

Life Cycle

Withholding

food and fluids

On June 30, 1988, in Yakima, Wash., a car failed to yield the right-of-way and slammed into a jeep, killing Barbie Blodgett's 19-year-old cousin, Nicole Valenzuela. Barbie's husband, David Blodgett Jr., and their 13-month-old son, David III, escaped with minor injuries.

Barbie Blodgett, then 24 years old and three months pregnant, was not so lucky. She was thrown from the vehicle, left unconscious and suffering from a brain stem injury. Barbie and her baby's tenuous hold on life were augmented by a feeding tube to her stomach for the next six months which provided the necessary nourishment to keep both of them alive.

In December of 1988, Barbie gave birth to a normal, healthy son, Simon. In January of 1989, Barbie regained consciousness.

Neither Barbie nor her son were terminally ill and both would have died had a family member or anyone been granted authority to remove the feeding tube. Although the potential for recovery from an unconscious state is marginal at best, Barbie was not unlike many other helpless, incompetent individuals whose lives depend on continued nourishment — food and fluids.

Food and fluids — are they “medical treatments” which can be withheld from certain individuals, or are they basic life provisions which should not be denied?

What happens to an individual when food and fluids are withheld? How are food and fluids provided to a person who cannot swallow? Are there alternatives for providing food and water? Who are the people from whom food and fluids are being withheld? What is the legal rationale which allows food and fluids to be withheld? Who makes these decisions for an incompetent person? Will starvation and dehydration become the routine method for causing the death of incompetent individuals or is this only the first step to lethal injections?

These are the difficult questions currently facing those making nutrition and hydration decisions for themselves or others. Through this series of *Life Cycle* articles, it is hoped that the reader will be provided with an overview and an understanding of the basic moral, ethical, medical and legal issues involved with the now “routine” practice of withholding food and water from incompetent patients. We also want to clarify for readers the often poorly understood medical and legal trends affecting some of the most helpless people in the United States today.

Withholding food and fluids:

The human tragedy of euthanasia

by David N. O'Steen, Ph.D.

When Paul Brophy died on October 24, 1986, his was one of the first cases in the United States of court-sanctioned euthanasia of an incompetent patient by starvation and dehydration. His death prepared the way for an epidemic of starvation and dehydration deaths, estimated in 1987 as already in the hundreds by the National Legal Center for the Medically Dependent and Disabled, Inc.

Paul Brophy was not terminally ill but in what is medically called a "persistent vegetative state." Since his death, the pool of intended victims has widened to include patients with increasingly greater mental awareness. The range of care withheld has expanded to include even feeding by mouth, vividly illustrated when the physician in the lone Bayer case was court-ordered to stop feeding Mrs. Bayer by mouth.

It is obvious that the real targets of euthanasia today are those most at risk. It is not patients whose deaths are imminent or even those who are terminally ill. It is patients who are very debilitated or very old, whose prospects for improvement are not good, yet who are likely to live for an indeterminate period of time if given the most basic care and treatment, food and fluids. Such patients are now candidates for euthanasia by starvation and dehydration exactly because they are not dying, or are not dying soon enough, in the opinion of some.

Clearly a significant line has been crossed. The issue has changed from the withdrawal of medical treatment, without which a patient will probably, but not always certainly, die, to the denial of food and fluids, without which a patient is certain to die.

Food and fluids: a pivotal issue

The current practice of euthanasia by starvation and dehydration has become reality without the public fully realizing

the true nature of this practice, or the fundamental change it signifies in our culture's treatment of those unable to care for themselves. This is, of course, precisely how proponents of denying food and fluids to certain patients had to accomplish their goal, since society-at-large would have initially found the notion of directly killing either terminally or non-terminally ill patients abhorrent.

Yet to starve or dehydrate a patient to death is just as direct a means of killing as shooting the individual or administering a lethal injection. That is the crucial point that must be recognized.

If the practice of euthanasia by starvation and dehydration is not ended, and gains widespread acceptance, then the fact that it is killing will eventually be recognized and accepted as well. At that point, euthanasia advocates can claim that there are much quicker and more humane ways to administer "aid in dying," such as by lethal injection.

Further, lethal injection for a large pool of incompetent, non-terminal, but "hopelessly ill" patients would be no more voluntary than their starvation deaths are today. The same arguments currently used to justify death-by-starvation decisions would apply point for point to guarantee that incompetent patients have a "right to die" by lethal injection at the request of another.

