witnesses.

2. Incorporation in medical record. A physician or other health care provider who is provided a copy of the declaration shall make it a part of the declarant's medical record.

3. Operative effect. A declaration has operative effect only when:

A. The declaration is communicated to the attending physician;

B. The declarant is determined by the attending physician to be in a terminal condition; and

C. The declarant is unable to make treatment decisions.

4. Suggested form. A declaration may, but need not, be in the following form:

DECLARATION

If I should have an incurable or irreversible condition that will cause my death within a short time, and if I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

Signed this _____day of _____.
date month year

Signature

City, County and

State of Residence _____
city county state

The declarant is known to me and voluntarily signed this document in my presence.

Witness _____Address _____

Witness _____Address _____

§2923. Revocation of declaration

1. Revocation; communication. A declaration may be revoked at any time and in any manner by which the declarant is able to communicate an intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending physician or any health care provider upon communication to the physician by the declarant or by another who witnessed the communication of the intent to revoke.

2. Revocation part of medical record. The attending physician or health care provider shall make the revocation a part of the declarant's medical record.

§2924. Recording determination of terminal condition and contents of declaration

Upon determining that the declarant is in a terminal condition, the attending physician who has been notified of the existence and contents of a declaration shall record the determination and the substance of the declaration in the declarant's medical record.

§2925. Treatment of qualified patients

1. Decisions regarding use of life-sustaining procedures. A qualified patient has the right to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so. If a qualified patient is not able to make those decisions, the declaration shall govern decisions regarding use of life-sustaining procedures.

2. Comfort care; alleviation of pain. This chapter does not prohibit any action considered necessary by the attending physician to provide for comfort care or the alleviation of pain.

§2926. Transfer of patients

An attending physician or health care provider who is unwilling to comply with this chapter shall take all reasonable steps to effect the transfer of the declarant to another physician or health care provider in order to comply with this chapter.

§2927. Immunities

1. Actions in the absence of actual notice of revocation of declaration. In the absence of actual notice of the revocation of a declaration, the following, while acting in accordance with the requirements of this chapter, are not subject to civil or criminal liability or charges of unprofessional conduct:

A. A physician who causes the withholding or withdrawal of life-sustaining procedures from a qualified patient; and

B. A person who participates in the withholding or withdrawal of life-sustaining procedures under the direction or with the authorization of a physician.

§2928. Penalties

1. Willful failure to transfer. A physician or health care provider who willfully fails to transfer in accordance with section 2926 is guilty of a Class E crime.

2. Failure to record determination of terminal condition. A physician who willfully fails to record the determination of a terminal condition in accordance with section 2924 is guilty of a Class E crime.

3. Concealing, canceling, defacing or obliterating declaration. Any person who willfully conceals, cancels, defaces or obliterates the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another is guilty of a Class E crime.

4. Falsification or forgery of declaration. Any person who falsifies or forges the declaration of another or willfully conceals or withholds personal knowledge of a revocation as provided in section 2923, with the intent to cause a withholding or withdrawal of life-sustaining procedures, is guilty of a Class B crime.

§2929. General provisions

1. Death not suicide or homicide. Death resulting from the withholding or withdrawal of life-sustaining procedures pursuant to a declaration and in accordance with this chapter does not, for any purpose, constitute a suicide or homicide.

2. Declaration not to affect insurance. The making of a declaration pursuant to section 2922 does not affect in any manner the sale, procurement or issuance of any policy of life insurance, nor is it deemed to modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

3. Requirement of declaration as condition for insurance or health care services. A person may not prohibit or require the execution of a declaration by any individual as a condition for being insured for or receiving health-care services.

4. Presumption concerning life-sustaining procedure. This chapter creates no presumption concerning the intention of an individual who has not executed or who has revoked a declaration with respect to the use, withholding or withdrawal of life-sustaining procedures in the event of a terminal condition.

5. Patient's right concerning withholding or withdrawal of medical care. Nothing in this chapter may be interpreted to increase or decrease the right of a patient to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so, or to impair or supersede any right or responsibility that any person has to effect the withholding or withdrawal of medical care in any lawful manner. In that respect, the provisions of this chapter are cumulative.

6. Mercy killing, euthanasia or suicide. This chapter does not condone, authorize or approve mercy killing, euthanasia or suicide.

§2930. Recognition of declarations executed in other states

A declaration executed in another state in compliance with the laws of that state or this State is validly executed for purposes of this chapter.

§2931. Presumption of validity

A physician or health care provider may presume in the absence of actual notice to the contrary that a declaration executed in this State or another state complies with this chapter and is valid.

#257LHS

APPENDIX E

The following statutes may be useful in examining the current law regarding:

1) The potential liability of health care providers and others who participate in actually terminating or withholding available medical treatment, whether or not the action (or nonaction) is in accordance with the patient's wishes (17-A MRSA §§31, 35, 109, 201, 203, 207, 208, 555; 32 MRSA §§2105-A, 3282-A);

2) Liability for attempting or aiding suicide (17-A MRSA §§106, 201, 204); and

3) The appointment and duties of guardians and the possible scope of powers of attorney (18-A MRSA §§5-304, 5-307, 5-310, 5-311, 5-312, 5-501).

§31. Voluntary conduct

1. A person commits a crime only if he engages in voluntary conduct. Voluntary conduct includes an act or a voluntary omission.

2. An omission is voluntary only if the actor fails to perform an act of which he is physically capable and which he has a legal duty and an opportunity to perform.

3. Possession is voluntary conduct only if the possessor knowingly procured or received the thing possessed or was aware of his control thereof for a sufficient period to have been able to terminate his possession.

§35. Definitions of culpable states of mind

1. "Intentionally."

A. A person acts intentionally with respect to a result of his conduct when it is his conscious object to cause such a result.

B. A person acts intentionally with respect to attendant circumstances when he is aware of the existence of such circumstances or believes that they exist.

2. "Knowingly."

A. A person acts knowingly with respect to a result of his conduct when he is aware that it is practically certain that his conduct will cause such a result.

B. A person acts knowingly with respect to attendant circumstances when he is aware that such circumstances exist.

3. "Recklessly."

A. A person acts recklessly with respect to a result of his conduct when he consciously disregards a risk that his conduct will cause such a result.

B. A person acts recklessly with respect to attendant circumstances when he consciously disregards a risk that such circumstances exist.

C. For purposes of this subsection, the disregard of the risk, when viewed in light of the nature and purpose of the person's conduct and the circumstances known to him, must involve a gross deviation from the standard of conduct that a reasonable and prudent person would observe in the same situation.

4. "Criminal negligence."

A. A person acts with criminal negligence with respect to a result of his conduct when he fails to be aware of a risk that his conduct will cause such a result.

B. A person acts with criminal negligence with respect to attendant circumstances when he fails to be aware of a risk that such circumstances exist.

C. For purposes of this subsection, the failure to be aware of the risk, when viewed in light of the nature and purpose of the person's conduct and the circumstances known to him, must involve a gross deviation from the standard of conduct that a reasonable and prudent person would observe in the same situation.

5. "Culpable." A person acts culpably when he acts with the intention, knowledge, recklessness or criminal negligence as is required.

§106. Physical force by persons with special responsibilities

1. A parent, foster parent, guardian or other similar person responsible for the long term general care and welfare of a person is justified in using a reasonable degree of force against such person when and to the extent that he reasonably believes it necessary to prevent or punish such person's misconduct. A person to whom such parent, foster parent, guardian or other responsible person has expressly delegated permission to so prevent or punish misconduct is similarly justified in using a reasonable degree of force.

2. A teacher or other person entrusted with the care or supervision of a person for special and limited purposes is justified in using a reasonable degree of force against any such person who creates a disturbance when and to the extent that he reasonably believes it necessary to control the disturbing behavior or to remove a person from the scene of such disturbance.

3. A person responsible for the general care and supervision of a mentally incompetent person is justified in using a reasonable degree of force against such person who creates a disturbance when and to the extent that he reasonably believes it necessary to control the disturbing behavior or to remove such person from the scene of such disturbance.

4. The justification extended in subsections 1, 2 and 3 does not apply to the purposeful or reckless use of force that creates a substantial risk of death, serious bodily injury, or extraordinary pain.

5. A person required by law to enforce rules and regulations, or to maintain decorum or safety, in a vessel, aircraft, vehicle, train or other carrier, or in a place where others are assembled, may use nondeadly force when and to the extent that he reasonably believes it necessary for such purposes.

6. A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious bodily injury upon himself may use a degree of force on such person as he reasonably believes to be necessary to thwart such a result.

7. A licensed physician, or a person acting under his direction, may use force for the purpose of administering a recognized form of treatment which he reasonably believes will tend to safeguard the physical or mental health of the patient, provided such treatment is administered:

A. With consent of the patient or, if the patient is a minor or incompetent person, with the consent of the person entrusted with his care and supervision; or

B. In an emergency relating to health when the physician reasonably believes that no one competent to consent can be consulted and that a reasonable person concerned for the welfare of the patient would consent.

8. A person identified in this section for purposes of specifying the rule of justification herein provided, is not precluded from using force declared to be justifiable by another section of this chapter.

§109. Consent

1. It is a defense that, when a defendant engages in conduct which would otherwise constitute a crime against the person or property of another, such other consented to the conduct and an element of the crime is negated as a result of such consent.

2. When conduct is a crime because it causes or threatens bodily injury, consent to such conduct or to the infliction of such injury is a defense only if:

A. Neither the injury inflicted nor the injury threatened was such as to endanger life or to cause serious bodily injury;

B. The conduct and the injury are reasonably foreseeable hazards of joint participation in a lawful athletic contest or competitive sport; or

C. The conduct and the injury are reasonably foreseeable hazards of an occupation or profession or of medical or scientific experimentation conducted by recognized methods, and the persons subjected to such conduct or injury have been made aware of the risks involved prior to giving consent.

3. Consent is not a defense within the meaning of this section if:

A. It is given by a person who is declared by a statute or by a judicial decision to be legally incompetent to authorize the conduct charged to constitute the crime, and such incompetence is manifest or known to the actor;

B. It is given by a person who, by reason of intoxication, mental illness or defect, or youth, is manifestly unable, or known by the defendant to be unable, to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the crime; or

C. It is induced by force, duress or deception.

§201. Murder

1. A person is guilty of murder if:

A. He intentionally or knowingly causes the death of another human being;

B. He engages in conduct which manifests a depraved indifference to the value of human life and which in fact causes the death of another human being; or

C. He intentionally or knowingly causes another human being to commit suicide by the use of force, duress or deception.

1-A. For purposes of subsection 1, paragraph B, when the crime of depraved indifference murder is charged, the crime of criminally negligent manslaughter shall be deemed to be charged.

2. The sentence for murder shall be as authorized in chapter 51.

3. It is an affirmative defense to a prosecution under subsection 1, paragraph A, that the actor causes the death while under the influence of extreme anger or extreme fear brought about by adequate provocation.

4. For purposes of subsection 3, provocation is adequate if:

A. It is not induced by the actor; and

B. It is reasonable for the actor to react to the provocation with extreme anger or extreme fear, provided that evidence demonstrating only that the actor has a tendency towards extreme anger or extreme fear shall not be sufficient, in and of itself, to establish the reasonableness of his reaction.

5. Nothing contained in subsection 3 may constitute a defense to a prosecution for, or preclude conviction of, manslaughter or any other crime.

§203. Manslaughter

1. A person is guilty of manslaughter if that person:

A. Recklessly, or with criminal negligence, causes the death of another human being;

B. Intentionally or knowingly causes the death of another human being under circumstances which do not constitute murder because the person causes the death while under the influence of extreme anger or extreme fear brought about by adequate provocation. Adequate provocation has the same meaning as in section 201, subsection 4. The fact that the person causes the death while under the influence of extreme anger or extreme fear brought about by adequate provocation constitutes a mitigating circumstance reducing murder to manslaughter and need not be proved in any prosecution initiated under this subsection; or

C. Has direct and personal management or control of any employment, place of employment or other employee, and intentionally or knowingly violates any occupational safety or health standard of this State or the Federal Government, and that violation in fact causes the death of an employee and that death is a reasonably foreseeable consequence of the violation.

2.

3. Manslaughter is a Class A crime except that:

A. Manslaughter is a Class B crime if it occurs as a result of the reckless or criminally negligent operation of a motor vehicle; and

B. Violation of subsection 1, paragraph C is a Class C crime.

3-A. Aggravated punishment category for vehicular manslaughter. Notwithstanding subsection 3, if the State pleads and proves that at the time the vehicular manslaughter occurred the actor was in fact attempting to elude a law enforcement officer in violation of Title 29, section 2501-A, subsection 3, the sentencing class for the vehicular manslaughter is Class A.

§204. Aiding or soliciting suicide

1. A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide.

2. Aiding or soliciting suicide is a Class D crime.

§207. Assault

1. A person is guilty of assault if he intentionally, knowingly, or recklessly causes bodily injury or offensive physical contact to another.

2. Assault is a Class D crime, except in instances of bodily injury to another who has not attained his 6th birthday, provided that the actor has attained his 18th birthday, in which case, it is a Class C crime.

§208. Aggravated assault

1. A person is guilty of aggravated assault if he intentionally, knowingly, or recklessly causes:

A. Serious bodily injury to another; or

B. Bodily injury to another with use of a dangerous weapon; or

C. Bodily injury to another under circumstances manifesting extreme indifference to the value of human life. Such circumstances include, but are not limited to, the number, location or nature of the injuries, the manner or method inflicted, or the observable physical condition of the victim.

