1986

The Death-Prolonging Procedures Act and Refusal of Treatment in Missouri

Sandra H. Johnson
Saint Louis University School of Law

THE DEATH-PROLONGING PROCEDURES ACT AND REFUSAL OF TREATMENT IN MISSOURI

SANDRA H. JOHNSON*

I. INTRODUCTION

In our time, the fear of dying has taken on new meaning. The scenario of the last, shuddering breath taken as one lies in bed at home surrounded by family and friends has been replaced by a vision of weeks or months in a hospital or long-term care facility surrounded by machinery that extends one's dying at extraordinary expense but gives no hope of recovery. Caring for the terminally ill patient has also brought new fears for physicians. Added to the physician's personal fears of mortality and the inadequacy of medical science is a dread of civil liability and criminal prosecution if the physician does not "treat" the terminally ill patient with all readily available devices that sustain life for a period of time.

The perceived risks and legal uncertainties presented in medical treatment decisionmaking are especially acute in the case of the incompetent patient. The uncertainty, about both the law and the facts, is greater in this type of situation because the decision must be made by proxy. The choices the incompetent patient would make to resolve this very personal crisis are unknown. The frustration experienced by both patients and physicians in cases of terminal illness has generated a demand for statutes recognizing the legal effect of a "living will," a document executed by a competent individual to govern the course of medical care in the event he or she later becomes incompetent.[1]

On September 28, 1985, Missouri became one of the thirty-five

---

* Professor of Law, St. Louis University School of Law; Assistant Professor of Law in Internal Medicine, St. Louis University School of Medicine. Honors A.B., St. Louis University; J.D., New York University; LL.M., Yale Law School. I thank my colleagues Jesse Goldner and Dennis Tuchler for their generous assistance in reviewing earlier drafts of this Article. The research assistance of Wendy Wolf and Frances McDonald also deserves grateful acknowledgement.

1. These documents are more properly known as "advance directives" or "instruction directives." PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 136 (1983) [hereinafter cited as PRESIDENT'S COMM'N]. The term "living will" may be misleading, however, if it is understood as describing a document with absolute binding effect.

states that have enacted statutes giving legal effect to the living will.[2] Recognizing that "[e]ach person has the primary right to request or refuse medical treatment subject to the state's interest in protecting innocent third parties, preventing homicide and suicide and preserving good ethical standards in the medical profession,"[3] the General Assembly, with the passage of the Death-Prolonging Procedures Act, has created a method by which persons who have become incompetent may exercise this right.[4]

Prior to legislative recognition, the use of living wills and other forms of advance directives[5] had already become widespread.[6] Even

---

2. MO. REV. STAT. §§ 495.010-.055 (Supp. 1985) (popularly known as the Death-Prolonging Procedures Act). As of 1985, 35 states and the District of Columbia had passed such legislation. ALA. CODE §§ 22-8A-1 to -10 (1984); ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1983); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1986); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1985); FLA. STAT. ANN. §§ 765.01-.15 (Supp. 1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985); IDAHO CODE §§ 39-4501 to -4508 (1985); ILL. ANN. STAT. ch. 110½, §§ 701-710 (Smith-Hurd Supp. 1985); KAN. STAT. ANN. §§ 65-28,101 to 109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1984); NEV. REV. STAT. §§ 449.540-.690 (1985); N.M. STAT. ANN. §§ 24-7-1 to -11 (1981 & Supp. 1985); N.C. GEN. STAT. §§ 90-320 to 322 (1981 & Supp. 1983); OR. REV. STAT. §§ 97.050-.090 (1983); TEX. REV. CIV. STAT. ANN. art. 4590(h) (Vernon Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251-5262, tit. 13, § 1801 (Supp. 1985); VA. CODE §§ 54-325.8:1 to :13 (Supp. 1985); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (West Supp. 1986); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1985); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1985). Thirteen of the thirty-five states enacted living will legislation in 1985. *See* Otten *New 'Wills' Allow People to Reject Prolonging of Life in Fatal Illness*, Wall St. J., July 2, 1985, at 35, col. 4. In addition, in August 1985 the National Conference of Commissioners on Uniform State Laws approved a final version of its Uniform Act which gives effect to an advance directive. Uniform Rights of the Terminally Ill Act (Proposed Official Draft 1985).

3. MO. REV. STAT. § 459.055(1) (Supp. 1985).

4. Guardianship still remains an important mechanism in health care decisionmaking for incompetent individuals. MO. REV. STAT. § 431.061.1 (1978); *id.* § 475.120.3 (Supp. 1984). The Death-Prolonging Procedures Act does not eliminate this mechanism, but rather creates an alternative. *Id.* § 459.055(2). *See infra* notes 102-18 and accompanying text.

5. One form of advance directive used with some frequency is the durable power of attorney. Missouri has a durable power of attorney statute. MO. REV. STAT. §§ 486.550-.595 (Supp. 1984). The durable power of attorney survives the subsequent incapacity or disability of the principal until there is "a judicial determination of disability or incapacity of the principal." *Id.* § 486.560. If a guardian or conservator is appointed, the court may terminate the durable power of attorney. *Id.* § 486.565. It is unclear whether health care decisionmaking falls within the scope of this power because the statute does not define the acts delegable under the durable power of attorney. This uncertainty would arise in situations in which the durable power of attorney instrument specifically authorizes the attorney to give or withhold consent to medical treatment. Mo. Guardianship and Trust Law §§ 13.12, .50 (Mo. Bar 1985). If the durable power of attorney may be used to withhold consent, a second question arises: can such an instrument have a scope broader than the statutory limits set forth in the

without statutory recognition, the living will is relevant to the decision made on behalf of an incompetent patient to withhold or withdraw treatment. If nothing else, the document provides some evidence of the patient's choice while competent.[7] The popularity of living will statutes can be attributed to a growing belief that such legislation assures individuals that their choices concerning medical treatment will be honored, even if they become incompetent.[8] Health care professionals

---

Death-Prolonging Procedures Act? The durable power of attorney may be relevant to treatment decisions as evidence of the patient's choices, even if it is found to have no other legal effect. *See infra* note 7 and accompanying text.

6. "One New York group has distributed millions of living wills. The columnist who writes 'Dear Abby' reports receiving tens of thousands of request for copies each time she deals with the subject." PRESIDENT'S COMM'N, *supra* note 1, at 139-40 (footnotes omitted). The Commission's report also lists the following groups as having developed sample living wills: the Society for the Right to Die, the Euthanasia Education Council, the American Protestant Hospital Association, the American Catholic Hospital Association, and the American Public Health Association. *Id.* at 139 n.51.

7. The competent patient has the right to refuse medical treatment, including lifesaving treatment, unless that right is offset by competing state interests. *See, e.g., In re* Estate of Brooks, 205 N.E.2d 435 (1965) (Illinois Supreme Court upheld right of a mentally competent adult to refuse blood transfusions). This right of refusal has been limited by the state's interest in protecting innocent third parties. *See* Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir.) (ordering blood transfusions despite the refusal of a competent adult patient who had a dependent child), *cert. denied*, 377 U.S. 978 (1964). *Cf. In re* Osborne, 294 A.2d 372, 375 (D.C. 1972) (patient with two small children allowed to refuse blood transfusion upon a showing that he had "provided for the future well-being of the children").

The right to refuse treatment extends to incompetent patients as well. In Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 427 (Mass. 1977), the Supreme Judicial Court of Massachusetts recognized "a general right in all persons to refuse medical treatment in appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." *Id.* The Death-Prolonging Procedures Act also implicitly recognizes that the scope of the right to refuse medical care extends to incompetent patients in that it provides that "[e]ach person has the primary right to request or refuse medical treatment subject to the state's interest" and does not distinguish between competent and incompetent patients in the statement of that principle. MO. REV. STAT. § 459.055(1) (Supp. 1985).

The extension of this right leaves unanswered, however, the difficult question of how that right is to be exercised by or on behalf of an incompetent patient. The court in *Saikewicz* held that the doctrine of "substituted judgment" should control the decisionmaking process because it respects the "integrity and autonomy of the individual." 370 N.E.2d at 431. The substituted judgment doctrine focuses on the choice that the patient would have made had he been competent. Application of the doctrine raises a number of issues including the reliability of the evidence indicating the patient's choice and the permissibility of the choice itself when weighed against the state's interest in any given case. Mo. Guardianship and Trust Law § 12.1 (Mo. Bar 1985). A written declaration can be reliable evidence of the patient's choice, keeping in mind problems of interpretation and timeliness.

8. Distinguishing among statutes on the basis of whether or not they are "binding" creates confusion and may also be misleading without an examination of the scope

support such legislation in the belief that it will shield them from civil and criminal liability for complying with their patients' directives.[9] An examination of the Missouri living will statute, the Death-Prolonging Procedures Act, reveals the extent to which it meets these expectations.

