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Dignified Death And The Law Of Torts*

WILLARD H. PEDRICK**

When Don Weckstein invited me to deliver the 1990 Nathaniel L. Nathanson Memorial Lecture at the University of San Diego Law School, I accepted almost before he got the invitation out of his mouth. When I was a first year law student at Northwestern University Law School, Nat was a first year professor. Since he was then junior to the entire faculty, he was assigned the non-enviable task of teaching the Law of Agency. With Nat as our professor, we learned about "frolic and detour" and a lot more as well. He was a great teacher and a great scholar. I must read the last paragraph of my tribute to Nat in the San Diego Law Review:

There is a tale of the unlettered farmer who was asked whether he had seen

* These remarks were delivered on March 30, 1990 as the Nathaniel Nathanson Memorial Lecture for 1990 at the University of San Diego Law School and are published here with minor revisions. The usual academic ornamentation by way of footnotes have been added to enable interested persons to find the sources which were referred to in the lecture.

After delivery of the Nathanson Memorial Lecture on March 30, 1990, the long awaited decision of the United States Supreme Court in *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990), was decided on June 25, 1990. The Court, majority and dissenters, recognized the right of the patient in extremis to refuse medical treatment as a "liberty interest" protected by the fourteenth amendment. But for the unconscious patient in a persistent vegetative state, as was Nancy Cruzan, the Court majority held that any previous instructions or directions given by the now unconscious patient would have to be established by evidence satisfactory to the state court. The Missouri Supreme Court had adopted a "clear and convincing" standard of proof and had found that the evidence in the *Cruzan* case did not meet that standard. Consequently, the case had not been made for disconnection of life support systems. The United States Supreme Court affirmed the decision of the Missouri Court. Thus, it is left to the states to determine whether the patient, now unconscious, has authoritatively directed non-use of life support systems in the particular situation. The *Cruzan* decision is relevant to the present paper only in recognizing the doctrine of patient autonomy as an element of "liberty" protected by the fourteenth amendment.

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a display two nights earlier of shooting stars. He replied that he had missed the event, but noticed the following night that the stars 'seemed to have thinned out a bit.' When Nat Nathanson left us, the stars did *not* thin out, for the general radiance of the spirit of this great man was passed on to us, to all of us. It will continue to glow and will sustain, through our work and through time, the very enlightenment this warm, lively, witty, unassuming, resolute and wonderful man gave to us.¹

So, I am honored, indeed, to give the Nathanson Memorial Lecture this year.

A word about the title to these remarks. Generally speaking, my titles are more highly regarded than my speeches themselves. My favorite title in all of legal literature, not mine, appeared years ago in the *Indiana Law Journal*. The title belonged to a Note on the subject of voyeurism entitled, "Peeping Toms and Other Men of Vision." But this afternoon's title is not very exciting—deliberately so. It seemed political in this setting to make clear that I am not speaking about *Roe v. Wade*. It is rather the other end of life that I am addressing; hence the title, "Dignified Death and the Law of Torts."

How did I get interested in this topic? Well, I have been a Torts teacher and scholar for a very long time, and perhaps it is simply my age that disposes me to think about the end of life and circumstances surrounding it. Along with many of you, I can remember in 1976 when the Supreme Court of New Jersey held that the family of Karen Ann Quinlan was entitled to have her disconnected from the respirator that had sustained her vital signs though there was no real hope for her recovery to a meaningful existence.² Pursuant to the court order, they did disconnect, but it was another nine years of unconscious existence before Karen Ann finally succumbed.³

I have seen estimates ranging from 5,000 to 50,000 as the number of persons in a permanent vegetative state, who are presently sustained in what is classed as "life." These people are sustained by life support systems, principally respiratory mechanisms and tubes inserted into the patient's body for nutrition and hydration.⁴

A case very recently decided by the Supreme Court of the United States involved Nancy Cruzan, a young woman in Missouri who was brain damaged in an automobile crash and has been sustained in a vegetative state for seven years. Her life was being sustained by