2. Aggravated assault is a Class B crime.

§555. Endangering welfare of an incompetent person

1. A person is guilty of endangering the welfare of an incompetent person if he knowingly endangers the health, safety or mental welfare of a person who is unable to care for himself because of advanced age, physical or mental disease, disorder or defect.

2. As used in this section "endangers" includes a failure to act only when the defendant had a legal duty to protect the health, safety or mental welfare of the incompetent person.

3. Endangering the welfare of an incompetent person is a Class D crime.

§2105-A. Disciplinary actions

1. Disciplinary proceedings and sanctions.

1-A. Disciplinary proceedings and sanctions The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or of any rules adopted by the board. Investigation may include a hearing before the board to determine whether grounds exist for suspension, revocation or denial of a license, or as otherwise deemed necessary to the fulfillment of its responsibilities under this chapter. The board may subpoena witnesses, records and documents, including records and documents maintained by a health care facility, in any investigation or hearing it conducts.

The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but in no event later than within 60 days of receipt of this information. The licensee shall respond within 30 days. If the licensee's response to the complaint satisfies the board that the complaint does not merit further investigation or action, the matter may be dismissed, with notice of the dismissal to the complainant, if any.

If, in the opinion of the board, the factual basis of the complaint is or may be true, and it is of sufficient gravity to warrant further action, the board may request an informal conference with the licensee. The board shall provide the licensee with adequate notice of the conference and of the issues to be discussed. The conference shall be conducted in executive session of the board, unless otherwise requested by the licensee. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent.

If the board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take any of the following actions it deems appropriate:

A. Warn, censure or reprimand;

B. With the consent of the licensee, enter into a consent agreement which fixes the period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the licensee. A consent agreement may be used to terminate a complaint investigation, if entered into by the board, the licensee and the Attorney General's office;

C. In consideration for acceptance of a voluntary surrender of the license, negotiate stipulations, including terms and conditions for reinstatement, which ensure protection of the public health and safety and which serve to rehabilitate or educate the licensee. These stipulations shall be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office;

D. If the board concludes that modification or nonrenewal of the license might be in order, hold an adjudicatory hearing in accordance with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV; or

E. If the board concludes that suspension or revocation of the license is in order, file a complaint in the Administrative Court in accordance with Title 4, chapter 25.

2. Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5, section 10004. The following shall be grounds for an action to refuse to issue, modify, suspend, revoke or refuse to renew the license of a person licensed under this chapter:

A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued;

B. Habitual intemperance in the use of alcohol or the habitual use of narcotic or hypnotic or other substances the use of which has resulted or may result in the licensee performing his duties in a manner which endangers the health or safety of his patients;

C. A professional diagnosis of a mental or physical condition which has resulted or may result in the licensee performing his duties in a manner which endangers the health or safety of his patients;

D. Aiding or abetting the practice of nursing by a person not duly licensed under this chapter and who represents himself to be so;

E. Incompetence in the practice for which he is licensed. A licensee shall be deemed incompetent in the practice if the licensee has:

(1) Engaged in conduct which evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or

(2) Engaged in conduct which evidences a lack of knowledge, or inability to apply principles or skills to carry out the practice for which he is licensed;

F. Unprofessional conduct. A licensee shall be deemed to have engaged in unprofessional conduct if he violates any standard of professional behavior which has been established in the practice for which the licensee is licensed;

G. Subject to the limitations of Title 5, chapter 341, conviction of a crime which involves dishonesty or false statement or which relates directly to the practice for which the licensee is licensed, or conviction of any crime for which incarceration for one year or more may be imposed;

H. Any violation of this chapter or any rule adopted by the board; or

I. Engaging in false, misleading or deceptive advertising.

3. Confidentiality of information. Any reports, information or records provided to the board by a health care facility pursuant to this chapter shall be confidential insofar as the reports, information or records identify or permit identification of any patient, provided that the board may disclose any confidential information:

A. In an adjudicatory hearing or informal conference before the board or in any subsequent formal proceeding to which the information is relevant; and

B. In a consent agreement or other written settlement, when the information constitutes or pertains to the basis of board action.

A copy of any report, information or record received by the board under this subsection shall be provided to the licensee.

§3282-A. Disciplinary actions

1. Disciplinary proceedings and sanctions. The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or of any rules adopted by the board.

The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but in no event later than within 60 days of receipt of this information. The licensee shall respond within 30 days. If the licensee's response to the complaint satisfies the board that the complaint does not merit further investigation or action, the matter may be dismissed, with notice of the dismissal to the complainant, if any.

If, in the opinion of the board, the factual basis of the complaint is or may be true, and it is of sufficient gravity to warrant further action, the board may request an informal conference with the licensee. The board shall provide the licensee with adequate notice of the conference and of the issues to be discussed. The conference shall be conducted in executive session of the board, unless otherwise requested by the licensee. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent.

If the board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take any of the following actions it deems appropriate:

A. With the consent of the licensee, enter into a consent agreement which fixes the period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the licensee. A consent agreement may be used to terminate a complaint investigation, if entered into by the board, the licensee and the Attorney General's office;

B. In consideration for acceptance of a voluntary surrender of the license, negotiate stipulations, including terms and conditions for reinstatement, which ensure protection of the public health and safety and which serve to rehabilitate or educate the licensee. These stipulations shall be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office;

C. If the board concludes that modification or nonrenewal of the license might be in order, the board shall hold an adjudicatory hearing in accordance with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV; or

D. If the board concludes that suspension or revocation of the license is in order, the board shall file a complaint in the Administrative Court in accordance with Title 4, chapter 25.

2. Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5, section 10004. The following shall be grounds for an action to refuse to issue, modify, suspend, revoke or refuse to renew the license of a person licensed under this chapter:

A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued;

B. Habitual intemperance in the use of alcohol or the habitual use of narcotic or hypnotic or other substances the use of which has resulted or may result in the licensee performing his duties in a manner which endangers the health or safety of his patients;

C. A professional diagnosis of a mental or physical condition which has resulted or may result in the licensee performing his duties in a manner which endangers the health or safety of his patients;

D. Aiding or abetting the practice of medicine by a person not duly licensed under this chapter and who represents himself to be so;

E. Incompetence in the practice for which he is licensed. A licensee shall be deemed incompetent in the practice if the licensee has:

(1) Engaged in conduct which evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or

(2) Engaged in conduct which evidences a lack of knowledge, or inability to apply principles or skills to carry out the practice for which he is licensed;

F. Unprofessional conduct. A licensee shall be deemed to have engaged in unprofessional conduct if he violates any standard of professional behavior which has been established in the practice for which the licensee is licensed;

G. Subject to the limitations of Title 5, chapter 341, conviction of a crime which involves dishonesty or false statement or which relates directly to the practice for which the licensee is licensed, or conviction of any crime for which incarceration for one year or more may be imposed;

H. Any violation of this chapter or any rule adopted by the board;

I. Engaging in false, misleading or deceptive advertising;

J. Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;

K. Failure to report to the secretary of the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee; or

L. Failure to comply with the requirements of Title 24, section 2905-A.

MAINE REVISED STATUTES ANNOTATED
Title 18-A
(PROBATE CODE)

ARTICLE V
PROTECTION OF PERSONS UNDER
DISABILITY AND THEIR
PROPERTY

PART 3
GUARDIANS OF INCAPACITATED PERSONS

§5-304. Findings; order of appointment

(a) The court shall exercise the authority conferred in Parts 3 and 6 so as to encourage the development of maximum self reliance and independence of the incapacitated person and make appointive and other orders only to the extent necessitated by the incapacitated person's actual mental and adaptive limitations or other conditions warranting the procedure.

(b) The court may appoint a guardian as requested if it is satisfied that the person for whom a guardian is sought is incapacitated, that the appointment is necessary or desirable as a means of providing continuing care and supervision of the person of the incapacitated person and, if the allegedly incapacitated person has not attended the hearing, that an inquiry has been made as to whether he wished to attend the hearing. Alternatively, the court may dismiss the proceeding or enter any other appropriate order.

(c) In its order, the court may make separate findings of fact and conclusions of law. If a party requests separate findings and conclusions, within 5 days of notice of the decision, the court shall make them.

§5-307. Removal or resignation of guardian; termination of incapacity

(a) On petition of the ward or any person interested in his welfare, the court may remove a guardian and appoint a successor if in the best interests of the ward. On petition of the guardian, the court may accept his resignation and make any other order which may be appropriate.

(b) The ward or any person interested in his welfare may petition for an order that he is no longer incapacitated, and for removal or resignation of the guardian. A request for this order may be made by informal letter to the court or judge and any person who knowingly interferes with transmission of this kind of request to the court or judge may be adjudged guilty of contempt of court.

(c) Before removing a guardian, accepting the resignation of a guardian, or ordering that a ward's incapacity has terminated, the court, following the same procedures to safeguard the rights of the ward as apply to a petition for appointment of a guardian, may send a visitor to the residence of the present guardian and to the place where the ward resides or is detained, to observe conditions and report in writing to the court.

§5-310. Temporary guardians

If an incapacitated person has no guardian and an emergency exists, the court may exercise the power of a guardian or may appoint a temporary guardian pending notice and hearing. If an appointed guardian is not effectively performing his duties and the court further finds that the welfare of the incapacitated person requires immediate action, it may, with or without notice, appoint a temporary guardian for the incapacitated person for a specified period not to exceed 6 months. A temporary guardian is entitled to the care and custody of the ward and the authority of any permanent guardian previously appointed by the court is suspended so long as a temporary guardian has authority. A temporary guardian shall not seek the involuntary hospitalization of his ward in any institution outside this State. A temporary guardian may be removed at any time. A temporary guardian shall make any report the court requires. In other respects the provisions of this code concerning guardians apply to temporary guardians.

A petition for temporary guardianship may be brought before any judge if the judge of the county in which venue properly lies is unavailable. If a judge, other than the judge of the county in which venue properly lies, acts on a petition for temporary guardianship, he shall issue a written order and shall endorse upon it the date and time of the order. He shall then forthwith transmit or cause to be transmitted that order to the register of the county in which venue properly lies. Any order issued by a judge of a county, other than the county in which venue properly lies, shall be deemed to have been entered in the docket on the date and at the time endorsed upon it.

§5-311. Who may be guardian; priorities

(a) Any competent person or a suitable institution may be appointed guardian of an incapacitated person, except as provided in subsection (c).

(b) Subject to a determination by the court of the best interests of the incapacitated person, persons who are not disqualified have priority for appointment as guardian in the following order:

(1) The person or institution nominated in writing by the incapacitated person;

(2) The spouse of the incapacitated person;

(3) An adult child of the incapacitated person;

(4) A parent of the incapacitated person, including a person nominated by will or other writing signed by a deceased parent;

(5) Any relative of the incapacitated person with whom he resided for more than 6 months prior to the filing of the petition;

(6) A person nominated by the person who is caring for him or paying benefits to him.

(c) No owner, proprietor, administrator, employee or other person with a substantial financial interest in a facility or institution which is licensed under Title 22, sections 1817 and 7801, may act as guardian of an incapacitated person who is a resident, as defined in Title 22, section 7901-A.

§5-312. General powers and duties of guardian

(a) A guardian of an incapacitated person has the same powers, rights and duties respecting his ward that a parent has respecting his unemancipated minor child, except that a guardian is not legally obligated to provide from his own funds for the ward and is not liable to 3rd persons for acts of the ward solely by reason of the parental relationship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court:

(1) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, he is entitled to custody of the person of his ward and may establish the ward's place of abode within or without this State, and may place the ward in any hospital or other institution for care in the same manner as otherwise provided by law.

(2) If entitled to custody of his ward he shall make provision for the care, comfort and maintenance of his ward and, whenever appropriate, arrange for his training and education. Without regard to custodial rights of the ward's person, he shall take reasonable care of his ward's clothing, furniture, vehicles and other personal effects and commence protective proceedings if other property of his ward is in need of protection.

(3) A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service.

(4) If no conservator for the estate of the ward has been appointed, he may:

> **(i)** Institute proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform his duty;
>
> **(ii)** Receive money and tangible property deliverable to the ward and apply the money and property for support, care and education of the ward; but, he may not use funds from his ward's estate for room and board which he, his spouse, parent, or child have furnished the ward unless a charge for the service is approved by order of the court made upon notice to at least one of the next of kin of the ward, if notice is possible. He must exercise care to conserve any excess for the ward's needs.

(5) A guardian is required to report the condition of his ward and of the estate which has been subject to his possession or control, as specified by the court at the time of the initial order or at the time of a subsequent order or as provided by court rule.

The court on its own motion, or on the petition of any interested person, may appoint a visitor to review the guardian's report and determine if appropriate provisions for the care, comfort and maintenance of his ward and for the care and protection of his ward's property have been made. The visitor shall report his findings to the court in writing.

(6) If a conservator has been appointed, all of the ward's estate received by the guardian in excess of those funds expended to meet current expenses for support, care, and education of the ward must be paid to the conservator for management as provided in this code, and the guardian must account to the conservator for funds expended.

(b) Any guardian of one for whom a conservator also has been appointed shall control the custody and care of the ward, and is entitled to receive reasonable sums for his services and for room and board furnished to the ward as agreed upon between him and the conservator, provided the amounts agreed upon are reasonable under the circumstances. The guardian may request the conservator to expend the ward's estate by payment to 3rd persons or institutions for the ward's care and maintenance.

