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ADVANCE DIRECTIVES: A CASE OF CHANGING SOCIAL NORMS AND THEIR LEGAL IMPLICATIONS

IRA BEDZOW*

The frequently used terms “death with dignity” and the “right to die” encompass two ethically distinct concepts in the current debate over the autonomy of patients to end their lives, namely physician-assisted suicide and the right to refuse medical treatment. Although physician-assisted suicide has claimed the public spotlight, the right to refuse medical treatment has greater implications for patients and physicians. The right to refuse medical treatment and end-of-life decision-making arise more frequently and affect greater numbers of patients than does physician-assisted suicide.¹ Moreover, as the general population of this country ages, debates over the direction of end-of-life care will only continue to expand in significance and scope.

The growth of advance directive legislation² is a result of public awareness and the increasing priority accorded to patient auton-

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¹ While both physician-assisted suicide and the right to die involve the idea that individual autonomy should be primary, the ethical and legal considerations diverge due to the ethical distinction between active killing and allowing to die. Physician-assisted suicide is about the ethics of sanctioning the act of killing, whereas right to die cases involve a passivity in allowing the patient to refuse medical treatment, even if such treatment would be life-saving. In the latter, nature (and death) is allowed to take its course without human intervention. This just provides the ethical pivot between the two; the analysis between all of the components and implications of each would be too large a comparison for the scope of this article. See ROBERT M. VEATCH, *THE BASICS OF BIOETHICS* 85-91 (2d ed. 2002).

² A. E. Fade, *Advance Directives: Keeping up with Changing Legislation*, 16 *TODAY'S OR NURSE* 23, 23 (1994). The Patient Self-Determination Act (“PSDA”) of 1991 required hospitals to provide patients with information regarding their right to make advance directives pursuant to state law. *Id.* at 25-26. Further, upon admission, hospitals were required to determine whether a patient had an advance directive. However, the PSDA allowed individual states to determine the details, administration, requirements, and restrictions of such documents. *Id.* at 26. This resulted in significant variation in state policies relating to advance directives, involving areas such as the evidentiary threshold to cease intervention, the specific language or forms that must be used, whether a witness or notary must be present when drafting the document, etc. In an attempt to establish more uniformity across states, a number of states have enacted the Uniform Health Care Decisions Act. To download each state’s advance directives legislation, visit the National Hospice and Palliative Care Organization website. *Download Your State’s Advance Directives*, NAT’L HOSPICE & PALLIATIVE CARE ORG., <http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289> (last visited Mar. 1, 2016).

omy.³ Recently, the Care Planning Act of 2015 was introduced to create a Medicare benefit for people with grave illnesses to work with their doctors to define, articulate, and document their desired end-of-life goals.⁴ The American Medical Association, as stated in its Code of Ethics, also supports advance care planning and has asserted that physicians should comply with patients' directives.⁵ Yet, despite the increase in the significance given to individual patient autonomy, current laws regarding advance directives⁶ give little recourse to incompetent patients⁷ when physicians dismiss their desire to refuse end-of-

³ David J. Rothman, *The Origins and Consequences of Patient Autonomy: A 25-year Retrospective*, 9 HEALTH CARE ANALYSIS 255 (2001). Patient autonomy began to be asserted as a central principle in medical ethics starting in the 1960s. *Id.* at 255-56.

⁴ Care Planning Act of 2015, S. 1549, 114th Cong. (2015).

⁵ *AMA Code of Medical Ethics, Opinion 2.191 - Advance Care Planning*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2191.page> (last visited Mar. 1, 2016); *see also AMA Ethics Resource Center, End of Life Care, Advance Care Directives*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/end-of-life-care/advance-care-directives.page> (last visited Mar. 1, 2016).

⁶ Medical advance directives can take the form of a living will, a proxy directive, or a combination of both. A "living will" is an instruction directive about the kind of medical care an individual would or would not want for his or her end-of-life care. THE PRESIDENT'S COUNCIL ON BIOETHICS, *TAKING CARE: ETHICAL CAREGIVING IN OUR AGING SOCIETY* 57 (2005). A proxy directive allows a patient to choose a surrogate decision-maker when he or she becomes incompetent. *Id.* at 58. Advance directives are meant to give patients the ability to choose their course of medical treatment even after they lose decision-making capacity. *Id.* at 57. They are a means to preserve patient autonomy by giving patients anticipatory decision-making capability. *Id.* One difficulty with giving advance directives the same decision-making authority as contemporaneous statements made by competent individuals is the assumption that an incompetent patient's current wishes are consistent with their past wishes as expressed in their directive is a difficult assertion to make. *Id.* at 55. *See* Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 J.L. MED. & ETHICS 234 (1989). Ronald Dworkin, however, argues that despite the fact that a person's interests may change after becoming incompetent, it nevertheless does not undermine the authority of advance directives. RONALD DWORKIN, *LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM*, 190-91 (1993) *but see* Agnieszka Jaworska, *Respecting the Margins of Agency: Alzheimer's Patients and the Capacity to Value*, 28 PHIL. & PUB. AFF. 105 (1999) in which Jaworski limits Dworkin's view. The first legal literature on advance directives was written by Louis Kutner. Louis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal* 44 IND. L.J. 539 (1969).

⁷ In the medico-legal literature, a distinction is made between mental capacity and competence. In order for a person to exercise autonomy, he or she must be able to understand the information upon which the choice is made. This implies that the patient has capacity to do so. Capacity is determined by a "functional" test which assesses whether the person has the mental faculties to make rational decisions. It is generally assumed that if a patient can understand a procedure, judge the risks and benefits associated with it, and make a decision of whether to undergo the procedure or not, then the patient has capacity. Any physician can determine whether a patient has capacity or not, except when the patient has a mental illness; in those cases, a psychiatrist is often needed to determine capacity. Competence, on the other hand, is a legal concept where the state defines who

life treatment.⁸ Courts have also been unwilling to recognize claims made on behalf of incompetent patients whose physicians have ignored their advance directives.⁹ For this reason, scholars have called the statutory right to refuse end-of-life care an “illusory protection,”¹⁰ a “false promise,”¹¹ and a “right without a remedy.”¹² In a 2004 Hastings report,¹³ Angela Fagerlin and Carl Schneider, of the University of Michigan Center for Bioethics and Social Sciences in Medicine, wrote that living wills have failed and that they do not, and cannot,

has a presumption of capacity. Those who do not meet the state’s threshold of competence are deemed to lack the capacity to make some or all of their decisions and individuals are appointed to make those decisions on their behalf. Adults are presumed to be competent unless a court has ruled otherwise. However, if a person previously had capacity, his or her decisions that were made when capable/competent are valid even after he or she loses capacity. This allows for the use of advance directives.

⁸ Many advance directive statutes confine the use of advance directives to end-of-life decision-making and are limited to patients who are either terminally ill or in persistent vegetative states. Robert S. Olick, *Defining Features of Advance Directives in Law and Clinical Practice*, 141 CHEST J. 232, 233 (2012).

⁹ M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS. U. PUB. L. REV. 499 (1992); Nicole Marie Saitta & Samuel D. Hodge, Jr., *What are the Consequences of Disregarding a ‘Do Not Resuscitate Directive’ in the United States?* 32 MED. & L. 441 (2013); Nicole Marie Saitta & Samuel D. Hodge, Jr., *Wrongful Prolongation of Life-A Cause of Action That Has Not Gained Traction Even Though a Physician Has Disregarded a “Do Not Resuscitate” Order*, 30 TEMP. J. SCI. TECH. & ENVTL. L. 221 (2011) (hereinafter, *Wrongful Prolongation of Life-A Cause of Action*); see also Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 885-87 (1991); DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* 175 (1987); Sylvia McSkimming et al. *The Experience of Life-Threatening Illness: Patients’ and Their Loved Ones’ Perspectives*, 2 J. PALLIATIVE MED. 173, 180-82 (1999).

¹⁰ Marni J. Lerner, *State Natural Death Acts: Illusory Protection of Individuals’ Life-Sustaining Treatment Decisions*, 29 HARV. J. ON LEGIS. 175, 177 (1992); see also Saitta & Hodge, Jr., *Wrongful Prolongation of Life-A Cause of Action*, *supra* note 9.

¹¹ Mark Strasser, *A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right to Bodily Integrity*, 36 SAN DIEGO L. REV. 997, 998 (1999); see also Maggie J. Randall Robb, *Living Wills: The Right to Refuse Life Sustaining Medical Treatment—A Right Without a Remedy?*, 23 U. DAYTON L. REV. 169 (1997); S. Elizabeth Wilborn, *The Right to Refuse Medical Treatment: Where There Is a Right, There Ought to Be a Remedy*, 25 N. KY. L. REV. 649 (1998); Henry S. Perkins, *Controlling Death: The False Promise of Advance Directives*, 147 ANNALS INTERNAL MED. 51 (2007).

¹² A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625 (1986); Strasser, *supra* note 11, at 1039-40; see also Maggie J. Randall Robb, *supra* note 11, at 170; S. Elizabeth Wilborn, *supra* note 11, at 651.

¹³ Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 HASTINGS CENTER REP. 30 (2004). The Hastings Center Report explores the ethical, legal, and social issues in medicine, health care, public health, and the life sciences. *About the Hastings Center Report*, THE HASTINGS CTR., <http://www.thehastingscenter.org/Publications/HCR/About.aspx> (last visited Mar. 1, 2016). The Hastings Center is an independent, nonpartisan, and nonprofit bioethics research institute founded in 1969. *About Us: Our Mission*, THE HASTINGS CTR., <http://www.thehastingscenter.org/About/Default.aspx> (last visited Mar. 1, 2016).

achieve the goal of patient autonomy.¹⁴ Courts are more responsive to requests to enjoin physicians to comply with advance directives in cases where the patient's wishes may still be followed.¹⁵ Yet they have been reluctant to award damages when a patient was forced to endure a lingering death contrary to advance instructions.¹⁶

The difference between the public support for patient autonomy and the courts' (as well as advance directive statutes) seeming disregard of a patient's wishes has been ascribed to a *tension* between the priority of the individual versus interests of the state. Since the first end-of-life cases that dealt with refusing medical treatment, the courts have made it clear that the right of an incompetent patient to refuse treatment is not all-encompassing;¹⁷ rather, it must be honored if it supersedes state interests. However, the courts oftentimes require the state to demonstrate that it has a compelling interest that outweighs a

¹⁴ Fagerlin & Schneider, *supra* note 13, at 30. In applying the right to refuse treatment as stated in *Cruzan* to include an avenue for recourse if that right is violated, John Donohue sums up the difficulty of advance directive legislation and litigation as follows: "The right to refuse lifesaving medical treatment as recognized in *Cruzan* may prove to be a right in name only. While the Supreme Court and federal and state legislatures have taken steps to recognize and effectuate the right to die, the courts of this country have generally refused to hold that an infringement upon this right precipitates a compensable harm. The reluctance to recognize damages in actions asserting a violation of the right to die has been guided by a categorical refusal to recognize *life* as a cognizable injury deserving monetary damages." John Donohue, "Wrongful Living": *Recovery for a Physician's Infringement on an Individual's Right to Die*, 14 J. CONTEMP. HEALTH L. & POL'Y 391, 417 (1997) (emphasis added) (footnote omitted).

¹⁵ Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives: Liability for Providing Unwanted Life-Sustaining Treatment*, 20 J. L. MED. 1 (1999) "The question that must be answered is: 'What can be done to encourage physicians to follow patient decisions to stop heroic care at the end of life?' Patients and their families have legal recourse when their life-sustaining treatment decisions are not followed. As an immediate response, they can petition a court for an injunction or order directing the provider to remove or withhold the life-sustaining treatment. Liability against a provider is not sought in these suits. Rather, the relief the plaintiff seeks is simply a court order to enjoin the provider from continuing the life-sustaining treatment. Patients and their families have been following this route for more than two decades; the result almost always being the removal of the treatment." *Id.* at 2 (internal footnotes omitted). In support, Rodriguez cites *In re Travel*, 661 A.2d 1061, 1068-69 (Del. 1995); *Browning v. Herbert*, 568 So. 2d 4, 11 (Fla. 1990); and *DeGrella v. Elston*, 858 S.W.2d 698, 710 (Ky. 1993).

¹⁶ *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *Delio v. Westchester Cnty. Med. Ctr.*, 516 N.Y.S.2d 677, 679 (N.Y. App. Div. 1987); *Blackman v. NYC Health & Hosp. Corp.*, 660 N.Y.S.2d 643, 648-49 (N.Y. Sup. Ct. 1997); *In re Rosebush*, 491 N.W.2d 633 (Mich. Ct. App. 1992); *see also* Kellen F. Rodriguez, *supra* note 15; Vicki Joiner Bowers, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677 (1996).