1. Pedrick, *My Professor*, 22 *SAN DIEGO L. REV.* 433, 435 (1985).

2. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

3. M. HALL AND I. ELLMAN, *HEALTH CARE LAW AND ETHICS IN A NUTSHELL* 284 (1989).

4. Miller, *Right to Die, Damage Actions: Developments in the Law*, 65 *DEN. U.L. REV.* 181, 182 (1988). *See also* *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (Brennan, J., dissenting). The dissenting opinion of Justice Brennan in *Cruzan* states: "As many as 10,000 patients are being maintained in persistent vegetative states in the United States, and the numbers are expected to increase significantly in the near future." *Id.* at 2877 (Brennan, J., dissenting).

nasogastric tubes for nutrition and hydration, with an expectancy that this would continue for thirty more years.⁵ Why the Supreme Court of the United States saw fit to grant certiorari in the case is a bit of a mystery. It is true, of course, that Missouri, as the "show me" state, declined to allow removal of the nasogastric tube on the family's request, contrary to an almost solid line of authority in all the other states passing on the question, which uphold the right of the patient, or one representing the patient, to decide whether or not to continue life support systems when the situation is hopeless.⁶

It is true also that the lawyer for the family in the Nancy Cruzan case argued for the right to disconnect under a "right of privacy" theory which a number of the state courts, including California, have embraced. But the common law of torts makes the individual captain not only of the soul, but of the body as well — at least in situations where the prospects for recovery are hopeless and the question is whether the patient or someone on his or her behalf can order disconnection of a life support system. Certainly those of us who are interested in the subject had misgivings about the Supreme Court of the United States federalizing this area of tort law when the states, Missouri excepted, have been reaching quite satisfactory results under either state privacy rights or better still, the common law. In Missouri, a bill was introduced in the state legislature this year, supported by Attorney General Webster, to allow disconnection after three years. Perhaps compassion will ultimately come to Missouri.

In the Nancy Cruzan case, the Supreme Court devised a method for slightly avoiding the issue, a not uncommon outcome. The Court held that Nancy Cruzan's right to refuse medical treatment was hers alone, absent any state procedure for assertion of her rights by another. Thus, it was constitutionally permissible for Missouri to require "clear and convincing" evidence of Nancy's intentions.⁷

The Cruzans, incidentally, have been members of the Society for the Right to Die for some years, and in a letter to the New York Office of the Society, Nancy's father said in part,

Because of our love for her, after this period of time in which she has shown no improvement [now seven years], we feel the most humane and kind thing

5. *Cruzan*, 110 S. Ct. at 2845.

6. *See id.* at 2888 n.21 (Stevens, J., dissenting).

7. *Id.* at 2852-55. That, in fact, was the ground of the decision in the *Cruzan* case. But the Court went to some lengths to disavow the right of privacy as the ground for the constitutional protection of patient autonomy. Instead, the Court preferred to put the constitutional protection of the right to control one's body as a right of "liberty" under the fourteenth amendment. *See id.*

we can do is to help her escape this "limbo" between life and death that she is caught in by terminating her life. . .she would not have wanted to live like this and. . .our feelings are for her sake and not for ours.⁸

But to come back to the announced title, my law teaching career has been involved heavily in the fields of Estate Planning and Torts. The subject of the right to a dignified death and tort law is where the two fields intersect.

Another word or two by way of background: There is general popular concern about the overuse of life sustaining apparatus when there is no prospect of recovery. These technical achievements are viewed with great revulsion on the part of most people. Your chance, when dying, of being hooked to a life sustaining system is, at most, but one in twenty, and maybe only one in forty.⁹ But, polls indicate that now more than 80% of those queried think the patient or an agent should have the right to refuse use of life support systems when there is no hope of recovery.¹⁰

In 1976, California was the first state to enact a so-called "living will" statute.¹¹ That is a singularly inappropriate term for a statute that authorizes the individual, under certain circumstances, to direct that life sustaining apparatus is not to be employed to preserve an expiring life. I will have a bit more to say about the California statute later, but California was the first of some now forty states to enact legislation on this subject. More than a dozen states, including California, have also enacted special legislation authorizing execution of a durable power of attorney naming an agent to make health care decisions when the principal cannot.

