

#L-502

Memorandum 85-66

Subject: Study L-502 - Dying and Life Sustaining Procedures

At the January 1985 meeting of the Law Revision Commission, the Estate Planning, Trust & Probate Law Section of the State Bar handed out at the meeting a Memorandum relating to dying and life sustaining procedures and other matters. An extract of the relevant portions of the Memorandum is attached as Exhibit 1 to this Memorandum. The Memorandum suggests that the Commission recommend to the Governor that he appoint a "blue ribbon" statewide Commission to consider the legal problems related to dying and termination of life sustaining procedures. For more detail, see Exhibit 1 attached. The State Bar suggestion was briefly discussed at the January 1985 meeting. But the Commission took no action in response to the suggestion.

The staff believes that the suggestion of the State Bar Section merits serious consideration by the Commission. There are important questions that need to be clearly answered. Is a patient permitted to decline or to have withdrawn artificial administration of nutrition and hydration? The staff is of the view that this type of question is not a "legal" question--it is a moral question, and the development of an answer that will be generally accepted requires that persons in fields outside law and medicine be involved as well as lawyers and doctors. A blue ribbon Commission, as suggested by the State Bar Section, may be the best method of obtaining the needed answers to the difficult questions relating to dying and termination of life sustaining procedures.

The development of the answers to these difficult questions cannot be delayed. The courts are reluctant to answer the questions. The doctor and the patient's family need to have a clear answer to these questions. The questions are presented every day as dying patients seek dignity, freedom from pain, and relief.

An article entitled "The Elusive 'Right to Die,'" from the most recent issue of the Stanford Lawyer, provides valuable background information and is attached as Exhibit 2. Exhibit 3 is an article from the Pacific Law Journal that represents the kind of analysis that

is made when only a lawyer is involved in the decision making. Exhibits 4, 5, and 6 are newspaper articles, published within the last few days, that indicate the distress caused by the existing uncertainty in the law and the problems caused when a court judgment is required to terminate life sustaining procedures.

The staff believes that this issue is one of the most important that has been presented to the Commission for possible Commission action.

If the Commission decides to recommend to the Governor that a "blue ribbon" commission be established as suggested by the State Bar Section, the staff will obtain more information concerning the one appointed by the Governor in New York and will prepare a draft of a recommendation for consideration by the Commission at the next meeting.

Respectfully submitted,

John H. DeMouilly
Executive Secretary

EXHIBIT 1

MEMORANDUM

TO: California Law Revision Commission
(herein "Commission")

FROM: Estate Planning, Trust & Probate Law Section

DATE: January 22, 1985

RE: Durable Power of Attorney For Health Care;
and Memorandum 85-8 dated January 8, 1985

This memorandum is on behalf of the Estate Planning, Trust & Probate Law Section of the State Bar of California. It deals with the Durable Power of Attorney For Health Care in two respects:

2. Second, it comments and makes recommendations of a broader and more general nature regarding dying, the termination of life and the Durable Power of Attorney For Health Care.

The second part of this memorandum addresses a more pervasive issue of both national and California concern: dying, the termination of life and the Durable Power of Attorney For Health Care.

Nearly every week brings forth a new major development in the nationwide concern of many disciplines in dying and

the termination of life. Many disciplines are carefully considering the issues in terminating the life of an incapacitated person: ministers; theologians; philosophers; ethicists; physicians; health care providers; attorneys; legislators.

Even in the short two month period since the Commission issued its tentative recommendation L-500 in November, 1984, a number of very important events have occurred:

(a) "Negotiated Death": A new concept "negotiated death," or "death by consensus" is emerging in practice. The negotiations involve the doctor(s), family members, hospital staff, and attorneys for all sides. The issue: to end life sustaining treatment for terminally ill or comatose patients who may, or may not, have left directions for their own continuing care. This development has increased the use of hospital "Ethics Committees" and the formulation of practical guidelines for use in terminating life sustaining treatment.

(b) New York Commission. During the week of December 17-22, 1984, New York's Governor Cuomo appointed a 23 person "blue ribbon" commission on Life and The Law. It's initial report is due May 1, 1984, but the Commission will continue its work thereafter. Among its important topics is discontinuing life sustaining therapies for the terminally ill. (From New York Times, December 23, 1984, p. 12)

(c) Bartling v. Superior Court (Dec. 27, 1984)
2 Civil No. B007907. By far the most important single decision in the field of terminating life sustaining equipment - a respirator that controls the patient's air! The decision was announced on Thursday, December 27, 1984 by a unanimous three judge panel of the Court of Appeal. The legal ramifications of the Bartling case are still being studied by all physicians, other health care providers, district attorneys and private attorneys.

(d) Claire Conroy Case (New Jersey, January 17, 1985). On January 17, 1985, the New Jersey Supreme Court handed down its 6-1 decision in the long awaited case of Claire Conroy. The Court, by a 6-1 vote reversed a unanimous 1983 decision by the Appellate Division of the Superior Court. The full text of the Conroy decision has not been available to the writer of this memorandum at the date of this memorandum; however, its national impact will be very important.

II.

General Recommendation: Statewide Commission Appointed by Governor

The Executive Committee recommends that the Commission recommend to the Governor that he appoint a "blue ribbon" statewide Commission to consider the legal problems related to dying and termination of life sustaining procedures. We strongly believe that the Law Revision Commission does not have sufficient time to assemble the view points of the various disciplines that are essential to reach a considered consensus regarding these matters. We believe that a commission somewhat along the lines of the New York Commission is very much needed in California.

Our recommendation would be that the California commission serve without pay, as is true in New York, and that it be composed of the following:

1. The chairman or Executive Director of California Law Revision Commission.

2. From the ministry: one rabbi; one priest; one protestant

3. The president or other designated representative of California Medical Association.

4. The president or other designated representative of California Hospital Association.

5. A couple of professors from Academia who deal with questions pertaining to ethics and philosophical questions associated with dying.

6. A couple of attorneys appointed by the Board of Governors of State Bar of California. We believe that it should include the chairperson of Estate Planning, Trust and Probate Law section or someone designated by him.

7. President or designated representative of the District Attorneys Association.

8. A couple of "members at large" who may not be included in any of the above categories but who have both a concern and viewpoint re the problems of dying. We are thinking of such individuals as the director of a hospice, a representative of the elderly community, and others whose viewpoints should be expressed.

It would be the goal of the committee to study and make recommendations to the Governor with respect to proposed legislation.

The Elusive 'Right to Die'

Michael Gilfix '73

Few issues are as emotion-laden or complex as the oddly named "right to die." An outgrowth of advances in life-support technology, it evokes images of paradoxically sophisticated, yet intrusive, medical treatment. It creates dilemmas in public policy, medical economics, and human ethics. And it presents a number of legal questions that go well beyond the scope of settled law.

Despite these difficulties, life-support technologies are undeniably withheld or withdrawn in medical practice every day. Such decisions are commonly made by the physician in consultation with members of the patient's family. Fear of court involvement has, however, cast a pall over this already sensitive decision-making process.

Unfortunately (or fortunately, if you prefer), this fear is not without basis. In California, for example, two physicians who withdrew life-support systems from a terminally ill patient have faced both criminal homicide charges and civil damage actions. Still other physicians and their hospital have been sued for *refusing* to terminate life-support systems.

Until recently, the few courts to address this issue have taken an approach best described as reactive, with predictably little in the way of objective guidelines. Legislative initiatives have also, with rare exceptions, failed to define appropriate medico-legal standards.

As a result, many health professionals continue to feel exposed, uncertain, and at risk of becoming involuntary litigants every time they decide to

withhold or withdraw life-support technology from terminally ill, dying patients.

This ongoing uncertainty as to legal standards and liability has created a role for legal counsel. Attorneys are now participating on medical ethics committees at major hospitals across the nation. Some medical centers, including UCLA School of Medicine, have added attorneys to their faculties. And many individual doctors now seek legal advice before making or implementing decisions previously considered a private matter between physician and family.

While the body of law relating to terminal care is still evolving, there are precedents and procedures to which practicing attorneys may refer. This article explores the present status of the law in terms of both judicial interpretation and legislation—with particular attention to new "Durable Power

of Attorney for Health Care" laws allowing an individual to plan in advance for decision making during her own terminal illness.

It is, however, important to remember that such laws—though helpful to individual patients who have made legal arrangements for their own care—still leave medical professionals and hospitals without general decision-making guidelines and procedures applicable to that majority of terminally ill patients less knowledgeable about the law.

The lack of clear law in this area also has societal costs. With medical expenditures already consuming 10.8 percent of our gross national product, inappropriate spending on defensive terminal care is likely to be at the expense of other, more effective efforts, such as preventive medicine or care of patients with better chances of returning to health.

Judicial Interpretations: The Development of Patients' Rights

The existence of sophisticated life-support technology is, by definition, historically unprecedented. Cases raising issues of high-tech care of the terminally ill or comatose patient have been few, and courts have accepted them reluctantly. They consistently state that such issues are best left to families, physicians, and legislatures. In their rulings, they have had to build creatively upon legal principles crafted in simpler times.

One recurrent and appropriate theme in "right to die" litigation is the penumbral right to privacy—a principle rooted in *Union Pacific R. Co. v. Botsford*, 144 U.S. 250 (1891), and more recently developed in *Griswold v. Connecticut*, 381 U.S. 479 (1965). This

right to bodily and personal integrity has found its way to related areas of contraception, procreation and abortion. It is a concept heavily relied upon in *Bartling* (see below), one of the California "right to die" cases featured in a recent episode of "60 Minutes."

No less important is the seemingly well-established right of a competent individual to approve or reject any lawful form of medical treatment, as in *Cobbs v. Grant*, 8 Cal. 3d 229, 104 Cal. Rptr. 505 (1972). Justice Cardozo most lucidly established the principle in *Schloendorff v. Society of New York Hospitals*, 211 N.Y. 125, 105 N.E. 92, 93 (1914): "Every human being of adult years or sound mind has a right to determine what should be done with his own body." As we will see, however, this right has been far more elusive than Justice Cardozo could ever have anticipated.

Paramount among these cases ad-

ressing this issue is that of Karen Ann Quinlan, a young New Jersey woman who went into an irreversible coma some nine years ago and whose name has since become synonymous with the suffering of family members and the search for answers to impossible questions.