It is our challenge over the next decade to recognize the value and worth of each individual, regardless of what some see as a low "quality of life." We must reject the notion that previously vibrant individuals with diminished mental capacities are any less valuable than before. We must discard terminology which labels these vulnerable people as "vegetables." We must be vigilant that human resources are available and remain available to care for these individuals. Love, care, patience and sacrifice will be needed to ensure that vulnerable, incompetent patients who cannot speak for themselves are able to live with dignity until they die a natural death. At the same time, legal protection from euthanasia and guarantees of basic care, including provision of food and fluids, must be provided to patients.

David N. O'Steen, Ph.D., became the Executive Director of the National Right to Life Committee in 1984 following nine years as Executive Director of Minnesota Citizens Concerned for Life. He is a former college and university faculty member. He is the author of numerous articles on abortion and euthanasia legislation and politics.

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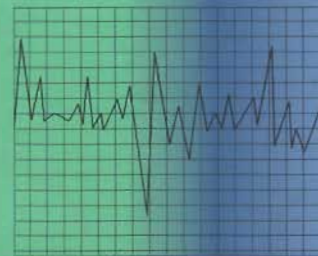
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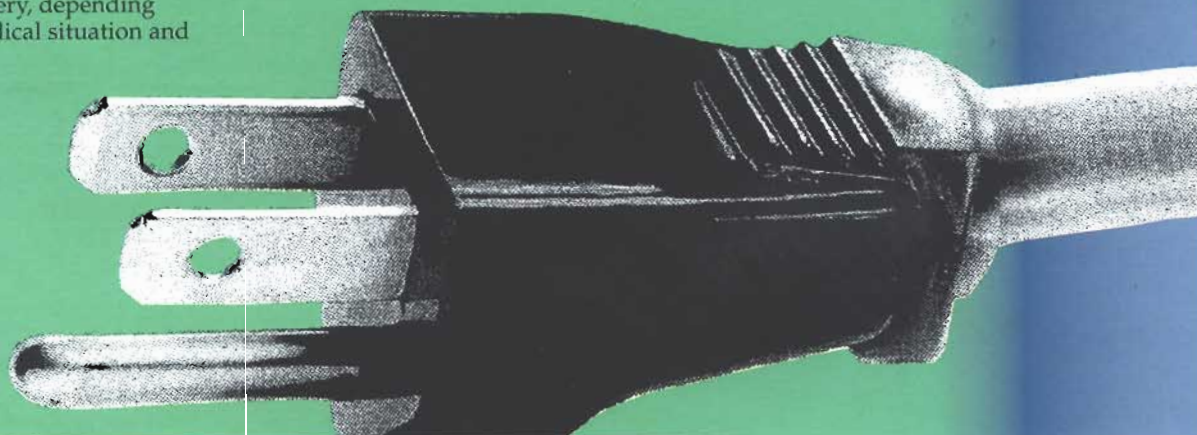
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The most common means of providing food and fluids by tube



Type of feeding	How feeding is provided	General use of type of feeding	Patients who receive this type of feeding
Intravenous Feeding	Needle is inserted into a vein, usually in the hand or forearm, allowing the person to be nourished through the circulatory system.	Generally used to provide fluid maintenance to prevent dehydration or to provide minimal nutrition on a short-term basis. Consists of sugar, salt and water.	<ol style="list-style-type: none"> 1. Post-operative patient who cannot have solid food. 2. Patient who is near death. 3. Patients, with a variety of illnesses, who need supplemental fluids on a short-term basis. 4. Patients who need medications such as antibiotics administered intravenously.
Peripheral Hyper-alimentation	Needle is inserted into a vein, usually in the hand or forearm, allowing the person to be nourished through the circulatory system.	Generally used as a temporary means of providing nutrition. Consists of a liquid nutritional supplement which is not as nutritional as hyperalimentation (see below) but provides more nutrition than intravenous feeding.	<ol style="list-style-type: none"> 1. Patient with a bowel obstruction. 2. Patient suffering from burns. 3. Patient with post-operative complications such as poor wound healing. 4. Patient undergoing repeated operations over a short period of time. 5. Some cancer patients undergoing chemotherapy.
Hyper-alimentation	Catheter is surgically placed in a vein in the neck allowing the person to be nourished through the circulatory system. Complicated surgery which requires close medical supervision.	Generally used to provide long-term nutrition. Consists of a full-liquid nutritional supplement.	<ol style="list-style-type: none"> 1. Patient with a bowel obstruction. 2. Patient suffering from burns. 3. Patient with post-operative complications such as poor wound healing. 4. Patient undergoing repeated operations over a short period of time. 5. Some cancer patients undergoing chemotherapy.
Nasogastric Tube (Enteral)	Soft, plastic, pliable tube is inserted through the nose to reach the stomach allowing the nutrition to enter directly into the digestive system.	Generally used to provide intermediate-term nutrition. Consists of a full-liquid nutritional supplement.	<ol style="list-style-type: none"> 1. Patient who is comatose, elderly, or on a respirator, or who has an intact bowel but cannot swallow. 2. Patient with a neurologic (brain) injury which impairs swallowing.
Gastrostomy, Jejunostomy, Gastrostomy Button	Tube is surgically inserted through the abdominal wall into the stomach or small intestine allowing the nutrition to enter directly into the digestive system. Installed on outpatient basis under local anesthetic or through surgery, depending upon the medical situation and need.	Generally used to provide long-term nutrition. Consists of a full-liquid nutritional supplement.	<ol style="list-style-type: none"> 1. Patient who cannot swallow due to brain tumor or other neurologic disease. 2. Patient with cancer of the esophagus or any disease which obstructs swallowing. 3. Patient who is comatose and cannot, or will not, swallow.