It is my thesis here today, and in my recent article on Arizona law,¹² that familiar principles of tort law can be enlisted to better assure that unwanted life support measures either will not be used, or will be withdrawn when that is the wish of the patient or the patient's agent. I propose to develop my thesis by considering a hypothetical action for a declaratory judgment on behalf of a desperately situated patient.

The patient, Ernest Dyer, is in a health care institution where the professionals have given advance notice of their intent to refuse to honor his decision to refuse resuscitation, dialysis, mechanical venti-

8. *U.S. Supreme Court to Hear First Right-to-Die Case*, SOCIETY FOR THE RIGHT TO DIE NEWSLETTER, at 4 (Fall 1989).

9. See Pedrick, *Arizona Tort Law and Dignified Death*, 22 ARIZ. ST. L.J. 63, 65 nn. 8-9 (1990).

10. In February of 1990, a poll commissioned by Time/CNN reported that 80% of people polled believe that doctors and families should be allowed to make the decision to withdraw life support systems in hopeless situations. Gibbs, *Love and Let Die*, TIME, March 19, 1990, at 62, 64.

11. CAL. HEALTH & SAFETY CODE § 7185 (West 1970 & Supp. 1990).

12. Pedrick, *supra* note 9.

lation or nutritional support. Dyer is suffering from Lou Gerhig's disease, emphysema, and is a recent victim of a rather severe stroke. The stroke left him with his mental facilities unimpaired, but he is now paralyzed on his right side. He is attended by Doctor Resolute and is presently in the NSD ("Never Say Die") Nursing Home. Though presently competent, Dyer is very concerned that he may become incompetent. Accordingly, he has given his doctor, Resolute, a written instruction that he does not wish life sustaining procedures to be used in his case. He has also executed a durable power of attorney naming his wife, Ernestina, as his agent for health care decisions and has executed a "living will" under the California statute. Despite Dyer's clear indication that he does not wish life-sustaining systems used in his case, Dr. Resolute and the NSD Nursing Home are committed to a philosophy of preserving life. Accordingly, they have made plain to Dyer and his wife that they will, if placed in a hopeless medical situation, use life-sustaining support systems. Against this scenario, Dyer and his wife have instituted an action in the California courts to secure a declaratory judgment answering three questions.¹³

Let us assume that our case, in due course, reaches the Supreme Court of California. I offer now a completely unofficial and unauthorized judgment for the court in the case.

First of all, I shall blithely and blandly assume that it is a proper case for a declaratory judgment. A health-care professional or institution that insists on moral grounds that life-sustaining procedures be initiated and not discontinued ought to be findable as a defendant. Indeed, a malpractice liability insurance company might very well be interested in seeing such a case brought before the court.

The "Right to Die" cases in which the courts have gone ahead and rendered judgment on the merits, notwithstanding the intervening death of the patient-plaintiff,¹⁴ on the ground that the issues raised are of great public importance, certainly support the view that a declaratory judgment action should lie in such a case.

The first question is whether the competent patient has the right to forbid use, or to order withdrawal, of a life support system. That right seems clearly established under California law. In company

13. To find California's Declaratory Judgment statute, *see* CAL. CIV. PROC. CODE §§ 1060-1062.5 (West 1980 & Supp. 1991).

14. *See* Rasmussen v. Fleming, 154 Ariz. 207, 213 n.4, 741 P.2d 674, 681 n.4 (1987) (citing cases holding that the death of the plaintiff in right to die cases does not render the case moot).

with virtually all other state court decisions on the subject, the California Court of Appeal, in two decisions, has resoundingly endorsed the doctrine of patient autonomy. As the appellate court stated in *Bouvia v. Superior Court* in 1986,

A person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to medical treatment. It follows that such a patient has the right to refuse *any* medical treatment even that which may save or prolong her life.¹⁵

That same sentiment was uttered in 1914 by Judge Cardozo, then on the Court of Appeal for New York, and was quoted by the California court in its opinion in *Bouvia*.¹⁶

Elizabeth Bouvia, as you may recall, was a quadriplegic suffering as well from cerebral palsy, confined to her bed, emaciated to the point where at the time of the trial she weighed only sixty-five or seventy pounds. Her lawsuit sought an injunction to remove the nasogastric tube, at her request, through which nutrition and hydration were supplied to keep her alive. The Court of Appeal reversed the lower court and ordered the health care institution in question to disconnect, at her request, the tube for feeding and hydration.

