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THE ILLUSION OF AUTONOMY AT THE END OF LIFE:
UNCONSENTED LIFE SUPPORT AND
THE WRONGFUL LIFE ANALOGY

Philip G. Peters, Jr.*

INTRODUCTION	674
I. THE CLINICAL DATA	677
II. THE LEGAL BACKGROUND	683
III. RESPECTING THE VALUE OF LIFE	690
IV. CALCULATING DAMAGES	696
A. Balancing Burdens and Benefits	698
B. Standing in the Patient's Shoes	699
C. The Value of Patient and Proxy Preferences	700
D. Unclean Hands and Limits on Offset	700
E. Past Jury Verdicts	703
F. Summing Up Calculability	706
V. CORRECTIVE JUSTICE	707
A. Compensation for Wrongful Treatment	708
B. Partial Recovery	711
C. Synthesizing the Justice Issues	717
VI. DETERRENCE AND OVERDETERRENCE	718
A. Providing a Legal Incentive to Respect Patients and Proxies	718
B. The Risk of Overdeterrence	721
C. Tailoring the Cause of Action	722
1. Unreasonable Failure to Know Patient Wishes	723
2. Reasonable Doubts About the Propriety of a Request to Terminate Treatment	725
D. Synthesizing the Deterrence Analysis	729
CONCLUSION	729

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Overwhelming evidence indicates that physicians routinely ignore patient preferences about life-sustaining care. Yet, the ability of wrongfully treated patients to recover compensatory damages has recently been placed in doubt. Both courts and commentators have suggested that actions for unconsented life support are analogous to actions for wrongful life and should, for that reason, be rejected. In this Article, Professor Philip Peters argues that the obvious similarity between the two kinds of claims is overshadowed by many factors that distinguish the two settings. As a result, Professor Peters concludes that a physician who wrongfully administers life-sustaining care over the objections of the patient or her proxy should be liable for compensatory damages.

INTRODUCTION

With the nation's attention now focused on assisted suicide, it would be natural to assume that the earlier battles over patient authority to refuse unwanted life-sustaining care had been won. Indeed, as a matter of legal doctrine, a patient's right to refuse life-sustaining care is virtually absolute. In hospital wards, however, that right is often illusory. In 1995, a major study of physician behavior, called the "SUPPORT study," confirmed what many smaller studies had previously suggested—physicians routinely ignore patient instructions about end-of-life medical care.¹ Even more alarmingly, this study found that a multi-million dollar intervention designed to improve respect for patient preferences had virtually no impact on physician behavior. Last spring, these investigators published three more studies further confirming the dismal truth—patient preferences rarely affect treatment decisions.²

1. See *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995) [hereinafter *SUPPORT*].

2. See Joan M. Teno et al., *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention*, 45 J. AM. GERIATRICS SOC'Y 500 (1997) [hereinafter Teno et al., *Advance Directives for Seriously Ill*] (finding that the use of advance directives did not improve patient-physician communication or affect treatment decisions, even with the SUPPORT intervention, and that half of the advance directives given to hospitals upon admission were not placed in the patients' charts); Joan M. Teno et al., *Do Advance Directives Provide Instructions That Direct Care?*, 45 J. AM. GERIATRICS SOC'Y 508 (1997) [hereinafter Teno et al., *Do Advance Directives*] (concluding that advance directives are typically too general to guide medical decision making and that specific instructions are violated half of the time); Joan M. Teno et al., *The Illusion of End-of-Life Resource Savings with Advance Directives*, 45 J. AM. GERIATRICS SOC'Y 513 (1997) (finding that the increased use of advance directives was not associated with a reduced resource use).

Given this clinical data, it should not be surprising that the number of lawsuits complaining of unwanted life support appears to be increasing.³ Standing in the way, however, is a surprisingly serious doctrinal obstacle. Lawsuits seeking damages for the unwanted extension of life bear a strong resemblance to actions for wrongful life. In wrongful life cases, disabled children allege that they were born because the defendant negligently deprived their parents of the opportunity to prevent their conception or birth. These children, like patients who complain about unconsented life support, contend that life itself is a compensable injury. Concerns about this contention have led nearly all courts to reject claims for wrongful life. If courts treat actions for unconsented life support as analogous, they are likely to reject them as well.

In October 1996, the Ohio Supreme Court became the first court to consider this argument against allowing recovery for unconsented life support. In *Anderson v. St. Francis-St. George Hospital, Inc.*,⁴ the court relied on Ohio case law rejecting recovery for wrongful life and denied recovery for unconsented care. Although the court conceded that physicians are legally required to accede to a patient's refusal of life-extending medical treatment,⁵ it nevertheless concluded that the prolongation of life is not a legally cognizable injury. As a result, the physician's breach of duty was a wrong "for which there simply should be no monetary compensation."⁶

The timing of this judicial opinion is exquisitely ironic. Judicial endorsement of the wrongful life analogy comes literally on the heels of clinical research confirming both that patient preferences are regularly ignored and also that this problem is deeply entrenched and resistant to costly cures. These two events—the SUPPORT studies and the judicial endorsement of the wrongful life analogy—frame the subject matter of this Article. The discussion that follows explores whether compensatory damages should be awarded to patients who are kept alive after they or their proxies have requested that life-sustaining efforts cease.

3. See Tamar Lewin, *Ignoring "Right to Die" Directives, Medical Community Is Being Sued*, N.Y. TIMES, June 1, 1996; see also 1 ALAN MEISEL, *THE RIGHT TO DIE* § 2.4, at 51 (2d ed. 1995).

4. 671 N.E.2d 225 (Ohio 1996).

5. See *id.* at 227.

6. *Id.* at 228. Since then, a Michigan trial court has reached the same conclusion. See *Osgood v. Genesys Reg'l Med. Ctr.*, No. 94-26731-NH (Mich. Cir. Ct. Mar. 7, 1997) (Opinion/Order as to defendant hospital's post-judgment motions) (reducing the judgment from \$16.5 million to under \$2 million). The case was settled prior to appeal.

