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Testimony of Suzanne Brown Walsh  
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## **In Opposition to Raised Senate Bill 669, An Act Concerning Living Wills**

Judiciary Committee  
March 14, 2008

Good morning, Senator McDonald, Representative Lawlor, and esteemed members of the Judiciary Committee. My name is Suzanne Brown Walsh. I am a Principal of Cummings & Lockwood in West Hartford, am currently Chair of the Connecticut Bar Association's Estates & Probate Section and am one of Connecticut's eight Uniform Laws Commissioners. I am also a past chair of the Connecticut Bar Association's Elder Law Section. Today I am testifying behalf of both the CBA Estates & Probate and Elder Law Sections. With me is Sharon Pope, the Secretary of the Elder Law Section, who is an attorney in private practice and a tenured Associate Professor in Legal Studies at the University of Hartford.

The Elder Law and Estates & Probate Sections both ***oppose* Raised Senate Bill 669, An Act Concerning Living Wills.**

There exist few more personal, intimate and private decisions than those made by individuals to accept or refuse medical treatment. Correspondingly, however, there are few actions that are more challenging to health care facilities than interpretation and implementation of decisions a patient would have made if capable of speaking for him or herself.

As presented, Senate Bill 669 is poorly drafted, employs highly subjective descriptors, and runs a substantial risk of overreach in making end-of-life determinations concerning individuals with disabilities and those who are diagnosed with dementia. The bill will neither serve the function of enhancing self-determination nor give sufficient guidance to health care providers to effectuate its terms. It should for those reasons not be favorably reported by the Committee.

Generally, Raised Senate Bill 669 seeks to expand the triggering requirements under which a Connecticut living will becomes operative to include "critical illness" and "permanent incapacity". Connecticut law currently provides the following definitions:

a terminal condition means the final stages of an incurable or irreversible medical condition which, without the administration of a life support system,

- will result in death in a reasonably short period of time, in the opinion of the attending physician; and
- a state of permanent unconsciousness includes permanent coma and persistent vegetative state and means an irreversible condition in which the individual is at no time aware of himself or the environment and shows no behavioral response to the environment.

Connecticut living wills are currently triggered only when an attending physician deems a patient to be in a terminal condition or permanently unconscious. Several other states; notably New Jersey, have expanded their laws to include alternate triggering conditions. While this issue merits further review in Connecticut, SB 669 so fatally fails to clearly define and anticipate concerns about the proposed alternate conditions that it should not go forward.

Our specific concerns about SB 669 include the following:

#### Section 1:

- SB 669 is attempting to expand the triggering conditions under which a living will becomes operative to include “critical illness” and “permanent incapacity”. The second term is referenced in Sections 2(a)(1)(C)(iii), 3 and 4, and arguably defined in Section 4 as “an incurable or irreversible neurological condition in which I cannot communicate my wishes”, but is not defined in Section 1. Even if the drafters intended this to be interpreted by reference to the current definition of the term “incapacitated”, there is no guidance on how to interpret the modifier “permanent”.

#### Section 2:

- Section 2(1)(1)(C)(iii) states that two physicians, including an attending and a physician qualified to make neurological diagnosis, must deem the individual to be “permanently incapacitated”. This is inconsistent with Sections 3 (living will form) and 4 (combined advance directives form). Section 3 refers to two licensed physicians, one of whom must be either a board certified neurologist or geriatrician. Section 4 refers to an attending physician and one other physician.

#### Sections 3 and 4:

- Sections 3 (living will form) and 4 (combined advance directive form) expand the list of “life support” measures to include “hospitalization in an acute care hospital”. Acute hospitalization is not analogous to the types of life support that are defined in Connecticut General Statutes §19a-570(7), which include mechanical or electronic devices and artificial means of providing nutrition or hydration. Further, it may be extremely problematic if an individual states in a living will or combined advance directives form that he or she wishes to forego

hospitalization, yet elects to receive artificial means of providing nutrition and hydration. This is because the procedure to put a gastrostomy tube in place requires hospitalization.