Interestingly, last year, sixteen years after the trial, Ms. Bouvia was reported as still surviving, with the tube still in place.¹⁷ Her weight had increased to ninety pounds. But she, through her litigation, vindicated her right to control her own destiny regarding acceptance or refusal of medical treatment.

It is established in California, as in virtually all other states, that health care givers are duty-bound under the common law of torts, as well as perhaps, the right of privacy or liberty under state and federal constitutions, to follow instructions regarding use or nonuse of life support systems from a competent patient, at least in the hopeless situation.

The second question is: does it make any difference whether the patient gives the direction when he or she is competent, or whether a surrogate decisionmaker gives it under a power of attorney for health care decisions, or under a previously executed living will? Perhaps we should start with the California version of the so-called "living will."¹⁸ I have examined this handiwork of the California legislature and I can only say that it is awe-inspiring.

The statute was drafted with limitations that make it virtually unusable. Commenting on the California Natural Death Act, the liv-

15. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300 (1986).

16. See *id.* at 1139, 225 Cal. Rptr. at 302, (quoting *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92, 93 (1914), "[E]very human being of adult years and sound mind has a right to determine what should be done with his own body.")

17. L.A. Times, May 23, 1988, § 1, at 14, col. 2.

18. CAL. HEALTH & SAFETY CODE § 7188 (West 1970 & Supp. 1991).

ing will statute, the founder and director of the Santa Monica based Hemlock Society said, "It was the first in the world but it was a mess. It was savaged by opponents and it came out a dog's breakfast."¹⁹ If the injury or illness has only produced a persistent vegetative state, as in the case of Nancy Cruzan, that condition, with the aid of the life sustaining support system, may not be regarded as terminal.²⁰ Further, a terminal condition must be certified by two physicians.²¹ Getting two physicians to agree on anything is probably almost as difficult as getting two lawyers to agree. Moreover, a nursing home employee informed me that to get one doctor to come to a nursing home is almost impossible. Worst of all, however, are the provisions that imply that a "living will" under the California statute will only be effective if it is executed after a diagnosis of a terminal condition, and then only within a cooling off period of fourteen days during which the document must be executed!²² Satisfying these conditions would be comparable to winning the state lottery! Consequently, the prospect is remote that we will ever know, from an appellate court decision in California, whether health care givers are bound to respect and adhere to instructions on the subject of life sustaining procedures in hopeless cases, as directed in a living will.

Fortunately, California, along with more than a dozen other states, has a special statute authorizing execution of durable powers

19. Oliver, *Right-to-Die Laws Take On New Life*, L.A. Times, May 23, 1988, § 1, 1, at 14, col. 1.

20. On February 13, 1990, the American Bar Association approved the revised Uniform Rights of the Terminally Ill Act. UNI. RIGHTS OF THE TERMINALLY ILL ACT (1989), 9B U.L.A. 79 (Supp. 1989). In commenting on the definition of a "terminal condition" in the act, the drafters observed that:

[T]he decision that death will occur at a relatively short time is to be made without considering the possibilities of extending life with life-sustaining treatment. The alternative is that required by a number of states—that death be imminent whether or not life-sustaining procedures are applied. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research has noted that such a definition severely limits the group of terminally ill patients able to qualify under these acts.

Id. § 1 Comment, 9B U.L.A. at 81-82 (Supp. 1991).