Predictably, the wrongful life analogy provides a useful starting point for examining complaints about unwanted life support. Because both wrongful life claims and actions for unconsented life support contend that life can be a compensable injury, they both raise questions about respect for life and the calculability of damages. But the wrongful life analogy is only a starting point for satisfactory exploration of the merits of a claim for wrongful resuscitation because wrongful treatment claims differ from wrongful life claims in several crucial respects. Public policy, for example, clearly supports the empowerment of patients and their proxies to decide whether life-extending treatment would be beneficial. In addition, children bringing wrongful life claims already receive some indirect legal protection through the wrongful birth actions that most states confer upon their parents. Furthermore, the calculation of damages—a problem less daunting than the wrongful life decisions have assumed—is more manageable at the end of life, when evidence of the patient's deliberations and the jury's ability to draw upon their own family and community experiences with end-of-life decision making will enhance the jury's ability to fairly assess damages. Unlike wrongful life cases, actions for unconsented life support also raise questions about the interplay between equitable and legal remedies.

These differences make it inappropriate to rely too readily on an analogy to the wrongful life cases. Instead, actions for wrongful life support warrant a thorough and independent analysis. This Article undertakes that analysis. Part I examines the bleak picture painted by existing data about physician behavior. Part II then reviews the law governing damage actions for unconsented life support, including the recent decisions endorsing the wrongful life analogy. The next two parts turn to the two unique policy concerns that doomed wrongful life claims and that potentially apply to damage actions by wrongfully resuscitated patients as well. Part III addresses the fear that recognition of a cause of action would show a disrespect for life, and Part IV examines doubts that damages can be fairly calculated. In each of these parts, I conclude that crucial factual differences between actions for unconsented life support and actions for wrongful life make the objections much less powerful at the end of life. The remainder of the Article then examines the fundamental issues of justice and deterrence raised when physicians provide unwanted life support. First, Part V explores the requirements of corrective justice and the emerging, but ultimately unpersuasive, view that partial recovery would provide an adequate remedy. Part VI then considers the goal of deterrence, examines the fear that liability will produce an undesirable chilling effect

on emergency medical care, and suggests how the underlying cause of action could be tailored to avoid this risk.

I. THE CLINICAL DATA

The same medical revolution that has given Americans longer, healthier, and more productive lives also has made it possible to prolong death in ways that many Americans fear.⁷ In the face of this technological paradox, the courts have recognized that patients and their surrogates may not wish to use all of the available life-sustaining technologies.⁸ Sadly, the medical evidence also indicates that patient preferences are routinely ignored.

The most ambitious and highly awaited study was undertaken under the sponsorship of the Robert Wood Johnson Foundation. In 1995, Phase I of the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) enrolled 9105 patients with life-threatening illnesses in five hospitals for a two-year study of clinical practices at the end of life. Phase II conducted a two-year controlled clinical trial of interventions intended "to improve end-of-life decision making and reduce the frequency of a mechanically supported, painful and prolonged process of dying."⁹

Phase I of the study revealed a disappointing failure of communication between patients and their physicians. Only 48% of the physicians could accurately identify their patients' preferences for cardiopulmonary resuscitation (CPR), even though all of the patients enrolled in the study were seriously ill and nearly half (48%) were expected to die within six months.¹⁰ Similarly, nearly half (49%) of the patients who wished to have CPR withheld never had a do-not-resuscitate (DNR) order written.¹¹

Disturbed by these findings, the study's investigators and leading physicians designed an intervention program to improve communication and decision making.¹² This Phase II intervention employed nurses to provide

7. See SUPPORT, *supra* note 1, at 1591.

8. See *infra* text at notes 114-115 and 193-195.

9. SUPPORT, *supra* note 1, at 1591.

10. See *id.* at 1593-94.

11. See *id.* at 1594. In addition, 46% of the DNR orders were written within two days of death; 38% of the patients who died spent at least 10 days in an intensive care unit; and, of those patients who died, 50% reportedly suffered moderate or severe pain at least half of the time. See *id.* at 1591.

12. See *id.* at 1592. The investigators hoped to achieve these goals "by providing timely and reliable prognostic information, by eliciting and documenting patient and family prefer-

treating physicians with accurate prognostic information and timely reports of patient or surrogate preferences¹³—the two most important factors cited by physicians when making end-of-life treatment decisions.¹⁴ To the obvious distress of the researchers, the Phase II intervention failed to significantly improve communication: only 40% of the patients discussed CPR with their physicians, as compared to 37% in the control group.¹⁵ Nor did the intervention improve outcomes in the five clinical areas targeted by the researchers: (1) the incidence and timing of DNR orders; (2) physician knowledge of patient CPR preferences; (3) the number of days that patients spent in an intensive care unit, comatose, or receiving mechanical ventilation; (4) the level of reported pain; and (5) the use of hospital resources.¹⁶ Moreover, the researchers could not find any subset of patients for whom outcomes had improved.¹⁷

Phase II's failure to improve physician knowledge of patient preferences is especially disturbing because physicians received at least one report of patient preferences in 78% of the cases.¹⁸ According to one reviewer, physicians acknowledged receiving these reports in only 34% of the cases.¹⁹

How alarmed should we be by these findings? On the one hand, the inevitable limitations of a single study caution against unduly dramatic conclusions. Other interventions might be more successful than the one attempted here.²⁰ Perhaps, for example, physician facilitators would have

ences . . . and by providing a skilled nurse to help carry out the needed discussions, convene the meetings and bring to bear the relevant information." *Id.*

13. *See id.* at 1596.

14. *See* Deborah J. Cook et al., *Determinants in Canadian Health Care Workers of the Decision to Withdraw Life Support from the Critically Ill*, 273 JAMA 703, 705 tbl.2 (1995).

15. *See* SUPPORT, *supra* note 1, at 1592. Of those who did not have such a discussion, 41% said they would have liked to discuss CPR. *See id.* at 1595.

16. *See id.* at 1592. Nor did outcomes improve over time to reflect evolving ethics and policy. *See id.* at 1596.

17. *See id.*

18. *See id.* at 1594. A nurse clinician either gave a patient's advance directive to the physician or placed it in the chart. *See* Teno et al., *Advance Directives for Seriously Ill*, *supra* note 2, at 502.

19. *See* Bernard Lo, *Improving Care near the End of Life: Why Is It So Hard?*, 274 JAMA 1634, 1635 (1995).