II. THE STRUCTURE OF THE STATUTE

The Missouri statute provides that a competent individual[10] may execute a declaration that directs the "attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to [the individual's] comfort or to alleviate pain."[11] If the individual becomes incompetent,[12] the declaration becomes effective, but with a number of limitations. First, the statute limits the medical procedures referred to in the declaration as "death-prolonging procedures"[13] and, in a related manner, limits the declaration's legally binding effect to situations in which the patient is terminally ill.[14] Second, it provides that a "physician, health care professional or facility or other person shall not act contrary to the declarant's expressed intent . . . without serious reason therefor consistent with the best interest of the declarant."[15] Third, the declaration is ineffective

---

of the statute as well. For example, one of several limitations in the California Natural Death Act makes the advance directive of a competent patient binding on the physician, but only if the document is executed after the patient has been diagnosed as having a terminal illness. CAL. HEALTH & SAFETY CODE §§ 7187(e), 7191 (West Supp. 1986).

9. These expectations may be entirely unrealistic because of the practical limitations of drafting. In the context of medical treatment decisions, both living wills and legislation giving them a particular legal effect unavoidably include terms that will require some interpretation by the attending physician. For example, if either the declaration or the statute refers to "terminal illness" as a precondition to its operation, a physician must define the meaning of terminal illness, as well as predict the course of a disease. These are judgments that necessarily involve some discretion. *See infra* notes 25-34 and accompanying text.

10. The statute defines "competent person" as an individual, "eighteen years of age or older of sound mind who is able to receive and evaluate information and to communicate a decision." MO. REV. STAT. § 459.010(2) (Supp. 1985). It further requires that a person be competent when the declaration is executed in order for it to be effective. *Id.* § 459.015.1. The statute provides that "a physician or medical care facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was competent when it was executed." *Id.* § 459.035.

11. *Id.* § 459.015.3 (section sets forth a sample declaration).

12. The statute provides that the declaration is to be given "operative effect only if the declarant's condition is determined to be terminal and the declarant is not able to make treatment decisions." *Id.* § 459.025. This determination must be recorded in the patient's medical record. *Id.* The living will statute allows revocation, however, "without regard to mental or physical condition." *Id.* § 459.020.1. *See infra* note 86.

13. MO. REV. STAT. §§ 459.010(3), .015.3.

14. *Id.* §§ 459.010(6), .025.

15. *Id.* § 459.025.

during the course of pregnancy.[16] Finally, the statute allows both physicians and health care facilities to refuse to comply with such directives, provided that they "take all reasonable steps to effect the transfer of the declarant to another physician" or facility.[17]

In order to enforce a declaration within these limits, the statute provides that "it shall constitute unprofessional conduct" for a physician or other licensed health professional or facility to act contrary to a declaration of which they have actual knowledge, unless there is a serious reason for doing so that is consistent with the best interest of the declarant.[18] The statute protects persons who comply with a declaration in "good faith and pursuant to customary medical standards"[19] from criminal and civil liability and charges of unprofessional conduct.[20] The last major section of the statute provides, in part,[21] that

> [n]othing in [this act] shall be interpreted to increase or decrease the right of a patient to make decisions regarding use of medical procedures so long as the patient is able to do so, nor to impair or supersede any right or responsibility that any person has to effect the withholding or withdrawal of medical care in any lawful manner. In that respect, the provisions [of this act] are cumulative.[22]

The scope and effect of these limitations in the Missouri Act create problems of interpretation that will have an impact on the effectiveness of the statute. This Article examines these problems of interpretation in the context of the individual's legally recognized right to refuse medical treatment.

III. LIMITATIONS ON THE BINDING EFFECT OF THE DIRECTIVE

A. *"Death-Prolonging Procedures" and "Terminal Condition" Requirements*

The statute limits the binding effect of a declaration to the with-

---

16. *Id.*
17. *Id.* § 459.030.
18. *Id.* § 459.045.
19. *Id.* § 459.040. The use of the test, "customary medical standards," leaves open the possibility of litigation and liability based on the violation of such standards in the interpretation of the statute's definitions of terminal illness, *id.* § 459.010(6), and death-prolonging procedures. *Id.* § 459.010(3).
20. *Id.* § 459.040.
21. The final section of the statute also provides that the Act creates "no presumption concerning the intention of an individual who has not executed a declaration," *id.* § 459.055(3), encourages communication regarding treatment decisions among patients, families, and physicians, *id.* § 459.055(4), and makes explicit that the "act does not condone . . . or approve mercy killing." *Id.* § 459.055(5). *See infra* notes 34-47, 112, and accompanying text.
22. MO. REV. STAT. § 459.055(2) (Supp. 1985).

holding or withdrawing of "death-prolonging procedures."[23] Death-prolonging procedures are defined as

> any medical procedure or intervention which, when applied to a patient, would serve only to prolong artificially the dying process and where, in the judgment of the attending physician pursuant to usual and customary medical standards, death will occur within a short time whether or not such procedure or intervention is utilized.[24]

The statute further provides that the declaration "shall be given operative effect only if the declarant's condition is determined to be terminal."[25] It defines "terminal condition" as "an incurable or irreversible condition which, in the opinion of the attending physician, is such that death will occur within a short time regardless of the application of medical procedures."[26] Thus, the statutory definitions of death-prolonging procedure and terminal condition—prerequisites for the operation of a patient's directive—require the attending physician to make the determination that these preconditions are satisfied. The judgment of the attending physician is circumscribed only by the malpractice standard of "usual and customary" medical practice relative to diagnosis or prognosis. An examination of the statutory language and design, however, exposes constraints on the discretion of the attending physician.

The definitions of death-prolonging procedures and terminal condition require physicians to make a judgment based on "usual and customary medical standards."[27] The judgment called for, however, is one

---

23. The use of the phrase "death-prolonging" is incompatible with the legal determination of death because the phrase implies that death is an on-going process rather than a specific event. The Missouri determination of death statute does not recognize a process of death. *Id.* § 194.005; Johnson & Webb, *Matters Of Life And Death: Legal Issues In The Determination Of Death And Termination of Medical Treatment*, ST. LOUIS B.J., Winter 1982, at 6, 8. The phrase "death-prolonging" must have been considered synonymous with the phrase "prolonging the dying process," which is found in the sample declaration, MO. REV. STAT. § 459.015.3 (Supp. 1985), and in the definition of death-prolonging procedures. *Id.* § 459.010(3). Identifying a certain condition as "death" and certain procedures as "death-prolonging" can have important repercussions.

> [R]ecall the customary history of allowable but nonmandatory medical interventions. . . . [I]t is no longer customary to allow a person who has suffered from death of the whole brain to be maintained on a respirator simply because the family wants that done. Hard rationality prevails: the respirator does the (dead) patient no good; therefore it must be discontinued.

Callahan, *On Feeding the Dying*, HASTINGS CENTER REP., Oct. 1983, at 22, 22.

24. MO. REV. STAT. § 459.010(3) (Supp. 1985).

25. *Id.* § 459.025.

26. *Id.* § 459.010(6).

27. The definition of death-prolonging procedures explicitly requires that the judgment be based on "usual and customary medical standards." *Id.* § 459.010(3). The definition of terminal condition does not explicitly require this standard, but does so implicitly by using essentially the same definition as death-prolonging procedures and

for which there are no medical standards. First, the concept of a short time is not a medical judgment, but rather a personal judgment based on values or conditions that may change with the circumstances. When a patient has a disease that will cause his death, is three months a short time and two years a long time? Answering that question is certain to involve examination of factors such as the painfulness of the time remaining and the capacity of the patient for interaction with other persons.

The question of whether a period of time is long or short unavoidably relates to the context in which the time will be spent. Having spent an hour waiting for a bus on a streetcorner, unsheltered in a freezing rain, the busrider will complain about the long time spent waiting. Having spent an hour with a good and long absent friend, that same person will complain about the short time of the visit. Furthermore, the characterization of a particular measure of time as short or long depends not only on the nature of the task to be performed, but also on the environmental conditions—sitting on a lounge chair in the Sahara Desert as compared to sitting on that same chair on a Tahitian beach—as well as the personal preferences of the individual—perhaps a rock concert rather than the symphony, or a bingo game instead of aerobics.

Additional difficulties occur with the time element. Physicians may vary in their own interpretation of this concept of time.[28] Further, the statute may be viewed as requiring certainty in the prediction concerning the course and time span of a disease. The physician, on the other hand, typically describes only probabilities.[29]

Because the phrase "short time" cannot be medically defined, it must be interpreted in light of the statute's design. The statute is designed to limit the binding effect of a patient's declaration to situations in which the patient is terminally ill. The living will cannot be

---

also by requiring that the attending physician make the determination. *Id.* § 459.010(6). In addition, to be protected from civil and criminal liability, persons complying with a declaration must do so "in good faith and pursuant to usual and customary medical standards." *Id.* § 459.040.

28. The term "short" may be interpreted inconsistently among physicians. The President's Commission report suggests that variation among physicians on this issue may be due to the uncertainty of prognosis and to the treatment preferences of physicians. *See* PRESIDENT'S COMM'N, *supra* note 1, at 25-26.

29. The statute does not require certainty in these determinations as it refers to the physician's conclusions concerning the nature of the treatment as "judgment" and the condition of the patient as "opinion." MO. REV. STAT. §§ 459.010(3), .010(6) (Supp. 1985). The exercise of this judgment, however, is not dependent solely on the personal, as distinguished from the medical, opinion of the physician. *See supra* note 27. The Missouri statute, unlike other living will statutes, does not require consultation between two or more physicians for a determination of the patient's condition. *See, e.g.*, N.C. GEN. STAT. § 90-322(a)(2) (1981). Of course, consultation would be advisable if at all beneficial or if customary within the medical profession.

used as the sole basis for withholding or withdrawing medical procedures from incompetent patients with conditions that are life threatening, but remediable if treated.