Tube feeding: Easy or burdensome?

by Curtis E. Harris, M.D.

In the majority of cases where a patient cannot take food orally, nutrition and hydration are provided through a device called a "feeding tube." However, few people realize how simple this is to do, or even what such a tube looks like.

Many people are familiar with large stomach tubes they have seen attached to a friend or family member following surgery. These tubes are used to remove the stomach acids and bile for a short period of time to speed recovery after surgery. The tubes are often as large around as a pencil and they are usually uncomfortable.

Feeding tubes are much different than stomach tubes in size, use and comfort. The normal feeding tube is the diameter of a broom straw, or a 50-pound test fishing line. In fact, the "tube" is more properly termed a "feeding line" rather than a "tube," but for consistency throughout this article, the term "tube" will be used.


Feeding tubes have been used since 1822, but were perfected in the early 1970s. There are four basic ways a feeding tube can be used:

1. A nasogastric tube (inserted through the nostril and threaded into the stomach);

2. A gastrostomy tube (inserted into the stomach directly through the abdominal wall); 3. A jejunostomy tube (placed through the abdominal wall into the jejunum, the small intestine); 4. The "gastrostomy button" (a new skin-level feeding device which replaces the conventional gastrostomy or jejunostomy tubes, and is implanted under a local anesthetic on an outpatient basis. It allows the conscious ambulatory patient to insert or remove the feeding tube at will.)

These four methods of feeding should be used only when other methods of food intake cannot be used. Use of feeding tubes for convenience, instead of allowing a person to swallow naturally, causes the muscles to atrophy from lack of use. The loss of this ability ultimately creates dependency upon the feeding tube for sustenance.

Elderly patients usually do not go suddenly from eating independently to being totally unable to swallow. Rather, patients with a progressive mental illness (such as Alzheimer's) will, over time, need more and more human (not technological) assistance with eating. This assistance can be divided into at least five progressive levels:



Withholding food and fluids: What happens?

by Curtis E. Harris, M.D.

Imagine a hot summer day. You have worked hard outside. You're thirsty. Your tongue and lips are dry, and they stick together easily. Nothing sounds better than something cold to drink. How would you feel, both emotionally and physically, if you suddenly had no control over what you were able to do, and someone else decided thirst was not reason enough to give you a drink? Trapped? Frightened? Desperate? If you can feel these sensations and emotions, you have taken the first steps toward realizing what it means to be deprived of food and fluids.

How long does it take for someone to die from dehydration?

Depending upon the state of health prior to stopping fluids, three to ten days.

How long does it take for someone to die from starvation?

The average lean individual has enough energy stored in muscle and fat tissue to last 40 days. The more obese an individual, the longer that person will live without food. The effects of malnutrition can be seen daily on television in films of the Nazi Holocaust, and in the victims of starvation in Africa. Kwashiorkor disease, prevalent in Third World Countries, is caused by a deficiency in the quality and quantity of dietary protein, resulting in

hollow eyes, weakness, bloating of the abdomen, and loss of bowel and bladder control. Death by starvation is painful, slow and miserable, with many symptoms the same as found in dehydration. Death occurs when the heart and lungs simply fatigue and collapse.