20. One commentator pointed out that the study may have overenrolled patients and physicians who were uncomfortable dealing with death. *See* Greg A. Sachs, Letter, 275 JAMA 1229 (1996). Because the study enrolled patients in the hospital, it may have lost those patients and physicians opting for palliative care rather than death in an ICU.

more success than nurses.²¹ And the means of communication between the nurses and physicians may have been poorly designed.²² In addition, most patients and families were satisfied with their treatment.²³ Furthermore, the five outcomes criteria used in the study appear to assume that aggressive care near death is improper, an assumption that is inaccurate in cases in which the patient's prognosis is not hopeless.²⁴

On the other hand, the study's failure also provides substantial reason for deep disappointment. This intervention was designed and, at least to some extent, undertaken by physicians committed to an improvement in the process. The five participating hospitals had been chosen for "their willingness to undertake a substantial and controversial challenge."²⁵ The nurses engaged to improve the communications were "committed, energetic and highly trained."²⁶ Furthermore, the study had enough statistical power to detect even small positive effects.²⁷ Yet, the investigators could find no evidence of success.²⁸

More importantly, the disappointing findings of the SUPPORT study are consistent with evidence from other smaller studies, many of which preceded the SUPPORT study. In a 1994 review of that literature, David Orentlicher concluded that physicians are inclined to ignore patient instructions that do not match their own beliefs about patient welfare.²⁹ In a 1992 survey, for example, 31.3% of the respondents stated that the patient's right to choose was either unimportant or moderately important

21. See *SUPPORT*, *supra* note 1, at 1596. Although the nurses were substantially free to shape their own role, the physicians were free to limit nurse intervention; however, few did so. See *id.* at 1592.

22. See JUDITH AREEN ET AL., *LAW, SCIENCE AND MEDICINE* 133 (1996) (teachers manual).

23. See *SUPPORT*, *supra* note 1, at 1596.

24. See *Lo*, *supra* note 19, at 1635.

25. *SUPPORT*, *supra* note 1, at 1596.

26. *Id.*

27. See *id.*

28. See *id.* (finding no success even for subsets of patients or physicians). Not even enactment of the Patient Self-Determination Act (PSDA) during the pendency of the study improved outcomes. See *id.*; see also Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751 (Medicare and Medicaid, respectively) (codified as amended at 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f), 1396a(a)(57), 1396a(a)(58), and 1396a(w) (1994)) (requiring hospitals to inform patients of their right to govern their own medical care).

29. See David Orentlicher, *The Limitations of Legislation*, 53. MD. L. REV. 1255, 1281 (1994).

to decisions about life-sustaining care.³⁰ Physicians' willingness to comply also varied with patient prognosis.³¹ Because they were most willing to deviate from instructions when a patient's prognosis was most promising, these physicians appeared to be substituting their own beliefs about patient welfare for those of the patient.³² In a survey of Canadian family physicians conducted the same year, more than half of the physicians who had personal experience with advance directives said that they did not always follow the directions contained in the directive.³³

In a 1989 survey of Arkansas physicians currently engaged in general practice, 32.4% strongly agreed that "the training and experience of physicians gives them greater authority than patients in decisions about withholding 'heroic' treatment."³⁴ And in a 1993 survey of Rhode Island physicians, only 59% said they would turn off a respirator of a patient who had no hope of coming off the respirator and had requested discontinuation.³⁵

Not surprisingly, several other recent studies have found that patient preferences and patient directives do not affect either treatment patterns or resource use.³⁶ In fact, the problem persists even when patient wishes are

30. See Panagiota V. Caralis & Jeffrey S. Hammond, *Attitudes of Medical Students, Housestaff, and Faculty Physicians Toward Euthanasia and Termination of Life-Sustaining Treatment*, 20 CRITICAL CARE MED. 683, 686 tbl.4 (1992).

31. See *id.* at 687 tbl.5. While half of the physicians would discontinue ventilator support for a hypothetical patient with metastatic breast cancer or severe emphysema, less than one third would do so for a mildly demented elderly woman with pneumonia.

32. See Orentlicher, *supra* note 29, at 1284.

33. See David L. Hughes & Peter A. Singer, *Family Physicians' Attitudes Toward Advance Directives*, 146 CANADIAN MED. ASS'N J. 1937, 1941 (1992).

34. Kent W. Davidson et al., *Physicians' Attitudes on Advance Directives*, 262 JAMA 2415, 2416 tbl.3 (1989). Another 16.9% were undecided.

35. See Terri R. Fried et al., *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 153 ARCHIVES INTERNAL MED. 722, 723-724 tbl.3 (1993).

36. See Marion Danis et al., *A Prospective Study of the Impact of Patient Preferences on Life-Sustaining Treatment and Hospital Cost*, 24 CRITICAL CARE MED. 1811 (1996) (presenting a prospective study of hospitalized patients with a short life expectancy and finding no significant association between a patient's desire to receive treatment to prolong life and either life-sustaining treatment use or hospital costs); Lawrence J. Schneiderman et al., *Effects of Offering Advance Directives on Medical Treatments and Costs*, 117 ANNALS INTERNAL MED. 599 (1992) (concluding that advance directives had no significant effect on treatments or costs); Teno et al., *Advance Directives for Seriously Ill*, *supra* note 2, at 500 (finding, after the PSDA, that advance directives were more commonly noted in the chart (35%), but that less than half of the physicians were aware of the directives and that presence of the directives did not change the frequency of DNR orders or attempted resuscitation); Joan M. Teno et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resource for Seriously Ill Patients?*, 5 J. CLINICAL ETHICS 23, 27 (1994) (finding, prior to the PSDA, that patients with a living will were

stated with some specificity. A follow-up study by the SUPPORT investigators in spring 1997 found that treatment decisions deviate from even specific patient instructions half of the time.³⁷