One example of a situation that may fall outside the statute's scope is the case of an incompetent patient who, though otherwise healthy, develops gangrene in a leg as a result of either the poor treatment of a broken leg or other conditions. Without treatment, the gangrene will cause the death of the patient. But with treatment, which could include amputation, death will be avoided and the patient's life "saved." In this scenario, a statutory declaration refusing death-prolonging procedures could not in itself determine the decision to withhold treatment for gangrene. This is not to say, however, that the decision not to treat this patient may never be made, but rather that the operative effect of the living will as designed by the legislature does not extend to this situation.[30]

The legislature could have attempted to control the scope of the statute by listing categories of terminal illnesses that would be "approved" statutorily as preconditions for the effectiveness of an advance directive. This would have involved the legislators in the task of trying to discover and evaluate all potentially terminal conditions, including situations in which the confluence of illnesses makes the patient's death imminent. An example of the complexity that may be involved in deciding whether a disease falls within the definition of terminal condition is the situation of end-stage renal disease, which is treatable with hemodialysis. Depending upon the cause of the disease and the general condition of the patient, death may not occur within a "short time" if the treatment is given.[31] End-stage renal disease in some cases may not

---

30. *See, e.g.*, Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978); *In re* Quackenbush, 383 A.2d 785 (Morris County Ct. 1978) (both cases upholding right to refuse amputation even when operation would be lifesaving). *See also supra* notes 101-18 and accompanying text.

31. Survival and prognosis in patients with end-stage renal disease depend on the underlying cause of the disease process. Lower survival rates are found in patients with conditions such as diabetes mellitus, primary hypertension, or primary renal malignant lesions. *See* Hellerstedt, *Survival Rates of 2728 Patients with End-Stage Renal Disease*, 59 MAYO CLINIC PROC. 776 (1984). The coexistence of additional medical conditions also contributed to lower survival rates. *Id.* at 782. In determining actual patient survival from the institution of therapy until either death or the end of the study, both dialysis and transplantation were considered to be appropriate treatment modalities. *Id.* at 777. Of the 2728 patients, there were minimal survival differences by the third treatment year among the 4 treatment groups: in-home dialysis, in-center dialysis, living-related-donor transplants, and cadaver transplants. *Id.* at 778. The number of patients who die of end-stage renal disease within five years of diagnosis increases with patient age. *Id.* at 780. Transplanted patients, however, have a greater likelihood of rehabilitation. *Id.* Age of entry into a treatment program for end-stage renal disease affects patient outcome regardless of which treatment modality is chosen. *Id.* at 778. Dialysis is offered to virtually all patients with this disease. Johnson, *Treatment of Irreversible*

be a terminal condition as defined by the statute. Hemodialysis, then, would not be a death-prolonging procedure in these cases because death will not occur within a short time if that intervention is utilized. The judgment to discontinue hemodialysis treatment would be based on a complex set of interacting factors in each situation.

Under the statute's definitional approach, the task of applying the definitions of terminal condition and death-prolonging procedure in particular cases is left to the attending physician. Deference to the physician's judgment may be appropriate in this context because the prognosis for persons with particular diseases may change as new treatments develop. In addition, the physician is best able to account for the individual variations in physical condition among patients. The variations in risk among patients with end-state renal disease illustrate the range of relevant differences that may occur among patients with the same disease and the degree of discretion unavoidably allocated to the physician.[32] By deferring to the judgment of the attending physician, the legislature has placed the identification of terminal disease in the physician's hands. The relative indeterminancy of the definitions of death-prolonging procedures and terminal condition makes their identification in particular cases primarily a medical judgment, though necessarily contextual.

The time element in the definition of terminal condition in the statute causes a second problem as well. In many cases in which patients suffer terminal illness, medical procedures are available that will extend their remaining life span for some period of time without significantly altering the course of the disease. Karen Ann Quinlan presented

---

Renal Failure by Dialysis and Transplantation, in TEXTBOOK OF RENAL PATHOPHYSIOLOGY 312, 317 (F. Knox ed. 1978). When receiving dialysis treatments, more than 80% of patients survive the first year and approximately 50% live 5 years. *Id.* at 317. "Without dialysis, patients with advanced renal failure (plasma creatinine concentration of 11 mg/dl or more) have a mortality rate of 10% per month; a very small percentage survive for more than a year." *Id.* Patients who begin treatment before 35 years of age, who receive dialysis treatments at home, and who have fewer complications have the highest survival rates. *Id.*

32. *See supra* note 31. End-stage renal disease also presents a stark illustration of the fact that the categorization of a disease as terminal may be directly related to the unavailability of treatment because of financial, rather than scientific, limitations. Dialysis is dramatically effective in reducing the mortality rate of this disease. Johnson, *supra* note 31, at 317. Eighty percent of the costs of dialysis are funded by Medicare. Hellerstedt, *supra* note 31, at 776. The process by which a decision to provide federal funding for dialysis was made has been well analyzed. *See* G. CALABRESI & P. BOBBITT, TRAGIC CHOICES (1978). The process and substance of this decision has been reexamined in the context of the increased scientific capacity for organ transplantation. *See generally Report of the Massachusetts Task Force on Organ Transplantation*, 13 LAW, MED. & HEALTH CARE 8 (1985); Overcast & Evan, *Technology Assessment, Public Policy and Transplantation: A Restrained Appraisal of the Massachusetts Task Force Approach*, 13 LAW, MED. & HEALTH CARE 106 (1985).

exactly this situation in 1976. She was described by physician experts as

> comatose . . . [and] in a chronic and persistent "vegetative" state, having no awareness of anything or anyone around her and existing at a primitive reflex level. Although she does have some brain stem function (ineffective for respiration) and has other reactions one normally associates with being alive, such as moving, reacting to light, sound and noxious stimuli, blinking her eyes, and the like, the quality of her feeling impulses is unknown.
>
> . . . .
>
> . . . No form of treatment which can cure or improve that condition is known or available. As nearly as may be determined, considering the guarded area of remote uncertainties characteristic of most medical science predictions, she can *never* be restored to cognitive or sapient life.[33]

The court's opinion also summarized the consensus of the medical experts that "removal from the respirator would cause her death soon."[34]

In cases such as Quinlan's, death may occur within a short time regardless of treatment. What is unavoidable, however, is that death will occur within a shorter time without treatment. These cases may cause concern when considered in light of the statute's statement that the Act does "not condone, authorize or approve mercy killing or euthanasia nor permit any affirmative or deliberate act or omission to shorten or end life."[35] Legal prohibitions against euthanasia, mercy killing, and suicide, which are reaffirmed in similar terms in other living will statutes,[36] are consistent with the refusal of medical treatment in these circumstances.[37] Nor are these prohibitions inconsistent with

---

33. *In re* Quinlan, 355 A.2d 647, 655 (N.J. (1976) (emphasis in original).

34. *Id.* at 656. Quinlan did exist in the persistant vegetative state for approximately ten years, having been weaned from the respirator, but never recovered to a cognitive or sapient condition.

35. MO. REV. STAT. § 459.055(5) (Supp. 1985).

36. *See, e.g.*, Illinois Living Will Act, ILL. REV. STAT. ch. 110½, § 709(f) (1983) (expressing disapproval of mercy killing and euthanasia); Uniform Rights of the Terminally Ill Act § 9(g) (Proposed Official Draft) (National Conference of Commissioners on Uniform State Laws 1985) (expressing disapproval of mercy killing and euthanasia).

37. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484 (Ct. App. 1983). In *Barber*, the court noted that "[t]here is no criminal liability for failure to act unless there is a legal duty to act." *Id.* at 490. The court identified the critical issue in that case as "determining the duties owed by a physician to a patient who has been reliably diagnosed as in a comatose state from which any meaningful recovery of cognitive brain function is exceedingly unlikely." *Id.* The *Barber* court held that there was "no duty to continue treatment, once it has proved to be ineffective, "*id.* at 491, and that the failure to use a guardianship proceeding in this case did not make the physician's conduct unlawful. *Id.* at 492. In *In re* Colyer, 660 P.2d 738 (Wash. 1983) (en banc), the Washington Supreme Court held that "[a] death which occurs after the removal of

the refusal of life-sustaining medical treatment as a matter of ethics. In its *Declaration on Euthanasia*,[38] for example, the Catholic Church's Sacred Congregation for the Doctrine of the Faith distinguishes between its strong ethical prohibition of euthanasia and suicide and the acceptability of the refusal of extraordinary or disproportionate treatment. The latter is characterized by "the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."[39] The document further states that

> one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.[40]

The more recent *Guidelines for Legislation on Life-Sustaining Treatment*,[41] approved by the National Conference of Catholic Bish-

---

life sustaining systems is from natural causes, neither set in motion nor intended by the patient" and, therefore, is not suicide. *Id.* at 743. In *In re* Quinlan, 355 A.2d 647 (N.J. 1976), the New Jersey Supreme Court held that although removal of the respirator would accelerate the patient's death, such an act would not be criminal homicide because the patient would have died from "existing natural causes." *Id.* at 660-70. The court held that "[t]here is a real and in this case determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination." *Id.* at 670. In holding that the withdrawal of such treatment is not criminal homicide, the *Quinlan* court also considered the constitutional right to privacy: "We do not question the State's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy." *Id.* The court extended the constitutional protection against prosecution to "third parties whose action is necessary to effectuate the exercise of [the] right." *Id.* In each of these cases, the courts agreed that a guardianship proceeding was not required in every circumstance. *Barber*, 195 Cal. Rptr. at 492-93; *Quinlan*, 355 A.2d at 669; *Colyer*, 660 P.2d at 746.

