Ethical, Legal and Practical Considerations Regarding the Use of Enteral Nutrition in Mentally Incompetent Patients

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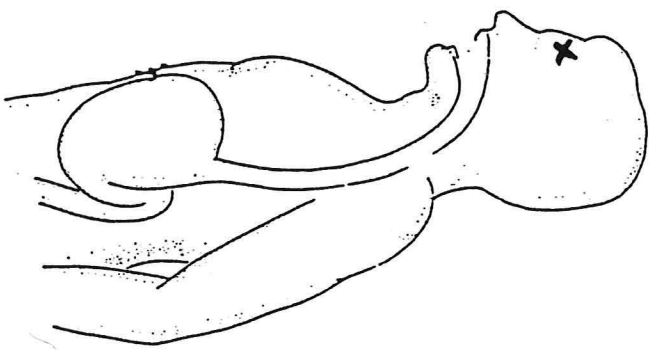

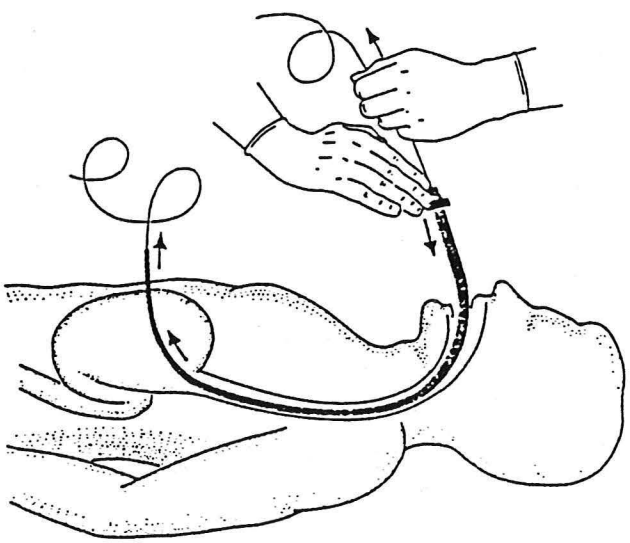

. . . the times has been,
that, when the brains were out, the man would die,
and there an end; . . .

Macbeth III.iv.77-79

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I. INTRODUCTION

Case I

FS is a 17-year-old man who was admitted to the hospital with an altered mental status. His mother stated that over the previous two weeks he had become bedridden and though seemingly awake was nonetheless unable to walk or eat. The mother acknowledged that prior to his illness, the patient had been abusing, by way of inhalation, several organic solvents including toluene. His physical examination was entirely normal with the exception of his neurologic exam which revealed a seemingly awake young man lying supine with his eyes open. He was drooling (in fact foaming at the mouth) and made incessant lip smacking noises. His muscle tone was notable for marked trunkal and extremity rigidity. When food was placed in his mouth, he was unable to swallow and was noted to aspirate some of the foodstuff.

Because of his inability to be fed orally and the uncertain prognosis regarding his encephalopathy, the medical service caring for him obtained informed consent from the patient's mother for placement of a percutaneous endoscopic gastrostomy tube (PEG). Despite the presence of an unusually deep J-shaped stomach, a feeding tube was placed endoscopically the next morning using the "push-technique" over a flexible guidewire. The next day enteral nutrition was initiated uneventfully and the patient was soon discharged to a nursing home.

To the pleasant surprise of the physicians on the gastroenterology service, FS walked into the GI lab three months later and asked if the feeding tube could be removed as he was no longer using it. The feeding tube was pulled out without any further instrumentation and the gastrostomy track spontaneously closed within a week. The current status of FS is unknown except that he has not required readmission to Parkland Hospital.

Case II

JD was a 74-year-old woman confined to a local nursing home with severe organic brain syndrome. She became febrile and developed labored breathing and was admitted to Parkland Hospital with a diagnosis of bronchopneumonia. On admission to the hospital the patient's temperature was 101 degrees, she was tachycardiac, dyspneic, and had coarse bronchi and rales over her right lung fields. A clogged naso-gastric tube was taped to her right nostril. Deep decubitus ulcers were present over her right iliac crest and her right lateral malleolus. On neurological exam, she was lying on her right side in a fetal position with stiff flexion contractors of the hip bilaterally. She was responsive only to painful stimuli.

A poor quality portable AP chest Xray confirmed the presence of right lower lobe consolidation and a naso-gastric tube correctly positioned in her stomach. Laboratory findings included a leukocytosis, mild hypoxemia, and a serum creatine of 6 that remained elevated after rehydration.

The patient was admitted to the medical service and treated with intravenous fluids, antibiotics and supplemental oxygen. Additional information obtained from the nursing home revealed that the patient suffered from severe Alzheimer's disease and had been unresponsive and in a fetal position for the past three years. She had been maintained on enteral nutrition via a nasogastric tube for the past two years. The nursing home had no record of any family members.

On the fifth hospital day, the gastroenterology service was consulted and asked to place a percutaneous endoscopic gastrostomy feeding tube as this was "necessary for the patient to return to her nursing home." The consulting resident on the gastroenterology service, after presenting the patient to his attending, expressed two reservations regarding the request for PEG placement. First, the patient was medically too unstable from a pulmonary point of view to withstand the sedation required for PEG placement and, second being mentally incompetent, the patient was unable to give informed consent to this invasive procedure. He privately went on to express considerable reservation regarding the humaneness of prolonging this individual's life indefinitely with a feeding tube and wondered aloud what the morally correct course of action should be. The

attending physician (in an act of cowardice) skirted the ethical issue and placed a note on the chart to the effect that PEG placement was contraindicated due to the patient's unstable medical condition.

The following day, the medical service called back the consulting resident insisting that the decision to forego PEG placement be reconsidered as they felt the patient's pulmonary status was "at baseline" and that they would obtain "consent" for the procedure by providing two physician signatures attesting to the fact that the procedure was medically indicated. The consulting service reexamined the patient and again declined to place a PEG, this time because the patient's gnarled body habitus from her flexion contractions would not allow her to be placed in a supine position for the endoscopy. A heated discussion ensued between the consulting service and the medical service and lasted until the patient died one hour later from respiratory failure.

These two cases illustrate the wide range of particular circumstances that accompany a seemingly straightforward request for the same medical intervention, placement of a feeding tube. In the first case, the gratifying clinical outcome allowed the physicians caring for the patient to have a warm feeling of satisfaction at having helped the patient recover. In the second case, a moral dilemma was encountered but not openly confronted, and the poor clinical outcome resulted in feelings of frustration and even anger on the part of the physicians, all of whom were trying to do the right thing.

Consultations requesting PEG placement that turn out like the latter case are not at all a rarity on a teaching service. Although many clinical studies have been done reporting excellent clinical outcomes after PEG placement, only one has included in its denominator all patients in whom a PEG placement was requested.

Lee and Harford at the Dallas Veterans Hospital (1) examined all requests for PEG placement that were received by the gastroenterology consulting service between October 1, 1989 and December 31. 1989.