In very limited, extreme circumstances, food and fluids can make suffering worse. For example, if food is given to a terminally ill patient with cancer obstructing the bowel, the pain may be made more severe. In this and other similar cases, a doctor should follow the ancient maxim "above all, do no harm."

It is vastly different to withhold food and fluids in the very limited circumstances when it is impossible to successfully feed an individual, or when the patient will die within hours or days, when contrasted with the routine withholding of food and fluids to hasten the death of a non-dying patient. These are vital distinctions which cannot be minimized or overlooked when determining when to provide nutrition and hydration.

References:

- Harrison's *Principles of Internal Medicine*, Eleventh Ed., McGraw/Hill, 1987.
- Cecil, *Textbook of Medicine*, Fifteenth Ed., Saunders, 1979.
- Maxwell and Kleeman, *Clinical Disorders of Electrolyte Metabolism*, Third Ed., McGraw/Hill, 1980.

Curtis E. Harris, M.D., M.S., is President of the American Academy of Medical Ethics, an educational and legislative lobbying organization of physician members only. Dr. Harris is a practicing endocrinologist and specializes in diabetes care. He is a member of the American Medical Association, the American Society of Internal Medicine, and the American Diabetes Association.

Legal theories behind death-by-starvation decisions

by David N. O'Steen, Ph.D.

1. Assistance in eating regular solid foods.
2. Spoon feeding with pureed foods.
3. Feeding liquid nutrients by cup or straw.
4. Feeding liquid nutrients by syringe.
5. Nasogastric tube (via nasal passage); or gastrostomy tube (surgically implanted.)

Given this steady progression of needs for human assistance in feeding, it should not come as a surprise that many feeding tubes are inserted, not because the patient has completely lost the ability to swallow, but rather because there are not enough staff hours to provide sufficient nutrition by mouth.

The feeding tube often solves difficult problems that plague the chronically ill patient, and provides comfort, ease and dignity. To term a feeding tube a "burden" is to distort the truth. To discontinue a feeding tube increases patient discomfort and may, directly or indirectly, cause death.

Medical science and practice have developed feeding tubes to a point where they are safe, inexpensive and painless. They are used daily in standard medical practice, and do not represent extraordinary or unusual medical care.

Effects of dehydration (lack of water) and starvation (lack of food):

- ☞ Dry mucous membranes (mouth, nose, throat and genital organs)
- ☞ Constipation
- ☞ Impaction (buildup of stool in the body), severe abdominal cramping and bloating, nausea and vomiting
- ☞ Electrolyte imbalances (salt and water problems in the blood and tissues)
- ☞ Arrhythmias (heart problems); myalgias and malaise (muscle pain and marked fatigue)
- ☞ Cough and shortness of breath
- ☞ Severe depression and confusion, severe agitation and fear, delusions
- ☞ Dry, cracked skin
- ☞ Urinary, vaginal and bowel infections
- ☞ Bronchitis and pneumonia
- ☞ Blood in the bowel, stomach, kidney and lungs; kidney failure
- ☞ General systemic collapse and death

If we are to combat euthanasia and protect vulnerable patients, it is important to understand the legal theories that the courts have constructed to permit patients to be starved and dehydrated to death. It is also important to understand how those theories could be further expanded to create a constitutional "right to die." Such a created constitutional right would prevent states from enacting legislation to protect these vulnerable, incompetent patients.

Traditionally, there has been a presumption that incompetent patients want to live. Therefore, it was assumed they would want beneficial medical treatment and routine care, including food and fluids. Euthanasia advocates have worked hard to replace this traditional presumption for life with a presumption that what incompetent patients really want is to refuse medical treatment, and even feeding, in order to exercise a newly proclaimed right — the "right to die."

An incompetent patient, unable to express personal wishes about exercising the "right to die" to a court, presumably must have a court-appointed third party make a "substituted judgment" for him/her. This "substituted judgment" supposes that a third party has the capability of substituting his/her own judgment for what the incompetent patient would decide so that supposedly the patient's own wishes are carried out.

The danger of this "substituted judgment" is that the right to make a starvation decision is usually transferred to the very person or persons who sought the starvation death in the first place. Also, there have even been instances where the court

itself has made the "substituted judgment."

The most grotesque aspect of this whole charade is that it is supposedly carried out for the benefit of the patient.

In the 1987 case of Mildred Rasmussen, decisions of an Arizona court upheld by the Arizona Supreme Court, even went beyond the doctrine of "substituted judgment." The court admitted that it could not pretend to know what the incompetent patient would really want.