Only one major study gives even mild cause for optimism,³⁸ and that optimism does not survive close analysis. In a 1991 study of nursing-home patients, Marion Danis and his co-authors found that 75% of the decisions made about life-sustaining care were consistent with the patient's living will.³⁹ This hopeful statistic, however, is tempered by the fact that 25% of the treatment decisions were contrary to patient directives.⁴⁰ Furthermore, as David Orentlicher points out, the concurrence of patients and physicians in the other 75% of the cases may simply mean that patient preferences often conformed with the preferences of their physicians.⁴¹ His hypothesis that physicians had simply acted on their own medical judgments is supported by the fact that the patients' living wills usually did not accompany them from the nursing home to the hospital.⁴² Moreover, the presence of a living will in the chart did not increase the odds of compli-

no more likely to have a DNR order entered, DNR withheld, or a different pattern of resource use). *But see* Joan M. Teno et al., *Preferences for Cardiopulmonary Resuscitation: Physician-Patient Agreement and Hospital Resource Use*, 10 J. GEN. INTERNAL MED. 179 (1995) (finding that both physician and patient preferences for CPR influenced total hospital resource consumption); *cf.* Christopher V. Chambers et al., *Relationship of Advance Directives to Hospital Charges in a Medicare Population*, 154 ARCHIVES INTERNAL MED. 541, 541 (1994); William B. Weeks et al., *Advance Directives and the Cost of Terminal Hospitalization*, 154 ARCHIVES INTERNAL MED. 2077, 2078 (1994). *See generally* 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 (1997) (reviewing the literature).

Other studies have found that discontinuance of life support is almost always undertaken at the suggestion of the physician, rather than vice versa, which strongly suggests that physicians control the decision. *See* David A. Schwartz & Philip Reilly, *The Choice Not to Be Resuscitated*, 34 J. AM. GERIATRICS SOC'Y 807 (1986) (finding, in a study of DNR orders, that physicians raised the issue in 90% of the cases); Nicholas G. Smedira et al., *Withholding and Withdrawal of Life Support from the Critically Ill*, 322 NEW ENG. J. MED. 309 (1990) (noting that only 6% of decisions to terminate treatment in this study of ICUs were initiated by patient or surrogate requests).

37. *See* Teno et al., *Advance Directives for Seriously Ill*, *supra* note 2, at 508.

38. *See* Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882 (1991).

39. *See id.* at 884. This included written directives from patient surrogates.

40. The 25% figure may slightly overstate the actual frequency of deviation from patient wishes (as distinguished from their written directives), as this figure appears to include two cases in which the patients changed their minds, and one in which the family changed its mind. *See id.* at 886. Also, at least 4 of the 24 cases of deviation from patient wishes reflected less (rather than more) aggressive treatment than the patient requested. *See id.*

41. *See* Orentlicher, *supra* note 29, at 1281-82.

42. *See* Danis et al., *supra* note 38, at 884. The living will was incorporated into the hospital chart in 25 out of 71 hospitalizations. *See id.*

ance with patient wishes.⁴³ As a result, this study provides little reason to believe that patient preferences are respected when they diverge from those of the physician.

One other 1995 study also deserves mention. In a study of 114 acute hospitalizations, all of the study subjects had previously executed advance directives.⁴⁴ Advance directives appeared to influence the treatment decision in twelve of the fourteen cases (86%) in which directives were recognized.⁴⁵ However, patient directives were recognized by the treating physicians in only 26% of the admissions involving incapacitated patients.⁴⁶ In the other 74% of the cases, "medical decisions appeared to be made without consulting the patients' designated proxy or living will."⁴⁷

Hospitals fare little better than physicians. One study of the Patient Self-Determination Act found that 40% of the advance directives received by hospitals were not included in the patient's chart.⁴⁸ A more recent 1997 study by the SUPPORT investigators confirmed this indictment of hospital practices: under ordinary circumstances, only 35% of the advance directives were noted in the medical chart.⁴⁹

Furthermore, physicians are usually unaware of advance directives even when they are placed in the chart. In one study, only 26% were aware and in another only 25%.⁵⁰ As a result, investigators have concluded

43. See *id.* at 885.

44. See R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, 274 JAMA 478 (1995). The original patient sample was drawn from patients with a directive in their outpatient charts. See *id.* at 482.

45. See *id.*

46. See *id.* at 480 (that is, in 14 of 39 admissions).

47. *Id.* at 481. In 30 of the 39 admissions in which existing directives were not acknowledged, the decisions had input from family members. In none of these cases was the person making the decision a proxy chosen at the patient's directive. See *id.* Whenever the physicians relied on a person who was an authorized proxy, the investigators treated this as recognition of an advance directive even if the chart contained nothing else to indicate awareness of the directive. See *id.* at 481. As a result, the study may overstate the incidence of recognition. See *id.* Most of the time, the family member consulted was not the patient's designated surrogate. See *id.* at 481. The authors place responsibility for the lack of recognition of advance directives on nursing homes, admitting clerks, physicians, patients, and their families. See *id.* at 481.

48. See OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH & HUMAN SERVS., PATIENT ADVANCE DIRECTIVES: FACILITY AND PATIENT RESPONSES (1993); see also Danis et al., *supra* note 38, at 884 (finding that the patient's living will went from the nursing home to the hospital chart in only 25 of 71 hospitalizations); Morrison et al., *supra* note 44, at 478.

49. See Teno et al., *Advance Directives for Seriously Ill*, *supra* note 2, at 500 (additionally finding that the rate increased to 78% when a nurse was specifically hired to facilitate communication).

50. See Morrison et al., *supra* note 44, at 480 (14 out of 39); Teno et al., *Advance Directives for Seriously Ill*, *supra* note 2, at 500 (by the second week only one in four physicians was aware of patient's advance directives).

that increasing the documentation of existing advance directives does not improve either patient-physician communication or decision making about resuscitation.⁵¹

The current prospects for self-determination are bleak. Cumulatively, the data suggest a disappointing absence of communication between patients and physicians, an inexplicable failure by hospitals to place patient directives in the chart, an inexcusable failure by physicians to familiarize themselves with available written information about patient preferences, and even an outright disrespect for patient wishes.⁵² Furthermore, the failure of the Phase II SUPPORT intervention warns that even a serious effort to enhance communication that commits as much professional time and resources as can reasonably be expected may not change established practices at all.⁵³ In the words of the SUPPORT investigators, "more proactive and forceful measures may be needed."⁵⁴

II. THE LEGAL BACKGROUND

Disrespect for the wishes of patients and their proxies can take the form of either overtreatment or undertreatment.⁵⁵ Each form of misconduct warrants redress. However, each cause of action raises its own distinct legal issues.⁵⁶ This Article addresses the doctrinal and policy issues presented when physicians are alleged to have administered unwanted treatments.