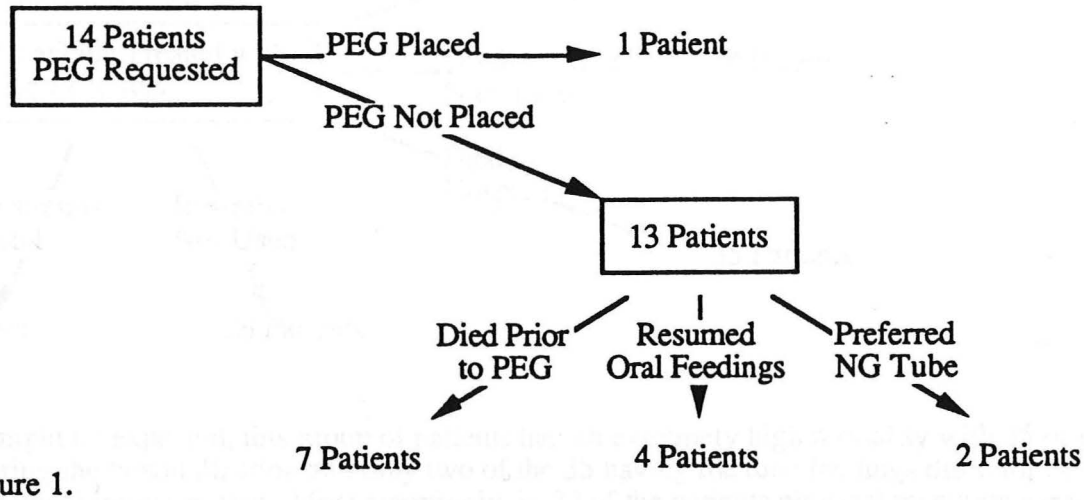

Figure 1.

As shown in Figure l, a total of 14 consults requesting PEG placement were received. The patients were all male with a mean age of 71 years. Seven of the consults came from the neurology service, six from general medicine and one from general surgery. The principal diagnoses of these patients included: cerebral vascular accident (8 patients), dementia (4), and metastatic cancer (2). Specific reasons given by the referring physician for the request for PEG placement included pulling out nasogastric tubes (7 patients), swallowing disorder secondary to neurologic disease (4), and refusal to eat (3).

Notably, eight of the 14 patients had "do not resuscitate" orders written in their charts indicating, interestingly, that on balance the referring physicians were able to make a clear

distinction in their own minds between "extraordinary therapy" such as cardiopulmonary resuscitation from "ordinary" therapy such as enteral nutrition.

Surprisingly, only one of these 14 patients actually had a percutaneous endoscopic gastrostomy tube placed. This particular patient had a neurogenic swallowing disorder as the indication for PEG placement. Of the 13 remaining patients, seven died in the hospital prior to the scheduled placement of a PEG. Four of the 13 resumed adequate oral intake on their own thus obviating the need for a PEG and two patients decided to continue to receive enteral feeding by a nasogastric tube after consultation with their family members.

Lee and Harford concluded from this small retrospective chart review that requests for PEG placements were often initiated prematurely in patients with an extremely limited life expectancy. Moreover, they felt that the reasons given by the referring physicians for PEG placement clearly emphasized biomedical concerns more than the patient's quality of life. Fundamentally, the referring physicians assumed that a biomedical effect (such as lowering the serum sodium concentration) would result in a benefit to the patient (improved quality of life) (2).

In another clinical study from a community-based teaching hospital in New York (3), Quill reviewed 55 elderly patients with severe chronic illness who were being treated with enteral nutrition by nasogastric tubes. He asked their physicians to complete a questionnaire designed to explore the physician's views of the benefits and burdens of enteral nutrition and then correlated the physician's stated beliefs with their actions as denoted in a review of the medical chart.

Although 90% of the physicians stated that they felt that the decision to initiate enteral feeding should be based on the patient's wishes, in only two of the 55 patients was oral or written consent noted in the chart.

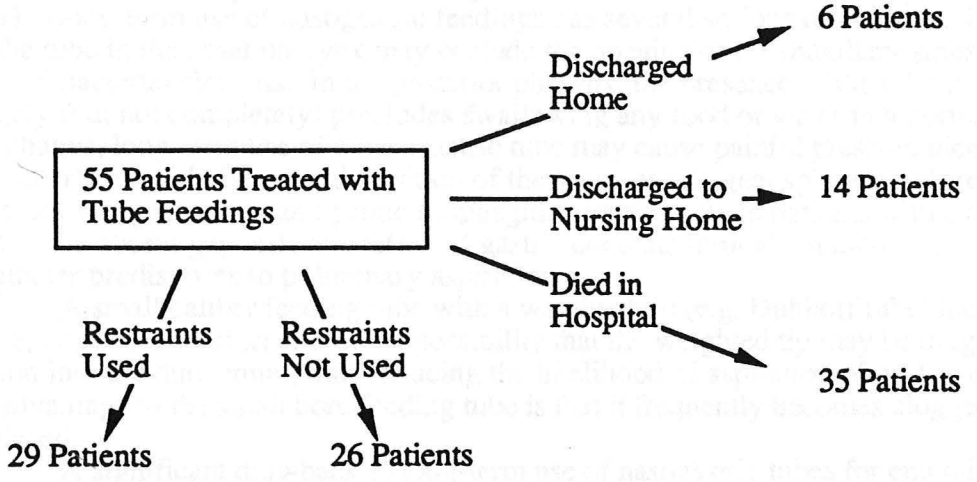

Figure 2.

As might be expected, this group of patients had an extremely high mortality with 35 of the 55 dying during the hospitalization and only two of the 55 having the tube feedings discontinued as a result of medical improvement. Most alarmingly, in 29 of the patients physical restraints were required to keep the nasogastric tube in place even when the indication for enteral nutrition was said to be patient comfort. Eight incompetent patients in this study group died while being kept in restraints in order to keep their nasogastric tubes in place. As did Lee and Harford at the Dallas Veterans Hospital, Quill concluded that the clinical reasoning leading to the decision to initiate enteral nutrition emphasized biomedical concerns much more than the patient's quality of life (by an 8:1 ratio).

Clearly then, based on our own anecdotal experience at Parkland and the Dallas Veterans Hospital as well as published chart reviews from elsewhere, ample room exists for improvement in our clinical decision making with respect to use of enteral nutrition.

II. TECHNICAL ASPECTS OF TUBE FEEDING

Feeding patients who are unable to swallow, through a surgically-placed gastrostomy tube, has been successfully used for over 100 years. During the 1970s, scientific advances in the field of nutritional support allowed for the commercial development of nutritionally balanced liquid feeding formulas and greatly simplified enteral nutrition (4).

In 1980, Jeffrey Ponsky at Case Western Reserve University, described a technique of placing a permanent feeding tube under endoscopic guidance, thereby obviating the need for general anesthesia and laparotomy (5, 6). As is often the case, the advent of a less invasive procedure greatly expanded the range of patients qualifying for the procedure. It is now possible to place a permanent feeding tube under light, conscious sedation in a mean time of 17 minutes on outpatients. The long-term economic implications (7) of applying this new technology to a rapidly aging population are enormous (8, 9).

Enteral nutrition by nasogastric tubes - The simplest way to gain access to the gastrointestinal tract in patients who cannot swallow is by blindly passing a tube through the nose into the stomach. Nasogastric tube placement can be carried out by any physician, most nurses and as we have all seen by some patients (10). Correct placement of the tube tip in the stomach should be checked by aspirating a large syringe full of air into the tube while auscultating the right upper quadrant and listening for the characteristic gurgling sound. If the tube is to be used for enteral nutrition, correct tube placement should be confirmed by an x-ray.

The main advantage to enteral nutrition by nasogastric tube is the ease with which the tube can be placed. Nasogastric tube feedings work quite well on a short-term basis (several weeks or less). Long-term use of nasogastric feedings has several serious drawbacks. First, the presence of the tube in the nasal pharynx may occlude the opening of the maxillary sinus resulting in a painful bacterial sinusitis. In the posterior pharynx, the presence of the tube is uncomfortable and largely (but not completely) precludes swallowing any food or water in a normal fashion. In the esophagus, long-term use of a nasogastric tube may cause painful pressure ulcerations to develop and interferes with the normal function of the lower esophageal sphincter, thereby promoting gastroesophageal reflux and peptic esophagitis. Particularly in patients with a depressed mental status and absent gag reflexes, reflux of gastric contents through an incompetent lower esophageal sphincter predisposes to pulmonary aspiration.