21. CAL. HEALTH & SAFETY CODE § 7187 (West 1970 & Supp. 1991).

22. See CAL. HEALTH & SAFETY CODE §§ 7188, 7191b (West 1970 & Supp. 1991) (implying that only after diagnosis of a terminally ill patient can an effective "living will" be executed under the California law). See Comment, *A Proposed Amendment to the California Natural Death Act to Assume the Statutory Right to Control Life Sustaining Treatment Decisions*, 17 U.S.F. L. REV. 579 (1983) (recommending that the California Natural Death Act be amended to dispense with the requirement that the terminal condition had been diagnosed fourteen days prior to the execution of the "living will").

of attorney for health care decisionmaking enacted in 1983,²³ which offers an opportunity which all should use.

One need not be in a terminal condition to appoint a proxy for health care decisionmaking and the executed power is good for seven years, subject to renewal.²⁴ In the best tradition of ambiguous draftsmanship, there are conflicting currents concerning the nature of the duty imposed on health care givers with respect to a surrogate agent's instructions under a durable power. Thus, one section implies that if there would be civil liability on the part of health care givers who failed to follow instructions to withhold life sustaining systems from a competent patient, then there would be similar liability with respect to instructions to withhold life sustaining systems on the order of the surrogate under the durable power.²⁵ But another section provides that there is no civil liability for failure to withdraw a life sustaining system although it may constitute unprofessional conduct if the health care giver fails to transfer the patient to another professional.²⁶

A 1988 decision of the Court of Appeal, taking the idea from California's living will statute, held that a physician who conscientiously objects on moral grounds to disconnecting a life support system, can escape liability by effecting a transfer of the patient to another health care giver who will carry out the order.²⁷ But speed in the transfer process will surely be required if liability is to be avoided. Nor is this a corner of the law where the doctrine of "all deliberate speed" should have any function. Medical associations and nursing home associations should compile lists of health care givers who will let hopeless patients die in comfort and dignity.

The final question raised in the declaratory judgment proceeding asks whether health care givers are subject to a claim for damages from the patient's estate, or from the surviving family members, or both, when instructions to withhold or withdraw life sustaining procedures are not followed.

Let us first consider the claim by the patient's estate (the claim could, of course, be asserted by the patient, but in many of these cases the patient dies before the slow-turning wheels of justice have reached a conclusion). If the estate brings the action on behalf of a

23. CAL. CIV. CODE §§ 2430-2440 (West 1974 & Supp. 1991) (Durable Power of Attorney for Health Care Decision Making).

24. *Id.* at § 2436.5.

25. *Id.* at § 2438.

26. *Id.* at § 2438(c).

27. *Conservatorship of Morrison*, 206 Cal. App. 3d 304, 311, 253 Cal. Rptr. 530, 534 (1988) (holding that a physician with moral scruples cannot be compelled to disconnect life support systems if transfer to an agreeable physician is feasible—with an implication that if such a transfer is not feasible, than the physician with scruples may nevertheless be ordered to disconnect).

deceased patient, then we must give brief attention to the California statute governing the survival of actions.²⁸ Unlike some survival statutes, the California act does not rule out actions for invasion of privacy (as is the case in Arizona and some other states)²⁹ but does, in company with many other statutes, rule out any claim after the death of the claimant for any damages for pain and suffering.³⁰ So, as under the ancient common law, it may be cheaper to kill than to maim. But the action for subjecting the patient to medical treatment against his or her will does not depend on pain and suffering as an element of damage.

An unauthorized, offensive touching of the patient has historically been classed as a battery.³¹ For a battery, the injured party is entitled, at minimum, to nominal damages and, as explained by Professor Dobbs in his treatise on Remedies, to so-called "general damages"³² in an amount determined by the jury. The law presumes general damage with respect to offensive touchings by the physician.

Moreover, the claim for unauthorized subjection to unwanted life sustaining procedures may generate punitive damages as well. A claim for punitive damages under the California Probate Code survives.³³ The statutory provision with respect to punitive damages provides that oppression "means despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights."³⁴ For a dying patient to be subjected to a life support system against his or her will is both offensive and outrageous. Surely this is one of the most horrific indignities to which a person can be subjected.

An article in *Law Medicine and Health Care* published in 1985, provides the following excerpt.