Ms. Quinlan's father, Joseph Quinlan, relied heavily upon his daughter's right to privacy in successfully petitioning a court to become her guardian. Backed by unanimous family agreement, he was given the right to withdraw the respirator that was, in expert medical opinion, keeping her alive. Ms. Quinlan confounded medical science and made her own situation even more poignant by surviving her sudden weaning from the respirator. She continues to exist to this day, but, significantly, her father has not sought court permission also to withdraw nutrition and hydration support from his daughter.

Unlike *Quinlan*—where the New Jersey court made a point of deferring to concurrence on the part of the physician, the family, and the hospital ethics committee—a Massachusetts court later held that court approval was necessary for the withholding of "extraordinary" life support. There, 67-year-old Mr. Saikewicz, who was both mentally retarded and terminally ill, was not capable of giving or refusing consent on his own behalf.

A later Massachusetts case, *In the Matter of Dinnerstein*, 6 Mass. App. 466, 380 N.E. 2d 134 (1978), departed from *Saikewicz* and reinforced the family/physician approach. It held that an attending physician may, with family agreement, issue an order for "no resuscitation" in the event of respiratory

or cardiac arrest.

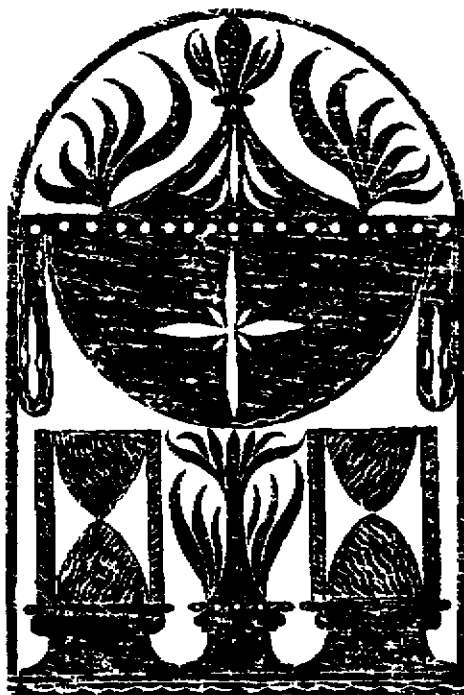
A 1981 New York court confirmed the patient's right to determine his own medical treatment. Brother Fox (a monk) was comatose and dependent on a respirator for life. On the basis of statements he had made to others about Karen Ann Quinlan's situation, it was established by clear and convincing evidence that, if he were able, he would have refused consent for use of the respirator, and such use was withdrawn. *Brother Fox* is highly significant because of its reliance on both oral and written statements previously made by a patient now hopelessly ill and totally lacking in capacity.

California Leading Cases: Barber and Bartling

The filing of criminal charges against physicians who exercise their best medical judgment and obtain unanimous family consent in ordering withdrawal of life-sustaining treatment would be viewed as an unconscionable and horrific development by the medical community. It would confirm their worse fears, and have a classic chilling effect on traditional, well-established medical care practices. Yet this is precisely what happened in the aftermath of a decision by two California physicians to let Clarence Herbert die.

Mr. Herbert had suffered cardiopulmonary arrest shortly after surgery for closure of an ileostomy, went into a coma, and was placed on a respirator. After five days, the physicians determined that Mr. Herbert's condition was irreversible and so advised his wife and family. With Mrs. Herbert's consent, use of the respirator was discontinued. Mr. Herbert continued, though still comatose, to live without assistance from the respirator. The physicians then obtained written spousal permission to terminate administration of nutrition and hydration; six days later, Mr. Herbert died.

Doctors Barber and Nejd1 were shocked, as was the entire medical community, when murder charges were



subsequently filed against them by the Los Angeles District Attorney. A legal roller coaster followed, with a municipal court judge dismissing the murder charges, a superior court judge reinstating them, and a court of appeals ultimately resolving the matter by effectively dismissing the charges in a precedent-setting opinion, *Barber v. Superior Court*, 147 Cal. App. 3d 10006 (1983).

The appellate court scolded the California legislature for failing to take the initiative, and stressed the lack of reliable standards and decision-making methods that would eliminate or minimize the need for court involvement.

The *Barber* court took a major and protective step forward in finding murder charges to be inappropriate. Going further, it outlined decision-making criteria that placed substantial reliance on the March 1983 *Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*. After confirming that a patient's wishes are always dominant, the court addressed situations with a focus on whether a particular procedure was "ordinary" or "extraordinary," and described a balancing analysis. That analysis focused on "whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused."

The court went on:

Under this approach, proportionate treatment is that which, in view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.

Citing *Quinlan* and *Dinnerstein*, a very definite dichotomy was drawn by the court between a normal, sentient existence on the one hand, and a "biological vegetative existence" on the other. Using this analysis, and because Mr. Herbert was diagnosed as irretrievably comatose, the court then addressed the question of who should make treatment decisions. It noted that the physicians acted properly in relying on Mr. Herbert's wife, who was identified as the most appropriate surrogate. In fact, Mrs. Herbert was joined by eight of their children in deciding to withdraw the medical treatment. This decision was bolstered by reports that Mr. Herbert had told his wife that he did not want to become "another Karen Ann Quinlan."

While *Barber* is lauded by medical care providers for affording them a measure of protection from criminal charges, it did not address exposure to civil litigation and its less demanding standard of proof. Indeed, the same physicians who implemented nontreatment decisions in Mr. Herbert's case are currently defending a multimillion-dollar civil action brought by Mr. Herbert's spouse, despite her earlier written approval of the actions taken.

While Doctors Barber and Nejd1 are being sued for seemingly following a family's decision, other physicians and a hospital in Glendale, California, were recently sued for refusing to follow a

patient's and his family's instructions.

In this case, William Bartling, now deceased, suffered from at least three terminal conditions. None of these conditions were certain to cause his death in the immediate future. The hospital's legal counsel was apparently the source of advice to maintain Mr. Bartling's treatment, indicating that to do otherwise could be viewed as active euthanasia. Causes of action in *Bartling* include violations of his constitutional rights (life, liberty, privacy), battery, intentional infliction of emotional distress, and conspiracy.

The Bartling family's approach represents a new aggressiveness in asserting patients' rights to self-determination—an approach also used in another 1984 California case, that of Elizabeth Bouvia, a cerebral palsy victim who unsuccessfully sought a hospital's assistance to effectively starve herself to death.

On December 27, 1984, a California appellate court rendered an opinion in *Bartling*, 209 Cal. Rptr. 220 (1984), that contributes even more clarity to legal and medical practitioners who are grappling with this issue. While not questioning the motives of the medical care providers in their refusal to withdraw Mr. Bartling's respirator, the court ruled that withdrawal should have been allowed. The court emphasized that

The right of the patient to self-determination as to his own medical treatment . . . must be paramount to the interests of the patient's hospital and doctors. The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged.

Significantly, the court concluded that prior judicial consent to withdraw treatment in such cases is not legally required.

Cases like these, widely reported in the media, illustrate the legal hazards surrounding decision-making about terminal care. What advice can attorneys give clients concerned about possible difficulties surrounding their own eventual dying process?

Planning for Decision Making in Terminal Condition

From both common sense and legal perspectives, it is wise to establish and exercise one's right to plan for incapacity, and a terminal condition. In recent years, this has been done by executing a "living will," which is an excellent expression of desire to die without needless and extraordinary medical interventions. Particularly, however, in states that have explicit legislation addressing this issue, the living will is not enough.

This discussion will focus on California law, because its two legislative enactments have conceptual siblings and progeny across the nation.

Natural Death Act

California's 1976 Natural Death Act, Cal. Health and Safety Code §§ 7185-94, was the first of its kind in the nation. In limited circumstances, an appropriately executed Natural Death Act (NDA) directive legally compels a physician to withhold or withdraw "life sustaining procedures."

The problem with this legislation is how rarely the confluence of all necessary facts occurs. If, for example, a person who is not facing death in the immediate future signs an NDA directive, it is not legally binding on a physician. To be binding, all of the following must be satisfied.

- The patient, a competent adult, must first be "certified" by two physicians as being "terminally ill"—a term defined as meaning that he is expected to die "imminently," which, though not defined in the legislation, is often taken to mean a period of two-to-three weeks.
- The patient must then survive 14 days, still be competent, and sign the directive in the presence of appropriate witnesses.

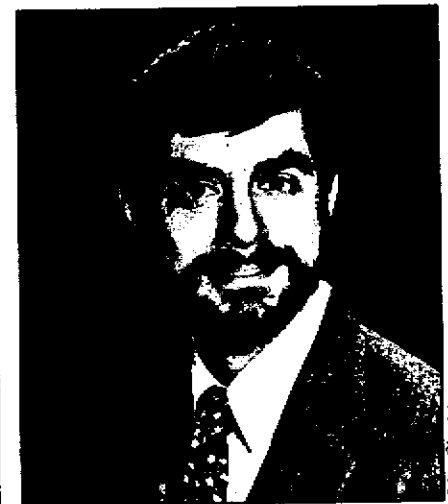
This has been aptly described as a classic Catch 22. And even if all conditions for the directive are met, the attending physician may still exercise

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His interest in the "right to die" issue grows out of long involvement with the problems of the elderly. In 1973, just after graduating from the School, he founded and became first director of Senior Adults Legal Assistance, in Santa Clara County.

Gilfix has served on the California State Bar Committees on Aging and on Legal Services for Handicapped Persons, and was from 1976 to 1979 a member of the executive committee of the Bar's Legal Services Section.

He and Dr. Thomas A. Raffin of Stanford University Medical Center recently coauthored an article for physicians, "Withholding or Withdrawing Extraordinary Life Support" (Western Journal of Medicine, September 1984), from which some material for the present article was drawn.



John Sheeritz

The artwork is from Early New England Gravestone Rubbings, by Edmund Vincent Gillon, Jr. (Dover, 1966), a book in the Stanford Art Library collection.

extensive independent judgment with relative impunity.

The NDA directive, then, represents a positive step but stops far short of securing patients' rights in this most difficult area of medical decision making.

Durable Power of Attorney

A much more significant development is the Durable Power of Attorney for Health Care (DPAHC) act, recently adopted in a handful of states, including California, where it passed in 1983 as a new section, § 2412.5, of the Uniform Power of Attorney statute, Cal. Civil Code §§ 2400 et seq. (1981). This measure lets a competent adult do two things.

First, she can name another person—the "attorney in fact"—who will be legally empowered to make medical care decisions for her if she is subsequently incapacitated and unable to do so on her own behalf. Thus, a surrogate decision-maker is effectively appointed without costly, cumbersome, and unreliable resort to the courts for such authority.