A small caliber feeding tube with a weighted tip (e.g. Dubhoff tube) has the advantages of a) better patient comfort and b) the possibility that the weighted tip may be dragged by peristaltic action into the duodenum, thus reducing the likelihood of aspiration of gastric contents (11). The disadvantage to the small bore feeding tube is that it frequently becomes clogged up and must be replaced.

A significant drawback to long-term use of nasogastric tubes for enteral nutrition that should not be underestimated is the damage done to the patient's self esteem. The presence of a nasogastric tube (even a small one) dangling from a patient's nostril is socially stigmatizing and may significantly impair a demented patient's few remaining outlets for social interaction.

In summary, enteral nutrition by nasoenteric tubes is ideally suited for short-term use in hospitalized patients; if the anticipated need for enteral nutrition is greater than one to two months, then placement of a permanent feeding tube by endoscopic technique should be offered to the patient.

Percutaneous endoscopic gastrostomy (PEG)- Inability to swallow either as a result of central nervous system impairment or obstructing neoplasms of the pharynx or esophagus is the most common indication for PEG placement.

Limitations - PEG placement is an elective procedure and should be performed only in patients which are a) hemodynamically stable and b) able to tolerate an hour or more of conscious sedation with intravenous benzodiazepines and/or narcotics. In addition, PEG placement should only be considered in patients who have the potential for extended survival outside of the hospital.

Patients who have undergone prior abdominal surgery may still be candidates for successful PEG placement as long as the left upper quadrant is not heavily scarred (e.g. a left upper quadrant colostomy). The determination as to whether a PEG placement is technically possible is best decided at the time of the endoscopy immediately preceding placement of the PEG.

PEG placement is contraindicated in patients with massive ascites or those undergoing peritoneal dialysis. Uncorrectable coagulopathies and near-total esophageal obstruction may also contraindicate the procedure.

PEG placement may be carried out through three different techniques: "push" technique, "pull" technique and the "introducer" technique.

"Push" technique - The patient is fasted for eight hours prior to the procedure and a single dose of an antibiotic (usually a cephalosporin) is administered prophylactically just before beginning. The patient is placed in the supine position on the endoscopy table and the abdomen is sterily scrubbed and draped. Intravenous sedation is administered and the posterior pharynx is anesthetized with a topical spray.

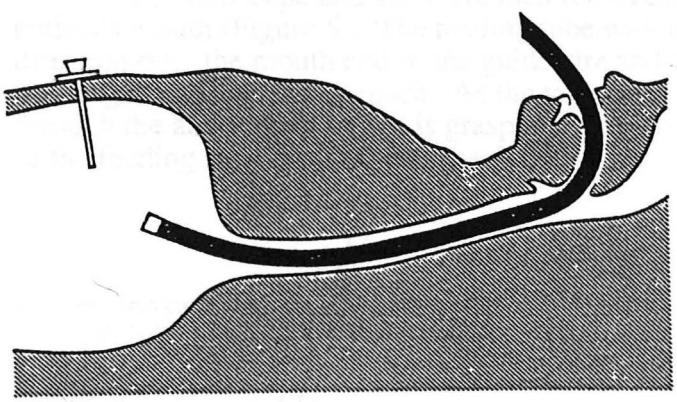

Figure 3.

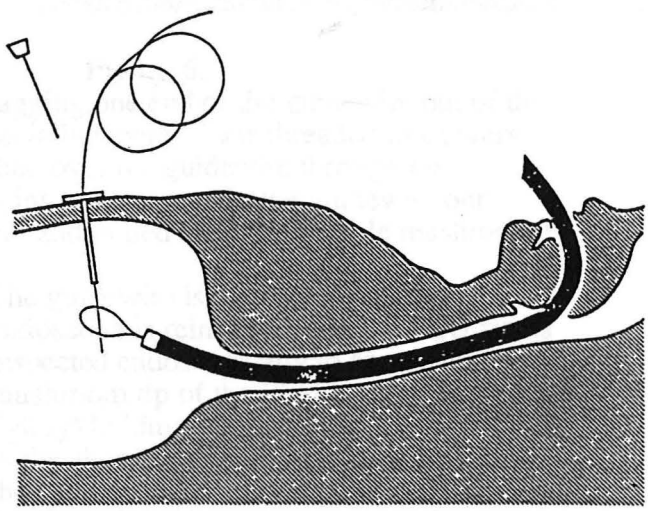

Figure 4.

An endoscope is inserted in the mouth (Figure 3) and the entire esophagus, stomach and duodenum are examined for any unsuspected lesions. The room lights are dimmed and the endoscope is pointed anteriorly while the abdominal wall is carefully inspected, looking for an area of transillumination. This point indicates the site at which the stomach and the abdominal wall are in close contact without interposed tissue (e.g. transverse colon). Finger pressure at the point of maximal transillumination will cause a distinct indentation in the anterior surface of the gastric wall as viewed by the endoscopist. This point, generally two to four centimeters inferior to the costal margin and two to four centimeters lateral to the midline, is then infiltrated with a local anesthetic, and an 18 gauge spinal needle is inserted through the abdominal wall into the stomach where it can be visualized penetrating the gastric mucosa by the endoscopist. The stylet is removed and a long flexible guidewire is inserted into the stomach and snared by the endoscopist (Figure 4).

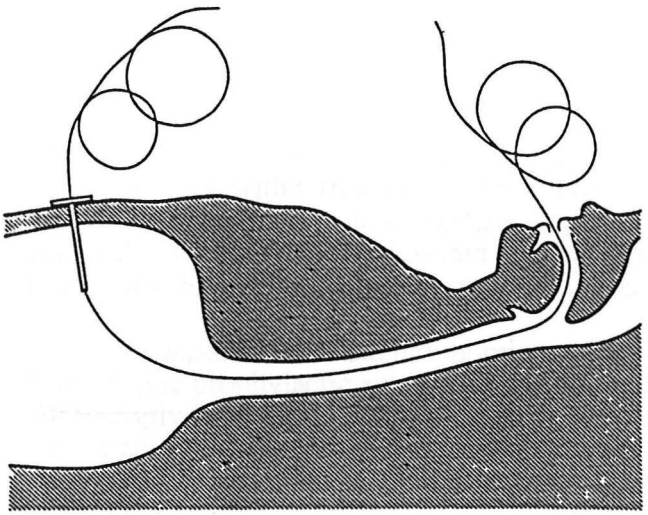

Figure 5.

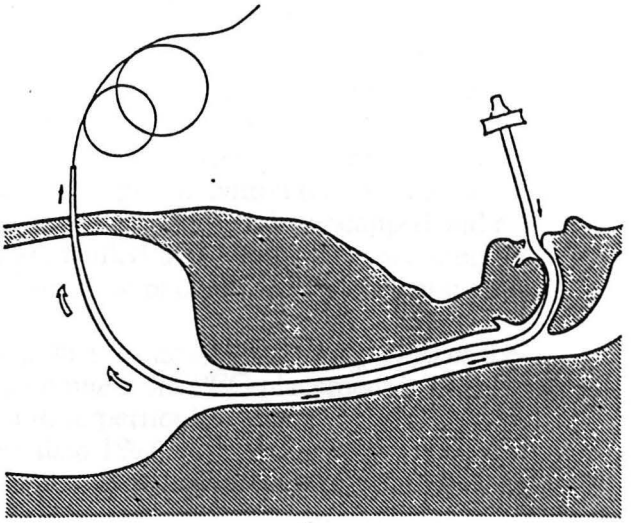

Figure 6.