MAINE REVISED STATUTES ANNOTATED
Title 18-A
(PROBATE CODE)

ARTICLE V
PROTECTION OF PERSONS UNDER DISABILITY AND THEIR PROPERTY

PART 5
POWERS OF ATTORNEY

§5-501. When power of attorney not affected by disability

If a principal designates another as his attorney-in-fact or agent by a power of attorney in writing and the writing contains the words: "This power of attorney shall not be affected by disability of the principal;" "This power of attorney shall become effective upon the disability of the principal;" or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding his disability, the authority of the attorney-in-fact or agent is exercisable by him as provided in the power, on behalf of the principal, notwithstanding later disability or incapacity of the principal at law or later uncertainty as to whether the principal is dead or alive.

The authority of the attorney-in-fact or agent to act on behalf of the principal shall be set forth in the power and may relate to any act, power, duty, right or obligation which the principal has or may acquire relating to the principal or any matter, transaction or property, real or personal, tangible or intangible, including, but not limited to, the power to consent to, withhold consent to or approve on behalf of the principal any medical or other professional care, counsel, treatment or service of or to the principal by a licensed or certified professional person or institution engaged in the practice of, or providing, a healing art. A power of attorney containing authority to consent to medical or other professional care must be notarized.

All acts done by the attorney-in-fact or agent pursuant to the power during any period of disability or incapacity or uncertainty as to whether the principal is dead or alive have the same effect and inure to the benefit of and bind the principal or his heirs, devisees and personal representative as if the principal were alive, competent and not disabled. If a conservator or guardian thereafter is appointed for the principal, the attorney-in-fact or agent, during the continuance of the appointment, shall account to the conservator or guardian rather than the principal. The conservator or guardian has the same power the principal would

have had if he were not disabled or incapacitated to revoke, suspend or terminate all or any part of the power of attorney or agency with the exception of a durable power of attorney to consent to medical or other professional care. The court shall have the power, upon petition of the guardian of an incapacitated person, to decide whether to revoke, suspend or terminate the authority of the attorney-in-fact or agent to consent to medical or other professional care.

APPENDIX F

UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

NATIONAL CONFERENCE OF COMMISSIONERS

ON UNIFORM STATE LAWS

MEETING IN ITS NINETY-EIGHTH YEAR
KAUAI, HAWAII

JULY 28 - AUGUST 4, 1989

UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

UNIFORM RIGHTS OF THE TERMINALLY ILL ACT

Prefatory Note

The Rights of the Terminally Ill Act is designed to provide various means by which an individual's preferences can be carried out with regard to administration of life-sustaining treatment. The Act permits an individual to execute a declaration that directly instructs a physician to withhold or withdraw life-sustaining treatment in the event the individual is in a terminal condition and is unable to participate in medical treatment decisions. In the alternative, the Act permits the individual to execute a declaration designating another individual to make such decisions. Finally, the Act authorizes an attending physician to withhold or withdraw life-sustaining treatment in the absence of a declaration, but only with the consent of a close relative and only if the treatment would not conflict with the known intentions of the individual.

The scope of the Act is narrow. Its impact is limited to treatment that is merely life-prolonging, and to patients whose terminal condition is incurable and irreversible, whose death will soon occur, and who are unable to participate in treatment decisions. Beyond its narrow scope, the Act is not intended to affect any existing rights and responsibilities of persons to make medical treatment decisions. The Act merely provides alternative ways in which a terminally-ill patient's desires regarding the use of life-sustaining procedures can be legally implemented.

The purposes of the Act are (1) to establish a procedure which is simple, effective, and acceptable to persons who may find themselves in a terminal condition and unable to participate in health-care decisions, (2) to provide a statutory framework that is acceptable to physicians and health-care facilities whose conduct will be affected, (3) to provide for the effectiveness of a declaration in states other than the state in which it is executed through uniformity of scope and procedure, and (4) to avoid the inconsistency in approach that has characterized early state statutes in the area.

The Act's basic structure and substance has been drawn from existing legislation in order to avoid further complexity and to permit its effective operation in light of prior enactments. Departures from existing statutes have been made, however, in order to simplify procedures, improve drafting, and clarify language. Selected provisions have been reworked to express more adequately a specific concept (i.e., life-sustaining treatment, terminal condition) or to reflect changes in established procedure (i.e., the qualifications of witnesses). The Act's stylistic and substantive departures from existing legislation were pursued for the purposes of clarity and simplicity.

The 1989 Act reflects changes and additions to the original Rights of the Terminally Ill Act, approved by the Conference in 1985. The principal changes are noted in the comments, but they can also be briefly listed. First, Section 2 has been expanded to permit individuals to designate other persons to make decisions regarding the withholding or withdrawal of life-sustaining treatment. Second, under new Section 7 consent to withholding or withdrawal of treatment may be obtained in the absence of a declaration. With few exceptions, changes in the original Act have been limited to Section 2 and (new) Section 7, so that states that have enacted the earlier version can easily incorporate the new provisions.

UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

SECTION 1. DEFINITIONS. As used in this [Act], unless the context otherwise requires:

(1) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.

(2) "Declaration" means a writing executed in accordance with the requirements of Section 2(a).

(3) "Health-care provider" means a person who is licensed, certified, or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

(4) "Life-sustaining treatment" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying.

(5) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(6) "Physician" means an individual [licensed to practice medicine in this State].

(7) "Qualified patient" means a patient [18] or more years of age who has executed a declaration and who

has been determined by the attending physician to be in a terminal condition.

(8) "State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(9) "Terminal condition" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

COMMENT

The Act's definitions of "life-sustaining treatment" and "terminal condition" are interdependent and must be read together. This has caused drafting problems in many existing acts, and the Act has been drafted to avoid the problems detected in existing legislation.

Most of the "life-sustaining treatment" and "terminal condition" definitions in existing statutes were considered problematical in that they (1) were tautological, defining "terminal condition" with respect to "life-sustaining treatment" and vice versa, and (2) defined terminal condition as requiring "imminent" death "whether or not" or "regardless of" the application of life-sustaining treatment. Strictly speaking, if death is "imminent" even with the full application of life-sustaining treatment, there is little point in having a statute permitting withdrawal of such procedures. The Act's definitions have attempted to avoid these problems.

The "life-sustaining treatment" definition found in many statutes inserts the clause "and when, in the judgment of the attending physician, death will occur whether or not such procedure or intervention is utilized," after the phrase "will serve only to prolong the dying process" found in the Act's provision. Because the Act's life-sustaining treatment definition concerns only those procedures or interventions applied to "qualified patients" (i.e., those who have been determined to be in a terminal condition), and because a terminal condition is defined as "incurable or irreversible" with death resulting "in a relatively short time," the requirement that death be "inevitable" has been satisfied by the presence of "qualified patient" in the life-sustaining treatment definition. Therefore, this additional clause was excluded because it was considered repetitious and possibly confusing.

The Act defines "life-sustaining treatment" in an all-inclusive manner, dealing with those procedures necessary for comfort care or alleviation of pain separately in Section 6(b), where it is provided that such procedures need not be withdrawn or withheld pursuant to a declaration. Most existing statutes incorporate "comfort care" as an exclusion from the definition of life-sustaining treatment. Because many such procedures <u>are</u> life-sustaining, however, the Act avoids definitional confusion by treating them in a separate provision that reflects the Act's policy more clearly, and better reflects the fact that comfort care does not involve a fixed group of procedures applicable in all instances.

Subsection (9) of Section 1 is the "terminal condition" definition. The difficulty of trying to express such a condition in precise, accurate, but not unduly restricting language is obvious. A definition must preserve the physicians' professional discretion in making such determinations. Consequently, the Act's definition of terminal condition incorporates not only selected language from various state acts, but also suggestions from medical literature in the field.

The Act employs the term "terminal condition" rather than terminal illness, and it is important that these two different concepts be distinguished. Terminal illness, as generally understood, is both broader and narrower than terminal condition. Terminal illness connotes a disease process that will lead to death; "terminal condition" is not limited to disease. "Terminal illness" also connotes an inevitable process leading to death, but does not contain limitations as to the time period prior to death, or potential for nonreversibility, as does "terminal condition."

The terminal condition definition requires that the condition be "incurable and irreversible." These adjectives were chosen over the similar phrase, "no possibility of recovery," because of possible ambiguity in the term "recovery" (i.e., recovery to "normal" or to some other stage). A number of state statutes now use "incurable" and/or "irreversible," and the terms appear to comport with the criteria applied by physicians in terminal care situations. The phrase "incurable <u>and</u> irreversible" is to be read conjunctively as long as the circumstances warrant. A condition which is reversible but incurable is <u>not</u> a terminal condition.

Subsection (9) also requires that the condition result in the death of the patient within a "relatively short time ... without the administration of life-sustaining treatment." This requirement differs to some degree from the language employed in most of the statutes. First, the decision that death will occur in a relatively short time is to be made without considering the possibilities of extending life with life-sustaining treatment. The alternative is that required by a number of states--that death be imminent whether or not life-sustaining procedures are applied.

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research has noted that such a definition severely limits the group of terminally-ill patients able to qualify under these acts. It is precisely because life can be prolonged indefinitely by new medical technology that these acts have come into existence. Though the Act intends to err on the side of prolonging life, it should not be made wholly ineffective as to the actual situation it purports to address. The provisions which require that death be imminent regardless of the application of life-sustaining procedures appear to have that effect. Therefore, such provisions have been excluded in the Act.

The terminal condition definition of subsection (9) requires that death result "in a relatively short time." Rejecting the "imminency" language employed in a number of statutes, this alternative was chosen because it provides needed flexibility and reflects the balancing character of the time frame judgment. Though the phrase, "relatively short time," does not eliminate the need for judgment, it focuses the physician's medical judgment and avoids the narrowing implications of the word "imminent."

The "relatively short time" formulation is employed to avoid both the unduly constricting meaning of "imminent" and the artificiality of another alternative--fixed time periods, such as six months, one year, or the like. The circumstances and inevitable variations in disorder and diagnosis make unrealistic a fixed time period. Physicians may be hesitant to make predictions under a fixed time period standard unless the standard of physician judgment is so loose as to be unenforceable. Under the Act's standard, considerations such as the strength of the diagnosis, the type of disorder, and the like can be reflected in the judgment that death will result within a relatively short time, as they are now reflected in judgments physicians must and do make.

The life-sustaining treatment and terminal condition definitions exclude certain types of disorders, such as kidney disease requiring dialysis, and diabetes requiring continued use of insulin. This is accomplished in the requirement that terminal conditions be "irreversible," and that life-sustaining procedures serve "only to prolong the dying process." For purposes of the Act, diabetes treatable with insulin is "reversible," a diabetic person so treatable is not in the "dying process," and insulin is a treatment the benefits of which foreclose it serving "only" to prolong the dying process.

SECTION 2. DECLARATION RELATING TO USE OF LIFE-SUSTAINING TREATMENT.

(a) An individual of sound mind and [18] or more years of age may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declarant may designate another individual of sound mind and [18] or more years of age to make decisions governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant, or another at the declarant's direction, and witnessed by two individuals.

(b) A declaration directing a physician to withhold or withdraw life-sustaining treatment may, but need not, be in the following form:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Signed this _____ day of _____, ____.

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____
Address _____

Witness _____
Address _____

(c) A declaration that designates another individual to make decisions to withhold or withdraw life-sustaining treatment may, but need not, be in the following form:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I appoint _____ or, if he or she is not reasonably available or is unwilling to serve, _____, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain, pursuant to the Uniform Rights of the Terminally Ill Act of this State.

[If the individual(s) I have so appointed is not reasonably available or is unwilling to serve, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.] The bracketed language should be stricken if not desired by a declarant.

Signed this _____ day of _____, ____.

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____
Address _____

Witness _____
Address _____

Name and address of designees.

Name _____

Address _____

(d) The designation of (i) a judicially appointed [guardian] or (ii) an attorney-in-fact [pursuant to the Uniform Durable Power of Attorney Act or the Model Health-Care Consent Act], who is authorized to make decisions regarding the withholding or withdrawal of life-sustaining treatment, constitutes for purposes of this [Act] a declaration designating another under Section 2(a).

(e) A physician or other health-care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, promptly so advise the declarant and the designee, if any.

COMMENT

Section 2 sets out the minimal requirements regarding the making and execution of a valid declaration. "Sample" declaration forms are offered in this section. The forms are not mandatory, as some acts require; they "may, but need not, be" followed. The forms provided also are not as elaborate as others. The drafters rejected more detailed declarations for two reasons. First, the forms are to serve only as examples of a valid declaration. More elaborate forms may have erroneously implied that a declaration more simply constructed would not be legally sufficient. Second, the sample forms' simple structure and specific language attempt to provide notice of exactly what is to be effectuated through these documents to those persons desiring to execute a declaration and the physicians who are to honor it.

Sections 2(a) and (c) of the Act authorize an individual by a declaration to designate another person to make decisions governing the withholding or withdrawal of life-sustaining care. The designated person must be an adult of sound mind, but no other restrictions are placed on the designation other than the requirements of form contained in Section 2(b). The designated person may be an attorney-in-fact who is so designated in the declaration or in another writing that conforms with the applicable requirements of each state for durable powers of attorney.

Section 2(c) provides a model form of declaration by which the designation of another decision-maker may be accomplished. The bracketed language in the Section 2(c) form of declaration is intended to allow a declarant two choices when designating another person to make treatment decisions. First, by striking the bracketed language, an individual may make an exclusive designation of another decision-maker, and if that person is not available to fulfill the responsibility, the declaration will have no effect. It is intended, in such an event, that the substituted decisions-makers who are authorized to make treatment decisions in Section 7(3)-(6) will be able to exercise decision-making authority pursuant to the terms of Section 7. The execution of a declaration exclusively designating another person to make treatment decisions, in other words, should not itself be construed as a "known and expressed intention of the individual" not to have life-sustaining treatment withheld or withdrawn under Section 7(c).