Secondly, she can specify the treatment she does or does not want. So long as such instructions are lawful, there are no restrictions on their content. They can pertain to potential complications and treatments for serious medical problems that are known to the principal.

For example, a person with lung cancer may become very sophisticated about her affliction and either authorize or reject particular treatments.

Again, this document would be utilized only in the event of the patient's incapacity. So long as she is able, she retains the legal, albeit sometimes elusive, right to make her own medical care judgments.

While DPAHC legislation does not provide guidelines for appropriate levels for terminal care, it nonetheless does empower decisions about use or non-use of extraordinary means. When these and

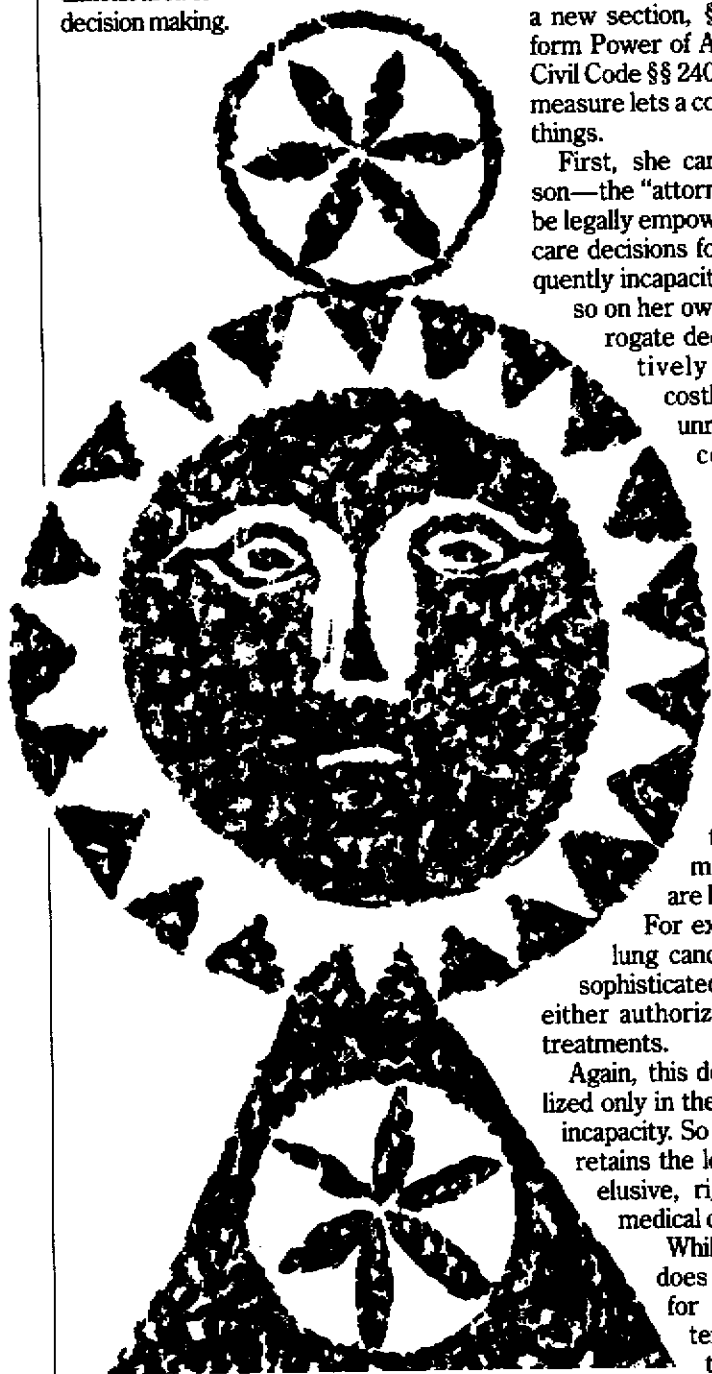
other treatment issues are faced, the attorney-in-fact is to act in the principal's "best interest"—a term not, unfortunately, defined in the legislation.

The term, however, was discussed in precisely this context in the 1983 *Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*. The Commission recommended considering such factors as relief of suffering, and the chance of restoring or preserving a functioning, qualitative life, with an emphasis on "the possibility of developing or regaining the capacity for self-determination."

Most persons executing a DPAHC indicate, with greater or lesser degrees of sophistication, that they do not want any medical treatments that would serve only to prolong the dying process. Motives include a sense of personal dignity and integrity, concern about needless suffering, and a desire to protect family members by removing such decision-making responsibilities from their shoulders. Another and major consideration is the cost of such care; older persons are particularly concerned that their dying will wipe out the cherished security—the "nest egg"—left their surviving spouses.

Reflective of the conceptual neutrality of this legislation on the "right to die" vs. "right to life" debate is the fact that a person can, as effectively, indicate that all conceivable steps be taken to preserve life. The objective, again, is to give adults the right to determine their course of treatment in advance, not to compel a particular result.

Critical to the ultimate reliability of DPAHC documents is the fact that physicians who rely on them are by statute insulated from criminal prosecution, civil liability, or proceedings that could expose them to findings of unprofessional conduct. To obtain these protections, a physician must believe in good faith that the attorney-in-fact has been properly authorized, and that the decisions being made are consistent with the wishes of the patient, either as expressed in the document





itself, or in some other way.

DPAHC legislation, then, is both reinforcing of the patient's rights and protective of the physician's interests. These ingredients, being inevitably intertwined and interdependent, are necessary to realistic, progressive legislation.

Withholding Nutrition and Hydration

One special problem deserves attention: instances where a person is irreversibly comatose or in a persistent vegetative state, survives independently of any mechanical medical device, but continues to depend on artificial administration of nutrition and hydration.

Are such life-sustaining procedures to be viewed in the same way as more obviously intrusive and/or technological treatments? Will instructions in DPAHCs to withhold such support be followed by physicians, and will such physicians be protected from criminal charges and civil judgments?

This question was addressed in *Barber*, where the appellate court was explicit in viewing artificial nourishment and hydration in the same way as any other life-support equipment. Most physicians and ethicists who have addressed the issue agree, but there is a subjectively credible view to the contrary. Some believe that there is symbolic significance in withholding food and water—the basics of life—and that doing so raises serious social policy issues that must be viewed differently from those of the more clearly mechanical forms of support.

The question was also addressed recently by the New Jersey Supreme Court in *In the Matter of Claire C. Conroy* (N.J., Jan. 17, 1985). Claire Conroy, now deceased, was an 84-year-old nursing home resident with severe physical and mental impairments. Although not in a vegetative or comatose condition, she was severely demented and unable to express any thoughts. She was maintained by a nasogastric

feeding tube. Her closest relative, convinced that removal of the tube would be her wish, sought court approval to do so.

The New Jersey court held that life-sustaining treatment can be removed in cases where it is clear that the incompetent patient would have refused if she were able. The court's remaining analysis is conceptually similar to the "proportionate treatment" test of *Barber*. Where patient wishes are not crystalline, it would use the "limited-objective test." Under this, treatment may be withdrawn where there is "some trustworthy evidence that the patient would have refused the treatment," and that the burdens of life, such as prolonged suffering, outweigh the benefits.

In a third scenario, where there is no evidence of what the patient would have wanted, the court explained its "pure-objective test." Here, the court focused on a net benefits vs. net burdens of life inquiry, and discussed such burdens in terms of pain—"recurring, unavoidable and severe"—such that continued life would be "inhumane."

Interestingly, the *Conroy* court ruled that none of these three alternative criteria were satisfied in Mrs. Conroy's case, and that there was no basis for withdrawal of her tube feeding.

Notwithstanding some points of disagreement, then, the most appropriate approach to this issue would seem to be clear. It is most consistent with court decisions, as well as the views of the Presidential Commission referred to above, and would apply the "proportionate-disproportionate" test developed in *Barber* and *Conroy*. *Potential for improvement*, rather than non-salient maintenance, should be paramount in determining the appropriate level of intrusive treatment. Using this approach, it is probable that clear rejection in a DPAHC of nourishment in the event of irreversible coma would be respected.

Lacking such a document, other evidence of the patient's desires must be given great credence, as should the patient's "best interests" as evaluated by the physician and family. Resort to

the courts, however unavoidable in many instances, must be viewed as a last resort.

Conclusion

When all the symbolic, "greater good" rhetoric and constitutional theory are cleared away, the individual human beings—Karen Ann Quinlan, Clarence Herbert, Claire Conroy, and William Francis Bartling—remain. Afflicted with varying medical crises and differing levels of capacity, they each suffered, and with them their families. Assessing each case were teams of physicians who did their best to determine the most appropriate course of medical treatment.

Their cases are by no means exceptional. Every day, dying patients seek dignity, freedom from pain, and relief. They seek to protect their loved ones from the agony of decision making and, it must be acknowledged, from economically devastating medical care costs. Physicians and families must grapple with these same, impossible questions, and find solutions that are as respectful as possible of the differing realities facing each party.

The courts, with admitted reluctance, have recently developed criteria and standards that can be utilized on a case-by-case basis. Far more productively, some legislatures have taken bold steps forward. They have provided a means by which individual wishes can be expressed and, ideally, respected without involvement from the courts.

It now remains for the legal and medical communities to educate the public about such developments as California's Durable Power of Attorney legislation, and, I would urge, to ensure passage of similar legislation in those states that have not yet done so. Nothing can be deemed more basic than the individual's right to control his or her own medical treatment without interference from others with a larger agenda. □

EXHIBIT 3

Withholding Food and Water from a Patient—Should it be Condoned in California?

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.
From the Hippocratic Oath

Courts long have recognized the right of a hospitalized patient to refuse medical treatment.¹ Courts also have declared that a close family member or guardian vicariously may assert a patient's right to refuse medical treatment if the patient is incompetent or comatose.² Recently, however, courts have been presented with the issues of whether a hospitalized patient has the right to refuse food and water and whether a guardian may assert that right on behalf of the hospitalized patient.³

In *Barber v. Superior Court*,⁴ two physicians were charged with murder for removing the intravenous tubes supplying nutrition and hydration⁵ to a comatose patient.⁶ The patient died from dehydration six days after the tubes were removed.⁷ The California Court of Appeal issued a writ of prohibition restraining the Superior Court from taking action on the murder charges.⁸ On the facts presented,⁹ the court declared that intravenous administration of food and water was the legal equivalent of the administration of other medical life-

1. See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160, 162-64 (Fla. Dist. Ct. App. 1978), *aff'd* 379 So.2d 359 (Fla. 1978); *In re Melideo*, 390 N.Y.S.2d 523, 524 (Sup. Ct. 1976); *In re Osborne*, 294 A.2d 372, 375-76 (D.C. 1972); *In re Brooks' Estate*, 205 N.E.2d 435, 442-43 (Ill. 1965).

2. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 270 N.E.2d 417, 419-20, 435 (Mass. 1977); *In re Schiller*, 372 A.2d 360, 366-67 (N.J. 1977); *In re Quinlan*, 355 A.2d 647, 671-72 (N.J. 1976).

3. See *In re Conroy*, 464 A.2d 303, 304 (N.J. Super. Ct. App. Div.), *certification granted*, 470 A.2d 418 (N.J. 1983); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1011, 195 Cal. Rptr. 484, 490 (1983).

4. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

5. Hydration is the administration of water to a patient. *STEDMAN'S MEDICAL DICTIONARY* 660 (23d ed. 1976).

6. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

7. Cox, *Justices Dismiss Murder Charges Against Doctors*, L.A. Daily J., Oct. 13, 1983, at 1, col. 2.

8. *Barber*, 147 Cal. App. 3d at 1022, 195 Cal. Rptr. at 494.

9. For a discussion of the relevant facts and circumstances presented in *Barber*, see *infra* notes 59-80 and accompanying text.

support systems.¹⁰ Since a doctor legally may remove life-support equipment,¹¹ and since *Barber* declared that food and water was the same as other life-support systems,¹² a doctor may remove intravenous tubes at the request of the patient's family without fear of criminal liability.¹³

Although *Barber* was a criminal case,¹⁴ the rationale of the court may be extended to a situation in which a civil court is requested to authorize the removal of nasogastric¹⁵ or intravenous feeding tubes from a comatose or otherwise incompetent patient.¹⁶ This author presents the argument, however, that because the administration of food and water is inherently different from the administration of medical treatment¹⁷ a hospital is obligated to provide nourishment to patients, regardless of the obligation, or lack thereof, to provide them with medical treatment.¹⁸ Although a patient has a right to refuse medical treatment,¹⁹ he does not have a comparable right to refuse food and water. Refusal of food and water by either the hospitalized patient or his surrogate is suicide²⁰ and should not be condoned by the courts. This author takes the position, therefore, that *Barber* should not be used as precedent in a civil case to permit food and water to be withdrawn from a living patient.²¹ An analysis of the distinction between the administration of food and water and the administration of medical care begins with an examination of the right of a patient or his surrogate to refuse medical treatment.

10. 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490.

11. *In re Barry*, 445 So. 2d 365, 367-68, 372 (Fla. 1984); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984). See, e.g., *In re Quinlan*, 355 A.2d 647, 662-64, 672 (N.J. 1976).

12. *Barber*, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490.

13. *Id.* at 1022, 195 Cal. Rptr. at 493-94.

14. *Id.* at 1010, 195 Cal. Rptr. at 486.

15. Nasogastric tubes enter the stomach through the nose and carry food or water to the patient. DORLAND'S MEDICAL DICTIONARY 868 (26th ed. 1981).

16. An example of a guardian petitioning a court to permit the removal of feeding tubes from an incompetent patient is *In re Conroy*, 464 A.2d 303 (N.J. Super. Ct. App. Div.), certification granted, 470 A.2d 418 (N.J. 1983). The court refused to allow the guardian to remove the feeding tubes. *Id.* at 315. For a discussion of the implications of *In re Conroy*, see *infra* notes 117-35 and accompanying text.

17. See *infra* notes 155-79 and accompanying text.

18. See *infra* notes 84-154 and accompanying text.

19. See *infra* notes 25-56 and accompanying text.

20. See, e.g., *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 625 (1982).

21. Only the implications of the withdrawal of food and water from a living patient will be discussed in this comment. For a discussion of the implications of the removal of life support from a brain dead patient, see *Dority v. Superior Court*, 145 Cal. App. 3d 273, 276-77, 280-81, 193 Cal. Rptr. 289, 291-92 (1983).

THE RIGHT TO REFUSE MEDICAL TREATMENT

In California, two bases exist by which a patient may refuse medical treatment; the California Natural Death Act²² and the constitutional right of privacy.²³ A surrogate, however, may assert a patient's right to refuse treatment only by virtue of the patient's right of privacy.²⁴ First, the Natural Death Act will be examined as a basis for refusing medical treatment.

A. The California Natural Death Act

California statutory law gives an adult the right to refuse medical treatment.²⁵ The Natural Death Act²⁶ provides a mechanism by which a terminally ill person²⁷ may request that life-sustaining procedures²⁸ be withheld or withdrawn. The procedures may be withdrawn only if the procedures merely serve to prolong the moment of death.²⁹ Death must be imminent whether or not the life-sustaining procedures are utilized.³⁰

The Natural Death Act contains the legislative finding that "adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of terminal condition."³¹ The patient must make a written directive instructing his physicians to withhold or withdraw life-sustaining procedures.³² The Act, however, does *not* contain a provision by which a third person may refuse medical treatment for an incapacitated

22. CAL. HEALTH & SAFETY CODE §§7185-7195. See *infra* notes 25-34 and accompanying text.

23. See *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984). *Bartling* cites *Barber* to support the holding of the court that a competent, hospitalized patient has the right to have a ventilator disconnected despite the fact that withdrawal of the ventilator would hasten his death. *Id.* at 196-97, 209 Cal. Rptr. at 226. See also *infra* notes 35-55 and accompanying text.

24. See *infra* notes 33-34 and accompanying text.

25. CAL. HEALTH & SAFETY CODE §§7185-7195.

26. *Id.*

27. "Terminal condition" is "an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient." *Id.* §7187(f).

28. "Life-sustaining procedure" is defined as "any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized." *Id.* §7178(c).

29. "Death" is defined as the irreversible cessation of the circulatory and respiratory systems or the irreversible cessation of all functions of the entire brain. *Id.* at §7180.

30. *Id.* §7187(c).

31. *Id.* §7186.

32. *Id.* For the written format that must be used to direct a physician to remove life-sustaining devices, see *id.* §7188.

patient.³³ Only the patient himself may refuse treatment pursuant to the Natural Death Act.³⁴ Through the vicarious assertion of the patient's right of privacy, however, a surrogate may accomplish the same result, termination of life-sustaining treatment.

B. The Right of Privacy

Courts have held that a patient may refuse to accept medical treatment because of the patient's constitutional right of privacy.³⁵ Although the United States Constitution does not describe a right of privacy explicitly³⁶ the concept of the right of privacy first acquired constitutional dimensions in Justice Brandeis' dissenting opinion in *Olmstead v. United States*.³⁷ Justice Brandeis wrote: "The protection guaranteed by the Amendments . . . conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."³⁸ The concept of a right of privacy was developed further in Justice Douglas' dissent in *Poe v. Lillman*,³⁹ in which he argued that a right of privacy was implicit in a free society.⁴⁰ The right of privacy "emanates from the totality of the constitutional scheme under which we live."⁴¹

In 1965, the right of privacy was recognized by a majority of the Supreme Court in *Griswold v. Connecticut*.⁴² In *Griswold*, the defendants were arrested for disseminating information regarding contraceptive devices to married persons.⁴³ The Court held that the constitutional right of privacy prevented a state from prohibiting the dissemination of contraceptive information to married persons.⁴⁴ The right of

33. See *id.* §§7185-7195.

34. See *id.* §7188.

35. See, e.g., *Satz*, 362 So. 2d at 162; *Saikewicz*, 370 N.E.2d at 424; *Quinlan*, 355 A.2d at 663-64.

36. *Roe v. Wade*, 410 U.S. 113, 152 (1972).

37. 277 U.S. 438 (1928). The issue before the Court in *Olmstead* was whether evidence of an incriminating telephone call secretly overheard by a government wire tap was admissible in a criminal trial in federal court. *Id.* at 455. The Supreme Court held that use of this evidence did not violate the defendant's fourth or fifth amendment rights and that the evidence therefore was admissible. *Id.* at 455-59. This holding later was overruled by the Supreme Court in *Katz v. United States*, 389 U.S. 347, 352-53 (1967).

38. *Olmstead*, 277 U.S. at 478.

39. 367 U.S. 497, 509-22 (1961). The Court dismissed the case that would have determined whether a state statute prohibiting the use of contraceptive devices and the giving of medical advice as to the use of such devices was constitutional. *Id.* at 499-500. The Court found that the state was not enforcing the prohibitory statute and thus the Court did not need to determine the statute's constitutionality. *Id.* at 502-08.

40. *Id.* at 521.

41. *Id.*

42. 381 U.S. 479 (1965).

43. *Id.* at 480.

44. *Id.* at 485-86.

privacy soon expanded to encompass areas other than dissemination of contraceptive information. For example, in *Roe v. Wade*⁴⁵ the Supreme Court extended the right of privacy into the area of abortion.⁴⁶ The Court held that the right "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."⁴⁷ The right of privacy prevents a state from completely prohibiting abortion.⁴⁸

In 1976, a court first extended the constitutional right of privacy to include the right to refuse medical treatment.⁴⁹ In *In re Quinlan*,⁵⁰ the New Jersey Supreme Court stated, in language reminiscent of *Roe*,⁵¹ that the right of privacy ". . . is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."⁵² In *Quinlan*, the patient's guardian requested authority from the court to remove life-support equipment from a comatose patient.⁵³ The court assumed that without the life-support equipment the patient soon would die.⁵⁴ The patient's guardian was permitted to withdraw the respiratory medical care by virtue of the patient's right of privacy.⁵⁵ The issue whether the patient's feeding tubes could be withdrawn was not raised.⁵⁶

Another example in which a patient's surrogate removed life-support from a comatose patient was the case of *Barber v. Superior Court*.⁵⁷ In *Barber*, however, the surrogate removing the life-support equipment also removed the patient's feeding and hydration tubes.⁵⁸ *Barber*, therefore, significantly departs from those cases allowing for removal of medical treatment.

45. 410 U.S. 113 (1972).

46. *Id.* at 153.