The eyewitness and long-term companion to the patient said:

When I came close to Brenda's bed I noticed they still didn't have an air way. I said: 'I want this resuscitation stopped immediately! Miss Hewitt doesn't want to be resuscitated! I'm legally authorized to make this decision for her. I have here the original of her living will signed by her before

28. CAL. PROB. CODE § 573 (West 1991).

29. *Id.* at § 573(c) (providing for survival of actions with no reference to privacy claims).

30. *Id.* (expressly excluding survival of "damages for pain suffering, or disfigurement").

31. W. PROSSER AND P. KEETON, *THE LAW OF TORTS* § 9 (5th ed. 1984).

32. D. DOBBS, *HANDBOOK ON THE LAW OF REMEDIES: DAMAGE—EQUITY—RESTITUTION* § 3.2, at 139 (1973).

33. CAL. PROB. CODE § 573(c) (West 1991) (specifically providing that "any penalties or punitive or exemplary damages" are to survive).

34. CAL. CIV. CODE § 3294(c)(2) (West 1985 & Supp. 1990).

witnesses. I've also a notarized medical consent and authorization, signed by her, for me to act on her behalf to consent to or withhold treatment. Using that authority, I want this treatment stopped at once! A few heads looked up, but that was all. The chest thumping continued without interruption. Finally, a doctor urged me, 'We must discuss this matter outside.' He gestured for me to follow him . . . Brenda was a heart-rending sight. A couple of hoses were stuck into her mouth, presumably ending in a tracheal tube. Her face was grotesquely distorted. There was a deep cut on the inside of her left thigh, and she was lying in a pool of pink arterial blood.³⁵

Commenting on this horrendous account of Ms. Hewitt's death in a New York hospital, the writer observed that, "[t]he hospital in which this intentional degradation of what could have been a dignified and peaceful death took place is not, unfortunately, unique among teaching hospitals."³⁶

Whether the claim on behalf of the patient, now deceased, is phrased as a battery or invasion of the right of privacy claim, the law on the subject is surely shaped by the law of torts and specifically the law of battery. In a battery action, the amount of damages awarded for both general and punitive damages is a matter that is left to the jury. In California, when the jury is outraged at the defendant's disregard of the legal rights of the injured party, the award can be substantial indeed.

It is my thesis that when health care givers subject a competent patient to life sustaining procedures against his or her will, the settled law of torts provides a remedy by way of an action for battery, with resultant liability on the part of the health care givers for substantial damages, both general and punitive. One or two cases in other jurisdictions³⁷ already sustain this quite conventional ground of liability.

When the instructions come from a surrogate agent under a durable power of attorney for health care decisionmaking, the answer may not be the same. In 1986, a California Court of Appeal decision declined to impose liability on an intentional or reckless infliction of mental suffering theory. The court reasoned that the health care giver's refusal to follow instructions contained in a living will, a written declaration, and under a durable power of attorney with instructions, was not outrageous in light of the unsettled state of the law at that time.³⁸ There was no discussion of the battery theory of liability.

35. Schucking, *Death at a New York Hospital*, 13 Law, Med. & Health Care 261, 263 (1985).

36. Annas, *Into the Hands of Strangers*, 13 Law, Med. & Health Care 271 (1985).

37. *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984). See Miller, *Right-to-Die Damage Actions: Developments in the Law*, 65 DEN. U.L. REV. 181 (1988).

38. *Bartling v. Glendale Adventist Med. Center*, 184 Cal. App. 3d 961, 970-71, 229 Cal. Rptr. 360, 364-65 (1986).

A 1989 California Court of Appeal decision seems to hold that the claimant, surviving wife, had no claim for intentional or reckless infliction of mental suffering because she did not seek to have the physician attempt to transfer the patient to a more agreeable care giver.³⁹

As the emerging state of the law now stands, the prospect of succeeding in a battery action, where the medical situation is hopeless and recognized as such by the attending physician, depends on whether the physician insists on continuing to serve the expiring patient while maintaining the patient on life support systems contrary to the surrogate's order, making no effort to have the patient transferred to another physician and another health care facility. If the health care giver declines, on moral grounds, to respect an order to disconnect and does not take immediate steps to transfer the patient, the physician should be liable for general and punitive damages.