The second choice available in the Section 2(c) form of declaration would make the declaration directly effective by its terms in the event that the substituted decision-maker were unavailable. This would be accomplished by not striking the bracketed language.

No limitation is placed in Section 2 on the person(s) who may be designated to make decisions about the withholding or withdrawal of treatment for the declarant. It is specifically anticipated, for example, that some people may choose to appoint their physician to make such decisions and, absent any ethical restrictions on such an appointment, Section 2 anticipates that the physician may act in the appointed capacity.

Persons may be appointed to make decisions for a declarant through a declaration in substantially the form contained in Section 2(c), through appointment of an attorney-in-fact pursuant to a durable power of attorney, or through a judicially appointed guardian. In all cases, the designee has full power to make the relevant decisions called for in the Act, and functions as the agent of the declarant. No specific standards, other than good faith, apply to decisions of the designee. Designation of another to make decisions pursuant to a durable power of attorney or judicially-appointed guardianship is treated as a declaration under the Act, so that, for example, decisions of the designee "govern" treatment decisions by the physician, and a physician who is unwilling to abide by such decisions (if medically reasonable) must transfer the patient to the care of another physician.

Designation by a durable power of attorney or judicially-appointed guardianship must be based on a sufficiently specific reference to health care or terminal care treatment decisions, as required by state law governing such appointments, to trigger application of the Act. No specific formulation of the terms of appointment is required, however. If appointment for purposes of health care decisions would be sufficient under state law to include withholding or withdrawal of treatment for a person in a terminal condition, that will suffice under the Act.

The Act's authorization for specific decisions does not in any way restrict authority that exists under state law. The Act is in this respect additive only. Thus, for example, if an attorney-in-fact would have the authority independent of this Act to authorize withdrawal of treatment for a person in a persistent vegetative state not covered by the terms of the Act, the Act's limitations would not circumscribe the attorney-in-fact's authority under other law.

In designating another person to make treatment decisions, it is assumed that a declarant will identify only a single decisionmaker. In view of this assumption, Sections 2(a) and (c) permit designation of an individual, rather than individuals, as the problems associated with identifying, locating, and communicating with multiple decisionmakers are substantial and the drafters did not want to encourage the practice.

The Act does not expressly prohibit multiple designees, however, and a declaration containing a multiple designation is not invalid under the Act. The absence of any provision permitting a majority of such designees to act in the case of a disagreement, however, means that the refusal of one member of a designee group to consent to withholding or withdrawal of treatment will foreclose any such consent under the Act unless the declaration specifically so provides. Because of the difficulties associated with multiple designees under the Act, declarants should be discouraged from the practice and, if such designations are made and any result other than the one stated above is desired, the declaration should so specify.

The Act's provisions governing witnesses to a declaration are simplified. Section 2 provides only that the declaration be signed by the declarant in the presence of two witnesses. The Act does not require witnesses to meet any specific qualifications for two primary reasons. First, the interest in simplicity mandates as uncomplicated a procedure as possible. It is intended that the Act present a viable alternative for those persons interested in participating in their medical treatment decisions in the event of a terminal condition.

Second, the absence of more elaborate witness requirements relieves physicians of the inappropriate and perhaps impossible burden of determining whether the legalities of the witness requirements have been met. Many physicians understandably and rightly would be hesitant to make such decisions and, therefore, the effectiveness of the declaration might be jeopardized. It should be noted, as well, that protection against abuse in these situations is provided by the criminal penalties in Section 10. The attending physicians and other health-care professionals will be able, in most circumstances, to discuss the declaration with the patient and family and any suspicion of duress or wrongdoing can be discovered and handled by established hospital procedures.

Section 2(e) requires that a physician or health-care provider who is given a copy of the declaration record it in the declarant's medical records. This step is critical to the effectuation of the declaration, and the duty applies regardless of the time of receipt. If a copy of the same declaration is already in the record, its re-recording would not be necessary, but its receipt should be noted as evidence of its continued force. Section 2(e) is not duplicative of Section 5 which requires recording the terms of the declaration (or the document itself, when available, in the event of telephonic communication to the physician by another physician, for example) at the time the physician makes a determination of terminal condition. It was deemed important that knowledge of the declaration and its continued force be specifically noted at this critical juncture.

Section 2(e) imposes a duty on the physician or other health-care provider to inform the declarant of his or her unwillingness to comply with the provisions of the declaration. This will provide notice to the declarant that certain terms may be deemed medically unreasonable (Section 11(f)), or that a different provider who is willing to carry out the Act (Section 8) should be informed of the declaration.

SECTION 3. WHEN DECLARATION OPERATIVE. A declaration becomes operative when (i) it is communicated to the attending physician and (ii) the declarant is determined by the attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and other health-care providers shall act in accordance with its provisions and with the instructions of a designee under Section 2(a) or comply with the transfer provisions of Section 8.

COMMENT

Section 3 establishes the preconditions to the declaration becoming operative. Once operative, Section 3 provides that the attending physician shall act in accordance with the provisions of the declaration or transfer care of the patient under Section 8. This provision is not intended to eliminate the physician's need to evaluate particular requests in terms of reasonable medical practice under Section 11(f), nor to relieve the physician from carrying out the declaration except for any specific unreasonable or unlawful request in the declaration. Transfer of the patient under Section 8 is to occur if the physician, for reasons of conscience, for example, is unwilling to carry out the Act or to follow medically reasonable requests in the declaration.

SECTION 4. REVOCATION OF DECLARATION.

(a) A declaration may be revoked at any time and in any manner by the declarant, without regard to the declarant's mental or physical condition. A revocation is effective upon communication to the attending physician or other health-care provider by the declarant or a witness to the revocation.

(b) The attending physician or other health-care provider shall make the revocation a part of the declarant's medical record.

COMMENT

Section 4 provides for revocation of a declaration and is modeled after North Carolina's similar provision. Virtually every other statute sets out specific examples of how a declaration can be revoked -- by physical destruction, by a signed, dated writing, or by a verbal expression of revocation. A provision that freely allowed revocation and avoided procedural complications was desired. The simple language of Section 4 appears to meet these qualifications. It should be noted that the revocation is, of course, not effective until communicated to the attending physician or another health-care provider working under a physician's guidance, such as nursing facility or hospice staff. The Act, unlike many statutes, also does not explicitly require that a person relaying the revocation be acting on the declarant's behalf. Such a requirement could impose an unreasonable burden on the attending physician. The communication is assumed to be in good faith, and the physician may rely on it.

In employing a general revocation provision, it was intended to permit revocation by the broadest range of means. Therefore, for example, it is intended that a revocation can be effected in writing, orally, by physical defacement or destruction of a declaration, and by physical sign communicating intention to revoke.

SECTION 5. RECORDING DETERMINATION OF TERMINAL CONDITION AND DECLARATION. Upon determining that the declarant is in a terminal condition, the attending physician who knows of a declaration shall record the determination and the terms of the declaration in the declarant's medical record.

COMMENT

Section 5 of the Act requires that an attending physician record the determination that the patient is in a terminal condition in the patient's medical records. The section provides that an attending physician must know of the declaration's existence. It is anticipated that knowledge may in some instances occur through oral communication between physicians. If the attending physician determines that the patient is in a terminal condition, and has been notified of the declaration, the physician is to make the determination of terminal condition, as defined in Section 1(8), part of the patient's medical records. There is no explicit requirement that the physician inform the patient of the terminal condition. That decision is to be left to the physician's professional discretion under existing standards of care. The Act also does not require, as do many statutes, that a physician other than the attending physician concur in the terminal condition determination. It appears to be the established practice of most physicians to request a second opinion or, more often, review by a panel or committee established as a matter of hospital procedure, and the Act is not intended to discourage such a practice. Requiring it, however, would almost inevitably freeze in a single process or set of processes for review in this evolving area of medicine. Because existing policies and regulations typically address the review issue, requiring a specific form of review in the Act was viewed as an unnecessary regulation of normal hospital procedures. Moreover, in smaller or rural health facilities a second qualified physician or review mechanism may not be readily available to confirm the attending physician's determination.

The physician must record the terms of the declaration in the medical record so that its specific language or any special provisions are known at later stages of treatment. It is assumed that "terms" of the declaration will be a copy of the declaration itself in most instances, although cases of an emergency character may arise, for example, in which the contents of a declaration can be reliably conveyed, and where obtaining a copy of the declaration prior to making decisions governed by it will be impracticable. In such cases, the terms of the declaration will suffice for recording purposes under Section 5.

SECTION 6. TREATMENT OF QUALIFIED PATIENTS.

(a) A qualified patient may make decisions regarding life-sustaining treatment as long as the patient is able to do so.

(b) This [Act] 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.

(c) The declaration of a qualified patient known to the attending physician to be pregnant must not be given effect as long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

COMMENT

Section 6(a) recognizes the right of patients who have made a declaration and are determined to be in a terminal condition to make decisions regarding use of life-sustaining procedures. Until unable to do so, such patients have the right to make such decisions independently of the terms of the declaration. In affording patients a "right to make decisions regarding use of life-sustaining procedures," the Act is intended to reflect existing law pertaining to this issue. As Sections 11(e) and (f) indicate, qualifications on a patient's right to force the carrying out of those decisions in a manner contrary to law or accepted standards of medical practice, for example, are not intended to be overridden.

In Section 6(b) the Act uses the term "comfort care" in defining procedures that may be applied notwithstanding a declaration instructing withdrawal or withholding of life-sustaining treatment. The purpose for permitting continuation of life-sustaining treatment deemed necessary for comfort care or alleviation of pain is to allow the physician to take appropriate steps to insure comfort and freedom from pain, as dictated by reasonable medical standards. Many existing statutes employ the term "comfort care" in connection with the alleviation of pain, and the Act follows this example. Although the phrase "to alleviate pain" arguably is subsumed within the term comform care, the additional specificity was considered helpful for both the doctor and layperson.

Section 6(b) does not set out a separate rule governing the provision of nutrition and hydration. Instead, each is subject to the same considerations of necessity for comfort care and alleviation of pain as are all other forms of life-sustaining treatment. If nutrition and hydration are not necessary for comfort care or alleviation of pain, they may be withdrawn. This approach was deemed preferable to the approach in a few existing statutes, which treat nutrition and hydration as comfort care in all cases, regardless of circumstances, and exclude comfort care from the life-sustaining treatment definition.

It is debatable whether physicians or other professionals perceive the providing of nourishment through intravenous feeding apparatus or nasogastric tubes as comfort care in all cases or whether such procedures at times merely prolong the dying process. Whether procedures to provide nourishment should be considered life-sustaining treatment or comfort care appears to depend on the factual circumstances of each case and, therefore, such decisions should be left to the physician, exercising reasonable medical judgment. Declarants may, however, specifically express their views regarding continuation or noncontinuation of such procedures in the declaration, and those views will control.

Section 6(c) addresses the problem of a qualified patient who is pregnant. The states which address this issue typically require that the declaration be given no force or effect during the pregnancy. Because this requirement inadvertantly may do more harm than good to the fetus, Section 6(c) provides a more suitable, if more complicated, standard. It is possible to hypothesize a situation in which life-sustaining treatment, such as medication, may prove fatal to a fetus which is at or near the point of viability outside the womb. In such cases, the Act's provision would permit the life-sustaining treatment to be withdrawn or withheld as appropriate in order best to assure survival of the fetus. Also, for example, if the qualified patient is only a few weeks pregnant and the physician, pursuant to reasonable medical judgment, determines that it is not probable that the fetus could develop to a point of viability outside the womb even with application of life-sustaining treatment, such treatment may also be withheld or withdrawn. Thus, the pregnancy provision attempts to honor the terminally-ill patient's right to refuse life-sustaining treatment without jeopardizing in any respect the likelihood of life for the fetus.

In the original Rights of the Terminally Ill Act, adopted by the Conference in 1985, Section 6(c) included the introductory phrase "Unless the declaration otherwise provides." In the current Act the phrase has been eliminated from Section 6(c) in order to conform with a similar provision in Section 7. Under the current provision, life-sustaining treatment may not be withdrawn from a woman known to be pregnant if it is probable that the fetus will develop to live birth with continuation of the treatment, notwithstanding expressed views of the patient to the contrary. In view of the requirement that development to birth be probable, and the frequently complicating impact of prolonged life-sustaining treatment for a terminal patient, the provision is likely to have an impact in relatively narrow circumstances.

Nevertheless, in states that wish to accommodate the declaration of a pregnant woman, the wording from the prior version of the Act may be used. Differences from the Uniform Act in this specific application would not undermine the interest in uniformity served by the Act.

SECTION 7. CONSENT BY OTHERS TO WITHDRAWAL OR WITHHOLDING OF TREATMENT.

(a) Life-sustaining treatment may be withheld or withdrawn from an individual who:

(i) has been determined by the attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment; and

(ii) has no effective declaration;

if written consent to the withholding or withdrawal of the treatment, witnessed by two individuals, is given to the attending physician. The consent may be given by the following individuals, in order of priority:

(1) The spouse of the individual;

(2) An adult child of the individual or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;

(3) The parents of the individual;

(4) An adult sibling of the individual or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation; or

(5) The nearest other adult relative of the individual by blood or adoption who is reasonably available for consultation.

(b) If any class entitled to act is not reasonably available and competent to serve, or declines to make a decision, the next class is authorized to act, but an equal division in a class does not permit the next class to act.

(c) Decisions to grant or withhold consent must be made in good faith. A consent is not valid if it conflicts with the expressed intention of the individual.

(d) A decision of the attending physician acting in good faith that a consent is valid or invalid is conclusive.