The endoscope and snare are then removed, dragging one end of the guidewire out of the patient's mouth (Figure 5). The feeding tube with a specially tapered tip is threaded in a reverse direction over the mouth end of the guidewire and pushed over the guidewire through the esophagus and into the stomach. As the tapered tip begins to emerge over the guidewire out through the abdominal wall, it is grasped by the assistant and pulled until the flexible mushroom tip of the feeding tube is into the stomach (Figure 6).

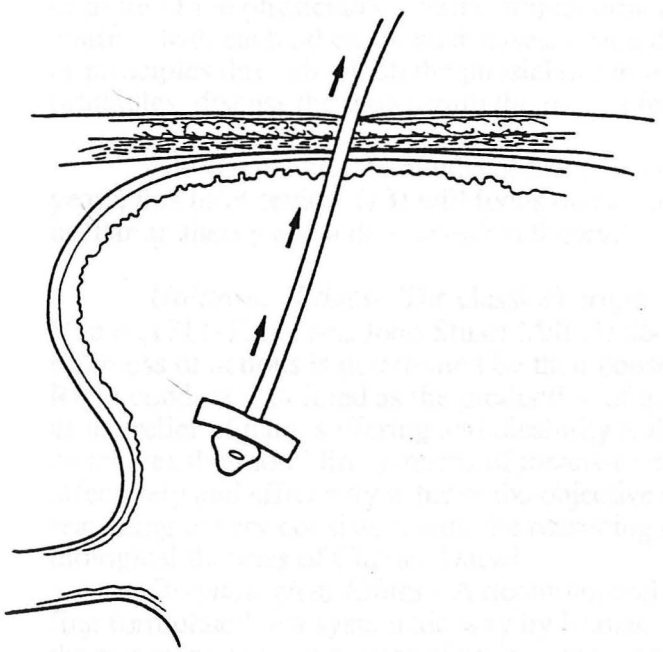

Figure 7.

The guidewire is then removed, the endoscope is reinserted, and the PEG site is inspected endoscopically to ensure that the mushroom tip of the PEG is snuggly (but not tightly) holding the gastric wall in apposition to the abdominal wall. An outer bolster is then slid over the outside portion of the feeding tube to hold the gastric and abdominal walls in apposition permanently (Figure 7). The tube may generally be used for enteral feeding within 24 hours after insertion.

"Pull" technique - This technique is similar to the push method except that instead of a flexible guidewire being used, a long length of suture material is pulled out of the patient's mouth by the endoscope (12). The feeding tube is tied to the end of the suture material, which is then pulled from the abdominal end of the string out through the patient's abdominal wall.

Introducer" technique - In this technique, no guidewire or string is pulled out through the mouth; rather, a short guidewire is inserted into the appropriate position in the stomach through an spinal needle, and the track is progressively dilated until the feeding tube can be inserted directly from the outside. This technique is more time-consuming but may be preferable in patients with

near obstructing lesions of the pharynx or esophagus which would not allow passage of the mushroom tip of the PEG.

Conversion to a "button" gastrostomy - If the patient is troubled by the presence of a tube dangling out of her abdominal wall, then after allowing the PEG track to mature for six weeks, the PEG can be removed and the track progressively dilated to allow insertion of a short (2-5 cm) wide-bore tube with a flexible mushroom tip on the inside and a plastic button (or cap) on the outside that lies flush with the surface of the abdomen. The button can then be uncapped and a disposable feeding catheter inserted into the stomach, food instilled through the tube and then the tube removed and the button recapped. This technique affords the patient the best cosmetic effect.

Complications - Excluding minor wound infections that occur approximately 10% of the time despite prophylactic antibiotics, the major complication rate from PEG placement is surprisingly low. Complications such as bleeding, perforation/peritonitis, gastro-colic fistula and necrotizing fasciitis should occur with a frequency of less than 1% (7). The cost of the procedure varies widely from one hospital to another, but the general range should be from $800 to $1200.

III. ETHICAL CONSIDERATIONS

Most decisions made in the practice of medicine have no moral dimension to them whatsoever. Competent patients present themselves for care to a physician who, acting in a professional manner, initiates the appropriate therapy that results in a satisfactory clinical outcome. On occasion, however, the correct course of action is entirely clear, and the physician's intuition may fail him, resulting in feelings of frustration. Often, the root cause of the frustration is that two or more of the physician's internal ethical principals (which she normally follows intuitively) conflict with each other. In such cases, a well developed ethical theory may provide a framework of principles through which the physician can recognize the conflict, prioritize the conflicting principles, discuss the issues with the patient (or his family), and proceed with morally appropriate actions.

Although a variety of ethical theories have been promulgated over the past two thousand years, this brief review (13) will focus on two of the major ethical theories in current use: a utilitarian theory and a deontological theory.

Utilitarian Ethics- The classical origins of utilitarianism are found in the writings of David Hume (1711-1776) and John Stuart Mill (1806-1873). Utilitarians maintain that the moral rightness of actions is determined by their consequences, specifically the maximization of good. Right conduct is defined as the production of good. As it relates to medicine, good may be defined as the relief of pain, suffering and disability and the prevention of premature death. A utilitarian conceives the moral life in terms of means-to-ends reasoning. He asks, "How we can we most effectively and efficiently achieve the objective of the greatest possible good?" Utilitarian reasoning is very consistent with the reasoning found in the natural sciences, particularly the biological theories of Charles Darwin.

Deontological Ethics- A deontological theory (from the Greek word *deon* , 'duty') was first formulated in a systematic way by Immanuel Kant (1734-1804). Deontologists maintain that the rightness and wrongness of actions are not determined exclusively by the production of good consequences. Other features of an action may also be relevant, such as the fact that it involves telling a lie, breaking a promise or compromising one's integrity. Kant held in his classic categorical imperative that the moral worth of a person's action depends exclusively on the moral acceptability of the rule on which the person is acting. Whereas the theory of utility would hold that the end justifies the means, Kant would hold that a human being must never be used as a means to an end. A Deontological theory places special significance on certain relationships that involve a sense of duty or obligation: parent and child, friend and friend, as well as physician and patient.

While the Utilitarian and Deontological ethical theories differ greatly in their philosophical roots, nonetheless, a common set of rules or ethical principles can be derived from both theories that are applicable to the practice of medicine. Although many rules can be formulated, for brevity's sake, they can all be reduced to four general principles (13):

1. Respect for Patient Autonomy
2. Principle of Nonmaleficence (do not harm the patient)
3. Principle of Beneficence (help the patient)
4. Principle of Justice (treat all patients fairly)

For physicians, the principle of Beneficence is the primary motivating factor that guides our professional lives. It is the reason that we chose medicine as our vocation, and adherence to this principle is a source of enormous personal satisfaction. Unfortunately, clinical decisions based strictly on the principle of Beneficence may conflict with the other equally valid principles, particularly respecting the patient's wishes and the obligation not to harm the patient.

Respect for patient autonomy -

This principle is derived from the basic tenet that authority for medical care resides not with the physician but rather flows from the patient (14, 15). As such, the physician's role is not to decide for the patient what is best but rather to enable the patient to make an autonomous decision for himself. A truly autonomous decision requires that three conditions be satisfied: the decision must be a) intentional, b) with understanding and c) voluntary. Intentionality may seem self-evident but it is worth pointing out that a patient cannot unintentionally agree to medical interventions by merely having agreed to be admitted to the hospital. They may have granted "consent" in a legal sense - they certainly have not made an autonomous decision to go along with the planned intervention.