38. *See* SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, DECLARATION ON EUTHANASIA (Vatican City May 5, 1980), *reprinted in* PRESIDENT'S COMM'N, *supra* note 1, at 300-07.

39. *Id.* at 305-06. The court in *In re* Quinlan, 355 A.2d 647, 658 (N.J. 1976), described discontinuation of the respirator as consistent with the Roman Catholic views presented by the amicus curiae brief of the New Jersey Catholic Conference (the organization of Catholic bishops in New Jersey). This was relevant, according to the court, because of the court's duty to examine the motivations of the guardian. *Id.* at 658.

40. SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, *supra* note 38, at 306.

41. GUIDELINES FOR LEGISLATION ON LIFE-SUSTAINING TREATMENT (National Conference of Catholic Bishops Nov. 10, 1984).

ops, Committee for Pro-Life Activities, in November 1984, provide that legislation should "[r]eaffirm public policies against homicide and assisted suicide. Medical treatment legislation may clarify procedures for discontinuing treatment that only secures a precarious and burdensome prolongation of life for the terminally ill patient, but should not *condone or authorize any deliberate act or omission designed to cause a patient's death.*"[42] The *Guidelines* also emphasize the Catholic Church's prohibition of euthanasia while noting that "[o]ne is not obliged to use 'extraordinary' means."[43] Thus, both legal and ethical analysts have distinguished "mercy killing" and "euthanasia" from the refusal of "extraordinary" life-prolonging treatment. The affirmation of prohibitions against mercy killing and euthanasia, so understood, apparently is the major thrust of the final section of the statute. The disapproval of any "act or omission to shorten or end life" should be interpreted to be consistent, rather than inconsistent, with the rejection of mercy killing or euthanasia, thus giving the "act or omission" phrase a more limited meaning than its literal scope. If this second clause were to be given its literal meaning, it would nullify the statute entirely because withholding or withdrawing life-sustaining treatment will by definition "shorten or end life."

The statute specifically provides elsewhere that death-prolonging procedures do not include medications or procedures that alleviate pain or provide comfort.[44] The declaration has no binding effect over these treatment decisions. If the statute also denied legal effect to declarations that direct the withdrawal or withholding of treatments that have no substantial effect on the course of the illness other than simply to delay an inevitable death, the statutory declaration would be effective to reject only medical treatments that are useless. Medical interventions or procedures that do not alleviate pain, do not provide comfort, or do not extend the life of the patient offer no benefit to the patient. Because customary standards of medical practice prohibit such interventions,[45] a patient directive is not necessary for this result.

---

42. *Id.* at Legislative Guideline (g) (emphasis added).

43. *Id.* at Moral Principles (5).

44. MO. REV. STAT. § 459.010(3) (Supp. 1985).

45. According to the Judicial Council of the American Medical Association, "it is unethical for a physician to provide or prescribe unnecessary services or unnecessary ancillary facilities." JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASS'N, CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION § 2.12 (1981). Similarly, medical groups have endorsed the premise that certain treatments may be superfluous. For instance, "cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or where prolonged cardiac arrest dictates the futility of resuscitation efforts." *Medicolegal Considerations and Recommendations*, 227 J. A.M.A. 864, 864 (1974). Directing futile treatment of this nature deprives the patient of a dignified death. *Id. See also* Murphy, *A New Form of Medical Malpractice?: Missouri's "Liv-*

Further, the meaning of "any affirmative or deliberate act or omission to shorten or end life" must be analyzed in light of the language used in other sections of the statute. For example, the definition of death-prolonging procedures refers to "any medical procedure or intervention which, when applied to a patient, would serve only to prolong artificially the dying process."[46] The sample declaration offered in the statute refers to "medical procedures that merely prolong the dying process" and states the patient's desire that his "dying not be prolonged by administration of death-prolonging procedures."[47] Each of these provisions refers to "prolonging" the dying process, and so they necessarily include a concept of time. The "dying process" is a process of life, not death, despite the statute's use of the adjective "death-prolonging."[48] Therefore, the statute necessarily gives legally binding effect to patient declarations that direct the withholding or withdrawal of treatments even when this decision may shorten this final period of life.

B. *Nutrition and Hydration*

As part of the definition of death-prolonging procedures, the statute specifically excludes those procedures necessary to provide comfort care and to alleviate pain, as well as "the performance of any procedure to provide nutrition or hydration."[49] An early, and perhaps continuing, fear associated with any procedure in which patients are labelled as "incurable" or "untreatable" is the fear that these patients will receive no care or treatment at all even though it may be necessary for their comfort while dying. This fear has lessened as health care professionals have become more aware of their role in caring for the incurable patient who has refused life-sustaining treatment and more knowledgeable about the kind of care that these patients need.[50] Nevertheless, the exclusion of comfort care and pain alleviation from the statutory definition of death-prolonging procedures clarifies this important distinction.

The exclusion of medical procedures that provide nutrition and hydration from the definition of death-prolonging procedures may be seen as a piece of the same cloth, of course, if the provision of nutrition and hydration by medical means makes the patient more comfortable. The connection between nutrition and hydration provided by medical means and the comfort of the dying patient, however, is not entirely clear.

---

ing Will" Statute, 42 J. MO. BAR 11, 17-18 (1986).

46. MO. REV. STAT. § 459.010(3) (Supp. 1985).

47. *Id.* § 450.015.3.

48. *See supra* note 23.

49. MO. REV. STAT. § 459.010(3) (Supp. 1985).

50. *See, e.g.*, Tehan, *Has Success Spoiled Hospice?*, HASTINGS CENTER REP., Oct. 1985, at 10, 10.

There are two types of medical procedures for the provision of nutrition to patients unable to feed themselves or to swallow spoon-feedings. First, nutrition may be provided by tubes that pass a formula directly to the stomach. This method is suitable only for patients whose gastrointestinal tract functions. The tube can be either a nasogastric tube passing through the nose to the stomach or a tube inserted surgically through the abdomen directly into the stomach (gastrostomy). The second medical procedure available for the provision of nutrition is the intravenous method. The peripheral intravenous method delivers fluid to the bloodstream through a needle in one of the patient's limbs. This relatively noninvasive and uncomplicated method is inadequate for the provision of nutrition. If the intravenous method is to be used for nutrition, an intravenous catheter must be inserted into a major vein in the patient's chest.[51]

Each of these procedures involves potential complications. The nasogastric tube may present problems of patient compliance. In some cases, the patient may have to be physically restrained from pulling out the tube.[52] Use of the nasogastric tube may cause aspiration pneumonia, dehydration, hyperosmolality, and diarrhea.[53] The gastrostomy entails the usual risks of minor surgery because the tube requires surgery for both insertion and removal.[54] The provision of nutrition via the central vein risks sepsis, central vein thrombosis, liver function changes, and electrolyte imbalance.[55] Each of these medical procedures for providing nutrition also presents some level of risk and discomfort. Unlike nutrition, hydration can be provided medically to the patient through a relatively noninvasive and uncomplicated intravenous line to a vein in the patient's limbs. Even though administration of artificial hydration is uncomplicated, it, too, may cause discomfort so that its benefits may be questioned in particular cases.[56]

During their final days, dying patients decrease fluid and food intake even when physically able to drink and eat.[57] Artificially supplying nutrition and fluids to these patients actually may cause harm in the

---

51. *See* Lynn & Childress, *Must Patients Always Be Given Food and Water?*, HASTINGS CENTER REP., Oct. 1983, at 17, 18 (discussing medical procedures for nutrition).

52. *Id.*

53. Dresser & Boisaubin, *Ethics, Law, and Nutritional Support*, 145 ARCHIVES INTERNAL MED. 122, 122 (1985).

54. Lynn & Childress, *supra* note 51, at 18.

55. Dresser & Boisaubin, *supra* note 53, at 122.

56. Zerwekh, *The Dehydration Question*, NURSING 83, Jan. 1983, at 47, 47. Increased vomiting may necessitate insertion of a nasogastric tube connected to suction, while increased urine output may require catheterization. Pulmonary edema would require suctioning because the congestion compromises the patient's ability to breathe and cough. *Id.* at 49.