¹⁷ *See* section titled "The Autonomy of Competent and Incompetent Patients" *infra* pp. 102-103. *See also* Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1 (1975). "As a general rule the exercise of any right may be limited if it conflicts with compelling state interests, at least where there are not less drastic means available to accomplish the state purpose." *Id.* at 16.

patient's right to refuse medical treatment.¹⁸ Therefore, in an end-of-life case involving a patient who lacks capacity, even if there is an advance directive, there still might be a legal presumption (and a medical proclivity¹⁹) that life should be preserved, though the priority of

¹⁸ *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 635-39 (Mass. 1986) (asserting state interest wanes where issue is when, not whether, death will occur); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424-27, 435 (Mass. 1977) (recognizing state's interest in preserving life diminishes where incompetent has no hope for recovery); *In re Spring*, 405 N.E.2d 115, 119, 123 (1980) (recognizing state's interest less compelling where patient suffers from incapacitating disease); NANCY M. P. KING, MAKING SENSE OF ADVANCE DIRECTIVES 62-66 (rev. ed. 1996) (explaining strong state interest when patient curable but weak interest when patient's condition hopeless).

¹⁹ With respect to the medical profession's inclination towards preserving life, see *AMA Code of Ethics, Opinion 2.21 - Euthanasia*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page?> (last visited Mar. 1, 2016) and *AMA Code of Ethics, Opinion 2.211 - Physician-Assisted Suicide*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page?> (last visited Mar. 1, 2016). It should be emphasized that the focus is on preserving life and not treatment per se and thus a physician is not ethically obligated to treat patients when it will not lead to the preservation of life. "Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care." *AMA Code of Ethics, Opinion 2.035 - Futile Care*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2035.page> (last visited Mar. 1, 2016). Physician reluctance to allow patients to refuse care is oftentimes due to a conflict in the values physicians hold between beneficence and respecting patient autonomy. When patient autonomy could result in maleficence to the patient, physicians frequently fall on the side of life. As David Orentlicher noted, "end-of-life decisions are frequently driven by the physician's values rather than the patient's values." David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1281 (1994). Physician deference to beneficence over patient autonomy therefore influences their disregard of advance directives, as demonstrated by the situations in which advance directives are ignored. Physicians often err on the side of caution when: (1) questions arise regarding an advance directive's authority in light of the patient's competence when executed; (2) questions arise regarding the context in which the directives are invoked; (3) when the directives conflict with hospital policy, family preference, or practice standards; and (4) when the directives are ambiguous and could be understood as erroneously communicating patient wishes. In each situation, the clarity of the patient's autonomous choice is opposed by presumptions that are held by family members or implied interests that are presumed by society's values. One may argue that medical providers' refusal to honor patients' wishes regarding end-of-life care is due to a fear of liability, yet physicians need not practice defensive medicine by dismissing advance directives since state statutes often provide medical professionals immunity in these situations. Furthermore, physicians will often dismiss directives to prolong someone's life if they think that medical treatment is futile. Renee M. Goetzler & Mark A. Moskowitz, *Changes in Physician Attitudes Toward Limiting Care of Critically Ill Patients*, 151 ARCHIVES INTERNAL MED. 1537, 1538 (1991). Regarding why physicians might ignore patients' advance directives, Lynch et. al. writes that "physician behavior is more likely to reflect a rational evaluation of risk. On one hand, saving a patient's life, even against the patient's wishes, carries a risk of only limited sanctions or liability; on the other, choosing not to treat a patient and thereby allowing him or her to die risks a

individual autonomy is still the dominant consideration. Similarly, proxy directives are limited by the authority expressly granted to the proxy either by state legislation or through precedent, to speak on the patient's behalf by the standard of surrogate decision-making that is acceptable in a particular state.²⁰

This article provides an alternative view of the tension between the priority of individual autonomy and state interests in end-of-life cases involving the right to refuse treatment. First, it argues that the state interest in preserving life, as well as other interests that the courts use to balance against the patient's right to refuse treatment, is not an imposition of the state on individual autonomy.²¹ Rather, the courts use "state interests" to protect individuals from a violation of their own autonomy. Just as the medical profession uses the notion of "implied consent," which allows physicians to rely on the general presumption that patients would consent to be treated at a time when

malpractice suit with the potential for significant damages, increased insurance payments, and harm to reputation." Holly Fernandez Lynch et al., *Compliance with Advance Directives: Wrongful Living and Tort Law Incentives*, 29 J. LEGAL MED. 133, 148-49 (2008) (footnote omitted); See also John M. Luce & Ann Alpers, *Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States and Providing Palliative Care to Them*, 162 AM. J. RESPIRATORY & CRITICAL CARE MED. 2029 (2000); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N. 2609 (2005); ROBERT POWELL CTR. FOR MED. ETHICS AT THE NAT'L RIGHT TO LIFE COMM., WILL YOUR ADVANCE DIRECTIVE BE FOLLOWED? A REPORT BY THE ROBERT POWELL CENTER FOR MEDICAL ETHICS (rev. ed. July 2015) www.nrlc.org/euthanasia/willtolive/PowellCenterReport13.pdf; Judy Greenwald, *Medical Ethics & Risk Management: Liability at Life's End; Providers Risk Suits by Reviving Patients*, BUS. INS. 1 (1996); Henry S. Perkins, *supra* note 11; David A. Asch et al., *Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes*, 151 AM. J. RESPIRATORY & CRITICAL CARE MED. 288 (1995); Andrew J. Billings, *The Need for Safeguards in Advance Care Planning*, 27 J. GEN. INTERNAL MED. 595 (2012); Timothy Gilligan & Thomas A. Raffin, *Whose Death Is It, Anyway?* 125 ANNALS INTERNAL MED. 137 (1996); Joel M. Zinberg, *Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives*, 13 VT. L. REV. 445 (1989).

²⁰ See, section titled "Surrogate Decision-Making & Proxy Directives" *infra*.

²¹ Judicial opinions have consistently recognized that the issue of medical decision-making for currently incompetent individuals through advance directives is best left to the legislature. See *In re Storar*, 420 N.E.2d 64, 73-76 (N.Y. 1981); *A.B. v. C.*, 477 N.Y.S.2d 281, 284 (N.Y. Sup. Ct. 1984); *In re Estate of Longeway*, 549 N.E.2d 292, 301, 306-07 (Ill. 1989) (Clark, J., dissenting); *In re Peter*, 529 A.2d 419, 429 (N.J. 1987); *In re Farell*, 529 A.2d 404, 407-08 (N.J. 1987); *In re Conroy*, 486 A.2d 1209, 1220-21 (N.J. 1985). Following the Supreme Court's decision in *Cruzan v. Dir.*, Mo. Dep't of Health, 497 U.S. 261 (1990), the New York State Legislature passed Article 29-C: Health Care Agents and Proxies. N.Y. PUB. HEALTH LAW §§ 2980-2994 (McKinney 2013). See also Neal F. Splaine, *The Incompetent Individual's Right to Refuse Life-Sustaining Medical Treatment: Legislating, Not Litigating, A Profoundly Private Decision*, 27 SUFFOLK U. L. REV. 905 (1993). Splaine argues that the legislature, and not the courts, should establish a framework for surrogate decision-making for incompetent persons. *Id.* at 908.

they cannot give such consent explicitly,²² the courts use “state interests” as a way to rely on a general assumption of what an individual may want when his or her desires are unknown or ambiguous.²³ Similarly, the different state standards relating to a proxy’s authority reflect the level of risk the different states are willing to tolerate. States have a genuine concern that the wishes of an incompetent patient will be misrepresented, either through giving the proxy too much leeway or not enough.

Second, this article demonstrates that there has been a steady increase in the recognition of individual autonomy over state interests both in legislation and in the courts. This trend has resulted in increased support for injunctive relief to give effect to a patient’s wishes.²⁴ However, the increased recognition of patient autonomy has still been limited in order to protect the ethical autonomy of medical professionals involved in these end-of-life cases. By failing to provide remedies to patients whose physicians have imposed medical care contrary to their presumed wishes, legislators and the courts protect the ethics of medical professionals so that they may practice according to their professional standards without fear of being coerced, either directly or indirectly, to act contrary to those standards. These professionals are shielded even when their actions may limit patient autonomy.

THE AUTONOMY OF COMPETENT AND INCOMPETENT PATIENTS

Patient autonomy is the cornerstone of freedom. As noted by the Supreme Judicial Court of Massachusetts in *Superintendent of Belchertown State Sch. v. Saikewicz*, for a competent patient, “[t]he value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.”²⁵ De jure, this right to autonomy does not disappear

²² Implied consent is consent that is not expressly granted by a person, but rather inferred from a person’s actions and the facts and circumstances of a particular situation.

²³ This does not include cases where the patient is in a prison and there are other state interests that must be considered. See footnote 66.

²⁴ Many living will statutes provide the option of transferring the patient if the medical provider refuses to comply with the patient’s advance directive. When this is not possible, then the medical facility will be enjoined to comply with the patient’s wishes.

²⁵ *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977) (footnote omitted). *Saikewicz* occurred shortly after *In re Quinlan*, 355 A2d 647 (N.J. 1976). Unlike in *Quinlan*, where the court relied on the guardian, physician, and ethics committee to permit the termination of life-prolonging treatment for the incompetent patient, in *Saikewicz*, the court considered the obligation to be primarily for the courts. *Saikewicz* at 434-35. Despite the strong duty to determine the interests of the incompetent patient, however, the court recognized that “the substantive rights of the competent and the incompetent person are the same in regard to the right to decline

when a patient lacks capacity.²⁶ As such, an incompetent patient does not lose his or her rights to decide the direction of medical care; rather, the patient loses the ability to express his or her rights. Therefore, the question for the courts is how to uphold the patient's interests given his or her inability to state them at present. As the Supreme Court of New Jersey has stated, "[s]ince the condition of an incompetent patient makes it impossible to ascertain definitively his present desires, a third party acting on the patient's behalf often cannot say with confidence that his treatment decision for the patient will further rather than frustrate the patient's right to control his own body."²⁷ Ambiguity in the patient's wishes creates a risk not only in achieving what the patient wants but conversely in potentially violating his or her rights if those desires are misunderstood. Since the courts can only infer what the patient wants, when interpreting his or her statements without any further clarification, the courts are more cautious in enforcing ambiguous advance directives and tend to limit the authority of the proxy for fear of getting it wrong.²⁸ The variability of the courts' standards for interpreting directives is due to the differences in how courts conceive the proper way to infer intention, given the gravity of the consequences, i.e. continued life or death.²⁹

DEVELOPMENT OF THE RIGHT TO REFUSE END-OF-LIFE CARE

The first major case dealing with withdrawal of life-sustaining treatment from an incompetent patient in which the state had to interpret the patient's unspoken wishes was *In re Quinlan*.³⁰ The patient

potentially life-prolonging treatment." *Id.* at 423. The *Saikewicz* case is therefore a good example of how the priority of autonomy is primary, yet the state, and not family or friends, must protect it.

²⁶ *In re Guardianship of Barry*, 445 So.2d 365, 370 (Fla. Dist. Ct. App. 1984) ("[T]he constitutional right of privacy would be an empty right if one who is incompetent were not granted the right to a competent counterpart to exercise his rights.") (citing *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 432 So.2d 611 (Fla. Dist. Ct. App. 1983) *Id.* *In re Colyer*, 660 P.2d 738, 744 (Wash. 1983) ("An incompetent's right to refuse treatment should be equal to a competent's right to do so. No court has denied an individual this right because of incompetency to exercise it.")

²⁷ *In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985).

²⁸ See section titled "Surrogate Decision-Making & Proxy Directives" *infra*.

²⁹ See, e.g. *In re Wendland*, 28 P.3d 151 (Cal. 2001) (Due process dictates that clear and convincing is the appropriate standard for review of a conservator's decision to withhold life-sustaining treatment because, even though Cal. Prob. Code §2355 gives the conservator exclusive authority, the conservator's exercise of decision-making power for the conservatee concerning life-sustaining treatment creates a tension between the conservatee's fundamental right to life and the conservatee's right to refuse medical treatment, and the consequences of error are grave and irrevocable.)

³⁰ Lynda M Tarantino, *Withdrawal of Life Support: Conflict Among Patient Wishes, Family, Physicians, Courts and Statutes, and the Law*, 42 BUFF. L. REV. 623 (1994);

had no hope of recovery and thus there was no medical benefit in continuing to provide treatment.³¹ In *Quinlan*, the New Jersey Supreme Court held that an incapacitated patient's constitutional right of privacy encompasses a right to refuse treatment.³² However, this right had to be balanced against other state interests, such as preserving the sanctity of life and defending the right of the physician to administer medical treatment according to his best judgment. Both of these interests allow for the protection of individual autonomy, since the former is meant to protect Karen Quinlan in case her surrogate was incorrect about her wishes, and the latter protects the physician. In Quinlan's case, the state interest in preserving life served as a counterweight to the subjective understanding of her wishes by her guardian, since it embodies a societal presumption that generally people want to live. This presumption was then weighed against the facts of Quinlan's condition. Weighing these factors and ruling that Karen Quinlan need not remain on life support, the court stated,

We think that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor, — she will never resume cognitive life. And the bodily invasion is very great, — she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube.³³

Matthew B. Hickey, *Oklahoma Advance Directive Act: Denying Choice to Those Who Cannot Choose—A Proposal for Legislative and Practical Alternatives*, 59 OKLA. L. REV. 449, 451-52 (2006).