Assuring that a patient decides "with understanding" is a more difficult criteria to meet. In almost all circumstances, the physician-patient relationship involves an imbalance in knowledge between the physician and the patient. The physician therefore is obligated to provide the patient with information sufficient to allow the patient to understand the potential risk and benefits of the planned intervention. Obviously, a patient's understanding is never as thorough or deep as the physician's, nor is it necessary that it be so. Partial understanding is the best that can be hoped for. Medically sophisticated patients may be able to process a great deal of information, whereas a less sophisticated patient may be able to understand only the more rudimentary aspects of the case. In either case, the physician's goal is to enable the patient to make an autonomous decision.

The third criteria, namely that the decision be voluntary, requires that the patient be allowed to decide one way or the other without coercion or threat of abandonment.

The mechanism used to ensure that patients are afforded the opportunity to make autonomous decisions is the process of *Informed Consent*. In a strictly legal sense, informed consent consists of documenting that the physician has <u>disclosed</u> certain information to a patient, and that the patient has signed his name on a piece of paper indicating <u>consent.</u> In an ethical sense, however, informed consent takes on added meaning with the emphasis placed on the patient's understanding.

The process of informed consent can be broken down into five distinct elements (13).

Threshold element

1. Competence

Information elements

2. Disclosure of information
3. Understanding of information

Consent elements

4. Voluntariness
5. Authorization

Competence- Before a patient can grant consent for a medical procedure or intervention, the physician must first decide whether or not the patient is competent to make the decision. Thus, the issue of competency may be considered a threshold element in the process of granting informed consent.

How should competency be decided? The following are seven different thresholds (13) that could be used to judge a patient incompetent to make an autonomous decision.

1. Inability to evidence a preference or choice
2. Inability to understand one's situation or relevantly similar situations
3. Inability to understand disclosed information
4. Inability to give a reason
5. Inability to give a rational reason (although some supporting reasons may be given)
6. Inability to give risk/benefit-related reasons (although some rational supporting reasons may be given)
7. Inability to reach a reasonable decision (as judged by a reasonable person's standard)

Clearly, the threshold is set progressively higher with No. 1 requiring only a simple indication of preference, while No. 7 requires evidence of reasoning. If a physician is primarily concerned about abuses of autonomy, the threshold will be set quite low, while another physician who is more concerned that every sick patient receive the best possible medical care (i.e. places a greater emphasis on the principle of beneficence) may set the threshold at the higher end. Thus, the threshold for competency is set by balancing the two conflicting ethical principles of beneficence versus respect for autonomy.

We can all recognize that not all decisions require the same level of competency. For example, a mildly demented resident in a nursing home may not be competent to handle his own financial affairs, nonetheless, he may be fully competent to decide what he wants to have for dinner. Clearly, the greater the potential benefit to the patient of the planned intervention, the higher the threshold should be set.

This concept has particular importance with respect to the issue of enteral nutrition in incompetent patients. If a patient suffers from a reversible dementia and enteral nutrition is indicated to "buy time" for the patient to recover, then the potential benefit to the patient is great; the principle of beneficence should override that of respect for autonomy and the threshold for incompetency should be set high. If, on the other hand, the dementia is clearly irreversible and the goal of the enteral nutrition is simply to provide patient comfort, then the principle of respect for autonomy supersedes that of beneficence and the threshold should be set at the low end. For patients who are completely demented, the only way they may have of indicating a preference is to pull out their feeding tubes (16). Such a gesture should always be thoughtfully and compassionately analyzed by the physician. If a patient repetively pulls out his feeding tube (or tries to), then the act should be interpreted as evidence that the tube feedings are not achieving their goal of comforting the patient.

Principle of Nonmaleficence (do not harm the patient)-

This principle has its ancient origins in the dictum *primum non nocere* (first, do no harm) which has over the ages been mistakenly attributed to Hippocrates (17, 18). The dictum by itself is not nor has it ever been a sufficient basis for the ethical practice of medicine, nonetheless, the principle of not harming the patient has profound implications with respect to tube feeding, especially when the principle comes in conflict with the obligation to do good for the patient.

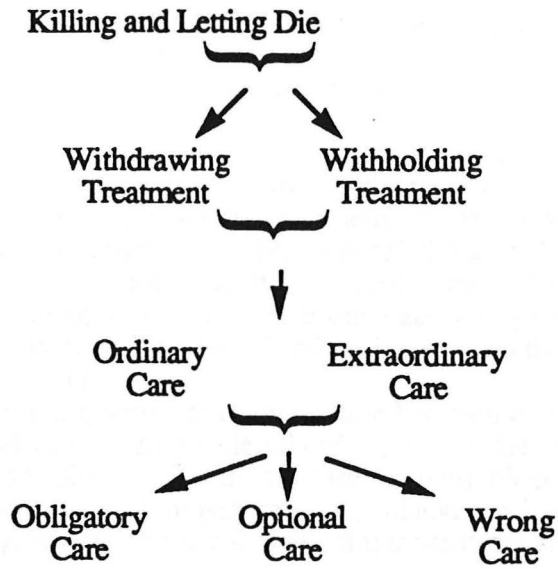

Figure 8.

Killing and letting die- Ethicists are divided into three schools on this issue. One group would hold that neither killing nor letting die is ever ethically permissible. A second group (including the American Medical Association) holds that actively killing a patient is never permissible whereas letting patients die is frequently both humane and correct (19). A third school of thought would hold that both killing and letting die are permissible under certain circumstances (20). The first school of thought, that prohibits both, would consider life to be unconditionally good and preferable to death under any circumstances. The latter group, on the other hand, argues that since the intent and outcome in both situations is the same (namely death), then any moral distinction between the two courses of action is specious. Moreover, recent developments in biomedical technology would seem to make it conceptually difficult at times to classify acts as either killing or letting die.

Most physicians hold a middle ground (21, 22, 23, 24, 25, 26). They would agree with the concept that life is not unconditionally good, but rather, good only to the extent that the individual is free from extreme suffering and is able to interact with his environment. However, physicians holding the middle ground believe that the moral distinction between killing and letting die should be preserved by maintaining a strict taboo against actively killing a patient. The rationale for maintaining the distinction is that of the utilitarian argument of a "slippery slope"; if the act of killing is condoned in one instance, then it may be impossible to prevent its practice in other inappropriate cases.

Withdrawing and withholding- After a decision has been made to allow a patient to die, the question often arises as to whether additional therapies should be withheld and/or existing therapies withdrawn. Physicians and family members are often comfortable with the idea of withholding any additional therapies, whereas they may perceive an ethical problem in withdrawing existing therapies that could result in the patient's death (27).

Does the distinction between withdrawing and withholding therapy have a moral significance? The argument against maintaining a distinction between withdrawing and withholding therapy centers on two points. First, as a practical issue, it is often difficult to decide whether a certain act (or omission of an act) constitutes withdrawing or withholding. For example, in Case II, the demented woman was admitted to the hospital with a clogged nasogastric tube. Would failing to replace that tube constitute withdrawing or withholding therapy? Additionally, by maintaining a distinction between these two acts, a physician may overtreat a patient because he

feels obligated to continue a treatment that is no longer medically indicated. Ironically, other patients may be undertreated because the physician fears that the decision to initiate a particular therapy is irreversible. For these reasons, the distinction between withdrawing and withholding therapy should be abandoned (13).