However, the court went on to reason that Miss Rasmussen's "right to privacy" was broad enough to encompass a fundamental right to refuse treatment and care, including food and fluids, a right she did not lose even though she was incompetent. From that point, the court concluded that a decision had to be made in her "best interest" which the court decided was that she not be fed.

Even more frightening is the prospect that the state courts will create a state constitutional "right to die" that mandates the withholding of necessary medical treatment, care and feeding from vulnerable, incompetent patients. This right would override the traditional state interest in protecting the lives of persons with serious and permanent disabilities.

While the U.S. Supreme Court declined in *Cruzan v. Harmon* to create a federal "right to die," the state courts are still free to do so under their state constitutions. The establishment of such a "right to die" would leave vulnerable, incompetent patients in that state with no legal protection from euthanasia based on someone else's decision, and would take from the states the power to enact laws protecting such patients.

Protecting vulnerable patients: the Oklahoma model

The 1987 passage of the "Hydration and Nutrition for Incompetent Patients Act" in Oklahoma is one very significant event in a decade when euthanasia has become a grim reality.

The Act presumes that every incompetent patient wishes to be provided with food and fluids to sustain life unless: (1) the patient is facing imminent death; (2) the provision of food and fluids would cause severe and long-lasting pain that

cannot be relieved or would be medically impossible; or (3) an informed consent decision has been made by the patient, when competent, that in case of a specific illness or injury, food and fluids can be withheld or withdrawn.

Citizens and legislators in Oklahoma have taken this important first step towards reversing the current pro-euthanasia trends and providing protection to vulnerable patients.

Summary of court actions regarding withholding of food and fluids from incompetent patients

Beginning in 1976 with *In re Quinlan*, heard by the New Jersey Supreme Court, there have been over 100 court cases involving the withdrawal of life-sustaining food and fluids from incompetent patients. The number of cases has accelerated in recent years and 12 cases have reached the highest state courts, with one case, *Cruzan v. Harmon*, reaching the U.S. Supreme Court in 1990.

From these cases, two trends appear to have developed. The first trend, which began in 1983, favored the withholding or withdrawal of food and fluids from certain patients. Within this trend, courts moved from authorizing removal of food and fluids administered by tube, to removal of oral feeding; from authorizing removal of food and fluids from unconscious patients, to semiconscious patients, to victims of diseases such as Alzheimer's; and from authorizing removal of food and fluids from patients who were dying, to those who were not dying.

The later trend, which began in 1987, reversed direction as courts began to favor the provision of food and fluids to these same types of patients.

These trends can be seen from descriptions of the following cases:

1983

Barber v. Superior Court.¹

FACTS: Clarence Herbert, 55 years old, comatose, not terminally ill.

HOLDING: Provision of food and fluids by tube constitutes medical treatment that can be withheld from persons who are comatose upon the request of the family.

DECISION: Removal of intravenous fluids was authorized.

1986

Brophy v. New England Sinai Hospital.²

FACTS: Paul Brophy, 48 years old, unconscious or noncommunicative state due to an aneurysm, not terminally ill.

HOLDING: Based on casual remarks made by patient prior to the onset of illness, the court held that the patient would, if competent, decline to receive food and fluids by tube.

DECISION: Gastrostomy tube could be removed or clamped

1987

In re Jobs.³

FACTS: Nancy Jobs, 31 years old, unconscious or noncommunicative state due to accident in surgery, not terminally ill.

HOLDING: A surrogate decisionmaker may withhold feeding by tube even when the incompetent patient has not left clear and convincing evidence of her intent.

DECISION: Authorized the removal of feeding tube.

1989

Gannon ex rel Coons v. Albany Memorial Hospital.⁴

FACTS: Carrie Coons, 86 years old, unconscious or noncommunicative state due to stroke, not terminally ill.

HOLDING: There was clear and convincing evidence that Ms. Coons would order the removal of the feeding tube under her circumstances. A "patient in a permanent vegetative coma...has no health and, in the true sense, no life, for the state to protect."

DECISION: Authorized the removal of the feeding tube. Within nine days of the court's order, Ms. Coons regained consciousness and when asked, said she would like to wait on any decision to remove the feeding tube. The court order was subsequently vacated.

1990

In re Browning.⁵

FACTS: Estelle Browning was 90 years old and incompetent due to stroke, but conscious and communicative. She suffered from an incurable but not necessarily terminal illness. Her living will stated that feeding by tube could be withheld or withdrawn if she was terminally ill and death was imminent.