³¹ *In re Quinlan*, 355 A2d 647, 650 (N.J. 1976). Medical benefit is generally understood as a physiological benefit through continued treatment. If there is no medical benefit to treatment, then treatment is generally understood to be futile. CAROLINE YOUNG, CYNDIE KOOPSEN, & DANIEL FARB, *END OF LIFE CARE ISSUES GUIDEBOOK* 117 (2005).

³² The Constitution does not expressly mention a right of privacy, but in *Roe v. Wade* the Supreme Court noted that “the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution.” *Roe v. Wade*, 410 US 113, 152 (1973). The *Quinlan* court addressed the right of privacy: “The right we here discuss is included within the class of what have been called rights of ‘personality.’ See *Pound*, ‘Equitable Relief against Defamation and Injuries to Personality,’ 29 Harv. L. Rev. 640, 668-76 (1916). Equitable jurisdiction with respect to the recognition and enforcement of such rights has long been recognized in New Jersey. See, e.g., *Vanderbilt v. Mitchell*, 72 N.J. Eq. 910, 919-20 (E. & A. 1907).” *In re Quinlan*, 355 A2d 647, 66 n.7 (N.J. 1976). The Quinlan court also cites several United States Supreme Court decisions, including *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Stanley v. Georgia*, 394 U.S.557, (1969); *Griswold v. Connecticut*, 381 U.S. 479 (1965), as well as referencing the New Jersey Constitution. N.J. Const. (1947), Art. I, par. 1. *Id.* at 663.

³³ *In re Quinlan*, 355 A2d 647, 664 (N.J. 1976).

After *Quinlan*, despite the New Jersey court's reliance on the constitutional right of privacy, most courts relied on the common law doctrine of informed consent as the basis for the right to refuse treatment in end-of-life cases,³⁴ although a few relied on both principles.³⁵

In the 1970s, there was still a measure of uncertainty about the enforceability of advance directives since the constitutional right to refuse treatment had not yet been firmly established.³⁶ Therefore, states began to enact legislation that formally recognized advance medical decision-making.³⁷ In 1976 California was the first state to enact an advance directive statute.³⁸ Titled the Natural Death Act (hereinafter, the "Act"), the Act's purpose was to legitimize living wills and give security to the enforceability of advance directives.³⁹ Barry Keene, the Act's author explained the Act's importance:

Conceived in the belief that the judiciary does not guarantee a timely and convenient forum to protect the rights of the dying at the time when they are systematically and deliberately stripped of their autonomy, the Act offers a procedure to enable the terminally ill patient to exercise control over decision-making relating to his medical treatment.⁴⁰

The statute was thus enacted to provide assurance for patient autonomy. Other states followed suit, using the California statute as a model.⁴¹

³⁴ *In re Storar*, 420 N.E.2d 64, 70 (N.Y. 1981); *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985). The right to refuse treatment is a corollary of the right to exercise informed consent for medical treatment. The common law requirement for informed consent is based on the statement by Justice Cardozo, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

³⁵ *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424, 435 (Mass. 1977). The benefit of establishing a constitutional basis for the right to refuse treatment through the right of privacy and not rely solely on the common law basis is that states are no longer able to pass legislation that would undermine the right to refuse treatment. Also, in cases where the patient is not competent, the common law right to refuse treatment may not be recognized. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

³⁶ ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* 7-20 (3d ed. 2004).

³⁷ THE PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 6, at 59.

³⁸ George J. Annas, *The Health Care Proxy and the Living Will*, 324 NEW ENG. J. MED. 1210, 1210 (1991).

³⁹ The Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-95 (repealed 2000).

⁴⁰ Barry Keene, *The Natural Death Act: A Well-Baby Check-Up on its First Birthday*, 315 ANNALS N.Y. ACAD. SCI. 376, 376 (1978).

⁴¹ NANCY S. JECKER ET AL., *BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE* 484 (2d ed. 2007).

The next major end-of-life case advancing the “right to die” debate was *Cruzan v. Director, Missouri Department of Health*.⁴² Before the dispute reached the United States Supreme Court, the Missouri Supreme Court held that medical nutrition could not be withdrawn from a patient in a permanent vegetative state unless there was an advance directive that was written in accordance with the state’s living will statute or there was “clear and convincing” evidence that the patient intended to decline the treatment.⁴³ Also, because the patient was neither terminally ill nor suffering, the court found that there was no reason to act contrary to the state’s interest in preserving life, since the interest in preserving life does not consider the quality of life preserved.⁴⁴ The Missouri Supreme Court recognized that there was a right to refuse treatment grounded in the common-law doctrine of informed consent, but expressed skepticism about its application in this case.⁴⁵ The Court also denied that there was a right to refuse treatment grounded in the right of privacy in its State Constitution and doubted whether such a right existed under the United States Constitution.⁴⁶ The appeal to the United States Supreme Court asserted that there is a constitutional right to refuse treatment grounded in the right of privacy, and that Missouri’s clear and convincing evidence standard was so high that it violated a patient’s constitutional right to refuse treatment.⁴⁷ In his opinion in *Cruzan*, Chief Justice Rehnquist wrote, “[b]ut for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”⁴⁸ This expanded the right to refuse treatment by giving support to the notion that refusing treatment is a constitutional right rather than solely a common law right, and, as a constitutional right, it would be secure against any possible reversal by statute. However, it also held that the Missouri’s clear and convincing evidence standard was not unconstitutional.⁴⁹ The Supreme Court stated,

Whether or not Missouri’s clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and

⁴² *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

⁴³ *Cruzan v. Harmon*, 760 S.W.2d 408, 424-26 (Mo. 1988).

⁴⁴ *Id.* at 419, 424.

⁴⁵ *Id.* at 416-17.

⁴⁶ *Id.* at 417-18.

⁴⁷ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 280 (1990).

⁴⁸ *Id.* at 279.

⁴⁹ *Id.* at 282-85.

preservation of human life, and there can be no gainsaying this interest. . . .

But in the context presented here, a State has more particular interests at stake. The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.⁵⁰

In *Cruzan*, the Supreme Court recognized that the choice to refuse medical treatment is deeply personal, but it affirmed the clear and convincing evidence standard based on its recognition of the risks involved in surrogate decision-making.⁵¹ The Court reasoned that an erroneous decision to continue care results in maintaining the status quo, yet an erroneous decision to withdraw life-sustaining treatment would be a mistake that cannot be corrected.⁵² The Supreme Court's decision thus bolstered individual autonomy by opening the door to considering that the right to refuse treatment is encompassed in the constitutional right of privacy; yet it decided that only clear and convincing evidence could substantiate the choice to exercise that right.⁵³

Immediately after the Supreme Court's ruling in *Cruzan*, Congress sought to reduce the problems associated with terminating life-sustaining treatment by mandating increased communication between patients and their health care providers.⁵⁴ It passed the Patient Self-Determination Act of 1990, requiring health care providers to give information to patients regarding advance medical directives, institutional protocols, and current state laws.⁵⁵ The requirement of increased communication between patients and medical professionals was meant to avoid potential ambiguity so that the exercise of patients' rights would not be limited. The Act also was seen by Congress as an attempt to bolster the rights of patients in health care decision-making. During a Senate finance subcommittee meeting, U.S. Representative Sander M. Levin, who sponsored the bill, outlined the bill's importance:

As I see it, this bill is about empowerment, not empowerment of the State, but empowerment of the individual. Without knowl-

⁵⁰ *Id.* at 280-81.

⁵¹ *Id.* at 281.

⁵² *Id.* at 283.

⁵³ *Id.* at 284.

⁵⁴ Michael A. Salatka, *The Patient Self-Determination Act of 1990: Issues Regarding the Facilitation of Advance Directives, Patient Autonomy, Assisted Suicide, and Euthanasia*, 1 J. PHARMACY & L. 155, 155-56 (1992).

⁵⁵ Omnibus Budget Reconciliation (Patient Self-Determination) Act, 42 U.S.C. § 1395cc (f) (2012).

edge there is no power. And what this bill in the Senate and in the House attempts to do is capacitate people in terms of periods of incapacitation by providing them knowledge, informing them, and making certain that their wishes are noted in a useful way on the record.⁵⁶

The Act was also meant to provide greater autonomy to incompetent patients by providing statutory affirmation to the common law right to refuse treatment.⁵⁷

Today, every state has advance directive legislation of one kind or another,⁵⁸ which provides for the ability of patients to execute either a living will, an appointment of a health care proxy, or a combination of both.⁵⁹ New York does not have a living will statute but it does have the Health Care Proxy law.⁶⁰ Despite the absence of a living will statute, New York's courts have consistently upheld the right of an adult to forego medical treatment when there is evidence that the individual demonstrated this intent when he or she had capacity to make decisions.⁶¹ Advance directive statutes are not meant to replace the legitimacy of advance directives under the common law,⁶² yet the requirements of a state's statute at times ends up limiting the common law legitimacy of advance directives.⁶³

⁵⁶ Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249, 256-57 (1997).

⁵⁷ RONALD W. SCOTT, LEGAL ASPECTS OF DOCUMENTING PATIENT CARE FOR REHABILITATION PROFESSIONALS, 137 (3d ed. 2006).

⁵⁸ Even though advance directives can be used to dictate the administration of treatment to incompetent patients as well, this article focuses primarily on their use as a means to forego treatment. With the exception of statutes permitting the appointment of a health care agent, most medical advance directive statutes limit the use of advance directives to end-of-life decision-making by making them applicable only to patients who are terminally ill or in persistent vegetative states.

⁵⁹ Statutory advance directives are written statements made by patients that accord with the state statute; however, the law also recognizes oral declarations and written documents that do not completely accord to state statute as either a valid advance directive or as an indication of the wishes of the patient.

⁶⁰ N.Y. PUB. HEALTH LAW §§ 2980-2994 (McKinney 2014). While New York does not have a statute governing living wills, in *O'Connor*, the New York Court of Appeals recognized the validity of living wills so long as they provide "clear and convincing" evidence of the individual's wishes. *In re O'Connor*, 531 N.E.2d 607, 613-14 (N.Y. 1988). See footnote 6 for an explanation of the difference between a living will and a proxy directive.

⁶¹ *O'Connor* at 531 N.E.2d at 613-614.

⁶² *Camp v. White*, 510 So.2d 166, 169-170 (Ala. 1987); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

⁶³ In *Ross v. Hilltop Rehab. Hosp.* the court wrote, "Plaintiff asserts this case involves the 'relatively straightforward legal question: Without court authorization, may a hospital or treating physician unilaterally override the medical treatment decisions made by a competent and informed patient?'" (Plaintiff's memorandum in support of motion, p. 1.) We disagree. The legal issues involved in this case are far more complicated than posited

THE STATE'S INTEREST OF PROTECTING THE AUTONOMY
OF THE INDIVIDUAL

Although courts recognize the right to forgo life-sustaining treatment, it is not considered an absolute right. Rather, when courts weigh the legitimacy of a decision to forgo life-saving treatment, patients' rights are balanced against certain state interests.⁶⁴ These interests, however, are considered only when there is ambiguity as to what an incompetent patient wishes.⁶⁵ Therefore, it would be more accurate to say that, when a patient's wishes are unclear, giving effect to those wishes is limited by the considerations that are presumed the individual would have. These presumptions are then weighed against the individual's statement(s) to infer what his or her autonomous choice would be if competent. This process is similar to the way in which the courts demarcate the boundaries of proxy decision-making, since in both cases it is a matter of putting another in the patient's place.

The state interests which the courts usually consider are: (1) preservation of life; (2) prevention of suicide; (3) protection of third parties; and (4) the ethical integrity of the medical profession.⁶⁶ While the first two interests are meant to protect the patient's autonomy, the latter two are meant to protect the autonomy of the patient's dependents and the physician. The general position with which the courts begin analysis is that individual interests are given priority over state interests in end-of-life cases.⁶⁷ However, if the state has a compelling

by plaintiff. The causes of action before us involve claims under Section 1983 and the Rehabilitation Act. Resolution of these claims involves determining the liability of a medical facility and physician under Section 1983 and the Rehabilitation Act for treating a patient who has requested termination of medical treatment when they have serious doubts as to the patient's mental capacity." *Ross v. Hilltop Rehab. Hosp.*, 676 F.Supp. 1528, 1530 (D. Colo 1987).

⁶⁴ *Gray v. Romeo*, 697 F.Supp. 580, 588 (D. R.I. 1988); *see also Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990).

⁶⁵ *Woods v. Kentucky*, 142 S.W.3d 24 (Ky. 2004).