The last question is whether the surviving family members may assert their own claim against the health care givers for intentional or reckless infliction of mental suffering due to the physician's refusal to honor the patient's, or the surrogate agent's order to withhold or withdraw life support systems. As I stated, a 1986 Court of Appeal decision⁴⁰ took the position that an intentional or reckless infliction of mental suffering action would not lie against health care givers who refuse to take orders to disconnect. The law on the "right to die" at that time had not been adequately developed in California. Under those circumstances, the Court of Appeal could not see the health care givers' good faith refusal, on moral grounds, to follow orders to disconnect, as rising to the level of "outrageous" conduct.

But since that 1986 decision, the law of California on the subject of patient autonomy has developed. Currently, the caregiver who defies the competent patient's or his or her agent's instructions as to the non-use of life sustaining procedures is not merely negligent. Such a caregiver is chargeable with conscious intentional wrongdoing. For the family, the appropriate theory of legal liability in such a case is for reckless infliction of mental suffering. Moreover, the health care giver is probably in communication with the patient's near relatives and is aware of their special sensitivity. Consequently, liability for the immediate family members' pain and suffering is probable.

39. *Westhart v. Mule*, 261 Cal. Rptr. 640, 644-45 (Cal. App. 4 Dist. 1989) (not officially published).

40. *Id.*

Cases of solely negligent conduct concerning the handling of dead bodies have imposed liability because the defendant knew the emotions of the family members would be seriously affected by a breach of duty.⁴¹ In such cases of a breach of duty toward family members known to be in an emotionally vulnerable state, the Restatement of Torts requirement that the resulting distress be severe has not been too rigorously applied.⁴²

The conclusion is that the health care giver who refuses to respect the competent patient's instruction, or the surrogate agent's instruction, regarding life sustaining procedures when the situation is hopeless and does not speedily undertake to effect a transfer of the patient, may well be subject to liability to close family members for intentional or reckless infliction of mental suffering and for punitive damages as well.

In the early development of the law on the subject of the "right to die," health care givers were concerned that they might (1) be subject to legal sanction, (2) be liable for wrongful death, or (3) criminally indicted for murder if they failed to utilize every technologically possible method to sustain their patient's life. Those fears are now without foundation.⁴³

My object in these remarks has been to demonstrate to the medical and legal professions of California, if that be needed, that there are now very real risks of legal liability if physicians and health care institutions decline to follow a competent patient's instruction on the nonuse of life sustaining procedures in hopeless situations. Furthermore, there may be risks of legal liability if they defy the surrogate agent's instruction without at once undertaking to transfer the patient to other agreeable health care givers. Thus, the sanction of general and punitive damages, administered under well settled principles of the common law of torts, should have a salutary effect on the conduct of a minority of health care givers whose personal scruples have impaired their ability to recognize the primacy of the patient's authority in hopeless situations. This is one sanction.

Perhaps an even more effective sanction to vindicate patient autonomy is to refuse to pay for life support systems supplied in defiance of the patient's instructions or the instructions of his or her

41. See W. PROSSER & P. KEETON, *supra* note 31 § 54 (5th ed. 1984).

42. See Pedrick, *Intentional Infliction: Should Section 46 be Revised?*, 13 PEPERDINE L. REV. 1 (1985).

43. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (physician charged with murder for removing the ventilator and nutritional support and hydration at the family's request—the California Court of Appeals sustained the trial court's dismissal of the murder charges). See also *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980). (The "living will statutes," now in effect in at least forty states, specifically provide that there shall be no civil liability for following the living will's instruction that life support systems not be used in hopeless situations.)

surrogate agent. I am not a contracts scholar, but I suggest families would be well advised to not pay for medical services that were countermanded.