HOLDING: Prior judicial approval is not required for a surrogate to consent to withdrawal of a feeding tube when patient, while competent, specifically expressed her wishes regarding medical treatment decisions orally or in writing.

DECISION: Authorized the removal of her feeding tube.

In re Swan.⁶

FACTS: Chad Swan, 17 years old, was

unconscious or noncommunicative due to a car accident. He was not terminally ill.

HOLDING: Pre-accident declarations made by a minor later left in a persistent vegetative state may be found sufficient to satisfy a termination that clear and convincing evidence exists of the minor's decision to discontinue nutrition and hydration.

DECISION: Authorized the withholding of a feeding tube.

1991

In re Crum.⁷

FACTS: Dawn Crum, 17 years old, was unconscious for six years as a result of a viral encephalitis infection. She was not terminally ill.

HOLDING: The court permitted the application of a substituted judgment analysis based on the fact that Dawn had been exposed to severely handicapped children in the past and had stated that "she would not want to live in a severely handicapped situation." The court concluded that Ohio law permits guardians of chronically unconscious minors to order the withdrawal of tube feeding.

DECISION: Authorized the withdrawal of tube feeding by decision of Dawn's co-guardians.

1992

In re Jane Doe.⁸

FACTS: Patient was a 33-year-old who was mentally retarded since infancy, persistently unconscious as a result of Canavan's disease.

HOLDING: The Court held that the "substituted judgment" standard could be applied based on a legal fiction that a never-competent patient was capable of issuing a prior refusal and that the patient's liberty interests require that the judges make the decision on her behalf. When making such decisions, the court found that a "preponderance" standard was appropriate.

DECISION: The Court authorized the removal of the feeding tube.

The Supreme Court decides *Cruzan*

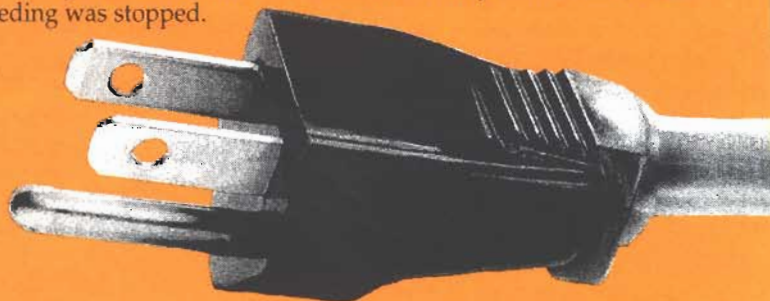
The U.S. Supreme Court entered the "right to die" debate in June 1990, when it issued its opinion in *Cruzan v. Harmon*. The parents of Nancy Cruzan, acting as legal guardians, sought to withhold tube-feeding from Nancy under the theory that she had a "right to die." A car accident left Nancy permanently unconscious and under the medical care of the State of Missouri. Missouri officials objected to the guardians' nontreatment request. The U.S. Supreme Court sided with the Supreme Court of Missouri and refused permission to end Nancy's nourishment.

The Court agreed that the U.S. Constitution may protect a competent person's freedom to refuse medical care in certain circumstances. Yet decisions made by competent persons refusing their own care differed significantly from nontreatment decisions made by others for unconscious or incompetent patients resulting in their deaths. Therefore, the states may create special safeguards to protect patients with severe disabilities.

"[W]e think a State may properly decide to decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life."¹ Nancy's statements about not wanting to live in a nursing home made before her accident were not "clear and convincing" statements of informed refusal and thus the guardians, doctors and the State were obligated to continue Nancy's nourishment.

Tragically, Nancy's feeding tube was withdrawn after a questionable ruling by the Missouri trial court that new evidence submitted by Nancy's legal guardians was "clear and convincing" proof of Nancy's intent to refuse nourishment. Nancy died December 26, 1990, 12 days after her feeding was stopped.

¹ Cruzan Slip Opinion, p. 17.



Can we always trust the guardian?

Excerpted from the briefs filed by E. Michael McCann, D.A., Milwaukee County, in the *Cruzan* and *L.W.* cases.^{1,2}

Only in recent years have we begun to understand the degree to which elderly citizens are the victims of domestic abuse. All too often, the frail elderly and persons with disabilities are victimized by family members or trusted caregivers. Looting of homes of incompetent parents, theft from jointly-held bank accounts, fraud and misuse of funds are all too common crimes.