(e) Life-sustaining treatment may not be withheld or withdrawn under this section from an individual known to the attending physician to be pregnant as long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

COMMENT

Section 7 provides a procedure by which an attending physician may obtain consent to the withholding or withdrawal of life-sustaining treatment in the absence of an effective declaration. It draws upon the definitions of the Act, as well as those sections bearing on the process for and the legal effect of withholding or withdrawal of treatment, but in most other respects it is free-standing. It can therefore simply be inserted as a new section in existing statutes that follow the original 1985 Uniform Act. For states that might want to adopt the Section 2 amendments, but not the Section 7 amendments, Section 7 can simply be deleted.

The purpose of Section 7 is to authorize persons other than the patient who are in a close familial relationship to the patient to consent to the withholding or withdrawal of life-sustaining treatment when the patient has no prior declaration, or when a prior declaration is not effective. Prior declarations might not be effective for a variety of reasons, including for example the expiration of a time limit, the failure to have the declaration properly witnessed, or the absence of a condition precedent contained in the declaration, such as the death or disability of a designated decision-maker.

Section 7 authorizes binding consent to the withholding or withdrawal of life-sustaining treatment for qualified patients. Members of the patient's family in designated priority order may consent to withholding or withdrawal of life-sustaining treatment, and such consent will be treated as if the individual had given it. Consent by the designated family members, however, must be given in good faith, and is not valid if it would conflict with the known and expressed intention of the patient.

The consent provision of Section 7 differs from the designation of another to make decisions under Section 2. Because the "consent" does not constitute a declaration under the Act, provisions that impose an obligation on the physician to seek out a designee under a declaration, that make the designee's decisions "govern" treatment, and that require transfer by a physician under Section 8, do not apply. Section 7, in short, is not a full alternative to a declaration, but is rather a means by which the attending physician can obtain legally reliable consent to the withholding or withdrawal of treatment for individuals in a terminal condition, should that be needed in the circumstances. Section 7 neither constitutes a de jure appointment of family to make such decisions in all cases, nor does it limit treatment authority authorized under other law.

SECTION 8. TRANSFER OF PATIENTS. An attending physician or other health-care provider who is unwilling to comply with this [Act] shall as promptly as practicable take all reasonable steps to transfer care of the declarant to another physician or health-care provider.

COMMENT

Section 8 is designed to address situations in which a physician or health-care provider is unwilling to make and record a determination of terminal condition, or to respect the medically reasonable decisions of the patient or designee regarding withholding or withdrawal of life-sustaining procedures, due to personal convictions or policies unrelated to medical judgment called for under the Act. In such instances, the physician or health-care provider must promptly take all reasonable steps to transfer the patient to another physician or health-care provider who will comply with the applicable provisions of the Act.

SECTION 9. IMMUNITIES.

(a) In the absence of knowledge of the revocation of a declaration, a person is not subject to civil or criminal liability, or discipline for unprofessional conduct, for carrying out the declaration or the instructions of a designee under Section 2(a) pursuant to the requirements of this [Act].

(b) A physician or other health-care provider, whose actions under this [Act] are in accord with reasonable medical standards, is not subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to those actions.

(c) A physician or other health-care provider, whose decisions about the validity of consent under Section 7 are made in good faith, is not subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to those decisions.

(d) A designee under Section 2(a) or a person authorized to consent under Section 7, whose decisions are made in good faith pursuant to this [Act], is not subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to those decisions.

COMMENT

Section 9 provides immunities for persons acting pursuant to the declaration and in accordance with the Act. Immunities are extended in Sections 9(a)-(c) to physicians as well as persons operating under the physician's direction or with the physician's authorization, to facilities in which the withholding or withdrawal of life-sustaining procedures occurs, and to designees or persons authorized to consent under Sections 2 or 7. Section 9(b) serves both to immunize physicians from liability as long as reasonable medical judgment is exercised, and to impose "reasonable medical standards" as the criterion that should govern all of the specific medical decisions called for throughout the Act. Section 9(b), in conjunction with Section 11(f), therefore, avoids the need to restate the medical standard in each section of the Act requiring a medical judgment.

SECTION 10. PENALTIES.

(a) A physician or other health-care provider who willfully fails to transfer in accordance with Section 8 is guilty of [a class _____ misdemeanor].

(b) A physician who willfully fails to record the determination of terminal condition in accordance with Section 5 is guilty of [a class _____ misdemeanor].

(c) An individual who willfully conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another is guilty of [a class _____ misdemeanor].

(d) An individual who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 4, is guilty of [a class _____ misdemeanor].

(e) A person who requires or prohibits the execution of a declaration as a condition for being insured for, or receiving, health-care services is guilty of [a class _____ misdemeanor].

(f) A person who coerces or fraudulently induces another to execute a declaration under this [Act] is guilty of [a class _____ misdemeanor].

(g) The sanctions provided in this section do not displace any sanction applicable under other law.

COMMENT

Section 10 provides criminal penalties for specific conduct that violates the Act. Subsections (a) and (b) provide that a physician's failure to transfer a patient or record the diagnosis of terminal condition constitutes a misdemeanor. Subsection (c) makes certain willful actions which could result in the unauthorized prolongation of life a misdemeanor. Subsection (d) governs acts which are intended to cause the unauthorized withholding or withdrawal of life-sustaining treatment, thereby advancing death. Subsections (e) and (f) concern situations that may be coercive, and therefore are against public policy.

Some of the criminal penalties -- particularly subsection (d) -- depart significantly from most existing statutes. Most statutes provide penalties for intentional conduct that actually causes the death of a declarant, and define such conduct as murder or a high degree felony. The Act does not take this approach. Assuming that such conduct will already be covered by a state's criminal statutes, the Act only addresses the situations in which the actor willfully falsifies or forges the declaration of another or conceals or withholds knowledge of revocation. To be criminally sanctioned as a misdemeanor under the Act the circumscribed conduct need not cause the death of a declarant. The approach taken by most states, that of providing a felony penalty for those acts that actually caused death, was considered unnecessary, as existing criminal law will also apply pursuant to Section 10(g). A specific penalty for the conduct described in Section 10(d), however, was deemed appropriate, as existing criminal codes may not adequately address it.

SECTION 11. MISCELLANEOUS PROVISIONS.

(a) Death resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this [Act] does not constitute, for any purpose, a suicide or homicide.

(b) The making of a declaration pursuant to Section 2 does not affect in any manner the sale, procurement, or issuance of any policy of life insurance or annuity, nor does it affect, impair, or modify the terms of an existing policy of life insurance or annuity. A policy of life insurance or annuity is not legally impaired or invalidated in any manner by the

withholding or withdrawal of life-sustaining treatment from an insured qualified patient, notwithstanding any term to the contrary.

(c) A person may not prohibit or require the execution of a declaration as a condition for being insured for, or receiving, health-care services.

(d) This [Act] creates no presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining treatment in the event of a terminal condition.

(e) This [Act] does not affect the right of a patient to make decisions regarding use of life-sustaining treatment, so long as the patient is able to do so, or impair or supersede any right or responsibility that a person has to effect the withholding or withdrawal of medical care.

(f) This [Act] does not require any physician or other health-care provider to take any action contrary to reasonable medical standards.

(g) This [Act] does not condone, authorize, or approve mercy-killing or euthanasia.

SECTION 12. WHEN HEALTH-CARE PROVIDER MAY PRESUME VALIDITY OF DECLARATION. In the absence of knowledge to the contrary, a physician or other health-care provider may presume that a declaration complies with this [Act] and is valid.

SECTION 13. RECOGNITION OF DECLARATION EXECUTED IN ANOTHER STATE. A declaration executed in another state in compliance with the law of that state or of this State is validly executed for purposes of this [Act].

COMMENT

Section 13 provides that a declaration executed in another state, which meets the execution requirements of that other state or the enacting state (adult, two witnesses, voluntary), is to be treated as validly executed in the enacting state, but its operation in the enacting state shall be subject to the substantive policies in the enacting state's law.

SECTION 14. EFFECT OF PREVIOUS DECLARATION. An instrument executed before the effective date of this [Act] which substantially complies with Section 2(a) must be given effect pursuant to the provisions of this [Act].

SECTION 15. UNIFORMITY OF CONSTRUCTION AND APPLICATION. This [Act] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this [Act] among states enacting it.

SECTION 16. SHORT TITLE. This [Act] may be cited as the Uniform Rights of the Terminally Ill Act (1989).

SECTION 17. SEVERABILITY. If any provision of this [Act] or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

SECTION 18. EFFECTIVE DATE. This [Act] takes effect on _____.

SECTION 19. REPEAL. The following acts and parts of acts are repealed:

(1)

(2)

(3)

APPENDIX G

UNIFORM LAW COMMISSIONERS' MODEL HEALTH-CARE CONSENT ACT

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS NINETY-FIRST YEAR
IN MONTEREY, CALIFORNIA
JULY 30 - AUGUST 6, 1982

WITH PREFATORY NOTE AND COMMENTS

The Committee that acted for the National Conference of Commissioners on Uniform State Laws in preparing the Uniform Law Commissioners' **Model Health-Care Consent Act** was as follows:

JOHN W. THOMAS, P. O. Box 1792, Columbia, SC 29202, *Chairman*

WILLIAM H. ADAMS, III, P. O. Box 4099, Jacksonville, FL 32201

MARION K. FINKELHOR, 706 City-County Building, Pittsburgh, PA 15219

ROBERT L. HAZARD, 465 Congress Street, Portland, ME 04101

RICHARD L. JONES, P. O. Box 218, Montgomery, AL 36130

HARRY D. LEINENWEBER, Suite 612, 57 North Ottawa Street, Joliet, IL 60431

MILLARD H. RUUD, University of Texas, School of Law, 727 East 26th Street, Austin, TX 78705

ANDREW W. MCTHENIA, JR., Washington and Lee University, School of Law, Lewis Hall, Lexington, VA 24450, *Reporter*

JOHN C. DEACON, P. O. Box 1245, Jonesboro, AR 72401, *President: 1979-1981 (Member Ex Officio)*

M. KING HILL, JR., Sixth Floor, 100 Light Street, Baltimore, MD 21202, *President: 1981-1983 (Member Ex Officio)*

CARLYLE C. RING, JR., 308 Monticello Boulevard, Alexandria, VA 22305, *Chairman, Executive Committee*

WILLIAM J. PIERCE, University of Michigan, School of Law, Ann Arbor, MI 48109, *Executive Director*

JOHN F. HAYES, P. O. Box 705, Hutchinson, KS 67501, *Chairman, Division D: 1979-1981 (Member Ex Officio)*

RICHARD C. HITE, 200 West Douglas Avenue, Wichita, KS 67202, *Chairman, Division D: 1981-1982 (Member Ex Officio)*

Review Committee

W. JOEL BLASS, P. O. Box 160, Gulfport, MS 39501, *Chairman: 1981-1982*

PHILLIP CARROLL, 120 East Fourth Street, Little Rock, AR 72201, *Chairman: 1980-1981*

M. MICHAEL CRAMER, 200-A Monroe Street, Rockville, MD 20850

CHARLES HOROWITZ, 2000 IBM Building, Seattle, WA 98101

DAVID S. KUNZ, 300 Bank of Utah Building, Ogden, UT 84401

Advisors to Special Committee on
Model Health-Care Consent Act

LEE J. DUNN, JR., *American Society of Law and Medicine*

WALTER FUNK, *The First Church of Christ, Scientist*

DENNIS J. HORAN, *American Bar Association, Section of Tort and Insurance Practice*

JEFFERY M. STOKOLS, *American Medical Association*

CLIFFORD STROMBERG, *American Bar Association, Section of Individual Rights and Responsibilities*

Copies of all Uniform and Model Acts and other printed matter issued by the Conference may be obtained from:

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS
645 North Michigan Avenue, Suite 510
Chicago, Illinois 60611

UNIFORM LAW COMMISSIONERS' MODEL HEALTH-CARE CONSENT ACT

Commissioner's Prefatory Note

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." Scholendorff v. Society of New York Hospitals, 211 N.Y. 125, 105 N.E. 92 at 93 (1914).

That often quoted statement of Judge Cardozo both states the premises underlying this Act and suggests by omission the subject matter of the Act. What if the human being is not of adult years and of sound mind or is otherwise unable to consent? Assuming consent is nonetheless required, who can give an effective consent? These questions plague hospital administrators, physicians and surgeons daily. They are also of grave importance to patients, their families and friends. Some certainty in this area of the law is needed for all the participants in the health care system, consumers as well as providers.

Scope of the Act

This Act is procedural in nature and is purposefully narrow in scope. Its primary aim is to provide authorization to consent to health care. It does *not* address the substantive issues of consent; for instance, what constitutes informed consent, whether informed consent is required or under what circumstances one has a right to refuse treatment.[1]

Many of the substantive aspects of consent involve conflicting social and ethical values. The law's response to many consent issues is halting and uncertain. It is reflective of the ambivalence in society. For instance, the right to refuse treatment raises questions about which there is no clear consensus in American law. The many ethical and moral dilemmas presented in those cases dealing with the right to refuse psychotropic drugs or the right to refuse necessary medical care suggest that further experimentation is in order to propose a model solution for these questions would stifle creativity and is neither practicable nor desirable.