- In Section 3 (living will form), those executing the form are instructed to “cross out and initial the life support systems above that you want administered”. In Section 4 (combined advance directives form), those executing the form are instructed to “cross out and initial the medical treatments above that you do not want administered”. This will unhelpfully engender confusion.
- Sections 3 (living will form) and 4 (combined advance directive form) refer without explanatory guidance to “acute loss of capacity”. It is unclear how health care providers will ascertain that loss of capacity is “acute” or “permanent”. It is also unclear whether the physician hold-harmless provisions of the living will statute will attach to situations of “acute loss of capacity”. Further, Section 3 uses the subjective term “no hope of survival”, as opposed to using legal descriptors of a situation in which treatment is futile. Finally, this section would permit medical treatment to be withdrawn if the individual is not “improving”, but does not provide guidance on how that should be determined.

For the foregoing reasons, we respectfully request that Senate Bill 669 not be favorably reported by the Committee. We remain available to answer any questions that you may have.

### **Background on the Development of Connecticut Law Concerning Advance Directives:**

Connecticut first enacted law concerning health care decision-making through the 1985 Connecticut Removal of Life Support Systems Act (the Act). The Act reflected the nascent stage of law in this area, focusing principally on holding harmless from liability medical providers who met specified criteria in withholding or withdrawing “life support” measures from individuals whose medical condition was terminal.

Stemming from a common law right to bodily self-determination, individual rights concerning health care had evolved over the course of the 20<sup>th</sup> century. First recognized was the right of individuals to give or withhold informed consent to medical procedures. Later, courts began to recognize proxies who were authorized to exercise “substituted judgment” on behalf of those who were unable to voice that consent themselves. States’ rights have historically been premised on protecting citizens and promoting medical ethics. The resultant requirements for withholding or withdrawal of life support in Connecticut embodied a negotiated balance between individual rights and those rights reserved to states.

In 1989, the Connecticut Supreme Court decided McConnell v. Beverly Enterprises by interpreting the Act to require, consistent with her prior expressed wishes, removal of a gastrostomy tube from Mrs. McConnell, a 57-year old emergency room nurse left in a

persistent vegetative state after a car accident. The following year, the U.S. Supreme Court heard the case of Nancy Beth Cruzan, a 25 year-old who had experienced a traumatic brain injury in a car accident. In this complex and much analyzed decision, the Court concluded that competent individuals have a constitutionally protected liberty interest in refusing unwanted medical treatment, but also found that states may require clear and convincing evidence of their wishes.

In light of both of these decisions, the Connecticut Legislature in 1991 expanded the scope of the Act, removing the requirements of informed consent of next-of-kin, adding the currently recognized alternate triggering condition of “permanent unconsciousness”, and establishing that artificial means of providing nutrition and hydration were included in the definition of “life support”. Further, in 1993, a combined advance directives form including the living will, appointment of power of attorney for health care decisions, anatomical gift and advance designation of conservator was enacted.

Finally, in 2006, the Elder Law and Estates & Probate Sections advocated, in partnership with a broad coalition of organizations and departments of the state, for amendments designed to modernize and simplify Connecticut’s advance directive law. This resulted in enactment by the legislature of Public Act 06-195, which made four principal changes:

- **Appointment of Proxy:** Following the lead of every state other than Montana and Alaska, the historically recognized powers of the health care agent and the attorney-in-fact for health care decisions were merged into a unified proxy called the "health care representative", who has the authority to make any and all health care decisions for a person who is incapable of expressing those wishes him or herself.
- **Expansion of Living Will Form:** The living will form was expanded to permit individuals to indicate their wishes concerning both life support and any other aspect of health care.
- **Clarification of the Role of Conservators:** Statutory language was amended to require that where a conservator of the person has been appointed by a Court of Probate for an individual who has been determined to lack legal capacity (a conserved person), that conservator must:
  - except as otherwise provided in statutes (e.g. statutes concerning shock therapy), comply with the previously executed advance directives of the conserved person; and
  - allow the conserved person's health care representative to continue to make health care decisions for him or her.

This language was later re-affirmed through 2007 amendments to Connecticut’s conservatorship statutes that were enacted by Public Act 07-116.

- **Recognition of Advance Directives from Other States and Countries:**  
Finally, P.A. 06-195 provided for recognition of advance directives that have been validly executed in other states and foreign countries.