⁶⁶ *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977). Another state interest is in the charitable and humane care of a patient. *See McKay v. Bergstedt*, 801 P.2d 617, 621 (Nev. 1990). Courts have also addressed state interests that may affect a patient's right to refuse life-sustaining treatment, including relevant state interests when the patient is a prisoner. Such interests include the preservation of internal order and discipline, the maintenance of institutional security, and the rehabilitation of prisoners. *Commissioner of Correction v. Myers*, 399 N.E.3d 452, 457 (Mass. 1979); *Thor v. Superior Court*, 855 P.2d 375, 369-70 (Cal. 1993). When refusal is a form of protest or an attempt to manipulate the system, the state interest will override patient autonomy. *Commissioner of Correction v. Myers*, 399 N.E.3d at 454, 457-58. When refusal is a sincere expression of a patient's right to bodily integrity, then the prisoner's right to refuse treatment will prevail.

⁶⁷ *See* footnote 18.

interest to override the expressed interests of the individual, then he or she will not be allowed to refuse treatment.⁶⁸ When a patient is competent, on the other hand, his or her right to forgo life-sustaining treatment overrides state interests to the contrary, regardless of prognosis, yet it may still be limited by the state interest in protecting third parties.⁶⁹

The state interest of preservation of life encompasses two separate but related concerns, namely, an interest in preserving the life of the particular patient and an interest in preserving the sanctity of life in general.⁷⁰ It is the most significant of the four state interests that the courts use to balance against an individual's right to refuse treatment.⁷¹ The Missouri Supreme Court held in *Cruzan* that the state's

⁶⁸ This was not always the case. In *Quinlan*, the New Jersey Supreme Court marked the balance and the underlying presumption as follows: "We think that the State's interest Contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest." *In re Quinlan*, 355 A2d 647, 664 (N.J. 1976). Because her prognosis was very poor and the bodily invasion required was great, the court recognized her right to withdraw treatment. *Id.* The implication is that the State's interests are primary and only when they weaken does the right of privacy grow. If the balance between prognosis and bodily invasion shifted, the state interest in preserving life might have overridden her right to refuse treatment.

⁶⁹ See *Public Health Trust v. Wons*, 541 So.2d 96, 97-98 (Fla. 1989) (It appears that, generally speaking, the courts have held that a fully competent adult patient may refuse on religious or other grounds to receive a lifesaving blood transfusion, even where the patient has minor children whom he supports, so long as these children will be adequately cared for in the event the patient dies. This result is, of course, different where the patient is not competent because of her medical condition to make a decision on the matter and is the mother of a minor child, or where the refusal to administer the blood transfusion would result in the death of the patient's unborn child, or where the minor children involved would be abandoned in the event of the patient's death.) See also *Winthrop Univ. Hosp.*, 490 N.Y.S. 2d 996, 997 (N.Y. Sup. Ct. 1985) quoting *In re President & Dirs. Georgetown Coll. Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964) "The State, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient has a responsibility to the community to care for her infant. Thus the People have an interest in preserving the life of a mother." This does not include complicated questions where pregnant women are refusing treatment. Those questions include an additional question over the status of the fetus. *In re Jobes*, 529 A.2d 434, 451 (N.J. 1987); *Thor v. Superior Court*, 855 P.2d 375, 387 (Cal. 1993); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304-05 (Cal. Ct. App. 1986); *Public Health Trust v. Wons*, 541 So.2d 96, 97-98 (Fla. 1989); *St. Mary's Hosp. v. Ramsey*, 465 So.2d 666, 667-69 (Fla. Dist. Ct. App. 1985); *Harrel v. St Mary's Hosp.*, 678 So.2d 455, 457 (Fla. Dist. Ct. App. 1996); *Shine v. Vega*, 709 N.E.2d 58, 63-65 (Mass. 1999); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *Fosmire v. Nicoleau*, 552 N.E.2d 77, 80-84 (N.Y. 1990); *In re Conroy*, 486 A.2d 1209, 1222-26 (N.J. 1985); *In re Browning*, 568 So.2d 4, 11-14 (Fla. 1990).

⁷⁰ *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985).

⁷¹ *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985); *Public Health Trust v. Wons*, 541 So.2d 96, 100 (Fla. 1989); *Delio v. Westchester Cnty. Med. Ctr.*, 516 N.Y.S.2d 677, 691 (N.Y. App. Div. 1987).

interest in preservation of life does not entail a judgment about the quality of an individual's life. It stated,

[I]t is tempting to equate the state's interest in the preservation of life with some measure of quality of life. . . . some courts find quality of life a convenient focus when justifying the termination of treatment. But the state's interest is not in quality of life. The broad policy statements of the legislature make no such distinction; nor shall we. Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified.⁷²

The state's interest in the sanctity of life, as the statement above attests, serves to protect individuals from being coerced into terminating treatment. Quality of life, however, oftentimes does become a factor, albeit under a different name, as when courts consider patients in permanent vegetative states or who have hopeless prognoses.⁷³ When the patient's condition is incurable or the patient's life is near its natural end, the state's interest to preserve life greatly diminishes. In such situations courts distinguish between evaluating quality of life and the diminishing state interest in preserving life in light of the patient's condition. Courts can view the invasiveness of the treatment as so extraordinary that it should be overridden in favor of the patient's interest in refusing care.⁷⁴ The Missouri Supreme Court in

⁷² *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988).

⁷³ Uniform Rights of the Terminally Ill Act (1989) §11 (a); *In re Gordy*, 658 A.2d 613, 618-19 (Del. Ch. 1994); *Woods v. Kentucky*, 142 S.W.3d 24, 50-51 (Ky. 2004); *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017, 1023 (Mass 1991); *McKay v. Bergstedt*, 801 P.2d 617, 621-25 (Nev. 1990); *Ragona v. Preate*, 6 Pa. D. & C.4th 202, 214-15 (Pa. Lackawana County Ct. 1990); *In re Ingram*, 689 P.2d 1363, 1371-72 (Wash. 1984); *Newmark v. Williams*, 588 A.2d 1108, 1117-20 (Del. 1991); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So.2d 921, 924 (Fla. 1984); *Barber v Superior Court*, 195 Cal. Rptr. 484, 492-93 (Cal. Ct. App. 1983).

⁷⁴ *In re Quinlan*, 355 A2d 647 (N.J. 1976) (A person has a right of privacy grounded in the Federal Constitution, U.S. Const. amend. XIV, to terminate treatment. Recognizing that this right is not absolute, however, courts balance it against asserted state interests. The state's interest weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981) (The court has the power, upon request of a duly appointed committee, to order termination of extraordinary life-sustaining treatments being administered to a person whose affliction has rendered him permanently comatose and, therefore, unable to make an intelligent and articulate choice with respect to continuation of the treatments.); *Woods v. Kentucky*, 142 S.W.3d 24 (Ky. 2004) (The explicit wishes of an incompetent patient regarding extraordinary life-prolonging treatment should be respected if expressed, while competent. Wishes expressed in a written document, i.e., a living will, provide the clearest evidence of a person's desire. A patient's own written declaration or designation of proxy creates a rebuttable presumption of a patient's wishes. A living will is persuasive evidence of an incompetent patient's intent and is entitled to great weight. A living will is one of several types of evidence of person's wishes against extraordinary life-sustaining treatment. It is reasonable

Cruzan added, “[t]his focus on the extraordinary/ordinary dichotomy provided a ready standard by which the patient’s interest could be assessed in a constitutional sense against the state’s interest in life.”⁷⁵

The reliance on the distinction between extraordinary and ordinary care has its origin in Catholic moral theology.⁷⁶ According to the traditional understanding of the dichotomy, ordinary care is always morally obligatory. Because of the potential burden to the patient and/or the community, extraordinary care is not morally obligatory. However, the distinction between ordinary and extraordinary treatment has changed since *Cruzan*, corresponding to the increase in the priority of individual autonomy.

The U.S. President’s Commission for the Study of Ethical Problems in Medicine and Behavioral Research currently defines extraordinary treatment as that which, in the patient’s view, entails significantly greater burdens than benefits and is therefore undesirable.⁷⁷ Ordinary treatment is that which, in the patient’s view, produces greater benefits than burdens, making it reasonable and thus morally required.⁷⁸ These definitions remove the burden of determining whether care is ordinary or extraordinary from the physician or from society and place it on the patient. The result, however, is that the definitions have become subjective and without common meaning across society. Since today the state no longer has a societal definition with which to balance the two sides, the weight of the right to refuse treatment will be even greater vis-à-vis state interest to preserve life.

When the patient’s condition is curable or the patient is not terminally ill, the weight of the state’s interest to preserve life increases. For example, in *Mack v. Mack*, the Court of Appeals of Maryland held that nutrition and hydration could not be withheld from a patient

for courts to employ a rebuttable presumption that a living will represents a competent individual’s informed preferences. Unequivocal oral statements also carry great weight. Such statements are admissible under Ky. R. Evid. 803(3), the state-of-mind exception to the hearsay rule, because the statement relates to future intent, not to a fact remembered.)

⁷⁵ *Cruzan v. Harmon*, 760 S.W.2d 408, 421 (Mo. 1988).

⁷⁶ *Nutrition and Hydration: Moral Considerations: A Statement of the Catholic Bishops of Pennsylvania* (Revised 1999), PENNSYLVANIA CATHOLIC CONFERENCE, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2191.page> (last visited Mar. 1, 2016).

⁷⁷ PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 88 (Mar. 1983) <http://kie.georgetown.edu/nrcbl/documents/pcemr/decidingtoforego-tx.pdf>.

⁷⁸ *Id.*

in a persistent vegetative state who was not terminally ill.⁷⁹ The court concluded its decision:

[U]nless and until current public policy, as we perceive it, is changed by the General Assembly, sustaining Ronald [Mack] and other persons like him, whose desires concerning the withdrawal of artificial sustenance cannot clearly be determined, is a price paid for the benefit of living in a society that highly values human life.⁸⁰

Yet this statement must be read against the backdrop of the conflicting and non-definitive testimony of what Ronald W. Mack had stated eight years before.⁸¹ Therefore, evidence of his wishes were inconclusive and ambiguous.⁸²

Though courts mention prevention of suicide as a state interest,⁸³ it is oftentimes summarily dismissed since the courts do not consider forgoing treatment to be suicide.⁸⁴ Courts reason that a patient who desires to terminate treatment does not want to kill himself or herself;⁸⁵ rather, the desire is only to avoid the suffering or indignity of living on life-sustaining equipment,⁸⁶ even if death is an ultimate consequence.⁸⁷

⁷⁹ Mack v. Mack, 618 A.2d 744, 746 (Md. 1993). There is no ethical or legal difference between withdrawing or withholding a medical therapy, which includes mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

⁸⁰ *Id.* at 761.

⁸¹ *Id.* at 748.

⁸² *Id.* at 748.

⁸³ Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977). Though committing suicide and attempted suicide is no longer treated as a crime in common law, many jurisdictions still have anti-suicide legislation as well as statutes making the providing to another of the means for taking one's own life a crime. There are also statutes prohibiting causing or inciting another to commit suicide.

⁸⁴ Satz v. Perlmutter, 362 So.2d 160, 163 (Fla. Dist. Ct. App. 1978); *In re Farell*, 529 A.2d 404, 411 (N.J. 1987); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225-26 (Cal. Ct. App. 1984); *McConnell v. Beverly Enters-Conn.*, 553 A.2d 596, 605, 608-09 (Conn. 1989); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 638 (Mass. 1986); *Eichner v. Dillon*, 426 N.Y.S.2d 517, 544 (N.Y. App. Div. 1980); *Leach v. Akron Gen. Med. Ctr.*, 68 Ohio Misc.1, 10 (Ohio Ct. Com. Pl. 1980); *Ragona v. Preate*, 6 Pa. D. & C.4th 202, 215 (Pa. Lackawana County Ct. 1990); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985); see Uniform Rights of the Terminally Ill Act (1989).

⁸⁵ *Vacco v. Quill*, 521 U.S. 793, 801-06 (1997); *Washington v. Glucksberg*, 512 U.S. 702 (U.S. 1997); *Sampson v. State*, 31 P.3d 88 (Alaska 2001); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225-26 (Cal. Ct. App. 1984); *McConnell v. Beverly Enters-Conn.*, 553 A.2d 596, 608-09 (Conn. 1989); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 638 (Mass. 1986).

⁸⁶ *Thor v. Superior Court*, 855 P.2d 375, 385 (Cal. 1993); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 720 (Conn. Super. Ct. 1984); *McKay v. Bergstedt*, 801 P.2d 617, 625-27 (Nev. 1990).

⁸⁷ *In re Quinlan*, 355 A.2d 647 (N.J. 1976); *Donaldson v. Lungren*, 4 Cal. Rptr.2d 59 (Cal. Ct. App. 1992); *McKenzie v. Doctors' Hosp. of Hollywood*, 765 F.Supp. 1504 (S.D.Fl.