51. See Teno et al., *Advance Directives for Seriously Ill*, *supra* note 2, at 500 (finding that increased documentation following enactment of the PSDA did not increase discussions with patients about resuscitation, DNR orders, or attempted resuscitation); Schneiderman, *supra* note 36 (finding that patients with and without advance directives were treated the same).

52. See Danis et al., *supra* note 38, at 882 (noting that physician awareness of patient wishes did not increase the likelihood that these wishes would be carried out).

53. See SUPPORT, *supra* note 1, at 1591. "The study certainly casts a pall over any claim that, if the health care system is given additional resources for collaborative decision making in the form of skilled professional time, improvements will occur." *Id.* at 1596.

54. *Id.* at 1591; accord Robert R. Frank & Margaret L. Campbell, Letter, 275 JAMA 1228 (1996).

55. For findings of undertreatment, see, for example, Alison B. Seckler et al., *Substituted Judgment: How Accurate Are Proxy Predictions?*, 115 ANNALS INTERNAL MED. 92, 95 (1991); see also Danis et al., *supra* note 38, at 886.

56. In routine cases, the negligent or intentional failure to provide life-sustaining care requested by the patient would support an action for wrongful death. A unique set of policy issues arise, however, if the physician contends that the requested treatment would have been "futile." I explored the disability rights issues raised by these futility arguments in an earlier article. See Philip G. Peters, Jr., *When Physicians Balk at Futile Care: Implications of the Disability Rights Laws*, 90 NW. U. L. REV. 798 (1997).

Actions for compensatory damages are the most powerful legal tool that patients and their families can employ to remedy the harms caused when physicians disregard their wishes. In the twenty years since the *Quinlan*⁵⁷ case created the modern field of death and dying law, patients and their representatives have employed a variety of legal theories in their efforts to recover damages for the administration of unconsented life-sustaining care. Most claims have been brought using tort theories such as battery,⁵⁸ negligence,⁵⁹ informed consent,⁶⁰ and the intentional infliction of emotional distress.⁶¹ A few patients have claimed that the unwanted administration of life support violated their federal civil rights.⁶² And some have sought more limited financial relief, requesting only to escape payment for the unconsented medical services⁶³ or to recover the legal costs of obtaining a favorable court order.⁶⁴

Until recently, these lawsuits were rarely successful.⁶⁵ By far the most common obstacle—one extending across all theories of recovery—has been judicial reluctance to impose liability on physicians and hospitals who continued life support when they were uncertain about the legal propriety of ceasing life support.⁶⁶

57. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

58. *See, e.g., Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360 (Ct. App. 1986); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984).

59. *See, e.g., Clark v. Perry*, 442 S.E.2d 57 (N.C. Ct. App. 1994); *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225 (Ohio 1996).

60. *See, e.g., Bartling*, 229 Cal. Rptr. at 360; *Benoy v. Simons*, 831 P.2d 167 (Wash. Ct. App. 1992).

61. *See, e.g., Bartling*, 229 Cal. Rptr. at 360; *McVey v. Englewood Hosp. Ass'n*, 524 A.2d 450 (N.J. Super. Ct. App. Div. 1987) (per curiam).

62. *See, e.g., Foster v. Tourtellotte*, 704 F.2d 1109 (9th Cir. 1983); *Ross v. Hilltop Rehabilitation Hosp.*, 676 F. Supp. 1528 (D. Colo. 1987).

63. *See, e.g., Grace Plaza of Great Neck, Inc. v. Elbaum*, 623 N.E.2d 513 (N.Y. 1993); *First Healthcare Corp. v. Rettinger*, 467 S.E.2d 243 (N.C. 1996).

64. *See, e.g., Gray v. Romeo*, 709 F. Supp. 325 (D.R.I. 1989); *McMahon v. Lopez*, 245 Cal. Rptr. 172 (Ct. App. 1988); *Bouvia v. County of L.A.*, 241 Cal. Rptr. 239, 243 (Ct. App. 1987).

65. *See* ELENA COHEN, 1 BIOLAW, at R:262 (1989) (reporting that no significant damage awards had been won by patients in the United States); 2 MEISEL, *supra* note 3, § 17.1, at 352 (same); M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499, 505-12 (1992) (same); Robert M. Veatch, *Foregoing Life-Sustaining Treatment: Limits to the Consensus*, 3 KENNEDY INST. ETHICS J. 1, 6 (1993) (same).

However, settlements were reported in two cases. *See* David H. Miller, *Right-to-Die Damage Actions: Developments in the Law*, 65 DENV. U. L. REV. 181, 197 (1988). Also, a Canadian court awarded damages of \$20,000. *See* *Malette v. Shulman*, [1990] D.L.R. 4th 321 (Can.).

66. *See, e.g., Foster*, 704 F.2d at 1109 (denying attorneys' fees because the hospital's legal duties were uncertain); *Bartling*, 229 Cal. Rptr. at 361; *Ross*, 676 F. Supp. at 1534 (noting that the law governing the withholding of nutrition was unclear); *McVey*, 524 A.2d at 450 (refusing

Not surprisingly, physicians have taken comfort in their de facto immunity. As Dr. Nancy Dickey, then chairwoman of the board of the American Medical Association, stated, "The thinking has been that if you do intervene and you shouldn't have, the worst that will happen is that the patient will live a little longer and that you'll never be held accountable if you keep the patient from dying."⁶⁷

Commentators, however, reasonably assumed that judicial solicitude for physicians would weaken as the courts more clearly enunciated the circumstances in which life-sustaining treatment could be refused.⁶⁸ Two factors strongly pointed to that conclusion. First, general principles of tort law ordinarily treat unconsented medical care as a battery.⁶⁹ Indeed, unconsented treatment is tortious even if it is harmless or beneficial.⁷⁰ In a few states, the advance directive statutes also expressly authorize civil actions.⁷¹ Second, the early judicial opinions had emphasized the unfairness of imposing liability on physicians who were forced to make life-and-death treatment decisions in the face of uncertain and evolving legal rules. However, these courts did not express any doubts about the propriety of imposing liability on physicians who had administered unwanted treatment under circumstances in which the legal authority of the patient or proxy to refuse consent was clear. Even the Supreme Court appears to have assumed that battery could lie for the unconsented and unjustified administration of life support.⁷²

to oblige physicians to determine the veracity or effect of the patient's purported oral instructions); *Grace Plaza*, 623 N.E.2d at 513 (permitting a physician to treat if she "harbors some uncertainty on the matter" until the issue is legally determined).