47. *Id.*

48. *Id.* The right of privacy also has been recognized in several other kinds of cases. See, e.g., *Loving v. Virginia*, 338 U.S. 1, 12 (1967) (right of privacy in marriage); *Carey v. Population Services International*, 431 U.S. 678, 684-86 (1977) (right of privacy implicated in statute prohibiting sale of contraceptives to minors); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (privacy interest in obscene materials in the home); *Rogers v. Okin*, 478 F. Supp. 1342, 1365-66 (D. Mass. 1979) (mental patient's ability to refuse the administration of antipsychotic drugs).

49. See, e.g., *Satz*, 362 So. 2d at 162; *Saikewicz*, 370 N.E.2d at 424.

50. 355 A.2d 647 (N.J. 1976).

51. *Roe*, 410 U.S. at 153 (1972). See *supra* note 47 and accompanying text.

52. *Quinlan*, 355 A.2d at 663.

53. *Id.* at 662-63.

54. *Id.* at 665.

55. *Id.* at 671-72.

56. *Id.*

57. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484.

58. *Id.* at 1010-11, 195 Cal. Rptr. at 486.

THE Barber DECISION

In *Barber v. Superior Court*,⁵⁹ a patient was hospitalized for routine abdominal surgery.⁶⁰ Following the surgery, the patient went into cardiorespiratory arrest⁶¹ and soon thereafter fell into a deep comatose state.⁶² Although the patient retained some minimal brain activity⁶³ and thus was not brain dead,⁶⁴ the patient's doctors concluded that the patient would remain in a permanent vegetative state.⁶⁵

After being told of the prognosis by the attending physicians, the patient's wife and family requested that all machines sustaining the patient's life be removed.⁶⁶ Accordingly, the doctors first removed the respirator and other life-sustaining machines; but the patient continued to live.⁶⁷ The doctors then ordered the removal of the intravenous tubes that provided food and water.⁶⁸ A short time later the patient died, not from the effects of the cardiorespiratory arrest, but from dehydration.⁶⁹

The physicians were charged with murder and conspiracy to commit murder.⁷⁰ The Court of Appeal issued a writ prohibiting the Superior Court from taking any further action on the charges,⁷¹ stating that a person either may accept or reject the use of life-support equipment that maintains his existence.⁷² The administration of nourish-

59. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

60. *Id.* at 1010, 195 Cal. Rptr. at 486.

61. *Id.*

62. *Id.*

63. *Id.* at 1013, 195 Cal. Rptr. at 488.

64. See *supra* note 29. The patient in *Barber* did have some brain activity and his circulatory and respiratory systems were functioning. *Barber*, 147 Cal. App. 3d at 1013, 195 Cal. Rptr. at 488. The patient was not dead according to California Health and Safety Code section 7180.

65. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

66. *Id.*

67. *Id.*

68. *Id.* at 1011, 195 Cal. Rptr. at 486.

69. Steinbock, *The Removal of Mr. Herbert's Feeding Tube*, 13 HASTINGS CENTER REP. 12, 14 (Oct. 1983).

During the presentation of the *Barber* case, the prosecution suggested that the patient was not, or was not known to be, permanently comatose when the intravenous tubes were removed. *Id.* at 13. The prosecution claimed that had the tubes not been removed, the patient might have recovered. *Id.*

A neurological expert called by the prosecution claimed that he believed the patient had a "good chance" of recovery. *Id.* at 14. Two other experts claimed that a doctor must wait at least two weeks after a person has entered a persistent vegetative state before a determination can be made with reasonable medical certainty that the patient's condition is hopeless. *Id.*

A nursing supervisor first balked when told to remove the patient's respirator and feeding tubes. *Id.* at 13. When the patient died as a result of the removal of the tubes, the supervisor's reaction was, "God, you mean if you don't wake up in three days this can happen to you?" *Id.*

70. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

71. *Id.* at 1022, 195 Cal. Rptr. at 494.

72. *Id.* at 1015-16, 195 Cal. Rptr. at 489-90.

ment through intravenous tubes was held to be legally equivalent to the use of a respirator or other forms of life-support treatment.⁷³ Since a respirator may be withdrawn from a comatose patient and because food and hydration is the equivalent of other life-support methods⁷⁴ feeding and hydration tubes also may be removed.⁷⁵

The *Barber* court believed that food was the equivalent of other life-support systems because feeding a patient intravenously is more similar to medical procedures than to typical human ways of eating.⁷⁶ The court contended that intravenous feeding should not be classified as either ordinary or extraordinary care,⁷⁷ but that feeding tubes may be disconnected when a patient has little chance for a return to sapient life.⁷⁸ Since food was the equivalent of medical care and because the patient had little chance for recovery,⁷⁹ the appellate court prohibited the lower court from taking any criminal action against the doctors who disconnected the feeding tubes.⁸⁰

Although the *Barber* court determined that the administration of food was the legal equivalent of the administration of medical care, many courts have treated food and medical care dissimilarly.⁸¹ Some courts have held that food is not the same as medical treatment and that a patient may not refuse food and hydration.⁸² This was the decision of Judge Hews of the California Superior Court in the recent case concerning Elizabeth Bouvia.⁸³

A PATIENT CANNOT REFUSE FOOD

The question whether a hospitalized patient may refuse food and water was placed squarely before the superior court when twenty-six year old Elizabeth Bouvia requested that the court enjoin the hospital

73. *Id.* at 1016, 195 Cal. Rptr. at 490.

74. *Id.*

75. *Id.* at 1016-18, 195 Cal. Rptr. at 490-91.

76. *Id.* at 1016-17, 195 Cal. Rptr. at 490.

77. *Id.* at 1018-19, 195 Cal. Rptr. at 491. If a court classifies treatment as ordinary care, the treatment is considered obligatory. See *infra* notes 138-48 and accompanying text.

78. *Barber*, 147 Cal. App. 3d at 1018-19, 195 Cal. Rptr. at 491-92.

79. The opinion of the court does indicate, however, that the patient had a chance for some degree of recovery. *Id.* at 1020, 195 Cal. Rptr. at 492. The court stated that the patient may have remained in a vegetative state or improved to full recovery. *Id.* at 1020, 195 Cal. Rptr. at 492. The chances for unimpaired recovery, however, were miniscule. *Id.* See also *supra* note 69 and accompanying text.

80. *Barber*, 147 Cal. App. 3d at 1023, 195 Cal. Rptr. at 493-94.

81. See, e.g., *Conroy*, 464 A.2d at 311; *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 627 (Sup. Ct. 1972).

82. *Chapman*, 450 N.Y.S.2d at 627.

83. *Cox, Lawyers, Doctors Back Court's Ban On Patient's Death*, L.A. Daily J., Dec. 19, 1983 at 1, col. 6.

where she was a patient from forcing her to accept food and water.⁸⁴ Bouvia, who was a quadriplegic suffering from cerebral palsy,⁸⁵ had decided that she would rather die than face life dependent on others for her survival.⁸⁶ Bouvia checked into a hospital and asked the hospital administrators to permit her to starve to death and to ease her way with hygienic care and pain-killing drugs.⁸⁷ Upon the refusal of hospital personnel to participate in Bouvia's attempt to kill herself, Bouvia sought to enjoin the hospital from administering food to her.⁸⁸ A California superior court refused to order the hospital to allow Bouvia to starve to death.⁸⁹ In fact, the judge ordered that should Bouvia try to refuse food, the hospital was permitted to force-feed her.⁹⁰ Thus, the court concluded that a hospitalized patient had no right to refuse food.⁹¹

Had the court determined that intravenous food and water were merely forms of medical treatment, the court would have evaluated Bouvia's request differently. A patient may refuse medical treatment by virtue of the constitutional right of privacy.⁹² If food and water were the legal equivalent of medical care, as the *Barber* court stated,⁹³ Bouvia could have refused intravenous feeding.⁹⁴ The *Bouvia* court, however, concluded that the administration of food was not the legal equivalent of the administration of medical treatment and, therefore, Bouvia had no right to refuse food while in the hospital.⁹⁵ The refusal of food and water was viewed as an act of suicide.⁹⁶ Since the patient had no right to commit suicide,⁹⁷ she had no right to ask the hospital

84. Cox, *Disabled Woman's Request to Die Raises Legal Furor*, L.A. Daily J., Dec. 8, 1983, at 1, col. 6.

85. *Id.*

86. L.A. Daily J., Dec. 23, 1983, at 14, col. 5.

87. Cox, *supra* note 84, at 1, col. 6.

88. *Id.*

89. Cox, *supra* note 83, at 1, col. 6.

90. L.A. Daily J., Dec. 23, 1983, at 14, col. 5. Bouvia was subjected to force-feeding until she checked out of the hospital. See L.A. Daily J., Dec. 28, 1983. She has since decided that she wishes to live and is no longer seeking death. N.Y. Times, April 24, 1984, §A, p. 14, col. 1.

91. See Cox, *supra* note 83, at 1 col. 6. The *Bouvia* court, however, gave no reason why a patient may not refuse food other than to declare that the refusal of food is suicide. See *id.*

92. See *supra* notes 49-55 and accompanying text.

93. *Barber*, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490.

94. Bouvia could have refused medical treatment by virtue of her constitutional right of privacy. See *supra* notes 49-55 and accompanying text.

95. L.A. Daily J., Dec. 23, 1983, at 14, col. 5.

96. *Id.*

97. California Penal Code section 401 holds any person who deliberately aids, advises, or encourages another to commit suicide guilty of a felony. The court in *Chapman*, 450 N.Y.S.2d 623, stated that the constitutional right of privacy did not include the right to commit suicide. *Id.* at 625. "To characterize a person's self-destructive acts as entitled to that constitutional protection would be ludicrous." *Id.* at 625.

to assist her in that act.⁹⁸ Other states, besides California, have been requested to permit a patient to refuse food. The New York decision of *Von Holden v. Chapman*⁹⁹ is another illustration of a refusal by a court to allow a person to starve himself to death under a claim of a constitutional right of privacy.