57. *Id.* at 47.

form of increased vomiting, pulmonary congestion, and increased urine output, among other discomforts, some of which require further medical procedures.[58] Comfort care for dehydration associated with dying may be better provided by means other than the medical provision of nutrition and hydration.[59] Thus, on an *individual basis* in these cases, the decision to withhold nutrition or hydration may be consistent with the best interest of the patient, the patient's choice, and the goals of the medical profession.[60]

The statutory exclusion of procedures that provide nutrition or hydration from the definition of death-prolonging procedures, and thus from the scope of the statutory declaration, should not be read as requiring such procedures in these cases. At a minimum, the Act's recognition of the best interest of the patient as a sufficient rationale for acting contrary to the declaration[61] would argue against a statutory interpretation that would require medical procedures not requested by the patient and which conflict with the patient's best interest by increasing discomfort, while only prolonging the dying process.

The case of the dying patient for whom medical procedures to provide nutrition and hydration would be uncomfortable as well as futile in significantly postponing death, however, has not created the current dispute over the legal and ethical appropriateness of the medical provision of nutrition and hydration that underlies the Act's special treatment of these procedures. The withholding and withdrawal of nutrition and hydration from persistently comatose individuals is an issue that has been accorded independent significance.[62] The apparent simplicity of artificial nutrition contrasts sharply with the visually striking mechanical nature of the use of a ventilator for a patient with the same condition. This can result in superficial distinctions based on the appearance of the "machinery." The independent significance of artificial

---

58. *Id.* at 49.

59. *Id.* at 48-49.

60. Although "nutrition-and-hydration" has become a singular noun, it is not appropriate in most circumstances to place medically provided nutrition in the same category as intravenous hydration. There need not be uniform treatment for nutrition and hydration. Rather, the treatments may differ in significant ways, including the invasiveness of the procedures, the risk of complications requiring further interventions, and the benefit to the patient. *See generally* Dresser & Boisaubin, *supra* note 53, at 124.

61. MO. REV. STAT. § 459.025 (Supp. 1985) ("A physician . . . or other person shall not act contrary to the declarant's expressed intent . . . without serious reason therefor consistent with the best interest of the declarant.").

62. *See, e.g.*, Horan & Grant, *The Legal Aspects of Withdrawing Nourishment*, 5 J. LEGAL MED. 595, 601 (1984) (illustrating the division of opinion over whether nutrition should be equated with life-prolonging measures such as ventilators). The specific and categorical exclusion of nutrition and hydration from the definition of death-prolonging procedures and, thus, from the operation of the living will is evidence of the significance of this issue. MO. REV. STAT. § 459.010(3) (Supp. 1985).

nutrition arises as well from the emotional connotation of feeding the helpless individual,[63] even when that individual no longer suffers the discomfort of thirst or hunger,[64] and in the perception that comparatively low technology is involved in such medical procedures.[65]

Many physicians, ethicists, and lawyers—perhaps an emerging majority—advocate that medical interventions supplying nutrition and hydration should be treated no differently from other medical procedures.[66] Under this premise, nutrition and hydration should be withdrawn or withheld if the patient would choose to forego them, or, in the absence of an expressed choice by the patient, if the burdens of the

---

63. *See* Callahan, *supra* note 23, at 22. Callahan emphasizes the importance of this emotional response:

> "Feeling" and sentiment are rarely absent from a well-ordered moral life. They serve to reinforce our convictions, warn us clamorously when some cherished values are in danger, and alert us that the consequences of some action may carry untoward ethical insults.
>
> . . . .
>
> . . . I see no social disaster in the offing if there remains a deep-seated revulsion at the stopping of feeding even under legitimate circumstances. No doubt some people will live on in ways beneficial neither to them nor to others. No doubt a good bit of money will be wasted indulging rationally hard-to-defend anti-starvation policies. That strikes me as a tolerable price to pay to preserve—with ample margin to spare—one of the few moral emotions that could just as easily be called a necessary social instinct.

64. *Id. See* Micetich, Steinecker & Thomasma, *Are Intravenous Fluids Morally Required for a Dying Patient?*, 143 ARCHIVES INTERNAL MED. 975, 977 (1983) (observing that the "bond of care" established with the dying patient makes it "psychologically much harder to take out an IV than not to order it"). *But see* Dresser & Boisaubin, *supra* note 53, at 124, who comment that an "important unresolved issue concerns . . . whether and how the unconscious patient perceives various approaches to nutritional support." Moreover, "[p]hysicians today assume that as the patient slips into a coma, no further awareness is present [because there is no response to even deep pain]. This assumption is impossible to prove or disprove at this time." *Id.*

65. This perception that the provision of nutrition involves a low technology is changing. In fact, the technological complexity of providing nutrition has increased a "tendency to examine its use in the light of other invasive technologies, e.g., respirators or dialysis machines." Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES INTERNAL MED. 129, 130 (1985). Most physicians, however, in a 1983 survey regarded the provision of intravenous fluids for hydration—as distinguished from nutrition—as ordinary, routine treatment. *See* Micetich, Steinecker & Thomasma, *supra* note 64, at 975. Of course, "ordinary" in this sense does not meet the more sophisticated analysis of treatment as extraordinary and, therefore, unrequired. *See supra* notes 37-43 and accompanying text.

66. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 490 (Ct. App. 1983); *In re* Hier, 464 N.E.2d 959, 964 (Mass. App. Ct. 1984); PRESIDENT'S COMM'N, *supra* note 1, at 90; Lynn & Childress, *supra* note 51, at 17-18; Meyers, *Legal Aspects of Withdrawing Nourishment from an Incurably Ill Patient*, 145 ARCHIVES INTERNAL MED. 125 (1985). *But see* Callahan, *supra* note 23; Horan & Grant, *supra* note 62.

procedures outweigh their benefit to the patient.[67] An analysis of the disproportionality of medically providing nutrition to a persistently comatose patient has led several writers to conclude that nutrition need not be provided under such circumstances.[68] Implicit in this analysis is the judgment that prolonged existence in a vegetative coma with no reasonable chance of recovery to a sapient, interactive state is of no benefit to the patient. Others maintain that the withdrawal or withholding of medically provided nutrition and hydration from permanently comatose patients should be treated differently from other medical procedures because they believe that the potentially negative perception of the physician's denial of nutrition or hydration could do irreparable damage to the physician-patient relationship in society.[69] Moreover, critics see a danger that this decision would be motivated primarily by economics.[70]

---

67. *See, e.g.*, Dresser & Boisaubin, *supra* note 53, at 123; Lynn & Childress, *supra* note 51, at 17-18; Meyers, *supra*, note 66, at 127-28.

68. *See, e.g.*, Meyers, *supra* note 66, at 128. Lynn and Childress also conclude that nutrition and hydration may be withheld from persons who have permanently lost consciousness because the procedures do not benefit them. Lynn & Childress, *supra* note 51, at 18. They also conclude, however, that nutrition and hydration may be continued "if family, friends, and caregivers feel that such procedures affirm important values even when they do not benefit the patient." *Id.* at 20-21. Micetech, Steinecker, and Thomasma argue that "[o]nly two conditions permit morally prolonging death—the presence of symptoms requiring palliation and family adjustment to death." Micetech, Steinecker & Thomasma, *supra* note 64, at 977. They conclude that intravenous fluids are not morally required for permanently comatose patients whose death is imminent (within two weeks) and who themselves, prior to incompetence have, or whose family has, requested that the treatment be withdrawn. *Id.* at 978. The Judicial Council of the American Medical Association decided unanimously at its meeting in March 1986 "that it, would be ethical for doctors to withold 'all means of life prolonging medical treatment,' including food and water, from patients in irreversible comas . . . even when death is not imminent." *Reassessing Care of Dying*, N.Y. Times, Mar. 17, 1986, at 1, col. 1.

69. According to some commentators,

> [t]he dedication of the profession to the welfare of patients might be severely undermined in the eyes of the public even by the apparent complicity of physicians in the deaths of the very ill, the permanently unconscious, or the pleasantly senile. The primary commitment of physicians to patients might be compromised . . . at precisely the time when physicians must reestablish the primacy of quality of care and not become overwhelmed by cost-containment efforts . . . .

Siegler & Weisbard, *supra* note 65, at 130. Micetech, Steinecker, and Thomasma argue that

> [i]f death can be seen as a comfort, as it would for the patients in our cases [for example, a 72-year old woman with metastatic bone disease for whom pain control was inadequate and who, after resuscitation due to arrest, remained in a deep coma] and their families, then ordering or continuing to use IV fluids may actually be seen as "cruel."

Micetech, Steinecker & Thomasma, *supra* note 64, at 977.

70. Daniel Callahan, challenging the position that withdrawal of nutrition and

In the few reported cases considering the question of withdrawal of nutrition or hydration, appellate courts have accepted the premise that medical procedures for providing nutrition are indistinguishable from other types of treatment.[71] They have analyzed the appropriateness of the procedures in terms of the patient's choice and the balance of the procedures' benefits and burdens to the patient.[72] Two cases have authorized the withholding or withdrawal of nutrition from patients living at the time of the decision:[73] one patient was in a persistent vegetative coma with no reasonable hope of recovery;[74] the other was incompetent but not comatose and could receive nutrition only through a gastrostomy.[75] In the latter case, the gastrostomy had become particularly invasive because of the need for repeated surgical reinsertion.[76] In each case, the court relied on evidence that the patient herself would have chosen to forego the procedure if she had been competent.[77] The

---

hydration is the same as withdrawing any other treatment, states that "denial of nutrition may in the long run become the only effective way to make certain that a large number of biologically tenacious patients actually die. Given the increasingly large pool of superannuated, chronically ill, physically marginal elderly, it could well become the nontreatment of choice." Callahan, *supra* note 23, at 22.

71. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 490 (Ct. App. 1983) ("[W]e view the use of an intravenous administration of nourishment and fluid, under the circumstances, as being the same as the use of the respirator . . . ."); Severns v. Wilmington Medical Center, 421 A.2d 1334, 1349 (Del. Super. Ct. 1980) (finding the question of whether food or nourishment are life-sustaining systems to be a factual problem requiring an evidentiary hearing); *In re* Hier, 464 N.E.2d 959, 964 (Mass. App. Ct. 1984) (rejecting guardian ad litem's argument that nutrition should be distinguished from treatment with the right of choice confined to the latter); *In re* Conroy, 486 A.2d 1209, 1236 (N.J. 1985) ("Analytically, artificial feeding by means of a nasogastric tube . . . can be seen as equivalent to artificial breathing by means of a respirator.").

72. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 493 (Ct. App. 1983) (if patient's choice cannot be ascertained, surrogate should consider "such factors as the relief of suffering . . . and the quality as well as the extent of life sustained"); *In re* Hier, 464 N.E.2d 959, 964 (Mass. App. Ct. 1984) ("[T]he judge properly took into consideration the facts that the proposed operation is intrusive and burdensome . . . [that the patient] has clearly indicated her opposition to the procedures . . . [and] that the benefits to be realized are diminished by her repeated history of dislodgments [of the nasogastric tube]. . . .").

73. In Barber v. Superior Court, 195 Cal. Rptr. 484 (Ct. App. 1983), the issue of the withdrawal of medically provided nutrition from a comatose patient came before the California Court of Appeal in the context of the physician's prosecution for murder. In *In re* Conroy, 486 A.2d 1209 (N.J. 1985), the patient had died while receiving nutrition through a nasogastric tube pending resolution of her guardian's request for its withdrawal.

74. Severns v. Wilmington Medical Center, 421 A.2d 1334, 1337 (Del. Super. Ct. 1980).

75. *In re* Hier, 464 N.E.2d 959, 961 (Mass. App. Ct. 1984).

76. *Id.* at 960-61.

77. The contrast in the application of "substituted judgment" in each of these cases highlights the vast range of situations in which this analytical tool has been used.

New Jersey Supreme Court also has reaffirmed the primacy of the patient's choice and best interests concerning treatment, but established complex procedures for consideration of a request for withdrawal of life-sustaining treatments, including medical procedures providing nutrition, from incompetent patients residing in nursing homes.[78] That procedure is currently being tested with its first request.[79] In contrast to the views espoused in the reported appellate cases, an unreported lower court decision refused to allow a guardian to authorize the withdrawal of medically provided nutrition to a patient in a permanent vegetative state.[80]

In Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. Super. Ct. 1980), Mary Severns had sustained severe head injuries in a car accident. The damage to the upper portion of her brain, which is responsible for cognition and emotion, was extensive. Her husband asked the court to appoint him as guardian and allow him to authorize removal of several life-sustaining medical treatments, including the nasogastric tube. In this case, the court had some evidence of whether this previously competent patient would have consented to such treatments. Before her accident, Mrs. Severns had stated specifically that she did not want to be maintained in a vegetative state. She had been an active member of the Delaware Euthanasia Education Council and had proposed to her husband that she wanted to prepare a living will for herself, but did not execute the document in deference to her husband's feelings. *Id.* at 158.

In contrast to *Severns*, the court in *In re* Hier, 464 N.E.2d 959 (Mass. App. Ct. 1984), had no evidence of the patient's choice and yet relied on substituted judgment as the justification for removal of the gastrostomy. Mary Hier was 92 years old and had been a patient in a psychiatric hospital for 57 years before being transferred to a nursing home. While acknowledging that because she was incompetent her actions had no legal effect, the court took Hier's opposition to the gastrostomy, which she had forcibly removed several times, as "indicative of the burden that she feels in being subjected to advanced medical technologies." *Id.* at 965. The *Hier* decision was criticized both in terms of legal analysis and fact. *See* Annas, *The Case of Mary Hier: When Substituted Judgment Becomes Sleight of Hand*, HASTINGS CENTER REP., Aug. 1984, at 23. In a postscript, Annas notes that on remand, the probate judge ordered surgery to replace the gastrostomy after hearing several additional medical witnesses. *Id.* at 25.

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

79. *Jersey Ruling on Ending Tube Feeding Invoked in Comatose Woman's Case*, N.Y. Times, Oct. 28, 1985, at 1, col. 6. The Ombudsman, charged with the task of initially deciding whether to allow removal of medically provided nutrition from nursing home patients, denied approval in this first case because it was not clear that death would occur within one year, as the *Conroy* court required. The patient in this case is in an irreversible coma and had clearly indicated previously her desire not to be maintained in a vegetative state. Although three physicians testified that she had less than a year to live, two physicians appointed by the Ombudsman concluded that the patient could live for years. The Ombudsman concluded that "medical experts find it impossible to state with authority that [the patient] will die within a year." *Ombudsman Bars Food-Tube Removal*, N.Y. Times, Mar. 7, 1986, at B2, col. 1.

80. Brophy v. New England Sinai Hosp., No. 85E0009-GI, slip op. (Mass. Probate Court, Oct. 21, 1985). Although Paul Brophy is in a persistent vegetative state, the court distinguished his case from that of Mary Hier because he did not require highly intrusive surgical procedures for nutrition, although he received nutrition through a gastrostomy. Furthermore, he was not "terminally ill, nor ha[d] he reached the end of his normal span of years." *Id.* at 49. The tube was not burdensome to

Because of the present controversy surrounding nutrition and hydration, and because the purpose of the statute is to attach legally binding effect to the rather broadly stated declaration, it is not surprising that the Death-Prolonging Procedures Act itself takes a conservative turn in this regard by excluding from its scope decisions concerning nutrition and hydration. The statute, in effect, allows for the independent development of a legal framework for the withdrawal or withholding of nutrition and hydration. Thus, the legislature has left the task to the courts, which, particularly in the context of guardianship proceedings, are better able to examine the facts of each case, and whose opinions will reflect, over time, developing knowledge and analysis of the questions that may emerge in ethics and medicine.[81] The framework developed by the courts should recognize declarations as evidence of the patient's choice when the patient specifically added to the declaration a directive that nutrition or hydration be withdrawn under certain circumstances.[82]

C. "*Best Interest of the Declarant*"

The legally binding effect of the declaration yields, at least temporarily, to the "physician, health care professional or facility or other person" who may act contrary to the declaration if there is "serious reason therefor, consistent with the best interest of the declarant."[83] This exception does not allow health care providers to continue or institute medical procedures refused by the patient under an otherwise effective declaration on any basis other than the best interest of the declarant. This section does not allow procedures refused in the declaration to be administered on the basis that refusal of such treatment violates the ethics or religious beliefs of the caregiver,[84] nor does the section suggest that refusal of treatment is categorically contrary to the best interests of any terminally ill patient. Only a generous, and

---

Brophy because the surgery had already taken place and maintenance of the stoma was uncomplicated. The court found that removal of nutrition and hydration would cause a painful death. This case has been appealed to the Massachusetts Supreme Judicial Court.

81. The issue of nutrition is, in fact, a good illustration of the development of such a consensus. *See supra* notes 66, 68, and accompanying text.

82. The Missouri statute provides that "the declaration may include other specific directions. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid declaration, and to this end the directions in the declaration are severable." MO. REV. STAT. § 459.015.3 (Supp. 1985).

83. *Id.* § 459.025.

84. The personal, professional, and religious beliefs of the health care provider are respected, however, to some extent. Health care professionals and facilities who are unwilling to comply with the patient's declaration may "take all reasonable steps to effect the transfer of the declarant" from their care. *Id.* § 459.030.

inappropriate, extension of the concept of best interest in relation to the declarant would support medical interventions performed for the sole benefit of the declarant's spouse or family.[85] The statute implicitly presumes that a decision by a competent, terminally ill individual to direct that "medical procedures that merely prolong the dying process" be withheld or withdrawn is a decision that is in the best interest of that individual, as determined by the individual himself.

Because the scope of the statute is narrow and is confined to the refusal of procedures that prolong the dying process of a terminally ill patient, it is hard to imagine situations in which the personal choice expressed in the advance directive of the competent individual, now incompetent, would be contrary to his best interests. The most likely situations in which there may be legitimate and serious reasons for acting contrary to the declaration are those that involve possible revocation of the directive,[86] questions concerning the competency of the declarant at the time the directive was executed,[87] and the nature of the medical condition of the declarant.[88]

---

85. An argument may be made that the terminally ill, incompetent patient, who has directed the withdrawal of death-prolonging procedures in a valid declaration, should be treated despite his choice because medical interventions would benefit the family and thus indirectly benefit the patient. The assumption that continued medical interventions could benefit the emotional well-being of the patient's family cannot be denied. A best-interest argument that would include the family's benefit would have to assume that the family's benefit, even when in conflict with the patient's own choice, is in the best interest of the patient himself.