67. Lewin, *supra* note 3, at A28.

68. See, e.g., 2 MEISEL, *supra* note 3, § 17.1, at 352; MICHAEL H. SHAPIRO & ROY G. SPECE, JR., *CASES, MATERIALS AND PROBLEMS ON BIOETHICS AND THE LAW* 278 (Supp. 1991); Gasner, *supra* note 65, at 518.

69. See RESTATEMENT (SECOND) OF TORTS § 15 cmt. a, illus. 1 (1965).

70. See, e.g., *Estate of Leach v. Shapiro*, 469 N.E.2d 1047 (Ohio 1984); *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956).

71. See, e.g., ME. REV. STAT. ANN. tit. 18-A, § 5-81 (West Supp. 1995) (authorizing actual damages plus attorneys' fees for intentional violations); NEB. REV. STAT. ANN. § 20-402(1) (Michie 1995) ("Unjustifiable violation of a patient's direction shall be a civil cause of action maintainable by the patient or the patient's next of kin."); N.M. STAT. ANN. § 24-7A-1 (Michie Supp. 1996) (same); TENN. CODE ANN. § 32-11-1-8(a) (Supp. 1996) ("Any health care provider who fails to make good faith reasonable efforts to comply with the preceding procedure as prescribed by the attending physician shall be civilly liable . . ."); see also UNIF. HEALTH CARE DECISIONS ACT § 10, 9 U.L.A. 242 (West Supp. 1996) (authorizing actual damages plus attorneys' fees for intentional violations and adopted in Maine and New Mexico).

72. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (discussing the common law view that even nonconsensual touching could constitute a battery).

Now a second generation of unconsented care cases is testing this hypothesis.⁷³ Some have resulted in sizable jury awards—\$500,000 in one reported instance⁷⁴ and \$16.5 million in another.⁷⁵ Given the empirical evidence that physicians routinely ignore advance directives, the emergence of these cases is certainly not surprising. Indeed, one reported motivation for these suits is “a desire on the plaintiffs’ part to effect a change in the culture of medicine.”⁷⁶

However, the fate of future lawsuits has been placed in serious jeopardy by a doctrinal obstacle whose power was not fully appreciated by the first generation of courts and commentators. That obstacle is the similarity that these lawsuits bear to wrongful life claims: both actions seek damages for unwanted life. In a wrongful life action, a child seeks damages from a provider whose negligence has resulted in the child’s conception or birth.⁷⁷ In the typical action for unwanted life support, the patient seeks damages for being kept alive against her wishes.⁷⁸ In both actions, life and its associated burdens are the harms alleged.⁷⁹ In wrongful life cases, the courts have been troubled by the policy implications of this allegation. In particular, they have worried that recognition of a claim based on the harmfulness of life would be inconsistent with respect for life. They have also harbored serious doubts about the calculability of damages for this

73. See *supra* note 3.

74. In San Francisco, a jury reportedly awarded a family of Jehovah’s Witnesses \$500,000 for giving a three-year-old child blood transfusions against parental wishes during a kidney transplant. See SHAPIRO & SPECE, *supra* note 68, at 328 (citing *Transfusion Dispute Nets Family \$500,000*, ARIZ. BUS. GAZETTE, Apr. 20, 1990, at 28).

75. See *Osgood v. Genesys Reg’l Med. Ctr.*, No. 94-26731-NH (Mar. 7, 1997) (reducing the judgment from \$16.5 million to under \$2 million). The case was then reportedly settled.

76. AREEN ET AL., *supra* note 22, at 135 n.20; see also Lewin, *supra* note 3, at A28.

77. See PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 370 (5th ed. 1984).

78. In rare circumstances, the action may not turn on the unwanted extension of life. For example, unconsented life-sustaining care, such as chemotherapy, could actually shorten the life of some patients. Samuel Oddi gives the example of transfusing a patient with incompatible blood. See A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 641 (1986) (noting that wrongful death damages would be the measure of damages). In other cases, unwanted life-sustaining care may be improperly performed, inflicting unnecessary injuries that make the patient’s life more painful or difficult. In that event, ordinary personal injury damages would provide the remedy.

79. See *Anderson v. St. Francis–St. George Hosp., Inc.*, 671 N.E.2d 225 (Ohio 1996); see also William C. Knapp & Fred Hamilton, “Wrongful Living”: Resuscitation as Tortious Interference with a Patient’s Right to Give Informed Refusal, 19 N. KY. L. REV. 253, 258 (1992); Adam A. Milani, *Better off Dead Than Disabled?: Should Courts Recognize a “Wrongful Living” Cause of Action When Doctors Fail to Honor Patients’ Advance Directives?*, 54 WASH. & LEE L. REV. 149, 222 (1997).

alleged harm. As a result, almost all courts have rejected wrongful life cases.⁸⁰ The same fate could await actions for unconsented life support.

Surprisingly, the wrongful life analogy received little serious judicial or scholarly attention until the past year. Instead, both courts⁸¹ and commentators⁸² focused on the other doctrinal and policy issues raised by claims for unwanted life support. Although Samuel Oddi used the phrases “wrongful living” and “wrongful prolongation of life” in 1986 to describe actions for unconsented life support,⁸³ the wrongful life analogy itself was typically overlooked altogether,⁸⁴ dismissed summarily,⁸⁵ or else mistakenly treated as inconsequential.⁸⁶ Until autumn 1996, no court or law review

80. See DAN B. DOBBS, *LAW OF REMEDIES* § 8.2, at 662 (2d ed. 1993); Philip G. Peters, Jr., *Rethinking Wrongful Life: Bridging the Boundary Between Tort and Family Law*, 67 *TUL. L. REV.* 397, 400–02 (1992). Only three states clearly permit some recovery, and they limit recovery to the extraordinary costs associated with the child’s birth defects. See *infra* text accompanying note 143.