A. Von Holden v. Chapman

In *Von Holden v. Chapman*, the court examined whether a prisoner should be allowed to starve himself to death.¹⁰⁰ Mark Chapman, the killer of former Beatle John Lennon, was committed to the psychiatric ward of Attica State Prison.¹⁰¹ To protest his commitment, Chapman attempted to starve himself to death.¹⁰² A New York trial court authorized the facility director to sustain Chapman's life by force-feeding.¹⁰³ Chapman appealed this order to the New York appellate court.¹⁰⁴

Chapman claimed that under the constitutionally protected right of privacy, a person must be allowed to refuse life-prolonging medical care.¹⁰⁵ Chapman contended that because food also would prolong his life, he therefore also had a constitutional right to refuse nourishment.¹⁰⁶ Chapman believed that his right of privacy should enable him to refuse all treatment that would tend to prolong his life, including the administration of food.¹⁰⁷

The court rejected Chapman's claim that the right of privacy entitled him to starve himself to death¹⁰⁸ holding instead that the refusal of food was suicide and could not be condoned.¹⁰⁹ The refusal of medical treatment, however, was not tantamount to suicide.¹¹⁰ The court stated:

98. Cox, *supra* note 83, at 1, col. 6. Recently, at the University Medical Center in Sacramento, California, a twenty-eight year old anorexic patient charged the hospital with holding and treating her against her will. Powell, *State Investigating Anorexic's Charges*, Sacramento Bee, Apr. 11, 1984, B3, col. 1. After the patient checked into the hospital for treatment for anorexia, she was placed under a conservatorship as "gravely disabled" and unable to sustain her life if released. *Id.* The State Department of Health investigated the case and found that the hospital had acted appropriately. *Id.* The Department determined that once a patient is admitted, the hospital must provide the patient with adequate food and water. *Id.* The patient has not taken the matter to court. *Id.*

99. 450 N.Y.S.2d 623.

100. *Id.* at 624, 625.

101. *Id.* at 624.

102. *Id.* at 625.

103. *Id.* at 624.

104. *Id.* at 625.

105. *Id.* at 626.

106. *Id.* at 625-27.

107. *Id.*

108. *Id.* at 626-27.

109. *Id.*

110. *Id.*

“Even superficial comparison of the right to decline medical treatment with the right to take one’s life [by starvation] illustrates their essential dissimilarity and to argue that because the State has recognized the former it must permit the latter would be to engage in the most specious reasoning.”¹¹¹

While Chapman could have refused medical treatment,¹¹² food was not medical treatment.¹¹³ The *Bouvia* and *Chapman* cases demonstrate that courts do not treat the administration of medical treatment and the administration of food in the same manner. In both cases, medical treatment could have been refused.¹¹⁴ In neither case, however, was the refusal of food allowed.¹¹⁵

The problem becomes more difficult when the patient would choose starvation, but is unable because the patient is incapacitated. Courts continue to treat the administration of medical care and food dissimilarly when a surrogate attempts to refuse food on a patient’s behalf.¹¹⁶ In the case of *In re Conroy*,¹¹⁷ a New Jersey superior court refused to permit the guardian of a hospitalized incompetent patient to remove feeding tubes on the patient’s behalf.¹¹⁸

A SURROGATE MAY NOT REFUSE FOOD ON A PATIENT’S BEHALF

Claire Conroy was a nursing home patient suffering from organic brain syndrome.¹¹⁹ She was unable to swallow sufficient amounts of food and water for her own sustenance and, therefore, was nourished through a feeding tube.¹²⁰ Although her brain functioned at a primitive level, Conroy had no cognitive ability.¹²¹ The medical diagnosis was inconclusive as to whether she was capable of experiencing pain.¹²²

Conroy was neither comatose, nor brain dead, nor in a chronic vegetative state.¹²³ The doctors had no reasonable expectation that Conroy’s prognosis would ever improve or that she would ever return

111. *Id.* at 627. The court, however, did not analyze the reasons why the right to decline medical treatment is different from the right to refuse food. *See id.* at 112. Chapman, like *Bouvia*, could have refused medical treatment by virtue of his constitutional right of privacy. *See supra* notes 49-55 and accompanying text.

113. *Chapman*, 450 N.Y.S.2d at 626-27.

114. *See supra* notes 49-55 and accompanying text.

115. *See supra* notes 84-98 and 100-13 and accompanying text.

116. *See, e.g., Conroy*, 464 A.2d at 315.

117. 464 A.2d 303 (N.J. 1983).

118. *Id.* at 306, 307.

119. *Id.* at 304.

120. *Id.*

121. *See id.* at 304-05.

122. *Id.* at 305.

123. *Id.* at 304-05.

to a cognitive and sapient state.¹²⁴ None of Conroy's medical conditions were fatal and her physicians could not predict when, or from what cause, she would die.¹²⁵

Conroy was declared incompetent, and her nephew was appointed as her guardian.¹²⁶ The guardian asked the nursing home to remove the nasogastric feeding tube,¹²⁷ but was refused. The guardian then sought a judicial declaration that he, the guardian, had the right to cause the tube to be removed claiming that he knew the patient's values and preferences¹²⁸ and that she never would consent to this type of feeding voluntarily.¹²⁹

Following a plenary trial, the trial court ordered removal of Conroy's nasogastric tube.¹³⁰ Pending appeal of that order, however, a stay was granted.¹³¹ Reversing the lower court, the Court of Appeal found that the administration of food and water through the nasogastric tube was not medical treatment that could be refused by a third person.¹³² According to the court, nutrition was a basic necessity of life that could not have been withdrawn by either the hospital or the guardian.¹³³ Even though the court concluded that Conroy would have chosen to terminate medical treatment had she been able to,¹³⁴ Conroy herself could not have refused food and, therefore, her guardian could not have refused it for her.¹³⁵

Other courts, in addition to the *Conroy* court,¹³⁶ have stated that although food is a basic necessity, life-support systems such as respirators are not basic necessities.¹³⁷ Medical experts often will classify medical care as either ordinary or extraordinary care,¹³⁸ classifying food as ordinary care and life-support systems as extraordinary care.¹³⁹ This distinction between ordinary and extraordinary care is further evidence that the administration of food should not be treated as the equivalent of the administration of medical treatment.

124. See *id.* at 305.

125. *Id.* at 305.

126. *Id.* at 304.

127. *Id.*

128. *Id.*

129. See *id.* at 306, n.4.

130. See *id.* at 304, 315.

131. *Id.* at 304.

132. *Id.* at 315.

133. *Id.* at 312.

134. *Id.* at 306, n. 4.

135. See *id.* at 311, 313-15.

136. *Id.* at 303.

137. See, e.g., *Barry*, 445 So. 2d at 368-69.

138. See D. WALTON, *ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS* 222-26 (1983).

139. See, e.g., *Conroy*, 464 A.2d at 312.

A. Ordinary and Extraordinary Care

The characterization of care as ordinary or extraordinary determines whether the care is obligatory or discretionary.¹⁴⁰ The definitions of ordinary and extraordinary care, however, are fluid and depend on the nature of the treatment and the patient's prognosis.¹⁴¹ This fluid definition led the *Barber* court to state that characterization as either ordinary or extraordinary begs the question.¹⁴² Nevertheless, in cases in which a characterization has been made by a court, the administration of food has been determined to be ordinary or normal care, and, therefore, obligatory.¹⁴³

In the recent case of *In re Barry*,¹⁴⁴ a Florida appellate court authorized the removal of a life-support system from an infant who was in a chronic permanent vegetative coma.¹⁴⁵ The infant had no cognitive brain function and was terminally ill.¹⁴⁶ The court order authorized the parents to cause the ventilator life-support system to be terminated and instructed the attending physicians not to furnish life-sustaining procedures thereafter except for the sole purpose of alleviating the child's pain and suffering and to keep him comfortable and provide him with "normal nutrition."¹⁴⁷ The court considered nutrition to be a normal part of the care required for a comatose patient while waiting for him to die.¹⁴⁸

In sum, courts traditionally have distinguished between the removal of food and water and the withdrawal of life-support systems. In *Bouvia*, the court refused to allow a hospitalized patient to refuse food in order to starve herself to death.¹⁴⁹ The New Jersey court in

140. Lynn and Childress, *Must Patients Always be Given Food and Water?*, 13 HASTINGS CENTER REP. 17, 19 (Oct. 1983).

141. One definition of ordinary care is: "[A]ll medicines, treatment, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience." *Conroy*, 464 A.2d at 312. "Extraordinary measures are complicated methods. They are impossible for the patient to use or apply by himself and present a costly and difficult burden. . . [T]hey represent a high level of danger, and the results are not predictable, i.e., the effectiveness is minimal or moderate while the dangers are maximal." *Id.*

142. See *Barber*, 147 Cal. App. 3d at 1018, 195 Cal. Rptr. at 491.

143. See, e.g., *Barry*, 445 So. 2d at 368-69. The ad-hoc committee on Ethics and Survival stated that a hospital standing committee organized to determine when medical care should be terminated should give due deliberation to petitions for cessation of extraordinary care. Waldman, *Medical Ethics and Hopelessly Ill Child*, 88 J. PED. 890, 892 (1976). The ad-hoc committee, however, distinguished between extraordinary and ordinary care stating that ordinary care was comprised of foods, fluids, oxygen, antibiotics, and pain killers. *Id.*

144. 445 So. 2d 365.

145. *Id.* at 367.

146. *Id.*

147. *Id.* at 369.

148. See *id.*

149. See *supra* notes 84-98 and accompanying text.

Conroy would not permit a surrogate to order a nursing home to withdraw food from a patient, holding that food was not the equivalent of medical treatment.¹⁵⁰ Courts also have distinguished between food and medical treatment by characterizing food as ordinary care and medical treatment as extraordinary care and have allowed the discontinuance of extraordinary care but have refused to allow the withdrawal of ordinary care.¹⁵¹ This is in contrast to the *Barber* decision which held that food was the equivalent of medical care.¹⁵² Although *Bouvia*, *Chapman*, and *Conroy* demonstrate that courts view medical treatment and food differently, in none of these cases did the court analyze or describe the differences between withholding medical care and withholding food. The courts simply state that medicine and food are dissimilar¹⁵³ or characterize food as ordinary care and therefore obligatory.¹⁵⁴ The final section of this comment, therefore, will discuss the policy reasons why, contrary to the holding of the *Barber* court, courts should continue to distinguish between food and medical treatment and not permit the withdrawal of food or water from a living patient.

POLICY REASONS FOR THE DISTINCTION BETWEEN FOOD AND MEDICAL TREATMENT

Ethics scholars have postulated a variety of reasons why food should be distinguished from medical treatment in the determination of what types of medical care morally can be withdrawn from patients.¹⁵⁵ Among the reasons postulated are the distinction between passively allowing a patient to die and actively killing the patient,¹⁵⁶ and the tutoristic desire¹⁵⁷ to provide a clear line to determine what type of care may be withdrawn from a patient.¹⁵⁸

A. Tutorism

The essential principle of tutorism is that obedience to established law generally is better and safer than liberal experimentation when

150. 464 A.2d at 311.

151. See *supra* notes 136-48 and accompanying text.

152. 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490.