This argument is unpersuasive. A person who has executed an advance directive presumably has weighed the consequences of this choice for his family and has concluded that making this decision himself while competent is beneficial to his family or that the burden placed upon the family by his refusal is less than the burden he would bear if treatment that prolongs his dying were to be continued.

86. The Act provides that "[a] declaration may be revoked at any time and in any manner by which the declarant is able to communicate his intent to revoke, without regard to mental or physical condition." MO. REV. STAT. § 459.020.1 (Supp. 1985). A person who believes that the patient has revoked the declaration would certainly be acting in the patient's best interest in refusing to comply with the document. Because the statute provides that revocation is effective regardless of the patient's mental condition, it presents the problem of ambiguous acts on the part of the incompetent patients. For example, if an incompetent patient gasps for air or gestures frantically when a respirator is removed, has he revoked his declaration? Clearly, the statute must allow for distinctions between physical acts that are essentially involuntary and do not imply a revocation and acts that are intentional. *Cf. supra* note 77.

87. The Act provides that "a physician or medical care facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was competent when it was executed." MO. REV. STAT. § 459.035 (Supp. 1985). Serious doubt about the competency of the declarant when the declaration was executed is certainly a serious reason, consistent with the best interest of the patient, for refusing to comply with a declaration that is valid on its face.

88. *See supra* notes 27-34 and accompanying text. Disputes may arise because the determination that the patient is in a terminal condition and that the treatment is a

Each of these claims calls into question the validity of the declaration itself. Rather than "overriding" the patient's choice, statutory recognition of the right to refuse to comply with an invalid declaration in these limited circumstances enhances the legitimacy of the advance directive. Should the decision be made to treat the patient, contrary to the patient's choice as expressed in the directive, the statute requires that the "serious reason . . . consistent with the best interest of the declarant" be recorded in the patient's medical record.[89] In some cases, there will be disagreement, perhaps between the patient's family and the physician, or among health care providers, or among family members, concerning the best interest of the patient. Any person who has serious reason to believe that the action taken by the physician is contrary to the best interest of the patient, whether this action is treatment contrary to the patient's declaration or nontreatment in compliance with the declaration, may petition the probate court for the appointment of a guardian. In the course of the guardianship proceeding, the dispute concerning compliance with the declaration would be resolved.

Health care providers and facilities should not use the guardianship proceeding, however, for approval of compliance with declarations on a routine basis. If medical treatment refused via the declaration is administered while the guardianship proceedings are underway, the health care provider is acting contrary to the declaration. This is prohibited by the statute except in very limited circumstances that do not support routine recourse to guardianship proceedings.[90]

D. *Enforcement*

The strength of the living will is that it places control of treatment decisions in the hands of patients while they are still capable of making those decisions, thus protecting them from involuntary treatment, expense, and litigation and sparing their family the burden of making the decision themselves. To fulfill this advantage, valid advance directives

---

death-prolonging procedure is a judgment. Such conflicts may be resolved by consultation among physicians. The statute, however, does not require such consultation. A family confronted with a dispute between physicians, with one physician unwilling to make this judgment, may seek a second opinion concerning the nature both of the patient's condition and the treatments available, if any. If the second physician disagrees with the first and concludes that the situation meets the preconditions of the Act, there is no bar to allowing the first physician to withdraw from the case and the second to comply with the directive, as long as the judgment conforms to the customary standards of the medical profession. If not resolved in this manner, the problem may be brought to court in the context of a guardianship proceeding.

89. MO. REV. STAT. § 459.025 (Supp. 1985).

90. The health care provider may refuse to comply with a declaration if he has a "serious reason therefor consistent with the best interest of the declarant." *Id.* § 459.025. The provider's concern with his own potential liability does not meet this criterion.

should be "self-enforcing" in all but the most unusual cases. One measure of the degree to which the declaration is self-enforcing is the extent to which the statute is clear and unambiguous in scope. A second measure is the extent to which the statute discourages voluntary noncompliance with a declaration unless the noncompliance is based on judgments recognized as legitimate under the statute.[91] Living will statutes can provide statutory penalties to deter noncompliance with valid declarations.[92] The possibility of civil liability for damages creates a second substantial deterrent for noncompliance.[93]

As previously noted, the Missouri Act includes the following penalty provision:

> It shall constitute unprofessional conduct if a physician or other licensed health care professional or facility with actual knowledge of a declaration acts, when the declarant is in a terminal condition and unable to make treatment decisions, contrary to the expressed intention of the declarant, as stated in his declaration, without serious reason therefor consistent with the best interest of the declarant.[94]

While the statute does not itself identify any penalty for unprofessional conduct,[95] such conduct may be relevant to the licensure and discipline

---

91. *Id.* This limitation on health care providers makes the declaration the final arbiter of the treatment question except in the unusual case in which the validity of a declaration is challenged or in which a valid declaration violates the best interest of the patient. The living will supplants the guardianship and is self-enforcing in the sense that there is no need for further legal procedures for compliance.

92. The Uniform Act provides that a physician who is not willing to comply with an operative declaration and who does not transfer the patient "as promptly as practicable" is guilty of a misdemeanor. Uniform Rights of the Terminally Ill Act § 6, 8(a) (Proposed Official Draft) (National Conference of Commissioners on Uniform State Laws 1985).

93. *See* Furrow, *Damage Remedies and Institutional Reform: The Right to Refuse Treatment*, 10 LAW, MED. & HEALTH CARE 152 (1982); Comment, *Damage Actions for Nonconsensual Life-Sustaining Medical Treatment*, 30 ST. LOUIS U.L.J. 897 (1986).

94. MO. REV. STAT. § 459.045.1 (Supp. 1985). The statute also includes other penalty provisions for different purposes. For example, any person who, with actual knowledge of a declaration, acts contrary to the declaration without justification based on the declarant's best interest "shall lose such rights of inheritance to the extent such loss is provided for by the patient's last will and testament." *Id.* § 459.045.2. Other penalties exist for the willful destruction, concealment, or forgery of a declaration (class A misdemeanor), *id.* § 459.045.3, and for the willful concealment of a revocation that causes treatment to be withheld resulting in the patient's death (class B felony). *Id.* § 459.045.4.

95. The value of penalty provisions has been questioned. "[I]f health care professionals are simply unsure of what patients want, or if they are willing to share decision-making responsibility but are apprehensive about their legal liability . . . the threat of penalties would be unnecessary and potentially counterproductive by fostering an adversarial relationship between patient and provider." PRESIDENT'S COMM'N, *supra* note 2, at 150. The Commission does note that penalties would be advisable if health care

of health care professionals or facilities and to civil litigation for damages.[96]

The Missouri Medical Practice Act[97] and Nursing Practice Act[98] specifically list the causes upon which denial, suspension, and revocation of a license may be based.[99] While neither Act lists "unprofessional conduct" as behavior that would support disciplinary action, each includes as specific grounds for discipline "misconduct . . . in the performance of the functions or duties of any profession licensed or regulated by this chapter."[100] Because the Death-Prolonging Procedures Act places a duty on physicians and nurses to comply with a valid declaration absent serious reason consistent with the declarant's best interest,[101] failure to comply with the declaration is a violation of a duty of professionals licensed under the Medical Practice Act or Nurse Practice Act. The statutory provision stating that failure to comply with the declaration constitutes "unprofessional conduct" should be considered synonymous with "misconduct" as provided for in the practice acts, thus creating a basis for professional discipline in the event of noncompliance. The effectiveness of this enforcement strategy depends on the willingness of the professional boards to act.[102]

IV. THE SCOPE OF THE ACT—CUMULATIVE RIGHTS

While this statute is important because it recognizes the validity of advance directives, it is equally important for what it does not do. The statute is not designed to serve as the complete definition of the right to refuse treatment, nor is the statute's declaration the sole means for the exercise of this right by incompetent individuals.

The statute provides:

---

professionals are "unwilling to share responsibility with patients and . . . tend to overtreat." *Id.*

96. A finding of unprofessional conduct may be used as a basis for civil liability. *See, e.g.*, Harnish v. Children's Hosp. Medical Center, 439 N.E.2d 240, 242 (Mass. 1982) (court found professional misconduct to be the equivalent of malpractice when physician performed surgical procedure without patient consent); Colton v. Dewey, 321 N.W.2d 913, 917 (Neb. 1982) (court found professional misconduct to be equivalent of malpractice when physician misrepresented effects of asthma therapy).

97. MO. REV. STAT. §§ 334.010-.620 (1978 & Supps. 1984, 1985).

98. *Id.* §§ 335.010-.096 (1978 & Supps. 1984, 1985).

99. *Id.* §§ 334.100, 335.066 (Supp. 1984).

100. *Id.* §§ 334.100(5), 335.066(5)(Supp. 1984).

101. *Id.* § 459.025 (Supp. 1985).

102. Both the Medical Practice Act, *id.* § 334.100.1, .2 (Supp. 1984), and the Nursing Practice Act, *id.* § 335.066.1, .2 (Supp. 1984), allow the appropriate board to effect the denial, revocation, or suspension of the professional license for violation of the standards listed in these acts. The State Board of Registration for the Healing Arts registers, licenses, and supervises physicians and surgeons. *Id.* § 334.120 (Supp. 1984). The Missouri State Board of Nursing regulates the practice of nursing. *Id.* §§ 335.021.1, .036 (Supp. 1984).