Ordinary care and extraordinary care- In the past (primarily for religious reasons) it was important in some circles to ascertain whether a patient's refusal of medical care constituted suicide. The doctrine evolved that refusal of "ordinary care" should be construed as suicide, while refusal of "extraordinary care" should not. The medical profession itself has picked up on this distinction by stating that "the patient or the patient's immediate family can decide about the cessation of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent" (19).

A problem arises in deciding where to draw the line between extraordinary and ordinary care. For example, if food and water are considered ordinary care, then are antibiotics to be considered extraordinary? If antibiotics are ordinary care, then are blood products and chemotherapy considered extraordinary? In general, surgical and mechanical interventions have been considered extraordinary, whereas pharmacological interventions have been considered ordinary care.

Obligatory, Optional and Wrong- A better framework for decision-making would seem to be to abandon the distinction between ordinary and extraordinary care and replace it with the classification scheme outlined above involving obligatory care, optional care and wrong interventions (13). Certain medical interventions would be considered obligatory on the basis of the principle of beneficence (the obligation to do good). Others would be considered wrong either because they were pointless, futile (28, 29, 30), imposed a burden on the patient out of proportion to the benefit, or conflicted with the patient's autonomous wishes. Many interventions, however, would fall into the optional category, indicating that they may be praiseworthy if carried out, but not necessarily blameworthy if withheld. Thus, in a given patient, dialysis, blood products, or simple antibiotics might all be considered optional therapies and could be used or withheld depending upon the burden to benefit ratio under the circumstances (31, 32).

Is food and water a special category of treatment? Must it be classified as obligatory in all circumstances? Those who argue in the affirmative would hold that food and water should be separated from all other medical interventions as being essential for biological life; all people (whether sick or not) are certain to die without food and water (33). Moreover, it is inhumane to allow a dying person to suffer from hunger and thirst. Thus, the provision of food and water becomes not so much a medical intervention, but rather a touchstone or *symbol* for compassionate treatment of a fellow human being.

Those opposed to conferring a special status on food and water (or medical nutrition and hydration as they prefer to call it) would argue that the provision of medical nutrition and hydration by tubes and catheters is inherently a medical intervention that may, in fact, impose a burden on the patient. Distinguishing between tube nutrition and other inexpensive medical interventions such as antibiotics or blood products has no moral significance. Additionally, they would point out that it may not be valid to project the common experience of hunger and thirst onto a dying or demented patient. Indeed, at least one study from the nursing literature has found that terminally ill patients are more comfortable without the provision of artificial feedings (34). My own personal opinion is that artificial nutrition through a tube should be considered a medical intervention, and as such, is not obligatory in every case (35).

How may these principles be applied in particular cases? In Case I, a young man with toluene encephalopathy was treated with PEG feedings for three months, during which time he made a complete recovery. His physicians acted on the principle of beneficence alone in ordering the tube feedings. Though the CNS prognosis was uncertain at the time, the potential benefit to the patient was great, certainly in comparison to the burden of PEG placement and tube feedings. Except for the legal requirement of obtaining his mother's permission, the issue of respecting

patient autonomy did not arise. The principle of beneficence took precedence over all other concerns.

In Case II, a woman with severe irreversible dementia from Alzheimer's disease was admitted to the hospital for treatment of aspiration pneumonia. She had been fed for two years by a nasogastric tube in a nursing home and her primary physician requested a PEG on the basis of beneficence. The consulting resident, who was responsible for arranging PEG placement, felt that the artificial feedings were futile therapy, given the irreversible nature of her severe dementia and, moreover, imposed a burden on the patient by possibly contributing to her aspiration pneumonia. In other words, the consulting resident placed the principle of nonmaleficence above the principle of beneficence. The patient died before the ethical conflict was resolved.

In both of these cases, the patients were mentally incompetent and thus unable to make autonomous decisions. In the first case, even if the patient's pre-morbid wishes had been known, the great potential for benefit might have justified overriding his wishes. In the latter case, where the principles of beneficence and nonmaleficence were in conflict, knowledge of the patient's pre-morbid choices could have had a major impact on the way she was cared for after she became demented. The next section will discuss the ways that competent patients can influence their medical care even if they should become incompetent in the future.

In summary, we have listed four general ethical principles (13) which may be used to guide clinical decision-making. This framework acknowledges that frequently one principle may fall in conflict with another, in which case thoughtful deliberations between the physician, the patient and the family can decide which ethical principle takes precedence under the circumstances. The principle of respect for patient autonomy recognizes the fact that ultimate authority for medical decisions resides with the patient. The physician's goal is to provide enough information to the patient so that he can make an autonomous decision. The threshold for determining a given patient's competency to decide is a difficult issue, and care should be taken to respect the patient's preferences, especially when the goal of treatment is patient comfort.

The principle of nonmaleficence distinguishes between killing and letting a patient die, a distinction that should be maintained. The distinction between withdrawing and withholding therapy, on the other hand, may lead to irrational use of medical care and should be abandoned. The distinction between ordinary and extraordinary care should be replaced with a classification scheme of obligatory, optional and wrong medical care. Food and water given artificially through tubes and catheters should be considered a medical intervention, and as such, is not obligatory in every case.

IV. LEGAL CONSIDERATIONS

Case III

NC was a 32-year-old woman who suffered from post anoxic encephalopathy caused by a motorcycle accident seven years ago (36). Her neurological exam was consistent with a persistent vegetative state. A CT scan of the head documents severe cortical atrophy.

After NC had been maintained on artificial nutrition and hydration by a feeding tube for four years, her parents (now her legal guardians) requested that the physicians remove the tube and allow their daughter to die.

The hospital insisted on a court order and a trial ensued. The initial trial verdict favored the parents but on appeal to the Missouri Supreme Court, the higher court held (37, 38) that "the State's interest is not in the quality of life...instead the State's interest is in life; that interest is unqualified". Thus Cruzan continued in her senseless state until the appeals process reached the United States Supreme Court. The Supreme Court upheld the Missouri high court's decision by finding that the state of Missouri had the right to set its own rules (39) for determining whether a patient's wishes were "clear and convincing evidence".

What are the implications of the Cruzan decision for physicians?

1. The Supreme Court affirmed the right of competent patients to refuse life-sustaining treatment.
2. The Court did not treat the foregoing of artificial nutrition and hydration differently from foregoing other forms of medical treatment (40).

3. The Court allowed the State of Missouri to set the standards of proof required to meet the terms of "clear and convincing evidence" that the patient would not have wanted artificial nutrition and hydration. The ruling specifically did not say that other states must adopt Missouri's strict standards (41), nor did it preclude Missouri from changing its own standards in the future.

Some months after the Supreme Court's decision, three friends of Nancy Cruzan came forward offering testimony that Nancy Cruzan had stated that she would not have wished to live under the circumstances. A court accepted this evidence as "clear and convincing"; the feeding tube was removed, and Nancy Cruzan died quietly 10 days later.

The Texas Natural Death Act-

What are the laws in the State of Texas concerning life-sustaining medical care for incompetent people? The Texas Natural Death Act is attached as appendix A to this protocol. This law is a forward-thinking and progressive piece of legislation that is intended to enable patients to make their wishes known regarding life-sustaining care in the event that they become mentally incompetent in the future. At the same time, it provides physicians maximum flexibility in directing care.

The Natural Death Act provides the patient with two different mechanisms for indicating his preferences: completing a living will and/or designating a surrogate decision-maker by executing a durable power of attorney for medical decisions (42). These two mechanisms are not mutually exclusive, but can be used together to complement each other, in which case the decision of the surrogate decision-maker takes precedence.