153. See *Chapman*, 450 N.Y.S.2d at 627; see also *Conroy*, 464 A.2d at 311.

154. See *Barry*, 445 So. 2d at 369; see also *Conroy*, 464 A.2d at 312.

155. See, e.g., Callahan, *On Feeding the Dying*, 13 HASTINGS CENTER REP. 22 (Oct. 1983); Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958); Lynn and Childress, *supra* note 139, at 17.

156. See *infra* notes 168-79 and accompanying text.

157. See *infra* notes 159-61 and accompanying text.

158. See *infra* notes 164-67 and accompanying text.

error may involve moral costs.¹⁵⁹ Tutorism expounds the theory that a set of standards is necessary to ensure that a patient with any chance for recovery will not be actively killed.¹⁶⁰ If a patient has a remote chance of recovery, tutorism dictates that a passive course of conduct be followed.¹⁶¹

Doctors often are unable to determine the causes of disease or whether an "incurable" patient will live or die.¹⁶² Doctors are fallible and capable of misdiagnosing the patient's chances for recovery.¹⁶³ When life and death are at stake, tutorism dictates that any error must always be made on the side of life.

Courts should continue as a matter of policy to order that even comatose patients receive food and water not only because courts should err on the side of life, but also because this policy provides a clear dividing line. If the tutoristic approach is not adopted, the consequence may be that killing comatose patients will become more accepted and commonplace.¹⁶⁴ Approval of the taking of a patient's life could set a dangerous precedent; once removal of feeding tubes is condoned, further steps in deciding who should live and who should die is an easier step to take.¹⁶⁵ If a court deems that a comatose patient should not live, and doctors are allowed to actively take the lives of their patients, it is difficult to know at what point this precedent will end.¹⁶⁶ If, however, courts refuse to allow feeding tubes to be removed from comatose patients, a bright line of certainty will be established.¹⁶⁷ Doctors will know what type of medical care may be withdrawn from what type of patient. Without such a line, doctors will find themselves in a quandary as to when the removal of feeding tubes is permitted.

B. Passive/Active Conduct

Philosophers distinguish between actively taking a life and passively

159. D. Walton, *supra* note 137, at 82.

160. *See id.* at 81.

161. *Id.*

162. *Id.*

163. Kennedy, *The Problem of Social Control of the Congenital Defective*, 99 AM. J. PSYCHIATRY 13, 14 (1942).

164. *See* Kamisar, *supra* note 155, at 1030.

165. *Id.*

166. *Id.* The defendants in *Barber* waited five days from the time the patient suffered a cardiorespiratory arrest until the time the doctors disconnected the feeding tubes. 147 Cal. App. 3d at 1010-11, 195 Cal. Rptr. at 486. Some have contended that the active termination of the chronically ill in Nazi Germany eventually led to the extermination camps of World War II. *See* Kamisar, *supra* note 154, at 1031-37.

167. *See* Kamiser, *supra* note 155, at 1037-38.

allowing a patient to live or die.¹⁶⁸ The difference between actively taking a life and allowing a patient to live or die is subtle and often difficult to grasp in the circumstances of a comatose patient. Actively taking a life entails engaging in conduct that necessarily results in the termination of the life of another; there is no alternative outcome.¹⁶⁹ Conversely, passively allowing a patient to live or die contemplates not committing an act that necessarily terminates the life of another.¹⁷⁰ Passive conduct allows for two possible alternative outcomes; the patient may either live or die.¹⁷¹ Taking a patient off a respirator may in fact allow that person to die, but this line of conduct also may be compatible with the patient's continued survival.¹⁷² For example, in the *Quinlan* case the removal of Karen Quinlan's respirator was authorized although the court believed that without the respirator Karen Quinlan would die.¹⁷³ The doctors, by disconnecting the respirator, engaged in a passive act because the patient could have either lived or died after disconnection.¹⁷⁴ Because the doctors in *Quinlan* only engaged in passive acts, Karen Quinlan continues to live today.¹⁷⁵

In contrast, when a physician disconnects a feeding tube, the patient will die just as surely as if the doctor had shot the patient.¹⁷⁶ Removing a feeding tube is necessarily incompatible with the patient's survival.¹⁷⁷ Food, unlike respiration, is never self-generating and must always come from a source outside the patient's own body. The disconnection of feeding tubes does not allow for alternative outcomes; the patient's death is assured.¹⁷⁸ Because the disconnection of feeding tubes necessarily results in the termination of the patient's life, the physicians disconnecting the tubes have actively caused the patient to die.¹⁷⁹ This is unlike the passive tutioristic approach that does not foreclose the possible alternative result of life.

168. D. WALTON, *supra* note 138, at 228-37. See also Kary, *A Moral Distinction Between Killing and Letting Die*, 5 J. OF MEDICINE AND PHILOSOPHY 326, 328-32 (1980). Killing someone is morally reprehensible, whereas letting someone die is not necessarily so. *Id.*

169. D. WALTON, *supra* note 138, at 234-35.

170. *Id.* at 234-36.

171. *Id.*

172. *Id.* at 236.

173. See *Quinlan*, 355 A.2d at 655.

174. See D. WALTON, *supra* note 138 at 236.

175. 70 A.B.A.J. 29-30 (Feb. 1984).

176. The withdrawal of treatment may be equated with thrusting a scalpel into the patient's heart. See D. WALTON, *supra* note 138 at 228.

177. See *id.* at 236.

178. *Id.*

179. *Id.* at 234-36. Douglas Walton, Professor of Philosophy at the University of Winnipeg, gives the example of a Captain Oates to illustrate the difference between an event which causes death with no possibility of intervening occurrences preventing death, and letting death occur

CONCLUSION

This author has demonstrated that a patient may terminate the administration of medical care by virtue of either the California Natural Death Act or the patient's constitutional right of privacy. When a patient is incompetent or incapacitated, a third person may assert the right to refuse medical care on behalf of the patient. The patient or the patient's surrogate may terminate medical care even when denying care will, in all likelihood, result in the patient's death.

The *Barber* court, in a criminal setting, held that the administration of food and water was the equivalent of the administration of medical care. Since a patient may refuse medical care, and because *Barber* held that food and water was the equivalent of medical care, a patient or his surrogate may refuse food and water. A doctor disconnecting a comatose patient's feeding and hydration tubes at the request of the patient's surrogate will not be subject to criminal liability.

In holding that the administration of food was legally equivalent to the administration of medical treatment, the *Barber* court departed from traditional analysis. Courts have not permitted hospitalized patients to refuse food and water. Instead, courts have held that the refusal of food is not the same as the refusal of medical treatment, but rather, the refusal of food is the equivalent of suicide. A patient's constitutional right of privacy does not give a patient the right to starve to death. Since a patient has no right to commit suicide, the patient has no right to ask a hospital to help the patient commit suicide. Neither may a surrogate refuse food on a patient's behalf.

The difference between food and medical treatment is evidenced further by the distinction made by courts between ordinary and extraordinary care. Extraordinary care is considered to be optional; the physician may choose to authorize the withdrawal of extraordinary care. Ordinary care, on the other hand, is obligatory; a doctor may not authorize the withdrawal of ordinary care. Food has been

by allowing for alternative events. *Id.* at 230-31. Captain Oates and his friends were trapped in a blizzard when Captain Oates walked to certain death into the blizzard to give his friends a better chance of survival. *Id.* at 230. Captain Oates, however, had a revolver and therefore could have shot himself in order to remove himself from the group. *Id.* If Captain Oates had shot himself, this would have constituted suicide. *Id.* at 231-32. The question that Walton poses is whether walking into the blizzard would also be active suicide since in all probability the result would be the same. *Id.*

Walton claims that the difference between Captain Oates walking into the blizzard and shooting himself is that walking into the blizzard allows for alternative events that could save Captain Oates. *Id.* For example, the Mounties may discover and save him. *Id.* at 232. If, however, Captain Oates shot himself, there would be no intervening events which could spare his life. *Id.* Thus, this illustrates the difference between actively seeking a death and passively allowing death to occur. *Id.* at 230-33.

characterized by the courts as ordinary care and therefore may not be withdrawn.

The *Barber* court also ignored the policy reasons behind distinguishing food and water from medical treatment. A distinction may be made between intentionally causing a patient's death and allowing the patient to either live or die. When food is withdrawn, the patient's death is assured. Since food is never self-generated, the withdrawal of food is necessarily incompatible with the patient's continued survival. When medical care such as a respirator is removed, the patient may either live or die. Thus, the alternative outcome of life is allowed and the doctor has not intentionally killed as is the case when food is denied.

In addition, physicians must be discouraged from actively taking lives. Once a court determines that a comatose patient should not live, standards determining which type of patient will be denied food and water will be difficult to set. Holding that food and water may never be withheld from a living patient provides a bright line of certainty. The holding of the *Barber* court, that the administration of food and water is the equivalent to the administration of medical care is, therefore, erroneous.

This author has presented the essential differences between the administration of medical care and the administration of food and water and the policy reasons behind those differences. The *Barber* decision should be limited to the facts presented in the case and should not be used as precedent. A court should not permit the denial of food and water to a comatose patient.

Stephen Mark Harber

EXHIBIT 4

San Jose Mercury News

Friday morning, June 7, 1985

Menlo Park man goes to court to end ailing wife's life

By Fran Smith
Mercury News Medical Writer

Elaine Robinson Pritchard, 43, stares from her bed in a Menlo Park nursing home, apparently seeing nothing. She can't sit up, eat, speak or recognize her family. Occasionally, she groans.

For more than three years, she has lain this way — not quite living, yet unable to die. Now, her husband wants to end the limbo.

In a hearing set for June 24 in San Mateo County Superior Court, Harold Pritchard will ask a judge to order what a doctor has refused to do: remove the feeding tube inserted in his wife's nose. If the bid is successful and the tube is yanked, Elaine Pritchard — once an ebullient woman who loved to cook, sew and play piano — will slowly starve to death.

Her mother, sister and brother oppose her husband's bid. But Harold Pritchard feels certain that his wife of 20 years would want to end the existence she has endured since Feb. 14, 1982, when a pickup truck smashed into the couple's car as they headed to a restaurant for Valentine's Day dinner.

Allowing her to die, he says, would restore the comfort and dignity that has been stripped from her life.

"People equate this with playing

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God," Pritchard, 55, the manager of a Menlo Park condominium complex, said in a recent interview. "Isn't it playing God to do things unnatural?"