In some circumstances involving care of the elderly by an adult son or daughter, a desire to expedite an inheritance may physically endanger the elderly parent. Many states have responded to reports of widespread abuse and neglect of the elderly by enacting "elder abuse" reporting laws.

Thus, it would be a mistake for courts to presume that, without careful court supervision, abuses will not occur in life-and-death health care decisions made by guardians. Courts must not think only of benign guardians and healthy families as they decide cases regarding the withholding or withdrawal of something as basic as food and fluids. To do so would be to ignore the startlingly high incidence of intra-family violence cases — including homicide — found in the nations' criminal courts.

Permitting all guardians total control over health care decisions for those who are incompetent would put the lives of many vulnerable citizens in grave danger. Prosecution of "mercy killers," difficult enough now, will become almost impossible if the killer only "humanely dispatched" a patient destined to die in a week or two — from dehydration. Can juries be expected to convict (of elder abuse or homicide) a family member who withholds food and water from an Alzheimer's patient?

Blanket judicial approval for guardians or families to bring about death by withholding basic care will erode existing protection for all citizens with severe disabilities from acts of passive and active euthanasia.

¹ In the *L.W.* case, the Wisconsin Supreme Court held that a guardian may withhold or withdraw nutrition or hydration from an incompetent ward in a persistent vegetative state.

² In *Spahn v. Wittman*, a nutrition and hydration case currently pending before the Wisconsin Supreme Court, the guardian is seeking to extend the ruling in the *L.W.* case to an Alzheimer's patient.

1995

In re *Fiori*.⁹

FACTS: The patient, who was 43 years old, had been rendered incompetent at the age of 21 after a motorcycle accident. A second injury left him in a persistent vegetative state. The patient was not terminal.

HOLDING: Even though the patient had not expressed a view on the withdrawal of life-sustaining treatment, the Court held that consent of a close family member, along with approval of two qualified physicians, is sufficient to allow removal of a gastrostomy tube in a patient in a persistent vegetative state. Clear and convincing evidence is not required in order to withdraw life-sustaining treatment of a persistent vegetative state patient.

DECISION: Ordered the patient's nursing home to withdraw the gastrostomy tube.

These cases are only a few of the many such cases which have arisen across the country. Many set dangerous precedents for the withholding of food and fluids from incompetent patients for whom there is no clear and convincing evidence of an informed refusal of nutrition. Such decisions constitute a sanctioning of nonvoluntary euthanasia, that is, the starvation and dehydration of patients most of whom would otherwise live indefinitely.

Case References:

¹ *Barber v. Superior Court*, 147 Cal.App.3d 1006, 195 Cal.Rptr.484 (Cal. Court of Appeals 1983).

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

³ *In re Jobs*, 108 N.J. 394, 529 A.2d 434 (New Jersey Supreme Court 1987).

⁴ *Gannon ex rel Coons v. Albany Memorial Hospital*, No. 0189-017460 (Albany County Superior Court, New York 1989).

⁵ *In re Browning*, 568 So.2d 4 (Florida Supreme Court 1990).

⁶ *In re Swan*, 569 A.2d 1202 (Maine Supreme Court 1990).

⁷ *In re Crum*, 580 N.E.2d 876 (Ohio Probate Court 1991).

⁸ *In re Jane Doe*, 583 N.E.2d 1263 (Massachusetts Supreme Judicial Court 1992).

⁹ *In re Fiori*, 652 A.2d 1350 (Superior Court of Pennsylvania 1995).

Establishing the link between death by starvation and death by lethal injection

by Dan Avila, J.D.

Paralyzed from the neck down, and receiving food through a stomach tube, Hector Rodas announced one day in 1986 his wish to die.¹ He asked the doctors at the Hilltop Rehabilitation Hospital in Grand Junction, Colo., to stop feeding him. When doctors objected, Rodas hired lawyers to take his case and sue the hospital. The Mesa County District Court in Grand Junction accepted the lawyers' argument that Rodas had a constitutional right to refuse feeding and ordered the hospital to abide by Rodas' request.² The hospital complied, clamping Rodas' feeding tube shut. Rodas died from malnutrition and dehydration 15 days after his feeding was stopped.

In a second lawsuit filed prior to Rodas' death, his lawyers also asserted that since Rodas had a right to die from starvation, he also had a "right to be provided with medication and medicinal agents that would cause his death and avoid a prolonged and painful death."³

David Miller, legal director of the American Civil Liberties Union (ACLU) in Denver, later told the press: "The point of [the suit] was to get a declaration that it would not be a criminal act to perform euthanasia."⁴

When the press later learned that Rodas had never wanted to die from a lethal injection, the second lawsuit was dropped. The attorneys had wrongly assumed that Rodas would favor death by injection.