The law was amended in 1989 to include minor (but significant) changes that expanded the definition of "terminal condition" to include incurable or irreversible conditions caused by injury, disease, or illness, which, without the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of the patient. This expanded definition of the phrase "terminal condition" would seem to include severe irreversible dementia caused by Alzheimer's disease. Further amendments are under consideration now that would specifically classify illness "in which thought, sensation, purposeful action, and social interaction are absent" as terminal conditions.

The Natural Death Act includes several provisions designed to protect both the patient and the physician. For example, the living will can be revoked at any time by the patient, even if the patient is judged to be mentally incompetent. Thus, the patient cannot become trapped by the provisions of his living will should he change his mind. Provisions of the living will do not become applicable until the attending physician and one other physician have certified in the medical record that the patient's condition is terminal. In addition, the attending physician is protected from both civil and criminal penalties for any actions taken in the course of carrying out the patient's directive. Finally, physicians are not obligated to withhold any medication or medical procedure deemed necessary to provide comfort or alleviate pain.

Patient Self-Determination Act-

In the the fall of 1990, the US Congress passed federal legislation termed the Patient Self-Determination Act (43) which will require that all hospitals receiving any Medicare funds set in place specific written policies ensuring that all patients, at the time of admission to the hospital, be provided with information informing them exactly what their rights are under state law regarding advance directives (i.e. living wills and surrogate decision-makers). The intent of this legislation is

to encourage patients to participate in their own medical care by indicating their wishes prior to the time they become mentally incompetent.

Though well-intentioned, the stipulation in this legislation that the information be provided to the patient at the "time of admission" to the hospital will create substantial problems for physicians and hospitals. Clearly, the appropriate time and place for deciding on exactly what to write into a living will is not the hectic and frightening environment of a hospital emergency room but rather, a setting more conducive to unhurried thought and quiet deliberation(44). Nonetheless, the Patient Self-determination Act of 1990 can be viewed as an opportunity for physicians to assist their patients in making autonomous decisions and thus improve the quality of care.

V. PRACTICAL CONSIDERATIONS

As a result of the above mentioned legislation, physicians and others will be called on to counsel patients about what to write into their living wills. The generic living will (included as a template in the Texas Natural Death Act) assumes that patients will be faced with the situation of a terminal illness in which death is imminent. Other, more likely scenarios such as a patient facing the prospect of a long, lingering death or a patient suffering from a coma with a small but finite chance of recovery are not covered.

In counseling patients about what to write in their living will, or more importantly, what directives to give their surrogate decision-maker, it would seem more useful for the physician to draw out several possible scenarios and let the patient indicate his preferences regarding artificial nutrition in each setting. Tube feeding is not, of course, the only medical intervention that patients need to decide about. CPR, mechanical ventilation, hemodialysis and the use of antibiotics are all life-sustaining treatments that may be considered "optional" during the last few months (or minutes) of life.

The following are four hypothetical situations (45) in which patients (and physicians eventually) might find themselves:

> Situation A: If I'm in a coma or a persistent vegetative state and, in the opinion of my physician and several consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my wishes regarding use of the following if considered medically reasonable, would be:
>
> Situation B: If I am in a coma and, in the opinion of my physician and several consultants, have a small likelihood of recovering fully, a slightly larger likelihood of surviving with permanent brain damage, and a much larger likelihood of dying, then my wishes regarding use of the following if considered medically reasonable, would be:
>
> Situation C: If I have brain damage or some brain disease that in the opinion of my physician and several consultants cannot be reversed and that makes me unable to recognize people or to speak understandably, and I also have a terminal illness, such as incurable cancer, that will likely be the cause of my death, then my wishes regarding use of the following if considered medically reasonable, would be:
>
> Situation D: If I have brain damage or some brain disease that in the opinion of my physician and several consultants cannot be reversed and that makes me unable to recognize people or to speak understandably, but I have no terminal illness, and I can live in this condition for a long time, then my wishes regarding use of the following, if considered medically reasonable, would be:

Most clinical situations involving incompetent patients will fall into one of these scenarios. Examples of specific diseases include:

A- comatose with multiple brain metastasis
B- comatose after suffering a subarachnoid hemorrhage two weeks earlier
C- severe AIDS dementia
D- severe Alzheimer's disease

By offering patients concrete examples of what might be anticipated in the future, they will be in a better position to understand the implications of their decisions, and thus better able to act autonomously.

By September 1, 1991, Parkland Memorial Hospital will have set in place its policies mandated by the Patient Self-Determination Act. Though substantial obstacles (such as record-keeping, language barriers, etc.) will need to be overcome, the hospital administration hopes to have a one-page document that will include a living will and a provision to designate a surrogate decision-maker with a durable power of attorney. Additionally, the document will have a provision whereby the patient can indicate his or her preference regarding tissue and organ donation.

These Advance Medical Directives will not eliminate ethical dilemmas from the practice of medicine. They can however, become a powerful device through which physicians enable their patients to make autonomous decisions. The future implementation of these devices can be seen as either a bureaucratic nightmare for physicians and hospitals or a genuine opportunity to improve the care we offer our patients. The ultimate outcome remains to be seen.

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Note: The author of this monograph has absolutely no expertise in any aspect of Legal Medicine. Nothing in this monograph should be construed as offering a legal opinion on any specific matter.

CHAPTER TWENTY—NATURAL DEATH

Article
4590h. Natural Death Act.

WESTLAW Electronic Research
See WESTLAW Electronic Research Guide following the Preface.

Article 4590h. Natural Death Act

Short title

Section 1. This Act shall be known and may be cited as the Natural Death Act.

Sec. 2. *DEFINITIONS.* In this Act:

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

(2) "Declarant" means a person who has executed or issued a directive under this Act.

(3) "Directive" means:

(A) a document voluntarily executed by the declarant as prescribed by Section 3(a) of this Act;

(B) a nonwritten directive issued by the declarant as prescribed by Section 3(b) of this Act; or

(C) a document executed as prescribed by Section 4D of this Act.

(4) "Life-sustaining procedure" means a medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, noted in the qualified patient's medical records, death is imminent whether or not such procedures are utilized *or will result within a relatively short time without application of such procedures.* "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort or care or alleviate pain.

(5) "Physician" means a physician and surgeon licensed by the Texas State Board of Medical Examiners or a properly credentialed physician holding a commission in the uniformed services of the United States who is serving on active duty in this state.

(6) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

(7) "Terminal condition" means an incurable *or irreversible* condition caused by injury, disease, or illness, which, *without* [~~regardless of~~] the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of the patient.

(8) "Competent" means possessing the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision.

(9) "Incompetent" means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision.

SECTION 2. Section 3, Natural Death Act (Article 4590h, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 3. (a) Any competent adult person may, at any time, execute a directive for the withholding or withdrawal of life-sustaining procedures in the event of a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant on his decease under any will of the declarant or codicil thereto or by operation of law. *The two witnesses to the declarant's signature shall sign the directive.* In addition, a witness to a directive shall not be:

(1) the attending physician *or* [,] an employee of the attending physician;

(2) an employee of [~~or~~] a health facility in which the declarant is a patient *if the employee is providing direct patient care to the declarant or is directly involved in the financial affairs of the facility;*

(3) [,] a patient in a health care facility in which the declarant is a patient; [,] or

(4) any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. [~~The two witnesses to the declarant's signature shall sign the directive.~~]

(b) A competent qualified patient who is an adult may issue a directive by a nonwritten means of communication. The declarant must issue the directive in the presence of the attending physician and two witnesses. The witnesses must possess the same qualifications as are required by Subsection (a) of this section. The physician shall make the fact of the existence of the directive a part of the declarant's medical record and the witnesses shall sign said entry in the declarant's medical record.