> Nothing [in this act] shall be interpreted to increase or decrease the right of a patient to make decisions regarding use of medical procedures so long as the patient is able to do so, nor to impair or supersede any right or responsibility that any person has to effect the withholding or withdrawal of medical care in any lawful manner. In this respect, the provisions [of this act] are cumulative.[103]

With this provision, the legislature confines the limitations of the statute to the operation of the declaration. This provision disclaims any effect on the scope of rights existing independently of the statute. This section clearly applies to patients competent to make medical decisions. It applies to incompetent patients as well and in similar fashion. A primary value of this severance is that it allows the individual right to refuse treatment to develop over time and on an individual basis. It avoids the excessive legalization of the dying process that would occur if the statutory declaration became the sole means for medical treatment decisionmaking.

The source of the right of competent patients to refuse medical treatment emerges from a theory of personal autonomy. Whether identified as a common-law right of self-determination[104] or a constitutional right of privacy,[105] the right to refuse treatment is not unlimited.[106] But the right of the competent patient to refuse medical treatment certainly extends beyond the boundaries established in the statute. The right of competent patients to refuse even lifesaving treatments has been upheld on many occasions.[107]

---

103. *Id.* § 459.055(2).

104. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 490 (Ct. App. 1983). This right of self-determination forms the foundation for the legal doctrine of informed consent. The *Barber* court noted that "where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that a competent adult patient has the legal right to refuse medical treatment." *Id.* at 489. Alexander Capron argues that "[i]t would have been possible to protect patients' right to self-determination about medical care through tort and contract doctrines, without turning to constitutional law." Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Self-Sustaining Treatment*, 1984 ARIZ. ST. L.J. 647, 657.

105. *See, e.g., In re* Quinlan, 355 A.2d 647, 663-64 (N.J. 1976).

106. As the Death-Prolonging Procedures Act provides, the right to refuse treatment is "subject to the state's interest in protecting innocent third parties, preventing homocide and suicide and preserving good ethical standards in the medical profession." MO. REV. STAT. § 459.055(1) (Supp. 1985). The New Jersey Supreme Court in *In re* Quinlan, 355 A.2d 647 (N.J. 1976), described the relationship between the state's interest and the individual's interest in the context of refusing life-sustaining treatment as follows: The "State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." *Id.* at 664 (emphasis in original). This "waxing and waning" view of privacy is criticized by Capron, *supra* note 104, at 656-58.

107. *See, e.g.*, Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986) (court upheld right of a mentally competent patient to refuse medically provided nutri-

As with the competent patient, the incompetent patient has a right to refuse medical treatment that is also based on the right of self-determination or privacy.[108] The living will statute recognizes that "[e]ach person has the primary right to request or refuse medical treatment,"[109] making no distinction between persons with the legal capacity to make the decisions for themselves and those without. The statute, by its own terms, does not override the physician's responsibility to withhold or withdraw treatment from an incompetent patient when it is otherwise appropriate to do so.[110]

The recognition of the incompetent patient's right to refuse medical treatment based on a theory of personal autonomy leaves unanswered the question of how this right is to be exercised when the patient is unable to do so for himself. In enacting the living will statute, the legislature has provided one method by which the particular group of incompetent patients who meet the preconditions of the statute[111] may make decisions about death-prolonging medical treatments. The guardianship procedure remains available for incompetent patients to whom the living will statute does not apply. This group of incompetent patients may include those who have never had the capacity to make medical decisions or those who, though previously competent, have not executed the statutory living will.[112] The guardianship proceeding is particularly appropriate in those cases in which the patient's own views are unknown as a result of life-long incompetency.[113] When there is

---

tion). *See also* cases cited *supra* note 7.

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

109. MO. REV. STAT. § 459.055(1) (Supp. 1985).

110. *Id.* § 459.055(2).

111. The advance directive provided for in the statute is available as a means of controlling the course of treatment for those incompetent patients who, when competent, executed a valid declaration and who now are terminally ill within the meaning of the statute.

112. The absence of a valid directive does not necessarily indicate that the individual desired treatment in circumstances that fall within the scope of the statute. The Act, in fact, provides that it creates "no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of medical procedures." MO. REV. STAT. § 459.055(3) (Supp. 1985). An inference reasonably drawn from this section is that the intention of the patient, even when the patient has not executed an advance directive, is relevant to the decision either to use or refrain from using medical procedures. The reasons for not executing a valid directive include ignorance of the availability of the instrument or the desire to allow family members to act as proxies in the belief that this will be more responsive to particular situations. The sensitivity of spouses to such planning may also be among the reasons for not executing a directive.

113. In these cases, reliance on the theory of substituted judgment through which the court tries to imagine the choice of a particular patient who has never had the capacity to exercise personal choice is inappropriate, even though the theory has been used. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 370

reliable evidence of a patient's choice, perhaps affirmed by family members, and the physician determines that the medical procedures at issue give no hope of recovery and would only prolong the dying process, little is gained by requiring in all cases that a guardian be appointed.[114] In fact, the argument can be made that the guardianship procedure may itself deny the patient's right by burdening the exercise of the right with legal procedures that afford no benefit to the patient.

The scope of the underlying right of the incompetent patient to refuse medical treatment may be at issue in the case of the patient who, while still competent, executes an advance directive, but with added directions. For example, a competent patient with end-stage renal disease treatable with hemodialysis may execute a declaration directing that, should she become irreversibly incompetent, hemodialysis is to cease. The statute specifies that the "declaration *shall* be given operative effect" only if the declarant's condition is terminal.[115] In this hypothetical case, if the patient does not have a terminal condition,[116] the declaration has no statutory "operative effect." Although this declaration cannot be considered binding, it certainly is relevant to the question of whether there is continuing consent to the treatment or whether the hemodialysis must be discontinued. In this case, the patient's choice may be effected by other means, including the guardianship.

In a similar situation, a competent patient may execute a declaration with an added provision that directs that medical procedures to provide nutrition not be instituted or continued should he become irreversibly comatose. In this case, the added clause will not have the same legal effect that the declaration has, because the statute specifically excludes medical procedures to provide nutrition from the definition of death-prolonging procedures.[117] On the other hand, the statute nowhere

---

N.E.2d 417 (Mass. 1977). When the patient has always been incompetent, it is appropriate to shift from substituted judgment to another standard that may be more protective of the dignity of an individual who has never exercised the freedom of choice.

114. With the exception of the family's approval, these conditions parallel the conditions required for operation of the declaration. MO. REV. STAT. §§ 459.010 (3), .010 (6) (Supp. 1985). Of course, one benefit of the guardianship procedure accrues not to the incompetent, but rather to the physician (i.e., protection from civil or criminal liability). Courts considering the question of criminal liability for the discontinuation or withholding of treatment, however, have consistently rejected the notion that such conduct is unlawful and, therefore, have held that there is no basis for criminal prosecution in this type of case. *See supra* note 37 and accompanying text. Protection from potential liability is also an apparent benefit of the Death-Prolonging Procedures Act. MO. REV. STAT. § 459.040. The potential for liability remains, however, for breach of customary medical standards in the determination of terminal illness, *id.* § 459.010(6), and for bad faith. *Id.* § 459.040.

115. MO. REV. STAT. § 459.010(6).

116. *See supra* notes 31-32 and accompanying text.

117. MO. REV. STAT. § 459.010(3) (Supp. 1985).

explicitly prohibits a decision to forego medical procedures to provide nutrition. It simply limits the binding effect of the declaration to the statutory definition of death-prolonging procedures. The appropriateness of decisions on nutrition or hydration must be examined independently, and the added clause is evidence of the patient's lack of consent to the nutritional procedures. The statute leaves the issue open in contexts other than the operative effect of an advance directive.[118]

In each of these cases, the initial question is whether there exists a right on the part of the incompetent patient to refuse medical treatment. The statute specifically provides that, if such a right exists, the statute shall not be construed to "impair or supersede" that right. The statute creates one method by which the rights of the incompetent may be exercised. The limitations in the statute narrow the scope of the method employed rather than the underlying right itself.

V. CONCLUSION

With the passage of the Death-Prolonging Procedures Act, the Missouri legislature has taken a step in creating a legal framework for the protection of the individual's right to refuse medical treatment. The method chosen suffers from serious flaws in the definition of its scope. For example, its limitation to situations in which death will occur within a short time, whether or not treatment is given, evidence more than the ordinary difficulties of drafting definitions in a complex area—it illustrates the inadequacy of a notion of terminal illness as a boundary on individual choice to refuse medical treatment. While the impact of treatment on life span is an important factor to consider in weighing the benefits and burdens of treatment, it is not the only factor and cannot, of itself, stand as an independent barrier to individual choice.

Despite such difficulties, the Death-Prolonging Procedures Act is a worthwhile effort and deserves the benefit of interpretation favorable to patients in their efforts to control the course of their own medical treatment. Lawyers can assist clients in this effort by explaining the inherent limitations of such a method and urging clients to discuss this document with their physicians in recognition of the very large role that the physician plays in the implementation of this Act.

118. *See supra* notes 61, 81-82, and accompanying text.