The press for March 19, 1990,⁴⁴ reports on a suit brought by Edward Winter, as plaintiff, against a hospital in Cincinnati that revived him at age eighty-two through electric shock, despite his claim that he had given instructions that CPR (cardiac pulmonary resuscitation) was not to be used in his case. Since revived, he has suffered strokes and though alive, he is partially paralyzed, bedridden in a nursing home, and seriously depressed—some life! I should think that under the law, he may well have an enforceable claim, although the question of how much damage should be awarded may present some hard questions. Nevertheless, he certainly ought not to be chargeable for medical expenses incurred after being subjected to unwanted medical procedures.

I suggest also, that Medicare and health insurance carriers should routinely inquire whether the health care giver had received instructions declining use of life support systems prior to a patient's death. In such cases, payment for medical services rendered *after* knowledge of the prohibition order ought to be refused. Such a policy adopted by Medicare, Medicaid, and the health insurance industry would, I believe, have a salutary effect in bringing an effective sanction to bear on health care givers, and through fiscal persuasion, should bring them to honor the instructions of patients and surrogate agents on this subject.

There are, of course, many interesting matters on which I have not commented. The Bar Association and the Medical Association in San Diego have issued a detailed procedure to be followed to assure death with dignity for those who have given the proper instructions.⁴⁵

Despite the best efforts of the legal and medical professions, however, there will probably continue to be vast numbers of persons who do not give advance thought to whether life support systems are to be employed when they come to the last mile. For such devil-may-care folks, the law must somehow provide an answer as to how the issue of the use and continuation of life support systems is to be

44. L.A. Times, Mar. 19, 1990, Overseas News Section, at 3; N.Y. Times, Apr. 17, 1990, Late Edition-Final, at B12, col. 1 (report that Mr. Winter died on Saturday, April 15, 1990).

45. L.A. Times, June 9, 1989, § 1, at 34, col. 1 (article by Jane Fritsch, describing the guidelines adopted by the San Diego County Bar Association and the County's Medical Society on termination of life-prolonging measures).

resolved. Fortunately, it is reasonably clear at this stage, in states other than Missouri, that if the family and the physicians agree, then it is proper, without a court proceeding, to terminate the life support system. Where there is disagreement, resort to a court proceeding through appointment of a guardian may well be required. Perhaps the legislature should prescribe procedures to be followed in such cases. There is now, as of August 1989, a revised Uniform Act on Rights of the Terminally Ill.⁴⁶ For thoughtless persons who die without wills, there is a state mandated system of intestate succession to property. But the issues raised in connection with the hard "right-to-die" cases are difficult and generate fierce emotional responses. The draft Uniform Act on the Rights of the Terminally Ill looks promising.

It is remarkable that these modern technological marvels which serve to hold death at bay, while the patient lives on in a vegetative state, generate legal questions for which some of the answers are to be found in the ancient common law of torts. But, the common law, as we know, is uncommonly creative and adaptable. Even without legislative assistance, it may help make death more tolerable in this technological age.

46. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989), 9B U.L.A. 79 (Supp. 1991) (approved by the Annual Conference, August 4, 1989 and approved by the American Bar Association, February 13, 1990). In its original 1985 version (9B U.L.A. 604 (1987)), the Uniform Rights of the Terminally Ill Act suffered from three serious deficiencies. Chapman, *The Uniform Rights of the Terminally Ill Act: Too Little, Too Late?*, 42 ARK L. REV. 319, (1989). Those deficiencies she pointed to were (1) absence of any provision for appointment of a proxy agent to make health care decisions; (2) the need for some provision to encompass the case of the permanently unconscious but not terminally ill patient; (3) the need for provision of some process for making the health care decision for the patient in extremis where no advance directive or appointment of a proxy has been made. *Id.* at 391-93. The 1989 revision of the Uniform Rights of the Terminally Ill Act meets these criticisms by providing for a proxy agent to make health care decisions when the patient is in extremis and provides that when the patient has neither given instructions nor appointed a proxy, the family may authorize withdrawal of life sustaining systems. The revised draft Uniform Act does not address the case of the patient who is unconscious without hope of recovery but is not in a terminal state. The Draft Act specifically disavows any entry into the euthanasia field.