"It can't be natural for an energetic woman to lie there. It can't be natural for a gourmet cook to eat that way."

In hospitals daily, families face the agonizing dilemma of whether to withdraw life-sustaining care, and, in effect, determine when patients die. Doctors must balance the benefits of continued care, fears of lawsuits and conflicts among relatives in deciding whether life is worth prolonging. The Pritchard case, however, involves something more.

It strikes at the core of a national debate over the manner in which life may be brought to an end. To some physicians, Harold Pritchard's wishes straddle the hazy line between permitting death and causing it.

"He just wants me to go in there and do his work for him," said Dr. George Waltuch, Elaine Pritchard's primary physician, who will not order nurses at Hillhaven Convalescent Hospital to cut off her food and liquid.

"I resent his suggestion that I refuse to do this or that," Waltuch added. "The only thing I declined to do was write an order that says, 'Starve this lady to death.'"

□

The couple had escaped to a beachfront condominium in Monterey for the weekend.

It was Valentine's Day. After brunch, Harold Pritchard watched a basketball game on television; Elaine read. Toward sunset, a gentle rain started to fall.

By the time they left for dinner, it was pouring. Harold Pritchard slowly backed his 1978 Ford Pinto out of the driveway. His wife shut the garage door and dashed into the passenger seat.

At 7:35 p.m., Harold Pritchard stopped at an intersection a block from the condo, where he waited to turn left. As the light changed to red, he proceeded. The driver of a pickup truck, approaching head-on, tried to run the light. The truck rammed into the Pinto, pinning Elaine Pritchard in the bucket seat.

'Felt huge impact'

"I never heard any scream," Harold Pritchard said. "I felt this huge impact. I felt like I was in a boat, getting knocked around."

Harold Pritchard slipped in and out of consciousness for several hours, and awoke at Eskaton Hospital. While doctors treated him for a concussion, a broken rib and cuts above his right eye, a brain surgeon told him that his wife had suffered extensive brain injury and asked for per-

mission to operate.

Elaine Pritchard spent a month hospitalized in Monterey. On March 13, she was transferred to Stanford University Medical Center. In May, she entered a rehabilitation program at Ralph K. Davies Medical Center in San Francisco. She stayed until August.

During those months, her husband visited every day. He ignored his small graphics business, which eventually folded. As a result of stress, he says, he developed high blood pressure.

But he remained optimistic.

"He was always hoping, praying for a miracle," said the couple's priest, Joseph Frazier, rector of St. Bede's Episcopal Church in Menlo Park.

The miracle never came.

There were tests, drugs, speech and physical therapy — more than \$200,000 worth of care — but no improvement in Elaine Pritchard's condition. Finally, Harold Pritchard checked his wife into a double room at Hillhaven.

□

Elaine Pritchard, say people close to her, was the dynamo of the couple — a bright blond extrovert who loved music, art, fine food, a good party.

When he remembers his wife that way, Harold Pritchard, gray-haired and lean, chokes on tears.

"Harold's a very introspective, quiet person," said Frazier, who supports the bid to allow Elaine Pritchard to die. "Elaine basically was his life."

"That's what makes this so difficult for him — to have this bright, energetic person in one moment turn into what's essentially a vegetable."

Called vegetative state

Doctors call her condition "persistent vegetative state." As many as 1,600 Americans share the fate, researchers say. Perhaps the most famous is Karen Ann Quinlan, 31, who lies in a New Jersey nursing home nine years after her parents successfully fought to have her respirator turned off.

Elaine Pritchard's brain is alive. She moans when nurses jostle her. Her large blue eyes follow visitors around the room, as if she wanted to look them over before deciding whether to say hello.

Her left leg and left arm jerk uncontrollably, and her left hand clutches anything placed in its grasp. One recent afternoon, when her husband leaned over to stroke her head, her hand flung and grabbed his arm. She seemed to yearn to pull him closer.

But medical experts believe she comprehends nothing. They assume she feels no pain. The stare, like the mind, they say, is blank.

At Hillhaven, her monthly bill — cov-

ered by Social Security, disability payments and an insurance settlement from the accident — runs \$2,000. Doctors say she can linger for decades. But at least six physicians have stated that she will never snap back to life.

In September 1983, Dr. Robert Spertell, a Redwood City neurologist who examined her summed up her prospects in a letter:

"It is felt that the prognosis for any meaningful recovery at this point is absolutely nil."

□

Last month — 1½ years after he first asked Waltuch to let his wife die — Prit-

chard petitioned the court to be appointed as her conservator. He wants "specific power to terminate artificial means of nutrition and hydration."

Pritchard says he knows his wife's wishes because the couple discussed the case of Karen Quinlan. Quinlan's parents live near the Pritchards' former home in Montclair, N.J., and the protracted battle that focused national attention on the issues raised by life-sustaining technology "really touched home for my wife and me," Harold Pritchard said.

Said would not want life

"She specifically said that if she were

ever in such a condition — where her body could be maintained, but where she was permanently unconscious — she would not want to be kept alive," Pritchard said in a six-page court document.

Pritchard and his attorney, Michael Gilfix of Palo Alto, believe that a feeding device, like the breathing machine that the Quinlan parents wanted to turn off, is a life support that may be discontinued when a patient has no hope.

But Waltuch says the plea by Pritchard and Gilfix crosses a line that even Quinlan's parents have drawn. Joseph and Julia Quinlan, whose daughter unexpectedly survived after her respirator was shut off, have never denied Karen Ann food.

When dying depends upon a device

By Fran Smith
Mercury News Medical Writer

Technology has complicated the process of dying. For every fatal ailment, a machine or method can delay the moment of death.

The public debate over life-support machinery focuses largely on two issues: At what cost should it be used? And how much pain or indignity should the hopelessly ill endure for extra time?

But the private decisions made in hospitals every day often hinge on a simple, pragmatic question: Which device would have to be removed in order for life to end?

If it's a respirator, doctors, lawyers and ethicists say, the decision to pull the plug rests on firm legal and ethical ground. If it's a feeding apparatus — either an intravenous line or a naso-gastric tube, such as the one keeping Elaine Pritchard of Menlo Park alive — the physician, patient and family face a tangle of problems.

Although courts in several states, including California, have ruled that a feeding device should be viewed no differently from a machine that sustains breathing, doctors fear they may face lawsuits or criminal charges if they withdraw food and water. Even more troubling, physicians say, is the symbolic value of food and the ethics of cutting it off, virtually assuring a protracted death.

"It's really the last thing a physician wants to volunteer to do," said Robert Girard, an attorney for the California Hospital Association.

A decade ago, the case of Karen Ann Quinlan catapulted the dilemma of prolonging life into the national spotlight. In her parents' fight to remove the comatose young woman from life supports, the respirator became an emblem of the controversy surrounding the right to die.

Since then, a long string of cases has established that a dying or hopelessly ill patient — or the family, if he is mentally incompetent — may demand to have the respirator turned off, and a doctor who complies will not be held liable.

Lawyers have batted about the feeding issue in only a few court cases.

One battle that shook up the medical profession involved two physicians at Kaiser-Permanente Hospital in Los Angeles. Dr. Neil Barber, an internist, and Dr. Robert Nejdil, a surgeon, were charged with murder after ordering the removal of feeding tubes from a man who had slipped into a coma after an operation.

Barber wrote the order at the written request of the patient's wife and eight children, and nurses pulled the tubes from 55-year-old Clarence Herbert on Aug. 31, 1981. He died six days later. One nurse who believed the action was wrong contacted the Los Angeles County district attorney, setting in motion a lengthy legal seesaw.

After a Municipal Court judge dis-

‘It's the last thing a physician wants to volunteer to do.’

— Attorney Robert Girard

missed the murder charges, a Superior Court reinstated them. An appellate court reversed the Superior Court and determined that removing food and water in this case was justified, ethical and lawful.

The New Jersey Supreme Court also sanctioned the removal of feeding devices in a case last year involving 84-year-old Claire Conroy, a nursing home resident who suffered a host of physical and mental disorders.

However, in December 1983, a Superior Court judge in Riverside refused to force a hospital to stop feeding Elizabeth Bouvia, 27, a cerebral palsy victim who wanted to die. Lawyers and ethicists point out an aspect that distinguished her case from the others: She intended to commit suicide. She was placed on a feeding device only after she stopped eating.

In its decision on the Kaiser case, the California appellate court said the distinction between respirators and feeding devices "seems to be based more on the emotional symbolism of providing food and water to those incapable of providing for themselves, rather than on any rational difference." Indeed, the debate treads on instinct as much as intellect.

Many doctors and nurses view food as something geared toward keeping the patient comfortable, not toward restoring health. And while use of a machine that fosters breathing marks the height of extraordinary care, feeding the ill seems to be an ordinary and humane gesture.

Moreover, it takes a person considerably longer to starve than to suffocate.

When a respirator is withdrawn, death usually occurs within minutes or hours. But a patient can linger a week or two without a feeding device.

But if one accepts the assumptions of experts, an unconscious patient such as Elaine Pritchard would not feel the pain of hunger or thirst. And if she did, no one knows whether starvation would be worse than being deprived of air, said her husband's attorney, Michael Gilfix of Palo Alto.

"There is good medical evidence to suggest that in terms of pain and terror, suffocation is at least as horrible an experience as starvation," Gilfix said.

But most people don't worry about which is worse. About 80 percent of Americans can expect to die in hospitals; many acknowledge that the moment and manner of their deaths may be orchestrated by doctors, nurses, attorneys and relatives.

"Most patients are not concerned about the differences between starvation and suffocation," said Dr. Nancy Dickey, chairwoman of the American Medical Association Judicial Council and a family physician in Richmond, Texas. "They simply say, 'If my brain — if my ability to reason — is gone, and there's no hope for my recovery, please don't impose on me the burden of living.'"

The Daily Recorder

Tuesday, June 4, 1985

Right to die

A Los Angeles Superior Court judge refused last week to rule on whether a hospital violated an elderly patient's civil rights by refusing to grant his request that he be disconnected from life support systems. William Bartling and his wife, Ruth, had filed suit last June to force Glendale Adventist Medical Center to disconnect the respirator keeping him alive. Bartling, 70, who suffered from five terminal illnesses, died in November, but his widow continued the suit in an effort to set a legal precedent. Bartling's attorney said Superior Court Judge Charles Jones dismissed the lawsuit because he thought it belonged in the appellate division. Hospital attorneys had blocked Bartling's lawsuit because they said disconnecting the respirator would be tantamount to murder.