This semantic shift is important because it allows the court to rely on the moral principle of double effect. The principle of double effect was originally developed by natural law theorists, and posits that a person may perform an act that has the potential for evil if the following four conditions are met: (a) the nature of the act is itself good, or at least morally neutral; (b) the agent intends the good effect and not the bad; (c) the bad is not a means to the good; (d) the good effect outweighs the bad effect in circumstances sufficiently grave to justify causing the bad effect and the agent exercises due diligence to minimize the harm. The principle allows for an act to be considered moral based on the intentions of the actor, even if its moral benefit would be less clear if viewed from a consequentialist perspective. The courts' reliance on the moral principle of double effect is further demonstrated by the fact that removal of a respirator without consent is treated as homicide.⁸⁸ Moreover, most, if not all, advance directive statutes specifically provide that the death of a patient refusing life-sustaining treatment in conformity with an advance directive does not constitute suicide or homicide.⁸⁹ The state's interest in preventing suicide includes an interest in avoiding undue influence for suicide and euthanasia.⁹⁰

1991); *Deel v. Syracuse Veteran's Admin. Med. Ctr.*, 729 F.Supp. 231, 232 (N.D.N.Y. 1990); *McConnell v. Beverly Enters-Conn.*, 553 A.2d 596, 605 (Conn. 1989); *Krischer v McIver*, 697 So.2d 97 (Fla. 1997); *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017 (Mass 1991); *In re Doe* 583 N.E.2d 1263 (Mass. 1992); *but see Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (Scalia, J., concurring).

⁸⁸ Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URB. L.J. 817, 846–48 (1997); David Orentlicher, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 447–48 (1997).

⁸⁹ NANCY M. P. KING, *supra* note 18, at 59-60 (rev. ed. 1996); *See also In re Colyer*, 660 P.2d 738, 751 (Wash. 1983) (The withdrawal of life sustaining treatment from an incurably ill patient does not constitute homicide if it is accomplished in good faith compliance with judicially imposed safeguards).

⁹⁰ In *Sanderson v. People*, 12 P.3D 851, 852 (Colo. Ct. App. 2000), the plaintiff wanted to execute an advance directive authorizing his wife to end his life in the event that his medical condition was hopeless, and he sought a declaratory judgment to assure that neither his wife nor the physician would be subject to criminal liability if they acted in accordance with the advance directive. The court ruled that the prohibition against euthanasia overrode the ability to rely on the free exercise clause of the First Amendment. The Supreme Court has also demonstrated an inclination towards preserving life over that of respecting individual autonomy in several decisions addressing physician-assisted suicide. For example, in *Washington v. Glucksberg*, the court stated that when the underlying reason for a person's desire to commit suicide is depression, treatment of the depression would be a better remedy than suicide. *Washington v Glucksberg*, 512 U.S. 702, 730-31 (1997). In effect, the court adopted the position of the medical community that the desire to commit suicide is often caused by a mental illness such that the physician has a duty to heal the person under implied consent. *Id.* at 730. In *Sampson v. State*, the Supreme Court of Alaska held that, while the statute prohibiting assisted suicide interfered with a person's liberty as guaranteed by the Alaska Constitution, it nevertheless served a

The interest in protecting third parties is usually relevant when there are interests of minor children who might incur emotional or financial loss if a parent refuses treatment. The courts will also give greater weight to state interests if a patient's prognosis is good and overriding the advance directive would prevent minors from becoming wards of the state.⁹¹ This interest might be employed even when the parent is competent.⁹² For example, the Supreme Court of New Jersey stated, "[w]hen the patient's exercise of his free choice could adversely and directly affect the health, safety, or security of others, the patient's right of self-determination must frequently give way."⁹³ This interest is based on the idea of individual liberty attributed to Oliver Wendell Holmes, Jr. but penned by Zechariah Chafee, "[y]our right to swing your arms ends just where the other man's nose begins."⁹⁴ It also is grounded in the principle of *parens patriae*, i.e. the state's obligation to intervene and to act as the parent of any child or individual who is in need of protection.

The state interest in maintaining the ethical integrity of the health professions is meant to defend the choice of a medical professional to act based on his or her profession's ethos and standards. While maintaining the ethical integrity of the health professions had been a strong state interest and was pitted against an individual patient's right to refuse treatment in the early end-of-life cases, it is the least influential interest of the four state interests that courts usually consider,⁹⁵ and it has continued to be significantly weakened.⁹⁶ Its decline in promi-

legitimate governmental purpose. *Sampson v. State*, 31 P.3d 88, 95-96 (Alaska 2001). Moreover, if the court permitted assisted suicide for competent patients, it might provide an opening to allow it for incompetent patients who have an advance directive. *Id.*

⁹¹ *In re Dubreuil*, 603 So. 2d 538 (Fla. Dist. Ct. App. 1992) (The Court authorized a hospital and its attending physicians to perform blood transfusions on petitioner's mother, notwithstanding that she was a Jehovah's Witness and had refused the transfusions. The District Court affirmed the Trial Court's decision because the state's interest in protecting her four minor children from abandonment in the event of her death outweighed her wishes. However, the Supreme Court of Florida in a 5:2 decision overruled the District Court's decision. *In re Dubreuil* 629 So. 2d 819 (Fla. 1993). The Hospital on behalf of the state failed to satisfy the heavy burden required to override the patient's constitutional right to refuse medical treatment).

⁹² *In re President of Georgetown Coll. Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977).

⁹³ *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985).

⁹⁴ Zechariah Chafee, Jr., *Freedom of Speech in Wartime*, 32 HARV. L. REV. 932, 957 (1919).

⁹⁵ *In re Browning*, 568 So.2d 4, 14 (Fla. 1990); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304 (Cal. Ct. App. 1986).

⁹⁶ Though, it is still used in its consideration of physician assisted suicide. In *Washington v. Glucksberg*, the court cited the American Medical Association's ("AMA") language: "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." American Medical Association, Code of Ethics § 2.211 (1994)."

nence, however, is not a result of the courts' reprioritizing the autonomy of the individual patient over that of the medical professional. Rather, it is due to the changing ethics of the medical profession itself. Ethical standards have migrated, from being paternalistic and valuing sustaining the life of a patient over all else, to one that balances the value of sustaining life with the value of deferring to the preferences of a patient.⁹⁷ For example, courts have cited the American Medical Association's Code of Ethics to justify a changing stance on the ethical integrity of the profession vis-à-vis withholding and withdrawing treatment.⁹⁸ As the medical profession is part of the greater society, the shift in medical ethics reflects the broader shift in civil society's values to prioritizing individual autonomy over the sanctity of life and its move away from moral theology to a more secularized medical ethics.

The courts also take account of the conscientious objection of individual medical professionals or institutions.⁹⁹ Inclusion of conscientious objection in maintaining the ethics of the profession is based on a physician's permission to act within the realm of conscience when

Washington v Glucksberg, 512 U.S. 702, 731 (1997). Similarly, in *Vacco v. Quill*, the court cited the AMA position on physician-assisted suicide to distinguish it from the withholding and withdrawing of treatment. *Vacco v. Quill*, 521 U.S. 793, 799 n.6 (1997).

⁹⁷ *In re Colyer*, 660 P.2d 738, 743-44, 749-50 (Wash. 1983).

⁹⁸ *AMA Code of Medical Ethics, Opinion 2.20 – Withholding or Withdrawing Life-Sustaining Medical Treatment*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.page?> (last visited Mar 1, 2016). The opinion was issued in 1984. See *In re Guardianship of L.W.*, 482 N.W.2d 60 (Wis. 1992) "The state's interest in protecting the integrity of the medical profession is not implicated in this case. . . . Their [L.W.'s physicians] actions were consistent with current medical ethics in so far as approval was sought and given by the Bioethics Committee of Franciscan Health System. *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* 2.18, 'Withholding or Withdrawing Life-Prolonging Medical Treatment' (1986); *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 *Neurology* 125 (1989). Thus a decision to withhold or withdraw treatment will not impugn the integrity of the profession. Indeed, the existence of a protected right to refuse treatment for all individuals competent or incompetent may in a sense protect the integrity of the medical profession. In the absence of such a protected right, physicians may be discouraged from attempting certain life-sustaining medical procedures in the first place, knowing that once connected they may never be removed. *Conroy*, 98 N.J. at 370, 486 A.2d at 1234. The existence of this right will prevent premature and rash decisions to allow a patient to die, and will remove the potential conflict for the medical profession between ordinary compassion and the Hippocratic Oath." *Id.* at 91. See also *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988); *Woods v. Kentucky*, 142 S.W.3d 24, 50-51 (Ky. 2004); *In re Estate of Prange*, 166 Ill. App. 3d 1091 (Ill. App. Ct. 1988) (judgment in the case was vacated and the opinion was withdrawn by order of the Illinois Supreme Court.).

⁹⁹ *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 639-40 (Mass. 1986); *Gray v. Romeo*, 697 F.Supp. 580, 590-91 (D. R.I. 1988); *In re Morrison v. Abramovice*, 253 Cal. Rptr. 530, 534-35 (Cal. Ct. App. 1988); *In re Requena*, 517 A.2d 886 (N.J. Super. Ct. Ch. Div. 1986).

personal views differ from that of patients.¹⁰⁰ In these cases, courts have tried to accommodate the conflicting views of patients and health care providers by requiring the patient to be transferred to another facility, rather than by forcing the health care provider to act against his or her conscience.¹⁰¹ However, in a few cases medical professionals have been required to comply with the patient's wishes when no other facility for transfer was available.¹⁰² This accommodation, however, is not unique to the courts; most advance directive statutes recognize the right of health care providers not to comply with patients' wishes due to conscience, yet all note that reasonable efforts must be made to find a transfer facility.¹⁰³

SURROGATE DECISION-MAKING & PROXY DIRECTIVES

Even though the common law confers on all patients the right to make their own health care decisions, originally surrogates could only act on behalf of incompetent patients when there was clear and convincing evidence of their wishes from before he or she became incompetent.¹⁰⁴ The authority of surrogates has expanded over time, either by statute or judicial interpretation.¹⁰⁵ Today, since there is no uniform national standard, a surrogate's decisional authority is determined by the prevailing standard in the given state.¹⁰⁶ Each standard of surrogate decision-making rests on a balance between patient autonomy and the risk of violating that autonomy.

The most stringent standard is the demand that the surrogate have express knowledge of the patient's actual wishes; this is called

¹⁰⁰ Lois Snyder, *American College of Physicians Ethics Manual: Sixth Edition*, 156 ANNALS INTERNAL MED. 73, 82 (2012).

¹⁰¹ *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 639-40 (Mass. 1986). Indiana even allows for refusal not based on conscience; see Illinois 745 ILCS 70/1-14). See also Patient Self-Determination Act 42 USCA 139(w)(3).

¹⁰² *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987).

¹⁰³ ROBERT POWELL CTR. FOR MED. ETHICS, WILL YOUR ADVANCE DIRECTIVE BE FOLLOWED? 8 (rev. ed. 2015), <http://www.nrlc.org/uploads/medethics/WillYourAdvanceDirectiveBeFollowed.pdf>. See above for individual state statutes regarding the requirement of making reasonable effort to find a transfer facility. *Id.* at A1 – A18.

¹⁰⁴ Carol Ann Colabrese, *In re Storar: The Right to Die and Incompetent Patients*, 43 U. PITT. L. REV. 1087 (1981).

¹⁰⁵ Some state statutes prohibit a proxy from withholding or withdrawing life-sustaining treatment under certain conditions (Alaska, Delaware, Florida, Tennessee, West Virginia), and others limit a proxy's authority to make decisions (Delaware, Georgia, Illinois, Michigan, Nevada, New Jersey, New York, Oregon, Virginia, West Virginia).

¹⁰⁶ Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-to-Die Jurisprudence*, 25 U. MICH. J. L. REFORM 133, 135-36 (1991); Roach argues for uniformity among state laws. *Id.* at 136.

the subjective standard.¹⁰⁷ This was the sole standard adopted in 1998 by the New York Court of Appeals¹⁰⁸ before the New York Family Health Care Decisions Act of 2010.¹⁰⁹ If that standard is not met, life-sustaining treatment must be continued.¹¹⁰ The New York Court of Appeals insisted on this standard despite the possibility that the patient might have changed his or her mind without articulating the change.¹¹¹ Without such a “clear expression of a present intention to forego treatment,” withdrawal cannot be granted. In *In re O’Connor*, the New York Court of Appeals articulated the standard as follows:

But the existence of these problems does not lead inevitably to the conclusion that we should abandon the inquiry entirely and adopt as guideposts the objective factors used in the so-called “substituted judgment” approach. That approach remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient’s expressed intent, with every effort made to minimize the opportunity for error.

Every person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances. This is a demanding standard, the most rigorous burden of proof in civil cases. It is appropriate here because if an error occurs it should be made on the side of life.¹¹²

Besides New York, state courts that required this high standard in certain end-of-life cases, include California,¹¹³ Michigan,¹¹⁴ and Wis-

¹⁰⁷ RAYMOND J. DEVETTERE, PRACTICAL DECISION MAKING IN HEALTH CARE ETHICS: CASES AND CONCEPTS 211 (3d ed. 2010).