The "who" questions of consent (who is authorized to consent for himself or for another) do not, in the routine cases, present serious, unresolved moral issues. Yet, at best, the law on these questions is far from clear and has been described as "haphazard".[2]

This Act is drafted to provide assistance in the cases that occur daily and routinely in medical practice. It is not designed to provide answers for the extraordinary cases, such as terminal illness, organ donation, and the treatment of mental illness. These extraordinary cases present separate and discrete problems involving not only issues of competency but of the authority of a substitute decision-maker as well. To force a single solution to these many problems would be

[1] While numerous states adopted informed-consent legislation within the last decade, others declined to do so. There is no reason to believe that those states with informed-consent legislation are dissatisfied with their efforts nor is there reason to believe that uniform legislation on this subject would be enacted by those states that decided not to adopt informed-consent legislation in the 1970s. Basically, informed-consent legislation is an idea whose time has come—and gone. In addition and by way of illustration of its narrow scope, this Act is not concerned with: whether; how and under what circumstances liability will be imposed on a health care provider for failing to obtain consent; whether and to what extent consent requirements are relaxed in emergencies; whether consent must be express or implied; the evidentiary problems that arise in proving that consent was in fact obtained; or how much and what kind of information must be provided to the patient to satisfy the standards of informed consent.

[2] Kindregan, The Courts as a Forum for Life and Death Decisions: Reflections on Procedures for Substitute Consent, 11 Suffolk L.Rev. 919, 924 (1977). For a particularly enlightening discussion of many of the problems of "substitute consent" see A. Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision-making, 1979 Wis.L. Rev. 413, 472–488 (hereinafter Meisel).

at best a procrustean fit. To provide a statutory solution to the problem of the administration of antipsychotic medication to a noninstitutionalized incompetent person which is consistent with the due process clause would be completely unworkable if the problem to be solved is how to render treatment to a child with a broken arm while its parents are on an extended trip.

While this Act does not, indeed cannot, solve all the myriad and complex issues of consent, it can serve a very useful function. In an effort to replace the murkiness of custom with the clarity of legislation and to provide guidance for those involved daily with the problem of how medical decisions are to be made for an individual who cannot do so for himself, this Act embraces five general concepts.

First, the Act designates the individuals who may consent to health care for themselves. (Section 2.) Section 2 restates the common law that adults may consent for themselves unless incapable of consenting. At common law, minors were not permitted to make health-care related decisions and the state entrusted that decision-making power to parents. However, over the years there have developed several well-defined exceptions to a minor's disability. Section 2 incorporates those more widely recognized exceptions. In addition to the general exceptions to the status of minority which permit minors to consent to all forms of health care, many states have carved out more limited exceptions that authorize minors to consent to particular forms of health care without parental consent, for instance, treatment for drug or alcohol abuse. Section 2 preserves existing state law on these matters.

Second, the Act provides a triggering mechanism to determine when an individual is incapable of consenting. (Section 3.) This decision is made by the health-care provider and the standard for determining that one is incapable of consenting is whether the individual is capable of making a decision regarding the proposed health care. It is important to note that the effect of a determination of incapacity is not to bypass consent but to shift the health care decision-making to a third party.

Third, the Act provides a scheme for determination of a proxy decision-maker to act for one incapable of consenting. (Section 4) At common law, parents were entrusted with making health care decisions for their children. The state's power to care for an incompetent adult was traditionally exercised through guardianship. That much is clear in existing law. However, unless the person in need of health care is an infant or has been accorded protection through a formal adjudication of incompetency, the common law affords no clearly established authorization for one family member to act for another. Courts and treatise writers have indicated that authorization from a spouse or other close family member is permissible.[3] While that accords with custom, actual adjudicated authority to that effect is sparse. Section 4 provides both an authorization and system of priorities for proxy decision-makers.

Fourth, the Act permits family members authorized to consent for another by Section 4 to delegate their authority to make health-care decisions. (Section 5) The authorization is intended to permit relatives to delegate their decisional power while they are separated from other family members. For instance, while children are away at summer camp the power of a parent to delegate decisional authority to a camp director would be extremely useful.

Fifth, the Act authorizes an individual to appoint another to serve as a health-care representative and to make health-care decisions on his behalf. (Section 6) A concern for personal autonomy underlies this provision. Section 6 is designed to provide an alternative to the system of third-party consent outlined in Section 4. Section 6 permits an individual to make his own designation if he so chooses. While the provision is perhaps novel to the field of health care, the power to make such a designation exists in jurisdictions that have statutes similar to the Uniform Durable Power of Attorney Act.

One authorized to make health-care decisions for another is in every important sense of that word a fiduciary. A proxy decision-maker must use good faith and act in the best interest of the individual for whom decisions are made. Those authorized to act under Section 4 are empowered to act either because of a legally imposed relationship (in the case of a guardian) or because of a family relationship. A health-care representative authorized under Section 6 is empowered

[3] See Meisel, supra note 3.

because a patient has designated him to make treatment decisions; autonomy is the basis for the appointment.

The best interest standard governs both a Section 4 proxy and a Section 6 health-care representative. In the case of a Section 4 proxy, best interest incorporates an objective general standard, whereas the Section 6 health-care representative must also act in accordance with the purposes of the individual as stated in the appointment. Best interest is an evolving standard governed by state law. In the case of Section 4 proxy, best interest requires that the decision maker act reasonably. In most cases the Section 4 decision-maker will be a family member. His power does not arise from the patient having placed him in a position of trust but from his relationship to the patient. His power thus turns on the community's perception of what authority a relative ought to have. That is generally defined in terms of an objective best interest test. However, the Section 6 health-care representative acts because he has been designated to serve by the patient. Autonomy is the basis for that appointment and the health-care representative's obligation can be determined from the creator of the power, i.e., from the specific instructions in the document appointing him. When the patient has expressed his desire, that is the strongest evidence of his best interest.

There are important limitations on the substitute decision-maker's power contained in the Act. One of the most important limitations concerns the treatment of mental illness. The Act does not displace existing law on the consent related questions of mental-health treatment. One important issue that has been the subject of recent litigation concerns the right to refuse psychotropic drugs in the treatment of psychosis. Some litigated cases require prior *judicial* approval for the administration of these drugs to nonconsenting, noninstitutionalized, incompetent persons. See In the Matter of Guardianship of Roe III, —— Mass. ——, 421 N.E.2d 40 (1981). Many difficult questions remain unanswered; for instance whether absent an emergency, a state can forcibly medicate an involuntarily institutionalized person without a prior judicial determination of incapacity. See Mills v. Rogers, —— U.S. ——, 102 S.Ct. 2442 (1982). This is one of those areas in which there is no clear consensus and Section 11 of the Act preserves that ongoing debate. Section 11 does not authorize any individual to consent to mental-health treatment unless in compliance with state law.

UNIFORM LAW COMMISSIONERS' MODEL HEALTH-CARE CONSENT ACT

Sec.

§ 1. Definitions

As used in this [Act]:

(1) "Adult" means an individual [18] or more years of age.

(2) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

(3) "Health-care provider" means a person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

(4) "Minor" means an individual who is not an adult.

(5) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, government, governmental subdivision or agency, or any other legal entity.

Commissioners' Comment

The age of 18 is bracketed in the definition of an adult (subsection (1)) so that states with a different age for achieving adult status may insert whatever age is appropriate.

Health care (subsection (2)) includes any care, treatment, service or procedure to diagnose or treat a physical or mental condition. The term is broader in scope than medical care and includes care and treatment which is lawful to practice under state law, for instance, nursing care.

Since the definition of health care is broader in scope than medical care, there is a need to limit the coverage of the Act so that the rendition of routine care by family members would not be within its coverage. One limitation on the scope of the Act is found in the definition of a health-care provider in subsection 3. That definition excludes those who are not licensed, certified or otherwise authorized to render health care. Hence, the rendition of simple care by a family member to one who is ill at home would not be covered by this Act while that same treatment would be covered if provided in a hospital.

§ 2. Individuals Who May Consent to Health Care

Unless incapable of consenting under Section 3, an individual may consent to health care for himself if he is:

(1) an adult; or

(2) a minor and

(i) is emancipated,

(ii) has attained the age of [14] years and, regardless of the source of his income, is living apart from his parents or from an individual in loco parentis and is managing his own affairs,

(iii) is or has been married.

(iv) is in the military service of the United States, or

(v) is authorized to consent to the health care by any other law of this State.

Commissioners' Comment

Section 2 describes those individuals who may consent to health care for themselves.[1] All adults, unless disqualified by Section 3, may consent to health care. These two provisions basically restate the common law with regard to consent by adults. At common law minors were not presumed to be competent to consent to health care. However, there are certain status exceptions, both statutory and common law, which render a minor capable of consenting. Section 2(2) is a compilation of the more widely recognized exceptions to the traditional requirement of consent by a parent or guardian which permit a minor, unless disqualified by Section 3, to consent to health care for himself as if he were an adult.

The exceptions are based on the assumption that a minor who has made the described decisions or taken the described actions in his life has demonstrated his capacity to make decisions concerning his health care. The emancipated minor exception is widely recognized in case law and in the statutes of more than thirty states. See Wilkins, *Children's Rights: Removing the Parental Consent Barriers to Medical Treatment of Minors*, 1975 Arizona St. L.J. 31, 59 (1975). Paragraph (2)(ii) is an explicit emancipation provision

based on objective criteria which will not require a formal adjudication of emancipation. The age is bracketed, but the age of 14 is a reasonable age when coupled with the other requirements of this paragraph.

Other objective criteria which courts and state legislatures have accepted as showing a minors' maturity to make decisions affecting his health, are marriage and service with the armed forces. (See, e.g., Ind.Ann.Stat. 16–8–4–1 (Burns 1973).) Once a minor has satisfied any of these criteria he may consent to health care for himself as if he were an adult.

In addition to the status exceptions permitting consent by minors, many legislatures have created additional exceptions authorizing minors to consent to treatment for specific conditions or diseases without regard to their status. For instance, 45 states presently allow minors to obtain treatment for venereal disease without parental consent. One or more states permit minors to consent to the following forms of health care:

(1) health care necessary to diagnose or treat pregnancy;

(2) health care necessary to diagnose or treat venereal disease;

(3) health care necessary to diagnose or treat alcohol or drug dependency or abuse;

(4) psychiatric or psychological counseling;

(5) health care necessary for the performance of an abortion;

(6) health care necessary for counseling in the use of contraceptive devices; and

(7) health care necessary for the performance of any type of sterilization.

Paragraph 2(v) of this Act leaves intact those state laws which permit a minor to consent to one or more specific health-care procedures, regardless of whether the minor meets the status exceptions of paragraph 2.

[1] While the language of Section 2 is cast in terms of an authorization to consent, that necessarily means that one authorized to consent may also refuse consent or withdraw consent to a course of health care once given.

§ 3. Individuals Incapable of Consenting

An individual otherwise authorized under this [Act] may consent to health care unless, in the good faith opinion of the health-care provider, the individual is incapable of making a decision regarding the proposed health care.

Commissioners' Comment

Section 3 uses the phrase incapable of consenting as opposed to incompetency. This choice is deliberate. Incompetency in American law carries the connotation of permanency and is often thought to involve an adjudicative declaration. However, a person may be *de jure* competent when in fact he is incapable of making a decision regarding his own health care. An otherwise competent adult who has been rendered unconscious in an accident is at that time *de facto* incompetent or incapable of making a decision regarding proposed health care.

Section 3 is phrased negatively as the law presumes that adults, and under certain circumstances minors as well, are capable of making decisions unless there is some determination of a contrary status. The determination called for in Section 3 is to be made by the health-care provider, and the standard is whether the individual is incapable of making a decision regarding the proposed health care. If the individual is capable of making a decision, the health-care provider must abide that decision.

Custom suggests and necessity dictates that the intital determination that one is incapable of consenting rest with the health-care provider. Section 3 in recognition of necessity legitimates that custom. Unlike the decision to invoke the emergency exception to the requirement of informed consent which has the effect of bypassing consent altogether, a decision that one is incapable of consenting merely shifts the decision regarding the rendition of health care to a third party. This is an important difference for the health-care provider's decision is *ex necessitae* a "low visibility" one. Any decision to bypass the patient by de-

ciding that he is incapable of making a decision endangers the values of individualism and personal autonomy. What is needed in any such decision is a proper combination of deference to professional judgment and health-care values on the one hand and respect for personal autonomy and individualism on the other. Reposing the ultimate decision to proceed with medical treatment in a third party should assure that values of personal autonomy and individualism receive proper consideration.

The requirement that the individual be incapable of engaging in decision-making is consistent with the underlying notion of consent. A unique human characteristic is the power to make decisions. The language of Section 3 focuses on the ability of one to make a decision as opposed to the content of a health care decision. A decision to refuse a specific course of treatment may be based on moral or religious grounds. An individual who refuses treatment because he has consistently relied on prayer for healing in accordance with his religious tradition is capable of making his own health-care decisions. A decision to refuse treatment made under those circumstances should be honored by a health-care provider.

The uncertainties of medical practice and the decision to be made do not make precise statements of the test for determining incapacity easy. However, the context in which the decision is made and the effect of such a decision render the lack of precision less onerous.[1] The health-care provider who decides that one is incapable of consenting must then turn to another who is charged with making the ultimate treatment decision in the best interest of the patient.

[1] See A. Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis.L.Rev. 413, 452, 472–473.

§ 4. Individuals Who May Consent to Health Care for Others

(a) If an individual incapable of consenting under Section 3 has not appointed a health-care representative under Section 6 or the health-care representative appointed under Section 6 is not reasonably available or declines to act, consent to health care may be given:

(1) by a guardian of his person, a representative appointed under Section 7, or a representative designated or appointed under other law of this State; or

(2) by a spouse, parent, adult child, or adult sibling, unless disqualified under Section 8, if there is no guardian or other representative described in paragraph (1) or he is not reasonably available or declines to act, or his existence is unknown to the health-care provider.