The Rodas case exposed the inevitable connection between clamping a patient's feeding tube (withdrawal of nutrition) and injecting poison through a needle. Practicing the former intensifies the demand for the latter. Death by dehydra-

tion and malnutrition is a painfully slow process, taking as long as 43 days in some cases.⁵ Death by lethal injection, we will be told, could be painlessly quick, and thus may seem the preferred option.

Currently, direct euthanasia is against the law in this country. Yet, by granting permission to remove food and water to bring on death, our courts have increased the likelihood that lethal injections will also be legalized.

Indeed, polls reveal support for legalized euthanasia among doctors, other professionals and the public. The Netherlands currently allow lethal injections (anywhere from 2,000 to 10,000 per year) and some American ethicists tout the Dutch practice as an "enlightened" model for this country.⁶ Prosecutors in some cases are simply refusing to prosecute even clear acts of direct euthanasia.⁷ Besides, pressure is growing to save health care money by rationing; what more efficient means is there to cut medical consumption than by eliminating the consumer?

Several courts have ruled that maintaining the lives of persons with serious and permanent mental disabilities is, in their view, rarely justified. One court even went so far as to assert: "As a matter of established fact, a patient [with no hope of recovering the ability to think] has no health, and in the true sense, no life, for the state to protect."⁸ In this "quality of life" mindset, all persons with less-than-perfect abilities and incurable disabilities would be prime candidates for lethal injections.

How might we reverse this trend and restore respect for all human beings, able and disabled? Are we doomed to repeat the Nazi "solution," whereby entire populations were branded "misfits" and eliminated? We could begin by recognizing the humanity of those incapacitated by disease, injury or illness. Being permanently unaware does not make one a "vegetable" or a "biological shell."

As a judge once wrote: "I am not prepared to accept the description cited to us of one expert that the patient is a 'plant.' Has any one ever seen a nursing

professional who did not treat a comatose patient with the deepest respect? Why do we speak to, comfort, and hold such patients? Because we realize that they are no less human than we[.] They are not the people that we knew, but they remain the people that we love."⁹

Proponents of lethal injections assert they are the compassionate ones, simply advocating "humane" solutions to suffering and hardship. They employ heart-tugging slogans such as "death with dignity" and "merciful release." They sound great, but what do they mean?

These emotional appeals should not alter our compassionate commitment to protecting and caring for the more vulnerable members of our society. Choosing life is sometimes not easy; protecting life is never a cinch. But the job can and must be done.

Dan Avila, J.D., is Staff Counsel for the National Legal Center for the Medically Dependent and Disabled, Inc., a public interest law firm advocating legal protection for persons with disabilities against discriminatory denial of medical treatment and other care such as tube-feeding.

Notes:

- ¹ "Quadriplegic Wins Right to Stop Living," *Wash. Post*, Jan. 23, 1987, at A, Col. 4.
- ² See, Nota Bene, *In re Rodas*, 2 *Issues in Law & Medicine* 471, 479 (1987).
- ³ See, Verbatim, Complaint for Declaratory Relief in *Rodas Case*, 2 *Issues in Law & Medicine* 499, 500 (1987).
- ⁴ See, Nota Bene, *Rodas v. ErkenBrack*, 2 *Issues in Law & Medicine* 481 (1987).
- ⁵ "Family's Long Ordeal Has Ended: Comatose Woman Dies After 43 Days Without Food," *Miami Herald*, Jan. 4, 1987, at 1A, Col. 1.
- ⁶ See Molenda, "Active Euthanasia: Can It Be Justified?" 3 *Euthanasia Review* 15 (1988); see also, de Wachter, "Active Euthanasia in the Netherlands," 262 *Journal of the American Medical Association* 3316 (1989).
- ⁷ See, e.g., "State Won't Arrest Doctors Suspected of Mercy Killing," *New Haven Register* (Conn.), Dec. 29, 1989, at 1 col. 1.
- ⁸ *In re Eichner* (Fox), 73, A.D.2d 431, 465, N.Y.S.2d 517, 543 (N.Y. App. Div. 1980).
- ⁹ *In re Peter*, 108 N.J. 365, 389, 529 A.2D 419, 431 (1987) (O'Hern, J., Dissenting).