¹⁰⁸ *In re Westchester Cnty. Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988); *In re Univ. Hosp. of the State Univ. of N.Y. Upstate Med. Univ.*, 754 N.Y.S.2d 153, 157-58 (Sup. Ct. 2002); *In re Eichner*, 426 N.Y.S.2d 517, 546-47 (N.Y. App. Div. 1980).

¹⁰⁹ N.Y. Public Health Law § 2994-d (McKinney 2011) (eliminating the clear and convincing standard for clinically appropriate end-of-life decisions). Under the statute, a surrogate makes decisions based on the patient’s wishes “if reasonably known” or else based on statutory criteria.

¹¹⁰ Because this standard demands that express preferences be relevant to the particular situation at hand, advance directives which provide general instruction or which do not address the particular circumstances may not be implementable. (See *In re Westchester Cnty. Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988); *In re Univ. Hosp. of the State Univ. of N.Y. Upstate Med. Univ.*, 754 N.Y.S.2d 153, 157-58 (Sup. Ct. 2002); *In re Eichner*, 426 N.Y.S.2d 517, 546-47 (N.Y. App. Div. 1980)).

¹¹¹ *In re Westchester Cnty. Med. Ctr.*, 531 N.E.2d at 613 (N.Y. 1988).

¹¹² *Id.* (citations omitted).

¹¹³ *In re Wendland*, 28 P.3d 151, 154 (Cal. 2001) (withhold artificial nutrition and hydration from a conscious conservatee who is not terminally ill, comatose, or in a

consin.¹¹⁵ In the cases where these states held to this standard, however, the question of withholding or withdrawing life-sustaining treatment related to patients who were neither terminally ill nor in a permanent vegetative state. Missouri held to this standard in *Cruzan*, yet has subsequently adopted a substituted judgment standard.¹¹⁶ While virtually all courts recognize that the subjective standard is the ideal, many courts will consider less demanding standards when necessary, such as when a patient has not made his or her preferences clear either through an advance directive or to a proxy.¹¹⁷

As distinguished from the subjective standard, the substituted judgment standard is the predominant standard for making end-of-life decisions for incompetent patients.¹¹⁸ It was first used as a way to exercise the right of self-determination for an incompetent patient in the *Quinlan* case, where the court stated that “the only practical way to prevent destruction of the right [to terminate treatment] is to permit the guardian and family of Karen to render their best judgment. . . as to whether she would exercise it in these circumstances.”¹¹⁹ What constitutes substituted judgment varies, from demanding the surrogate infer the patient’s actual wishes¹²⁰ to demanding that he or she infer the patient’s probable wishes.¹²¹ In attempting to apply the patient’s inferred wishes, the courts have also included other factors

persistent vegetative state, and who has not left formal instructions for health care or appointed an agent or surrogate for health care decisions).

¹¹⁴ *In re Martin*, 538 N.W.2d 399, 401 (Mich. 1995) (whether life-sustaining treatment in the form of a gastrostomy tube that provides nutritive support should be removed from a conscious patient who is not terminally ill or in a persistent vegetative state, but who suffers from a mixture of cognitive function and communication impairments that make it impossible to evaluate the extent of his cognitive deficits).

¹¹⁵ *In re Edna M.F.*, 563 N.W.2d 485, 486 (Wis. 1997).

¹¹⁶ *In re Warren*, 858 S.W.2d 263, 266 (Mo. Ct. App. 1993).

¹¹⁷ *In re Estate of Longeway*, 549 N.E.2d 292, 299-300 (Ill. 1989) (Under substituted judgment, a surrogate decision-maker attempts to establish, with as much accuracy as possible, what decision the patient would make if he were competent to do so. Employing this theory, the surrogate first tries to determine if the patient had expressed explicit intent regarding this type of medical treatment prior to becoming incompetent. Where no clear intent exists, the patient’s personal value system must guide the surrogate).

¹¹⁸ Mark R. Tonelli, *Substituted Judgment in Medical Practice: Evidentiary Standards on a Sliding Scale*, 25 J. L. MED. & ETHICS 22 (1997).

¹¹⁹ *In re Quinlan*, 355 A2d 647, 664 (N.J. 1976).

¹²⁰ *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 430-32 (Mass. 1977).

¹²¹ *In re Tavel*, 661 A.2d, 1061, 1070 (Del. 1995); *In re Howe*, No. 03 P 1255, 2004 WL 1446057 at *19-21 (Mass. Prob. & Fam. Ct. Dep’t Mar. 22, 2004); The approach has been expanded to include incompetent patients who have never been competent, as was the case when the Massachusetts Supreme Judicial Court in *Superintendent of Belchertown State School* applied the standard to a severely mentally retarded individual. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d at 430-32 (Mass. 1977); but see Steven M. Richard, *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by*

that should be considered. The additional factors include the patient's age, the probable side effects of treatment, the chance of producing a cure, the likelihood that treatment will cause suffering, the patient's ability to cooperate with the treatment, the patient's reactions when others in similar situations have received medical treatment, the patient's religious beliefs, the patient's previous conduct, family opinions or sentiments, the life expectancy of patient with or without treatment, the patient's mental and physical disability, the quality of life of the patient with or without treatment, and the views of the physician.¹²² The Supreme Court of New Jersey, explained,

[u]nder the substituted judgment doctrine, where an incompetent's wishes are not clearly expressed, a surrogate decisionmaker considers the patient's personal value system for guidance. The surrogate considers the patient's prior statements about and reactions to medical issues, and all the facets of the patient's personality that the surrogate is familiar with, of course, particular reference to his or her relevant philosophical, theological, and ethical values — in order to extrapolate what course of medical treatment the patient would choose.¹²³

These additional factors should be included when implementing substituted judgment because individuals are influenced by their familial, religious, and social surroundings. Therefore, the individual's statements should be interpreted in light of his or her background.

Through the substituted judgment standard, the surrogate attempts to implement the patient's wishes as would be determined if he or she were competent to decide. Through the best interests standard, on the other hand, the patient's best interests are based on objective criteria and not on what the surrogate believes to be the wishes of the patient.¹²⁴ With respect to refusal of life-sustaining care, the New Jersey Supreme Court in *In re Conroy* was the first to articulate what constitutes the best interests standard. The court provided for two "best interests" tests, i.e. a limited-objective and a pure-objective test.

Under the limited-objective test, life-sustaining treatment may be withheld or withdrawn from a patient in Claire Conroy's situation when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that

Incompetent Patients with No Prior Expression of a Treatment Preference, 64 NOTRE DAME L. REV. 394 (1989).

¹²² MEISEL & CERMINARA, *supra* note 36, at 4-21 - 4-25.

¹²³ *In re Jobes*, 529 A.2d 434, 444 (N.J. 1987) (footnote omitted).

¹²⁴ Loretta M. Kopelman, *The Best-Interests Standard as Threshold, Ideal, and Standard of Reasonableness*, 22.3 J. MED. & PHIL. 271, 277-78 (1997).

it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him.

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or withdrawn from a formerly competent person like Claire Conroy if a third, pure-objective test is satisfied. Under that test, as under the limited-objective test, the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. Subjective evidence that the patient would not have wanted the treatment is not necessary under this pure-objective standard.¹²⁵

While the best interests standard plays a dominant role in medical decision-making outside of the context of end-of-life care, it is not very prevalent in end-of-life cases.¹²⁶ The reason for its relative absence in end-of-life cases is that it is anathema to the idea of patient autonomy. Under a best interests standard the patient (or his or her surrogate) does not determine what is best, but rather the state decides based on societal standards. Moreover, the best interest standard runs a greater risk of violating an individual's rights, since its application does not account for the individuality of the patient. The benefit of this standard attains when there is no useful indication of the patient's wishes or when the court believes that the patient must be protected.¹²⁷ Some courts, when faced with no information of an incompetent patient's preferences, have continued treatment, presuming that the patient's best interests are in continuing to live rather than withdrawing treatment.¹²⁸ For those courts that use the best interests standard when there are no indications of a patient's preferences, the starting presumption is that continued treatment is in the patient's best interest.¹²⁹ The presumption prevails because, even

¹²⁵ *In re Conroy*, 486 A.2d 1209, 1232 (N.J. 1985).

¹²⁶ The best interests standard was rejected in New Jersey in favor of a substituted judgment standard. See *In re Peter*, 529 A.2d 419, 429 (N.J. 1987); *In re Jobes*, 529 A.2d 434, 445-47 (N.J. 1987).

¹²⁷ As such, it would apply its *parens patriae* power for the sake of an incompetent patient.

¹²⁸ *DeGrella v. Elston*, 858 S.W.2d 698, 702 (Ky. 1993); *Mack v. Mack*, 618 A.2d 744, 757-61 (Md. 1993); *In re Martin*, 538 N.W.2d 399, 413 (Mich. 1995); *Cruzan v. Harmon*, 760 S.W.2d 408, 424 (Mo. 1988); *In re Westchester Cnty. Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988).

¹²⁹ Allen Buchanan and Dan Brock argue, "[t]he proper question for such patients [in a PVS] . . . is not 'Would withdrawal of life support best serve the patient's interest?' but

if one may argue that it is of no benefit to the patient to continue living, there is also no burden to the patient in continuing to live either.¹³⁰ If the patient's life would continue to be one of suffering, or if the prognosis is dire, then the presumption may be overcome.¹³¹

PROTECTING THE ETHICS OF THE MEDICAL PROFESSION

Just as the courts rely on state interests to protect the patient from enduring the consequences of a potential misrepresentation of his or her wishes, the courts also protect medical professionals when their actions are contrary to the assumed wishes of the patient. Courts grant this protection because, as the New York Court of Appeals phrases it, the error was made on the side of life.¹³² Some states provide a basis for a civil cause of action within the state's living will statutes,¹³³ yet violation of a statute in these cases does not automatically give rise to civil liability.¹³⁴ Plaintiffs have been unsuccessful in end-of-life cases that arise from unwanted treatment, despite the fact that the cases have been brought based on a number of statutory claims, such as consumer protection acts,¹³⁵ advance directive statutes,¹³⁶ surrogate decision-making statutes,¹³⁷ brain death statutes,¹³⁸ and unlawful practice of medicine statutes.¹³⁹ This is, in part, due to the fact that most states do not provide for penalties or damages when

rather "Would continued support provide any benefit?" ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 132 (1989); See also Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986).

¹³⁰ Mack v. Mack, 618 A.2d 744, 759-61 (Md. 1993); *In re Guardianship of LW*, 482 N.W.2d 60, 75 (Wis. 1992); *In re Peter*, 529 A.2d 419, 423-25 (N.J. 1987).

¹³¹ *In re Guardianship of LW*, 482 N.W.2d 60, 72-74 (Wis. 1992); *In re AB*, 768 N.Y.S.2d 256, 262, 271-72 (N.Y. Sup. Ct. 2003); *In re Warren*, 858 S.W.2d 263 (Mo. Ct. App. 1993); *In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981).

¹³² *In re Westchester Cnty. Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988).

¹³³ Saitta & Hodge, Jr., *Wrongful Prolongation of Life-A Cause of Action*, *supra* note 9. States whose statutes mention civil or criminal liability with regards to advance directives include Tennessee, Oklahoma, Texas, Virginia, Georgia, Florida, Connecticut, Arizona, Washington, New York, Nevada, Massachusetts, Louisiana, Kentucky, Mississippi, Iowa, Colorado, Wisconsin, Rhode Island, Ohio, and Nebraska. *Id.* However, the statutes are ambiguous such that they recognize the existence of advance directives while limiting the power of their enforcement. *Id.* at 227-28.

¹³⁴ RESTATEMENT (SECOND) OF TORTS §874A (1977). Also, certain state statutes shift the responsibility of disciplinary action onto the state licensing authorities.

¹³⁵ *Gragg v. Calandra*, 696 N.E.2d 1282, 1288-89 (Ill. 1998); *Spring v. Geriatric Auth. of Holyoke*, 475 N.E.2d 727, 735-36 (Mass. 1985); *Benoy v. Simons*, 831 P.2d 167, 172 (Wash. Ct. App. 1992).

¹³⁶ *Wright v. Johns Hopkins Health Sys. Corp.*, 728 A.2d 166, 175-76 (Md. 1999).

¹³⁷ *Collins v. Lake Forrest Hosp.*, 821 N.E.2d 316 (Ill. 2004).

¹³⁸ *Law v Camp*, 116 F. Supp.2d 295 (D. Conn. 2000).