81. Prior to 1996, the only state to address the wrongful life analogy was Washington—one of the three states permitting partial recovery in wrongful life actions. See *Benoy v. Simons*, 831 P.2d 167, 170 (Wash. Ct. App. 1992). That case refused to recognize a new action for “wrongful prolongation of life;” it rejected the wrongful life analogy because the breaches of duty in the two types of cases differ.

82. See *infra* text at notes 84–86.

83. See Oddi, *supra* note 78.

84. See, e.g., David H. Miller, *Right-to-Die Damage Actions: Developments in the Law*, 65 *DENV. U. L. REV.* 181 (1988); Steven I. Adlestone, Note, *Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy*, 46 *VAND. L. REV.* 1255 (1993).

85. See, e.g., Richard P. Dooling, Comment, *Damage Actions for Nonconsensual Life-Sustaining Medical Treatment*, 30 *ST. LOUIS U. L.J.* 895, 916–18 (1986); see also Gasner, *supra* note 65, at 511 n.83 (distinguishing the cases because unconsented care cases do not involve an allegation that the plaintiff would never have existed but for the tortious conduct); Knapp & Hamilton, *supra* note 79, at 258 (acknowledging that both actions pose the same value question, but distinguishing the wrongful life cases on the grounds that they lack a decision by the patient before the fact); Oddi, *supra* note 78, at 641 n.75 (suggesting that only wrongful life actions require a comparison between life and nonlife).

In an interesting variation, one student note relies on the similarity to build a case for partial recovery, but fails to explain why the analogy will not doom the action altogether in the great majority of states that reject wrongful life actions. See Tricia Jonas Hackleman, *Violation of an Individual’s Right to Die: The Need for a Wrongful Living Cause of Action*, 64 *U. CIN. L. REV.* 1355, 1364–73 (1996).

86. See 2 MEISEL, *supra* note 3, § 17.17, at 401 (suggesting that rejection of a “wrongful living” cause of action “would work no hardship on the plaintiff in terms of establishing liability” because the plaintiff would continue to have claims for battery or negligence); see also Willard H. Pedrick, *Dignified Death and the Law of Torts*, 28 *SAN DIEGO L. REV.* 387, 390 (1991) (suggesting that an action would still lie in battery). Recent critics of a wrongful living cause of action have made the same error. See *Anderson v. St. Francis–St. George Hosp., Inc.*, 671 N.E.2d 225, 228 (Ohio 1996); Milani, *supra* note 79, at 223. For a discussion, see *infra* text accompanying note 218.

article had seriously explored either the appropriateness of the wrongful life analogy or its full implications.⁸⁷

In autumn 1996, the Ohio Supreme Court decided *Anderson v. St. Francis-St. George Hospital, Inc.*⁸⁸ *Anderson* involved the treatment of Edward Winters, a competent and alert eighty-two year old with multiple health problems, including two previous heart attacks and chronic heart disease. Dismayed by death-prolonging treatments that had been given to his wife, he instructed his physician to withhold extraordinary life-saving measures in the event of further illness. A "no code blue" order was placed in his chart. On May 28, 1988, Mr. Winters suffered ventricular tachy-chardia. Despite the "no code" order, he was resuscitated by shocking his heart with an electric current. Two days later, he suffered a stroke that paralyzed his right side. Before his death two years later, he sued the hospital for battery, negligence, and "wrongful living" because the hospital had failed to respect his wish not to be resuscitated.⁸⁹

Although the Ohio Supreme Court conceded that Mr. Winters's physicians were legally required to comply with his directions,⁹⁰ it denied him recovery on the grounds that the prolongation of his life was not a compensable injury.⁹¹ "There are some mistakes, indeed even breaches of duty," it concluded, "for which there simply should be no monetary compensation."⁹² In reaching this conclusion, the court quoted from prior wrongful life opinions in which it had both "recognized 'the impossibility of a jury placing a price tag' on the benefit of life,"⁹³ and also "disapproved of awarding damages on the relative merits of 'being versus nonbeing,'"⁹⁴ However, the court did suggest that providers would be liable in battery for any damages "directly" caused by unwanted treatment, such as tissue burns or broken bones.⁹⁵

In spring 1997, in *Osgood v. Genesys Regional Medical Center*,⁹⁶ a Michigan trial court joined *Anderson* in endorsing the wrongful life anal-

87. In 1993, however, Norman Cantor did note the analogy. See NORMAN CANTOR, *ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY* 133 (1993).

88. 671 N.E.2d 225 (Ohio 1996).

89. See *Anderson v. ADMR*, 614 N.E.2d 841, 843 (Ohio 1992).

90. See *St. Francis-St. George*, 671 N.E.2d at 227.

91. See *id.*

92. *Id.* at 228.

93. *Id.* (quoting *Johnson v. University Hosp. of Cleveland*, 540 N.E.2d 1370, 1378 (Ohio 1989)).

94. *Id.* (quoting *Bowman v. Davis*, 356 N.E.2d 496, 499 n.3 (Ohio 1976)).

95. *Id.* at 229.

96. No. 94-26731-NH, at 11, 15 (Mich. Cir. Ct. Mar. 7, 1997) (Opinion/Order as to defendant hospital's post-judgment motions).

ogy. Because Michigan courts reject claims for wrongful life, the trial court held that "Michigan does not recognize a claim premised on medical treatment which is alleged to be wrongful solely because it results in continued 'living.'"⁹⁷ On that basis, the court reasoned that the plaintiff was entitled only to nominal damages and medical expenses,⁹⁸ and the court therefore reduced a jury award of \$14,837,400 in compensatory damages to \$324,900. It also allowed the patient's mother to recover \$1,108,000 under an analogy to a wrongful birth claim.⁹⁹ The case was settled without appeal.