(b) Consent to health care for a minor not authorized to consent under Section 2 may be given:

(1) by a guardian of his person, a representative appointed under Section 7, or a representative designated or appointed under other law of this State;

(2) by a parent or an individual in loco parentis, if there is no guardian or other representative described in paragraph (1) or he is not reasonably available or declines to act, or his existence is unknown to the health-care provider; or

(3) by an adult sibling of the minor, if a parent or an individual in loco parentis is not reasonably available, declines to act, or his existence is unknown to the health-care provider.

(c) An individual delegated authority to consent under Section 5 has the same authority and responsibility as the individual delegating the authority.

(d) A person authorized to consent for another under this section shall act in good faith and in the best interest of the individual incapable of consenting.

Commissioners' Comment

Section 4 authorizes designated persons to exercise health-care decision-making powers for individuals who cannot consent for themselves and who have not appointed a health-care representative to act on their behalf as authorized in Section 6. If a health care representative has been appointed and is willing to act, that preempts the operation of this section.

Subsection (a) is concerned with adults and minors authorized to consent under Section 2. It sets forth an order of priority among substitute decision-makers. The first priority is given to individuals appointed by a court, a guardian or an individual appointed under Section 7. The second priority class is the family. Within this class, the spouse, parents, adult children and adult siblings are ranked equally. Any member of the class is authorized to act. Any decision establishing priority among family members would be largely arbitrary. The objective is to have someone who has a close personal relationship with the patient and who will consider his best interest acting for him. If one of those authorized to act disagrees with the decision of another who has been designated a proxy decision maker, that person can seek formal judicial appointment to act for the one incapable of consenting. However, an objector would be required to show that the other authorized decision-maker was not acting in the patient's best interest. (See Section 7.)

Subsection (b) authorizes substitute decision-makers for minors who are not authorized to consent under Section 2. The first priority is given to court-appointed officials. If the parents are alive, it is unlikely that there would be a court-appointed guardian and the parents would have first priority. If there is no court-appointed official and if the parents are unavailable, any adult brother or sister of the minor is authorized to make health-care decisions.

Family members authorized to consent for one incapable of consenting under this section may delegate their decisional authority to another. The person to whom authority is delegated under Section 5 has the same priority to act for the patient as the delegating individual.

One authorized by this section to act for another must act in good faith and in the best interest of the individual incapable of consenting.

§ 5. Delegation of Power to Consent to Health Care for Another

(a) An individual authorized to consent to health care for another under Section 4(a)(2), 4(b)(2) or 4(b)(3) who for a period of time will not be reasonably available to exercise the authority may delegate the authority to consent during that period to another not disqualified under Section 8. The delegation must be in writing and signed and may specify conditions on the authority delegated. Unless the writing expressly provides otherwise, the delegate may not delegate the authority to another.

(b) The delegant may revoke the delegation at any time by notifying orally or in writing the delegate or the health-care provider.

Commissioners' Comment

Section 5 permits a limited delegation of authority to consent for another. Family members authorized to consent for another under Section 4 may delegate their decisional authority. This provision should be helpful in situations in which parents want to delegate health-care decision-making to a temporary custodian of their children, for instance when parents plan to be away or when a child is at camp. This section follows closely Section 5–104 of the Uniform Probate Code.

§ 6. Health-care Representative: Appointment; Qualification; Powers; Revocation and Responsibility

(a) An individual who may consent to health care under Section 2 may appoint another as a health-care representative to act for the appointor in matters affecting his health care.

(b) A health-care representative appointed under this section must be an individual who may consent to health care under Section 2.

(c) An appointment and any amendment thereto must be in writing, signed by the appointer and a witness other than the health-care representative and accepted in writing by the health-care representative.

(d) The appointor may specify in the writing terms and conditions considered appropriate, including an authorization to the health-care representative to delegate the authority to consent to another.

(e) The authority granted becomes effective according to the terms of the writing.

(f) The writing may provide that the authority does not commence until, or terminates when, the appointor becomes incapable of consenting. Unless expressly provided otherwise, the authority granted in the writing is not affected if the appointor becomes incapable of consenting.

(g) Unless the writing provides otherwise, a health-care representative appointed under this section who is reasonably available and willing to act has priority to act for the appointor in all matters of health care.

(h) In making all decisions ragarding the appointor's health care, a health-care representative appointed under this section shall act (i) in the best interest of the appointer consistent with the purposes expressed in the appointment and (ii) in good faith.

(i) A health-care representative who resigns or is unwilling to comply with the written appointment may exercise no further power under the appointment and shall so inform (i) the appointor, (ii) the appointor's legal representative, if one is known, and (iii) the health-care provider, if the health-care representative knows there is one.

(j) An individual who is capable of consenting to health care may revoke: (i) the appointment at any time by notifying the health-care representative orally or in writing, or (ii) the authority granted to the health-care representative by notifying the health-care provider orally or in writing.

Commissioners' Comment

Section 6 is designed to extend the concept of patient autonomy by permitting a person to transfer his health care decision-making power to another. Many individuals who are competent to make health care decisions nevertheless want to delegate this decisional authority to a relative or friend. In addition, in the event they are rendered incapable of consenting, many people want the assurance that some other individual whom they trust will make health-care decisions on their behalf.

It is generally thought that if one cannot or does not exercise his own decisional authority in health-care matters this authority should be placed in the hands of the state (i.e., a court), a health-care provider or the next of kin. Any of these choices may be seen as a restriction on autonomous choice. Leaving this authority in the hands of

a court when there are other alternatives available is particularly vexing because it allows the state a measure of control over individuals to which it has no obvious moral right and for which it has no special expertise. Section 6 provides an alternative. The decision to allow the transfer of authority rests on the principle of the basic human need of self determination and individual autonomy. The patient himself can designate the person who is to make these health-care decisions. Section 6 does not prescribe the nature of the decision-making relationship between the appointing individual and the person appointed. The appointing individual has the opportunity to engage in moral discourse with his agent, and to specify in the document the terms and the conditions of the appointment.

Subsection (h) provides that a health-care representative must act in the best interest of the appointor consistent with the purposes expressed in the appointment and in good faith. Cases often purport to draw a distinction between a best interest and substituted judgment standard. (Compare In re Guardianship of Pescinski, 67 Wis.2d 4, 226 N.W.2d 180 (1975) (best interest) with In re Quinlan, 70 N.J. 10, 335 A.2d 647 (1976) (substituted judgment)). Yet the two terms reflect not so much a difference in concept as a difference in emphasis. The standard of best interest is generally thought to incorporate a concept of objective reasonableness with reference to the interests of society and others while the substituted judgment standard focuses on the interest of the particular patient. That the patient may define what is in his best interest and that such a declaration should be accepted by surrogate decision-maker is well recognized in many adjudicated cases. (See In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass.1977) and Eichner v. Dillon, 426 N.Y.S.2d 517 (1981)).

Personal autonomy is the basis for the concept of the health-care representative in Section 6. Where a person appointing a health-care representative has given particular instructions, those instructions should define the best interest of a patient. If no specific directions are given, the more general best interest standard applies.

If the health-care representative cannot in good conscience follow the directions provided by his appointor he must resign or seek relief from that mandate by a court. The health-care representative would be an interested individual entitled to petition a court under Section 7. In the event the health-care representative does not act, consent must be obtained from one of those individuals authorized in Section 4 to act for the patient or from a court under Section 7.

Section 6 is consistent with the Uniform Durable Power of Attorney Act. The appointment made under this section would be given effect without this Act in a jurisdiction which has enacted the Durable Power of Attorney Act. By incorporating this section into the Act, the power of appointment will be brought to the attention of persons who may not be aware of the Durable Power Act.

Because the power of appointment is unique, the Conference concluded it was desirable to set forth a suggested form instrument to be used for the appointment of a health-care representative.

Appointment of a Health-Care Representative

I, the undersigned, voluntarily appoint _____

whose telephone number and address are: _____

_____

as my health-care representative who is authorized to act for me in all matters of health care, except as otherwise specified below.

This appointment is subject to the following special provisions:

_____

_____

_____

_____

This appointment (becomes effective) (remains effective) (terminates) if I later become disabled or incapable of consenting to my health care. I (do) (do

not) authorize my health-care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, 19__.

_____
(signed)

_____
(address)

I declare that at the request of the above-named individual making the appointment, I witnessed the signing of this document.

_____
(signed)

_____
(address)

Acceptance by Health-Care Representative

I, the undersigned health-care representative, understand that acceptance of this appointment means that I have a duty to act in good faith and in the best interest of the individual appointing me. I further understand that I have a duty to follow any special instructions in the appointment. In the event I cannot do so, I will exercise no further power under the appointment and will inform (i) the individual appointing me, if that individual is capable of consenting, (ii) his/her legal representative, if known to me, and (iii) his/her health-care provider if known to me.

Dated this _____ day of _____, 19__.

_____
(signed)

_____
(address)

§ 7. Court-Ordered Health Care or Court-Ordered Appointment of a Representative

(a) A health-care provider or any interested individual may petition the [_____] court to (i) make a health-care decision or order health care for an individual incapable of consenting or (ii) appoint a representative to act for that individual.

[(b) Reasonable notice of the time and place of hearing a petition under this section must be given to the individual incapable of consenting and to individuals in the classes described in Section 4 who are reasonably available.

(c) The court may modify or dispense with notice and hearing if it finds that delay will have a serious, adverse effect upon the health of the individual.]

(d) The court may order health care, appoint a representative to make a health-care decision for the individual incapable of consenting to health care with such limitations on the authority of the representative as it considers appropriate, or order any other appropriate relief in the best interest of that individual, if it finds:

(1) a health-care decision is required for the individual;

(2) the individual is incapable of consenting to health care; and

(3) there is no individual authorized to consent or an individual authorized to consent to health care is not reasonably available, declines to act, or is not acting in the best interest of the individual in need of health care.

Commissioners' Comment

Section 7 is designed to operate in two basic situations. The first is that in which an individual is in need of health care and incapable of consenting and there is no one to act on his behalf. It is not infrequent that a person admitted to a hospital has no known relatives or friends. The second is that in which one authorized to act is not acting in the best interest of the individual who is incapable of consenting. If the parents of a minor refuse medical treatment because of the parents' religious convictions courts have not hesitated to take the decision-making authority from the parent when the child's life is endangered.[1]

The removal of a parent's power to consent is generally taken pursuant to state child neglect statutes. However, in some instances courts simply assume the decision-making authority under the *parens patriae* doctrine. Section 7 provides for the same kind of relief that is provided in the child neglect statutes. Section 7 provides a certain and expeditious means for removing one authorized to consent who is not acting in the best interest of a patient. The Act does not attempt to define best interest. There is a developing body of law on that question; however, its contours are not yet clear. (See M. Wald, *State Intervention on Behalf of "Neglected" Children: A Search for Realistic Standards*, 27 Stan.L.Rev. 985, 1031–1033 (1975).

Any health-care provider or any individual is given standing to petition for the appointment of a competent representative to consent to the rendition of health care. A court acting pursuant to this section is authorized to order health care or to appoint a competent representative who is authorized to make health-care decisions. This section does not displace any other state procedures designed to accomplish the same result. Because most states have existing mechanisms to address these questions, the purely procedural portions of Section 7, subsections (b) through (d) are bracketed. They may be deleted from the Act without destroying its integrity.

[1] On occasion, courts have ordered treatment over the parents' objection even though the proposed treatment was not necessary to save the child's life but posed substantial risks and was not certain to cure the condition. (See In re Sampson, 317 N.Y.S.2d 641 (1970) affirmed 29 N.Y.2d 900, 328 N.Y.S.2d 686 (1972).) In Sampson, the minor suffered from a massive overgrowth of facial tissue causing a severe deformity on the right side of his face and neck. The need for treatment was shown by testimony that he did not attend school and suffered a severe learning disability relating to the deformity. The court concluded that the disfigurement so limited the child's development that it had to assume responsibility and order the surgery, even though the procedure entailed obvious risks. (For a contrary result, see In re Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955).)

§ 8. Disqualification of Authorized Individuals

(a) An individual who may consent to health care for himself under Section 2 may disqualify others from consenting to health care for him.

(b) The disqualification must be in writing, signed by the individual, and designate those disqualified.

(c) A health-care provider who knows of a written disqualification may not accept consent to health care from a disqualified individual.

(d) An individual who knows he has been disqualified to consent to health care for another may not act for the other under this [Act].

Commissioners' Comment

A full recognition of individual autonomy requires not only that one be authorized to appoint his health-care representative but that he also be authorized to say whom he does not want to act for him. Section 8 permits this disqualification. A patient may not want to go through the formality of

appointing a Section 6 health-care representative but may well wish to exclude certain persons from acting on his behalf.

One who is disqualified under Section 8 has no authority to act. However, unless that disqualification is known to a health-care provider, he may nevertheless rely on an authorization from one who is disqualified. (See Section 9.)

§ 9. Limitations of Liability

(a) A health-care provider acting or declining to act in reliance on the consent or refusal of consent of an individual who he believes in good faith is authorized by this [Act] or other law of this State to consent to health care is not subject to criminal prosecution, civil liability, or professional disciplinary action on the ground that the individual who consented or refused to consent lacked authority or capacity.

(b) A health-care provider who believes in good faith an individual is incapable of consenting under Section 3 is not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to follow that individual's direction.

(c) A person who in good faith believes he is authorized to consent or refuse to consent to health care for another under this [Act] or other law of this State is not subject to criminal prosecution or civil liability on the ground he lacked authority to consent.

Commissioners' Comment

Under Section 9, the health-care provider is permitted to rely on the consent of an individual whom he believes in good faith is authorized to consent to health care. In meeting this standard under the Act, a health-care provider could not close his eyes to the truth, of course, but to prescribe an affirmative requirement of detailed investigation would make reliance impossible.