¹³⁹ *Blouin v. Spitzer*, 213 F.Supp.2d 184, 196-97 (N.D.N.Y. 2002).

medical providers fail to comply with advance directives.¹⁴⁰ It is also, in part, because some state statutes give medical providers immunity even when they do not comply with a patient's advance directive if providers use their best medical judgment when making these decisions.¹⁴¹ The majority of states, however, confer immunity only when medical providers comply with directives or transfer the patient to a health care provider willing to comply.¹⁴² For those states with very narrow statutory immunity provisions, the courts, at times, will nevertheless interpret the provisions more broadly. For example, in *Stolle v. Baylor College of Medicine*, the Texas Court of Appeals interpreted the language of "failing to effectuate a qualified patient's directive" to allow for the administration of "heroic efforts" to save the patient.¹⁴³ The parents claimed that the physicians negligently disregarded instructions not to use heroic efforts or artificial means to prolong the child's life.¹⁴⁴ The Court's reasoning was that if the child had been in a terminal condition, she could be a "qualified patient" and the physicians would be immune under Tex. Health & Safety Code Ann. §672.016 (b).¹⁴⁵ However, if the child was not in a terminal condition, then the condition for withholding life-sustaining procedures contained in the "Directive to Physicians" was not met.¹⁴⁶ In effect, either way one looks at the case, the physicians had immunity.

¹⁴⁰ The exceptions are Alaska, Mississippi, Nebraska, Rhode Island, Tennessee. Some states provide a criminal penalty for noncompliance (Arkansas, California, Montana, Nebraska, Nevada), while others relegate disciplinary action to the licensing authorities (Montana, New Jersey, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, West Virginia Wisconsin).

¹⁴¹ These statutes seem superfluous since the courts already refuse to recognize a common law cause of action for wrongful living. Since there is no civil or criminal liability, there is no need for the statute. See OKLA. STAT. TIT. 63, §3101.10 (B) (2015); CAL. PROB. CODE §4740 (West 2015); GA. CODE ANN. §31-32-10(a)(3)(2015); NEV. REV. STAT. §449.640 (2015); MINN. STAT. §145C.11(c) (2015). Utah, did have a statutory penalty for failure to comply with a living will (Utah Code Ann. § 75-2-1112 (2004)), yet it has subsequently been repealed. Also, many living will statutes provide the option of transferring the patient if the medical provider refuses to comply with the patient's advance directive. Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 768 (1987). This option limits statutory compulsion to comply, while also providing the courts a mitigating circumstance so as not to impose penalties if transfer was not possible. *Id.* at 769. See also Saitta & Hodge, Jr., *Wrongful Prolongation of Life-A Cause of Action*, *supra* note 9.

¹⁴² See ABA, COMM'N ON LAW & AGING, MYTHS AND FACTS ABOUT HEALTH CARE DIRECTIVES, http://www.americanbar.org/content/dam/aba/migrated/Commissions/myths_fact_hc_ad.authcheckdam.pdf.

¹⁴³ *Stolle v. Baylor Coll. of Med.*, 981 S.W.2d 709 (Tex. App. 1998).

¹⁴⁴ *Id.* at 710.

¹⁴⁵ *Id.* at 713-14.

¹⁴⁶ *Id.* See also THE PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 6, at 53-91.

The California Court of Appeals ruled that a physician is granted immunity by the provisions of an advance directive statute even when he fails to comply with a request to forgo treatment.¹⁴⁷ Certain states have given greater support to patients' rights to refuse end-of-life care by making medical providers civilly or criminally liable for failure to comply with patients' wishes, yet the courts have not enforced these penalties when noncompliance leads to prolonged life.¹⁴⁸

In a number of cases plaintiffs have sued for damages in federal court, alleging that the unwanted administration of treatment violated a federally protected right, since the right to refuse treatment has been grounded in the constitutional right to privacy.¹⁴⁹ These cases have been difficult to win, since the defendants, i.e. physicians and health care institutions, were private parties acting as private citizens and not under the color of state law.¹⁵⁰ Moreover, for the claim to prevail, the defendant's actions, acting as an agent of the state, must shock the conscience of the court.¹⁵¹ Similarly, if it is objectively reasonable that the state official believed he or she was not violating a patient's rights, the doctrine of qualified immunity protects the state official from liability.¹⁵²

Plaintiffs have also attempted to rely on common law remedies for noncompliance with an advance directive. Cases in which patients seek to recover damages for receiving unwanted treatment are commonly known as "wrongful living" or "wrongful prolongation of life" suits.¹⁵³ These names, however, are a bit misleading, since "wrongful living" and "wrongful prolongation of life" are not causes of action

¹⁴⁷ Duarte v Chino Cmty. Hosp., 85 Cal. Rptr.2d 521, 524-25 (Cal. Ct. App. 1999).

¹⁴⁸ Anderson v. St. Francis – St. George Hosp., Inc., 671 N.E.2d 225 (Ohio 1996); Bowman v. Davis, 48 Ohio St. 2d 41, 45, 356 N.E.2d 496, 499 fn. 3 (1976); Johnson v. Univ. Hospitals of Cleveland, 44 Ohio St. 3d 49, 58, 540 N.E.2d 1370, 1378; Hester v. Dwivedi, 1999 Ohio App, LEXIS 595 (Ohio Ct. App., Hamilton County 1999); See also Nadia N. Sawicki, *A New Life for Wrongful Living*, 58 N.Y.L. SCH. L. REV. 279, 290-91 (2013).

¹⁴⁹ Blouin v. Spitzer, 213 F.Supp.2d 184, 190-91 (N.D.N.Y. 2002); *In re Guardianship of Chantel Nicole R.*, 821 N.Y.S.2d 194 (N.Y. App. Div. 2006).

¹⁵⁰ Wassif v. North Arundel Hosp. Assoc., Inc., 582 A.2d 269 (Md. Ct. Spec. App. 1990) but see West v. Atkins, 487 U.S. 42, 57-58 (1988).

¹⁵¹ Bartling v Glendale Adventist Med. Ctr., 229 Cal. Rptr. 360, 363-64 (Cal. Ct. App. 1986); Bendiburg v. Dempsey, 707 F. Supp. 1318 (N.D.Ga. 1989).

¹⁵² Blouin v. Spitzer, 213 F.Supp.2d 184 (N.D.N.Y. 2002).

¹⁵³ A. Samuel Oddi, *supra* note 12. "Wrongful living" as a cause of action was first proposed by Samuel Oddi. *Id.* Oddi defines the wrongful living cause of action as follows: "Whether the interfering treatment is conducted with our without due care is irrelevant, except insofar as such treatment prolongs the life of the individual contrary to the right to die. If the interfering treatment is made and the patient lives, then interference with the right to die involves compensation for living. This is a 'wrongful living' cause of action." *Id.* at 641.

but rather are concepts in damages.¹⁵⁴ The reason for considering “wrongful living” a concept in damages rather than a cause of action is based on the notion that life is a consequence of an action whose measure might be valued; the act of prolonging a patient’s life on the other hand would have to be either a breach of duty or battery. For example, the Ohio Supreme Court in *Anderson*, writes, “[i]n reality, a claim of wrongful living is a damages concept, just as a claim for ‘wrongful whiplash’ or ‘wrongful broken arm,’ and must necessarily involve an underlying claim of negligence or battery.”¹⁵⁵ The torts under which one may sue for receiving unwanted treatment are assault and battery,¹⁵⁶ intentional infliction of emotional distress,¹⁵⁷ invasion of privacy,¹⁵⁸ and negligence.¹⁵⁹ Sometimes a plaintiff may claim breach of contract.¹⁶⁰ Each of these torts is difficult to substantiate when the patient is incompetent and his or her wishes are known only through an advance directive. For example, the core cause of battery is touching without valid consent, even if the treatment is beneficial to the patient.¹⁶¹ With an incompetent patient, however, informed consent may not be straightforward as the instruction directive¹⁶² or a proxy directive¹⁶³ might be ambiguous. Even when courts

¹⁵⁴ *Anderson v. St. Francis – St. George Hosp., Inc.*, 671 N.E.2d 225, 227 (Ohio 1996); See Holly Fernandez Lynch et al., *supra* note 19, “Although courts have phrased their reluctance to allow recovery under such circumstances as a rejection of the ‘cause of action’ of wrongful living or wrongful prolongation of life, a careful reading of each court’s analysis points instead to rejection of compensation for this particular set of damages.” *Id.* at 142.

¹⁵⁵ *Anderson v. St. Francis – St. George Hosp., Inc.*, 671 N.E.2d 225, 227 (Ohio 1996).

¹⁵⁶ *Leach v. Shapiro*, 469 N.E.2d 1047, 1051-52 (Ohio Ct. App. 1984); *Bartling v Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360, 364 (Cal. Ct. App. 1986).

¹⁵⁷ *Bartling v Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360, 364-65 (Cal. Ct. App. 1986); *Gragg v Calandra*, 696 N.E.2d 1282, 1289 (Ill. 1998).

¹⁵⁸ *Leach v. Shapiro*, 469 N.E.2d 1047, 1054 (Ohio Ct. App. 1984).

¹⁵⁹ *Benoy v Simons*, 831 P.2d 167, 170 (Wash. Ct. App. 1992).

¹⁶⁰ See *Terry v. Red River Ctr. Corp.*, 862 So. 2d 1061, 1063 (La. Ct. App. 2003); *In re Spring*, 405 N.E.2d 115 (Mass. 1980); *Grace Plaza of Great Neck, Inc. v. Elbaum*, 588 N.Y.S.2d 853, 854-55 (N.Y. App. Div. 1992) (the nursing home sued for breach of contract after the husband refused to pay for services provided to his wife after he demanded the nursing home stop providing nutrition and hydration to his wife).

¹⁶¹ RESTATEMENT (SECOND) OF TORTS §905 cmt. b (1979); *Leach v. Shapiro*, 469 N.E.2d 1047, 1051-52 (Ohio Ct. App. 1984) (A physician who treats a patient without consent commits a battery, even though the procedure is harmless or beneficial.)

¹⁶² An instruction directive (a/k/a a “living will”) is a written document that specifies which treatments an individual does and does not want, in the case that that individual becomes incompetent.

¹⁶³ A proxy directive assigns the health-care decisions of an individual to another in the event the individual becomes incompetent.

recognize a battery claim, however, they are still reluctant to award damages to patients who received life-sustaining treatment.¹⁶⁴

Intentional infliction of emotional distress requires outrageous conduct by the defendant, intent to cause or reckless disregard of the probability of causing emotional distress, severe emotional suffering, and actual and proximate causation of emotional distress.¹⁶⁵ What constitutes outrageous conduct is usually considered as conduct which a reasonable member of the community would deem outrageous.¹⁶⁶ This definition creates some difficulty, since a physician acting for the purpose of saving a life is typically not seen as being outrageous.¹⁶⁷ This is compounded by the general presumption that patients desire to live, and acting under this presumption falls within the professional standard.¹⁶⁸

The general tort of invasion of privacy has four particular torts within it: intrusion upon seclusion, appropriation of name or likeness, publicity given to private life, and publicity placing a person in a false light, none of which can easily incorporate a right to refuse end-of-life care.¹⁶⁹ Moreover, the ability to bring an action for violation of privacy must be brought while the patient is still living.¹⁷⁰ Plaintiffs have brought claims for violation of privacy, whereby the right of privacy is grounded in the constitutional right, yet plaintiffs who have made such claims have not been overly successful in having damages awarded.¹⁷¹

To sue for negligence, there must be a duty, a breach of that duty, the breach must be the cause of harm, and there must be actual damages resulting from that harm.¹⁷² In fact, it is very difficult to show

¹⁶⁴ *Grace Plaza of Great Neck, Inc. v. Elbaum*, 588 N.Y.S.2d 853, 860 (N.Y. App. Div. 1992). In some of the states in which the right to die is broader than in New York, it has been held that no cause of action for battery may be maintained against a medical professional who continues to provide treatment to a patient over the objections of the patient's family. *Id.* at 858.

¹⁶⁵ WILLIAM P. STATSKY, *ESSENTIALS OF TORTS* 82 (3d ed. 2011).

¹⁶⁶ *Id.*

¹⁶⁷ *Morgan v. Olds*, 417 N.W.2d 232, 236-37 (Iowa Ct. App. 1987); *but see Strachan v. John F. Kennedy Mem'l Hosp.*, 538 A.2d 346, 351-52 (N.J. 1988) (though the patient was already dead according to brain death standards); *Gragg v. Calandra*, 696 N.E.2d 1282, 1289-90 (Ill. 1998).

¹⁶⁸ In right to die cases, the plaintiff always says he or she desires to live yet just not in the way in which he or she is living currently. While this allows for the courts to rely on double effect, it also allows the courts the ability to be lenient in intentional infliction of emotional distress cases.

¹⁶⁹ MEISEL & CERMINARA, *supra* note 36, at 11-26.

¹⁷⁰ RESTATEMENT (SECOND) OF TORTS §652I (1977).

¹⁷¹ *Klavan v. Crozer-Chester Med. Ctr.*, 60 F.Supp. 2d 436, 440-41, 443-44 (E.D. Pa. 1999); *Ross v. Hilltop Rehab. Hosp.*, 676 F.Supp. 1528 (D. Colo. 1987).