(c) A declarant shall notify the attending physician of the existence of a written directive. If the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication, another person may notify the physician of the existence of a written directive. The physician shall make the directive a part of the declarant's medical record.

(d) A written directive may be in the following form:

"DIRECTIVE TO PHYSICIANS

"Directive made this _____ day of _____ (month, year).

"I _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

"1. If at any time I should have an incurable *or irreversible* condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent *or will result within a relatively short time without application of* [~~whether or not~~] life-sustaining procedures [~~are utilized~~], I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

"2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

"3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

"4. This directive shall be in effect until it is revoked.

"5. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

"6. I understand that I may revoke this directive at any time.

"Signed _____

City, County, and State of Residence _____

[~~The declarant has been personally known to me and I believe him or her to be of sound mind.~~] I am not related to the declarant by blood or marriage; [,] nor would I be entitled to any portion of the declarant's estate on his decease; [,] nor am I the attending physician of the declarant or an employee of the attending physician; *nor am I* [~~or a health facility in which the declarant is a patient, or~~] a patient in the health care facility in which the

declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease. *Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.*

"Witness _____

"Witness _____

(e) The directive may include other directions, including a designation of another person to make a treatment decision in accordance with Section 4A of this Act for the declarant if the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication.

Revocation of directive

Sec. 4. (a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

(1) by being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction;

(2) by a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. Such revocation shall become effective only on communication to an attending physician by the declarant or by a person acting on behalf of the declarant or by mailing said revocation to an attending physician. An attending physician or his designee shall record in the patient's medical record the time and date when he received notification of the written revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical records; or

(3) by a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only on communication to an attending physician by the declarant or by a person acting on behalf of the declarant. An attending physician or his designee shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical records.

(b) Except as otherwise provided in this Act, there shall be no criminal or civil liability on the part of any person for failure to act on a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

Patient's present desire to supersede directive; failure of directive to designate person to make decision; duty of attending physician

Sec. 4A. The desire of a qualified patient who is competent shall at all times supersede the effect of a directive. If an adult qualified patient is comatose, incompetent, or otherwise mentally or physically incapable of communication and has issued a directive under this Act without designating a person to make a treatment decision, the attending physician shall comply with the directive unless the physician believes that the directive does not reflect the present desire of the patient.

Designated person and attending physician to make decision to withhold or withdraw life-sustaining procedures

Sec. 4B. If an adult qualified patient who has designated a person to make a treatment decision as authorized by Section 3(e) of this Act is comatose, incompetent, or otherwise mentally or physically incapable of communication, the attending physician and the person designated by the patient may make a treatment decision to withhold or withdraw life-sustaining procedures from the patient.

Failure to execute directive; legal guardian or relatives and attending physician to make decision to withhold or withdraw life-sustaining procedures; presumption from failure to execute directive not to arise

Sec. 4C. (a) If an adult qualified patient is comatose, incompetent, or otherwise mentally or physically incapable of communication, and the person has not issued a directive under this Act, the attending physician and the legal guardian of the patient may make a treatment decision that may, based on knowledge of what the patient would

desire, if known, include a decision to withhold or withdraw life-sustaining procedures from the patient.

(b) If the patient does not have a legal guardian, the attending physician and at least two, if available, of the following categories of persons, in the following priority, may make a treatment decision that may, based on knowledge of what the patient would desire, if known, include a decision to withhold or withdraw life-sustaining procedures:

(1) the patient's spouse;

(2) a majority of the patient's reasonably available adult children;

(3) the patient's parents; and

(4) the patient's nearest living relative.

(c) A treatment decision made under Subsection (b) of this section must be made in the presence of at least two witnesses who possess the same qualifications as are required by Section 3(a) of this Act.

(d) The fact that an adult qualified patient has not issued or executed a directive does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining procedures.

Persons entitled to execute directive on behalf of patient under 18 years of age; patient's desire to supersede directive

Sec. 4D. (a) The following persons may execute a directive on behalf of a qualified patient who is under 18 years of age:

(1) the patient's spouse, if the spouse is an adult;

(2) the patient's parents; or

(3) the patient's legal guardian.

(b) The desire of a qualified patient who is under 18 years of age and who is competent shall at all times supersede the effect of a directive executed in accordance with this section.

Pregnant patients; life-sustaining procedures not to be withheld or withdrawn

Sec. 4E. Life-sustaining procedures may not be withheld or withdrawn under this Act from a patient who is pregnant.

Duration of directive

Sec. 5. A directive shall be effective until it is revoked in a manner prescribed in Section 4 of this Act. Nothing in this Act shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 3 of this Act, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

Civil or criminal liability

Sec. 6. No physician or health facility which, acting in accordance with the requirements of this Act, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom unless negligent. No health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this Act shall be subject to any civil liability unless negligent. No physician, or health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this Act shall be guilty of any criminal act or of unprofessional conduct unless negligent. No physician, health care facility, or health care professional shall be liable either civilly or criminally for failure to act pursuant to the declarant's directive where such physician, health care facility, or health care professional had no knowledge of such directive.

Prerequisites for withholding or withdrawal of life-sustaining procedures; civil or criminal liability for failure to effectuate directive; certification of patient as qualified

Sec. 7. (a) Before withholding or withdrawing life-sustaining procedures from a qualified patient under this Act, the attending physician shall determine that all steps proposed to be undertaken are in accord with the provisions of this Act and the existing desires of the qualified patient.

(b) No physician, and no health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of a qualified patient. If the attending physician refuses to comply with a directive or treatment decision, the physician shall make a reasonable effort to transfer the patient to another physician.

(c) An attending physician who has been notified of the existence of a directive executed under this Act shall, on diagnosis of a terminal condition, provide for certification of the patient as a qualified patient.

Effect on offense of aiding suicide and insurance policies

Sec. 8. (a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this Act shall not, for any purpose, constitute an offense under Section 22.08, Penal Code.

(b) The making of a directive pursuant to Section 3 of this Act shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, or insurer issuing insurance, may require any person to execute a directive as a condition for being insured for, or receiving, health care services nor may the execution or failure to execute a directive be considered in any way in establishing the premiums for insurance.

Tampering with directive

Sec. 9. A person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a Class A misdemeanor. A person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 4 of this Act, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for criminal homicide under the provisions of the Penal Code.

Mercy killing not condoned

Sec. 10. Nothing in this Act shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this Act.

Act as cumulative

Sec. 11. Nothing in this Act shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this Act are cumulative.

Acts 1977, 65th Leg., p. 1085, ch. 398, eff. Aug. 29, 1977. Sec. 3 amended by Acts 1979, 66th Leg., p. 1783, ch. 724, § 1, eff. Aug. 27, 1979; Sec. 5 amended by Acts 1979, 66th Leg., p. 1784, ch. 724, § 2, eff. Aug. 27, 1979; Sec. 7(b) amended by Acts 1979, 66th Leg., p. 1785, ch. 724, § 3, eff. Aug. 27, 1979; Sec. 3 amended by Acts 1983, 68th Leg., p. 741, ch. 175, § 1, eff. Aug. 29, 1983; Sec. 2 amended by Acts 1985, 69th Leg., ch. 870, § 1, eff. Sept. 1, 1985; Sec. 3 amended by Acts 1985, 69th Leg., ch. 870, § 2, eff. Sept. 1, 1985; Secs. 4A to 4E added by Acts 1985, 69th Leg., ch. 870, § 3, eff. Sept. 1, 1985; Sec. 7 amended by Acts 1985, 69th Leg., ch. 870, § 4, eff. Sept. 1, 1985.