Similarly, a health-care provider who makes a determination that one is incapable of consenting and thus calls in a third-party decision-maker is not subject to liability for discharging his obligation in good faith.

An individual acting for another is in every sense of the word a fiduciary and has those obligations which a fiduciary owes his ward. The immunity provided in this section does not protect a substitute decision-maker from negligence or other breach of duty but only from acting without authority if he in good faith believes that he is authorized to give consent.

§ 10. Availability of Medical Information

An individual authorized to consent to health care for another under this [Act] has the same right as does the individual for whom he is acting to receive information relevant to the contemplated health care and to consent to the disclosure of medical records to a comtemplated health-care provider. [Disclosure of information regarding contemplated health care to an individual authorized to consent for another is not a waiver of an evidentiary privilege.]

Commissioners' Comment

An individual authorized to consent for another stands in the shoes of the patient when making health-care decisions. The individual authorized to consent is entitled to receive information relevant to the proposed health care whether or not that is allowable under any other provision of state law. This section guarantees that right but makes no attempt to define the scope of disclosure required.[1]

In many cases, proper diagnosis and treatment require that medical information must be passed from one doctor or hospital to another. Because of the confidential or privileged nature of much of this information, the patient's consent is necessary before the information can be disclosed. (61 Am.Jur. 2d Physicians & Surgeons § 101 (1972) and 20 A.L.R.3d 1109 (1968).) To the extent that the patient has a right which can be waived, an individual acting on his behalf has the same right of waiver. The Act does not determine whether confidential information or a privilege exists in the first instance.

[1] For a detailed bibliography of informed consent see A. Meisel, The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability By Way of Informed Consent, 56 Neb.L.Rev. 51, 75 n. 64 (1977) and A. Meisel, The Exceptions to the Informed Consent Doctrine: Striking A Balance Between Competing Values in Medical Decisionmaking, 1979 Wisc.L.Rev. 413 n. 3.

§ 11. Effect on Existing State Law

(a) This [Act] does not affect the law of this State concerning an individual's authorization to make a health-care decision for himself or another to withdraw or withhold medical care necessary to preserve or sustain life.

(b) This [Act] does not affect the requirements of any other law of this State concerning consent to observation, diagnosis, treatment, or hospitalization for a mental illness.

(c) This [Act] does not authorize an individual to consent to any health care prohibited by the law of this State.

(d) This [Act] does not affect any requirement of notice to others of proposed health care under any other law of this State.

(e) This [Act] does not affect the law of this State concerning (i) the standard of care of a health-care provider required in the administration of health care, (ii) when consent is required for health care, (iii) informed consent for health care, or (iv) consent to health care in an emergency.

(f) This [Act] does not prevent an individual capable of consenting to health care for himself or another under this [Act], including those authorized under Sections 4, 5 and 6, from consenting to health care administered in good faith pursuant to religious tenets of the individual requiring health care.

Commissioners' Comment

Section 11 contains important limitations. It is written to make clear that this Act does not intrude into areas of the law where its operation would be inappropriate.

The law with respect to the withdrawal of life support systems in the case of the terminally ill is changing rapidly. At least 10 states have Natural Death Acts and there have been several court decisions concerning the issue of termination of treatment. Nothing in this Act changes existing law in that regard. All proxy decisionmakers are charged with acting in the best interest of the patient who is incapable of consenting. If a patient had appointed a health-care representative and had made known his wish that life support systems be withdrawn

in the event of terminal illness, many courts would consider that evidence conclusive of the patient's best interest. However, this Act does not provide an answer to the question of what is in the patient's best interest in such a circumstance.

Subsection (b) provides that the Act will not override the operation of mental health codes. All states require that commitment proceedings be surrounded with stringent procedural safeguards which must be adhered to before an individual can be involuntarily committed. Subsection (b) makes it clear that this Act does not allow any individual authorized to consent for another to bypass those commitment statutes under the guise of a voluntary commitment. In addition, subsection (b) prohibits this Act from being used to authorize forcible drug medication unless in conformity with other proper procedural requirements.

Subsection (c) is written to make it clear that this Act does not authorize one to consent to medical procedures which are prohibited by law.

The Supreme Court has held in Belloti v. Baird, 443 U.S. 622 (1979) that minors are entitled to consent to an abortion without parental consent. That holding is recognized in Section 2 which permits minors to consent to health care which is otherwise authorized by law. However, the Supreme Court held in the case of H. L. v. Matheson, 450 U.S. 398, 101 S.Ct. 1164 (1981) that a state requirement of notice to parents does not violate the constitutional rights of a minor. Subsection (d) is written to ensure that state statutes, such as the Utah statute under review in *Matheson*, are not affected by this Act.

This Act is narrow in scope. It is not concerned with the standard of care required of health-care providers. It is not concerned with whether, how and under what circumstances consent to health care is required. Nor is it an informed consent statute. As outlined in the Prefatory Note, this statute is basically a procedural one and matters of state substantive law are unchanged.

Section 2 of this Act limits health-care providers to those who are licensed, certified or otherwise authorized to provide health care. Practitioners of religious healing, for instance, Christian Science Practitioners are not licensed, certified or authorized by the state but practice as a matter of the free exercise of religion. Yet spiritual healing is a well recognized form of health care and there is no intention to make this religious activity illegal by the operation of this Act. There is no intention to prevent an individual capable of consenting to health care from consenting for another or himself to spiritual healing which is health care administered in good faith pursuant to religious tenets of the individual requiring health care as a matter of free exercise of religion. Certainly those practitioners of religious healing should not be required to seek state authorization to practice their faith. Hence, subsection (f) is an express savings clause to permit one to consent to spiritual healing as health care.

§ 12. Severability

If any provisions of this [Act] or the application hereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

§ 13. Uniformity of Application and Construction

This [Act] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this [Act] among states enacting it.

§ 14. Short Title

This [Act] may be cited as the Uniform Law Commissioners' Model Health-Care Consent Act.

§ 15. Repeal

The following acts and parts of acts are repealed:

(1)

(2)

(3)

§ 16. Time of Taking Effect

This [Act] shall take effect _____.

APPENDIX H

BIBLIOGRAPHY

39 Maine L. Rev. 83-148 (1987), Maine's Living Will Act and the Termination of Life-sustaining Procedures.

41 Maine Law Review 447 (1989), Note: In re Gardner: Withdrawing Medical Care from Persistently Vegetative Patients.

A Matter of Choice: Planning Ahead for Health Care Decisions, (An information paper prepared for use by the Chairman and Ranking Minority Member of the Special Committee on Aging, United States Senate), December, 1986, American Association of Retired Persons.

Adams, Betty, The Livermore Falls Advertiser, October 4, 1984, The "Silent Epidemic," Head Injury in Maine.

Archives of Internal Medicine, vol. 149, p. 1925, September 1989, Editorial: Understanding the Benefits and Burdens of Tube Feedings.

Beauchamp, Tom L and Childress, James F., Principles of Biomedical Ethics, 1989 (third edition).

Berrol, Sheldon, Archives of Physical Medicine Rehabilitation, Vol. 67, May 1986, p. 283, Considerations for Management of the Persistent Vegetative State.

BIFOCAL (American Bar Association Commission on Legal Problems of the Elderly), Summer, 1989, Symposium Considers Legal, Medical and Ethical Aspects of Health Care Decision-making.

Brody, Baruch, Life and Death Decision Making, 1988.

Callahan, Daniel, The Hastings Center Report, October 1983, p. 22, On Feeding the Dying.

Declaration on Euthanasia, adopted by the Sacred Congregation for the Doctrine of the Faith, Approved by Pope John Paul II, Released to the public June 26, 1980.

Gavin, William J., American Philosophy Association Newsletter on Philosophy and Medicine, November 1988, vol. 88:1, The Gardner Case in Maine: Summary and Reflections.

Gianelli, Diane M., American Medical News, October 13, 1989, Guidelines sought on ending life-sustaining treatment.

Health Law Vigil, vol. 11, no. 3 (January 29, 1988), JCAHO (Joint Commission on Accreditation of Healthcare Organizations): Accreditation Requires DNR Policy.

Hentoff, Nut, The Death Doctors, The Village Voice.

Higashi, K., et al, Journal of Neurology, Neurosurgery, and Psychiatry, 1981, 44, p. 552, Five-year follow-up study of patients with persistent vegetative state.

Jennett, B., et al, Neurosurgery, Vol. 4, No. 4, April, 1979, p. 283, Prognosis of Patients with Severe Head Injury.

Koop, C. Everett and Grant, Edward R., Journal of Law, Ethics and Public Policy, Vol. 2, 1986, p. 585, The "Small Beginnings" of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing.

MacDonald, Michael G., Kathryn C. Meyer and Beth Essig, Health Care Law: A Practical Guide, 1985 (supp. 1989).

Meisel, Alan, The Right to Die, 1989.

Mills, Janet T., D.A., Letter to the Editor, Kennebec Journal, Depriving non-competent persons of food and water, April 24, 1989.

Munsat, Stuart and Cranford, AAN, Neurology, January, 1989, Guidelines on the vegetative state: Commentary on the American Academy of Neurology statement.

New York Times, July 25, 1989, Does Right to Privacy Include Right to Die? Court to Decide (Cruzan).

New York Times, September 11, 1989, Judges Anguish Over Medical Issues.

O'Rourke, Kevin, America, November 22, 1986, The A.M.A. Statement on Tube Feeding: An Ethical Analysis.

Oxman, Jon S., 1989 Me. Bar J. 10 (Jan. 1989), In Re Joseph Gardner, The Balance Between Patient Rights and Self-determination and the State's Responsibility to Preserve Life.

Position of the American Academy of Neurology on certain aspects of the care and management of the persistent vegetative state patient, Adopted by the Executive Board, American Academy of Neurology, April 21, 1988

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions, March, 1983.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, March, 1983.

Pushcock, Thomas A., Maine Lawyer's Review, January 1988, Gardner Dies - But Debate over Self-determination Goes on in Law, Medicine.

Pushcock, Thomas A., Maine Lawyer's Review, January 1989, Probate Court Finds Guardian May Make Decision to Withhold Hydration, Nutrition, Medicine from Ward in Persistent Vegetative State.

Quill, Thomas E., Archives of Internal Medicine, vol. 149, p. 1937, September 1989,Utilization of Nasogastric Feeding Tubes in a Group of Chronically Ill, Elderly Patients in a Community Hospital.

Rozovsky, Fay A., Consent to Treatment: A Practical Guide, 1984 (supp. 1988).

Shuttleworth, E., Neurology, March, 1983, No. 33, p. 372, Recovery to social and economic independence from prolonged postanoxic vegetative state.

Siegler, Mark and Weisbard, Alan J., Archives of Internal Medicine, Vol. 145, January, 1985, p. 129, Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?

Siegler, Mark, Hastings Center Report, vol. 16, no. 3, 1986,Ethics Committees; Decisions by Bureaucracy.

Simmons, Jack H., Maine Lawyer's Review, October, 1988, Commentary: Life or Death; and November/December, 1988, Commentary: Life, Death and the Criminal Law.

Smith, David H. and Robert M. Veatch, ed., Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, The Hastings Center, 1987.

Society for the Right to Die, Artificial Nutrition and Hydration, September, 1989.

Society for the Right to Die, Handbook of Living Will Laws: 1987 Edition.

Trial Court Decision in Houle Case, Superior Court of Cumberland, February 14, 1974, David G. Roberts, Justice of the Superior Court.

Wanzer, Sidney H., et al, New England Journal of Medicine, April 12, 1984, Special Article: The Physician's Responsibility Toward Hopelessly Ill Patients.

Wanzer, Sidney H., et al, New England Journal of Medicine, March 30, 1989, Special Article: The Physician's Responsibility Toward Hopelessly Ill Patients, A Second Look.

Withholding or Withdrawing Life Prolonging Medical Treatment, Statement of the Council on Ethical and Judicial Affairs, American Medical Association (March 15, 1986).

CITATIONS OF SELECTED RIGHT TO DIE
COURT DECISIONS

Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983).

Bouvia v. County of Riverside, No. 159780 (Cal. Super. Ct. Riverside County Dec. 16, 1983) (Hews, J.).

Bouvia v. Superior Court (Glenchur), 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Ct. App. 1986), *review denied* (Cal. June 5, 1986).

Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E.2d 626 (1986).

In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), *overruled in part*, In re Guardianship of Hamlin, 102 Wash. 2d 810, 689 p.2d 1372 (1984).

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

Cruzan, by Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), cert. granted, 58 USLW 3046.

In re Conservatorship of Drabick, 200 Cal. App. 3rd 104, 245 Cal. Rptr. 840 (Cal. App. 6 Dist. 1988).

In re Dinnerstein, 6 Mass. App. 466, 380 N.E.2d 134 (Ct. App. 1978).

In re Eichner (In re Storar), 52 N.Y.2d 420 N.E.2d 64, 438 N.Y.2d 266, *cert. denied*, 454 U.S. 858 (1981).

In re Gardner, 534 A.2d 947 (Me. 1987).

In re Guardianship of Hamlin, 102 Wash. 2d 810, 689, P.2d 1372 (1984).

Matter of Jobes, 529 A.2d 434 (N.J. 1987).

O'Connor, Matter of Westchester County Medical Center on Behalf of, 534 N.Y.S.2d 886, 72 N.Y.2d 517, 531 N.E.2d 607 (1988).

In re Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976), *overruled in part*, In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

Rasmussen v. Fleming, No. 2 CA-CIV 5622 (Ariz. Ct. App. 2 Div. June 25, 1986), *petition for review filed* (Ariz. July 10, 1986).

Satz v. Perlmutter, 362. So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452 (D.D.C. 1985).