¹⁷² RESTATEMENT (SECOND) OF TORTS §328A (1965); "cause of harm" encompasses both the legal cause-in-fact and the proximate cause.

negligence in end-of-life cases, because in the majority of jurisdictions, the plaintiff must establish by expert testimony that the defendant failed to uphold the professional standard¹⁷³ or that there was a causal relationship between conduct and result, which must be established according to an objective standard.¹⁷⁴ Also, for unconscious patients, who have no sensation of pain or awareness, it is very difficult to prove damages, since the patient suffers no physical or mental harm from the treatment.¹⁷⁵ The courts do not consider life to be a legally compensable injury. Moreover, though legislation has lowered the bar for informed refusal of treatment through advance directives,¹⁷⁶ the standard for informed refusal for incompetent patients who have surrogates is still very high.¹⁷⁷

Courts have also dismissed wrongful life cases by upholding the requirements of a state statute at the expense of the common law legitimacy of advance directives. For example, in *Wright v. Johns Hopkins Health Systems*, the Maryland Court of Appeals ruled that a patient's living will was inoperative, since there was no evidence that a physician certified that the patient had a terminal condition as required by the state statute.¹⁷⁸ In reaching its conclusion, the court wrote,

Essentially the plaintiffs urge this Court to recognize a common law action for having administered CPR that would be viewed as unauthorized under the evidence most favorable to the plaintiffs in this case. . . . We shall not use our power to declare the common law to move the line between an authorized and an unauthorized DNR

¹⁷³ RICHARD E. SHANDELL ET AL., *THE PREPARATION AND TRIAL OF MEDICAL MALPRACTICE CASES* 4.02[2] (rev. ed. 2010).

¹⁷⁴ *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); see also Robert Gatter, *Informed Consent Law and the Forgotten Duty of Physician Inquiry*, 31 *LOY. U. CHI. L. J.* 557 (2000).

¹⁷⁵ *Morgan v. Olds*, 417 N.W.2d 232, (Iowa Ct. App. 1987) (“When a doctor implements a course of treatment without obtaining the patient’s consent, he breaches his duty and is liable to the patient for any resultant damages. Similarly, when a doctor fails to obtain the consent of the incompetent patient’s surrogate decisionmaker, he breaches his duty to the patient and is liable for any resultant damages. The patient, however, is the only party who may recover for the breach since the duty is owed to the patient and not the surrogate decisionmaker or the patient’s family.”) *Id.* at 236 (citations omitted).

¹⁷⁶ OHIO REV. CODE ANN. §§2133.01-15 (2015); OHIO REV. CODE ANN. §§1337.11-17 (2015).

¹⁷⁷ *Leach v. Shapiro*, 469 N.E.2d 1047 (Ohio Ct. App. 1984) (A patient has the right to refuse treatment, and that this refusal may not be overcome by the doctrine of implied consent. Before this refusal can controvert the implied consent of a medical emergency, however, it must satisfy the same standards of knowledge and understanding required for informed consent.).

¹⁷⁸ *Wright v. Johns Hopkins Health Sys. Corp.*, 728 A.2d 166, 175 (Md. 1999) was superseded by statute Health Care Decisions Act 2000 Md. Laws 152, MD. Code Ann. Health-Gen, § 5-608, recognized in *Plein v. Dep’t of Labor*, 800 A.2d 757 (Md. 2002).

further from the statutory, oral advance directive than the type of DNR order that we have recognized above as authorized.¹⁷⁹

Other courts have held that, since plaintiffs could seek *ex ante* injunctive relief, there is no need to award *ex post* recovery of damages when they did not seek such relief.¹⁸⁰ Some courts are also reluctant to award damages when the patient's refusal of care was too far removed or in a different context than the situation which was the basis of the claim.¹⁸¹

Even though the courts do not consider "wrongful life" to create a harm that leads to damages,¹⁸² plaintiffs may still sue for recovery for damages caused by unwanted medical treatment, such as burns received from defibrillation or broken ribs from manual resuscitation.¹⁸³ Plaintiffs can also sue for the medical costs incurred by unwanted treatment.¹⁸⁴ For example, in *Anderson v. St. Francis-St. George Hospital*, the Supreme Court of Ohio recognized that, by administering CPR to a patient who had a DNR order at his request, the nurse breached the duty of honoring the patient's wishes.¹⁸⁵ However, the Court recognized that the only damages recoverable were those suffered by the patient directly caused by the battery, in this

¹⁷⁹ *Wright v. Johns Hopkins Health Sys. Corp.*, 728 A.2d 166, 178-79 (Md. 1999).

¹⁸⁰ *Estate of Taylor v. Munice Med. Investors*, 727 N.E.2d 466 (Ind. Ct. App. 2000).

¹⁸¹ *Werth v. Taylor*, 475 N.W.2d 426 (Mich. Ct. App. 1991); *Leach v. Shapiro*, 469 N.E.2d 1047 (Ohio Ct. App. 1984). The sentiments of the courts are similar to those expressed by the President's Bioethics Commission which states, "Even when people are prepared to execute living wills, it is doubtful whether they have clear and definite ideas about the treatment they would want if and when they become incapacitated. There are, to begin with, simply too many possible future situations that the patient must try to imagine, each with its unique combination of burdens, benefits, and risks, making the notion of "informed consent" long in advance of treatment a highly questionable one. And those patients who are tempted to reject certain kinds of future medical intervention (on the ground that they "wouldn't want to live like that") may not understand how short-term use of some of the same interventions could restore them to basic or even normal function."

¹⁸² *Benoy v Simons*, 831 P.2d 167, 170 (Wash. Ct. App. 1992); *Klavan v. Crozer-Chester Med. Ctr.*, 60 F.Supp.2d 436 (E.D. Pa 1999); *Anderson v. St. Francis - St. George Hosp., Inc.*, 671 N.E.2d 225, 228 (Ohio 1996).

¹⁸³ *Allore v. Flower Hosp.*, 699 N.E.2d 560 (Ohio Ct. App. 1997).

¹⁸⁴ *Gragg v Calandra*, 696 N.E.2d 1282, 1285-86 (Ill. 1998); *First Healthcare Corp. v. Rettinger*, 456 S.E.2d 347 (N.C. Ct. App. 1995), *rev'd*, 467 S.E.2d 243 (N.C. 1996). In an action to recover for nursing home services rendered to a patient who was kept alive by means of a nasogastric tube and who had executed a living will, the trial court erred in granting summary judgment for plaintiff nursing home where genuine issues existed as to whether the attending physician directed the removal of the nasogastric tube and whether a second physician confirmed the attending physician's conclusion that the patient's condition was terminal and incurable before the tube was removed by court order as was required by the living will statute, N.C.G.S. § 90-321. If the statutory requirements were met, then defendant would be responsible only for charges from the date they were met until her husband would have died had the tube been removed, instead of for charges from the date she requested removal of the tube until he actually died some four months later.

¹⁸⁵ *Anderson v. St. Francis-St. George Hosp. Inc.*, 671 N.E.2d 225, 227 (Ohio 1996).

case the administration of CPR.¹⁸⁶ The Court ruled that there was no cause of action in wrongful prolongation of life or even for the pain and suffering that resulted from the extension of the patient's life.¹⁸⁷ Under intentional tort theories, a victim may also collect damages for the dignitary harm of being treated without consent,¹⁸⁸ yet, in these cases, the courts offer nominal damages at best.¹⁸⁹ Also, while it is in theory possible to award damages for pain and suffering, in most end-of-life cases the patient is unconscious and therefore unaware of any pain or suffering, so proof of damages is impossible.¹⁹⁰

In two wrongful living suits, plaintiffs were awarded monetary compensation by the jury for damages, yet they were either subsequently reduced by the judge or justified on other grounds. In a 1996 case, a Michigan jury awarded \$16.5 million to the family of Brenda Young, a comatose woman who was giving life-sustaining treatment against her will.¹⁹¹ Yet on appeal, the court reduced the jury's award to \$1.4 million.¹⁹² Similarly, in 2007, a Florida jury awarded a nursing home resident \$150,000 in a wrongful living suit; the court upheld the award but only on the theory that the plaintiff's advance directive was part of her contract with the nursing home.¹⁹³ Therefore, the award

¹⁸⁶ *Id.* at 229.

¹⁸⁷ *Id.* at 228; *see also* Estate of Taylor v. Munice Med. Investors, 727 N.E.2d 466 (Ind. Ct. App. 2000) (the court affirmed that Ind. Code § 16-36-1-8 did not support a wrongful prolongation of life cause of action); Cronin v. Jamaica Hosp. Med. Ctr., 875 N.Y.S.2d 222 (N.Y. App. Div. 2009); Scheible v. Joseph L. Morse Geriatric Ctr., 988 So.2d 1130 (Fla. Dist. Ct. App. 2008).

¹⁸⁸ FRANK J. VANDALL ET AL., TORTS: CASES AND PROBLEMS 15 (2d ed. 2003).

¹⁸⁹ Tatman v. Fort Sanders Reg'l Med. Ctr., No. E2000-02163-COA-R3-CV, 2001 WL (Tenn. Ct. App. 2001); *see also* Alan Meisel, A "Dignitary Tort" as a Bridge between the Idea of Informed Consent and the Law of Informed Consent, 16 L. MED. & HEALTH CARE 210 (1988).

¹⁹⁰ David W. Leebron, *Final Moments: Damages for Pain and Suffering Prior to Death*, 64 N.Y.U. L. REV. 256, 297 (1989).

¹⁹¹ Maturity News Service, *Patient Who Was Kept Alive Settles Out of Court*, DESERT NEWS (May 1, 1997 12:00 AM), <http://www.deseretnews.com/article/558083/Patient-who-was-kept-alive-settles-suit-out-of-court.html?pg=all>; Tamar Lewin, *Ignoring "Right to Die" Directives, Medical Community Is Being Sued*, N.Y. TIMES, (June 2, 1996), <http://www.nytimes.com/1996/06/02/us/ignoring-right-to-die-directives-medical-community-is-being-sued.html>; Laura Parker, *In a Crisis, Do-Not-Revive Requests Don't Always Work*, USA TODAY, Dec. 20, 2006, http://usatoday30.usatoday.com/news/health/2006-12-19-do-not-revive-cover_x.htm.

¹⁹² Maturity News Service, *Patient Who Was Kept Alive Settles Out of Court*, DESERT NEWS (May 1, 1997 12:00 AM), <http://www.deseretnews.com/article/558083/Patient-who-was-kept-alive-settles-suit-out-of-court.html?pg=all>

¹⁹³ Missy Diaz, *Jury: Home Violated Living Will: Nursing Facilities Must Heed Patient's Wishes, Panel Rules*, SunSentinel (Mar. 17, 2007, http://articles.sun-sentinel.com/2007-03-17/news/0703170091_1_nursing-home-morse-verdict); *Jury Awards \$150,000 for Failure to Follow Directive*, ELDER L. ISSUES: FLEMING & CURTI, P.L.C. (Mar. 26, 2007) <http://www.elder-law.com/2007/Issue1439.html> (last visited Mar. 5, 2016).

was based on a breach of contract and not on a tort or a statutory liability.¹⁹⁴

The immunity provided in state statutes and the difficulty for plaintiffs to win wrongful life claims provide the other half of the debate over autonomy in right-to-die cases. While legislation and the courts protect patient autonomy regarding directing that a patient's wishes be followed, they protect the ethical autonomy of the medical professional by refusing to award damages if those wishes are not followed. Medical professionals are not coerced to withhold and withdraw treatment, except in rare circumstances when the patient cannot be transferred. They are also allowed to practice according to their professional standards, which indirectly reinforces the state interest of protecting the ethics of the medical profession. Statutory immunity and the court's unwillingness to award damages reinforces respect for the decision-making of the physician, which includes understanding the medical situation and complying with the wishes of the patient within the physician's understanding of the patient's wishes or presumed wishes.

CONCLUSION

With respect to care of the elderly, research has shown that the end-of-life wishes of many Americans are not fulfilled due to the lack of clear communication to health care providers.¹⁹⁵ This causes distrust of the medical profession, confusion among patients and their families over end-of-life care, and a high economic and social burden in terms of medical costs and family caregiving. Rather than understanding the controversy over "death with dignity" and the "right to die" as that between the rights of the individual and the interests of the state. It would be more fruitful to understand it as being between demanding greater patient autonomy on the one hand and avoiding violations of patient autonomy and that of the medical provider on the other. A shift in orientation would ameliorate the friction between patients and their caregivers, it could provide a more productive means for recognizing the underlying concerns that give rise to this tension, and it might give way to an approach to end-of-life care that finds a proper balance in protecting the rights of individuals. It may also promote shared decision-making between patients and health care providers, allowing for advance care planning rather than potentially ambiguous advance directives.

¹⁹⁴ *Scheible v. Joseph L. Morse Geriatric Ctr.*, 988 So.2d 1130 (Fla. Dist. Ct. App. 2008).

¹⁹⁵ INST. MED., *DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE* 3-3 – 3-5 (2014).