In addition, a 1997 law review article by Professor Adam Milani draws heavily on the wrongful life analogy for its arguments opposing recognition of a "wrongful living" cause of action.¹⁰⁰ Professor Milani opposes actions for wrongful living because: (1) they would harm the interests of disabled persons; (2) they require a decision about the harmfulness of life that courts cannot handle and that is antithetical to the value placed by the law on human life; (3) they require an impossible calculation of damages; and (4) there are adequate remedies available under traditional tort law.¹⁰¹ He would, however, permit a battery action for the recovery of extraordinary expenses caused by the patient's extended life.¹⁰²

Is the wrongful life analogy sound? Only partially. Although the end-of-life cases are, of course, similar to the wrongful life cases in their contention that life itself is a compensable injury, they also differ in important respects. In the wrongful life setting, for example, courts have worried that they would offend public policy if they endorsed allegations made by legal representatives of an unplanned child that the child would have been better off unborn.¹⁰³ At the end of life, on the other hand, public policy clearly supports the right of patients and often their proxies to refuse life-extending care. As a result, a reasonable argument can be made that redressing the violation of those rights would neither offend public policy nor constitute a repudiation of the value of life. Furthermore, the calculation of damages may be less daunting at the end of life than at conception because jurors have the concrete deliberations of the patient or proxy to guide them, and because they can more readily place themselves in the shoes of the patient approaching death than in the shoes of a child who

97. *Id.* at 11.

98. *See id.* at 15.

99. *See id.* at 18-19.

100. *See Milani, supra* note 79.

101. *See id.* at 154.

102. *See id.* at 223-27.

103. *See infra* text accompanying notes 106-111.

allegedly would have been better off unborn. These distinguishing factors make the public policy and calculability concerns less powerful at the end of life. In addition, wrongfully resuscitated patients lack the financial protections that wrongful birth actions provide for wrongfully conceived children. As a matter of both corrective justice and deterrence, therefore, wrongfully resuscitated patients more crucially need an action of their own.

The analogy is imperfect in other respects as well. For example, the exposure to tort liability for unconsented life support could conceivably make physicians hesitant to render emergency care in some settings, a danger not precisely mirrored in wrongful life cases. Moreover, patients and families who wish to terminate heroic efforts may be able to seek injunctive relief (rather than damages), a remedy not available to the child bringing a wrongful life case. Consequently, the unconsented care cases force us to ask whether equitable remedies should be preferred to legal ones, thereby reversing the usual presumption favoring legal redress.¹⁰⁴ Less obviously, the unconsented care cases also invite us to consider whether compensatory damages should be available in a more narrow range of cases than those eligible for equitable relief.¹⁰⁵

These differences make reflexive borrowing of the wrongful life analogy inappropriate. Instead, actions for unconsented care warrant a thorough and independent analysis of their own.

III. RESPECTING THE VALUE OF LIFE

In the wrongful life cases, many courts have been deeply troubled by the contention that life itself is a legally compensable harm. They feared that recognition of wrongful life actions by disabled children would be "a repudiation of the value of human life."¹⁰⁶ "[T]he courts of this State," wrote the Supreme Court of New Hampshire, "should not become involved in deciding whether a given person's life is or is not worthwhile."¹⁰⁷ In the eyes of the law, continued the court, all lives have equal value. Similarly, the Supreme Court of Illinois believed that "[s]uch a disavowal of life offends society's deeply rooted belief that life, in whatever condition, is more precious than nonexistence."¹⁰⁸ This perspective led the North Carolina Supreme Court to conclude that "life, even life with severe

104. See DOBBS, *supra* note 80, § 1.1, at 3.

105. This topic is discussed in Part VI. Redefining the substantive right in light of the requested remedy would deviate from traditional practice. See *id.* § 1.1, at 1-2.

106. *Blake v. Cruz*, 698 P.2d 315, 321 (Idaho 1984).

107. *Smith v. Cote*, 513 A.2d 314, 352 (N.H. 1986).

108. *Siemieniec v. Lutheran Gen. Hosp.*, 512 N.E.2d 691, 702 (Ill. 1987).

defects, cannot be an injury in the legal sense."¹⁰⁹ Many other courts have reached the same conclusion,¹¹⁰ at times implying that recognition of the cause of action would threaten societal respect for persons with severe disabilities.¹¹¹

Actions seeking damages for unconsented life support are potentially vulnerable to the same objections. Here, too, the plaintiff contends that life and its burdens are harmful.¹¹² Consequently, it is not surprising that the Ohio Supreme Court borrowed language from wrongful life opinions to support its conclusion that the prolongation of life cannot be a legal detriment.¹¹³ Despite the superficial similarity, however, courts should resist the temptation to borrow the language and reasoning of the wrongful life cases without reflecting upon the quite different circumstances and perspectives that inform the law of death and dying.

At the end of life, state courts and legislatures have already made the crucial policy decision that the prolongation of life is not always a blessing. They have come to terms with the reality that some life-sustaining treatments are more burdensome than beneficial and that patients and their families, not physicians, should make these decisions. Although courts still acknowledge that the state has an interest in the preservation of life,¹¹⁴ they routinely conclude that this interest is outweighed by the patient's right to decide.¹¹⁵

Competent and previously competent patients have a virtually absolute power to refuse life-sustaining care.¹¹⁶ Most states also permit proxies

109. *Azzolino v. Dingfelder*, 337 S.E.2d 528, 532 (N.C. 1985).

110. See, e.g., *Blake*, 698 P.2d at 322 ("To recognize wrongful life as a tort . . . is completely contradictory to the belief that life is precious."); *Siemieniec*, 512 N.E.2d at 702 ("[T]he public policy . . . to protect and to preserve the sanctity of all human life . . . militates against the judgment that an individual life is so wretched that one would have been better off not to exist."); *Bruggeman v. Schimke*, 718 P.2d 635, 642 (Kan. 1986) ("[W]hether the person is in perfect health, in ill health, or has or does not have impairments or disabilities, the person's life is valuable, precious, and worthy of protection.")

111. See *Phillips v. United States*, 508 F. Supp. 537, 543 (D.S.C. 1980); *Berman v. Allan*, 404 A.2d 8, 12-13 (N.J. 1979).

112. See, e.g., *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 228 (Ohio 1996).

113. See *id.*

114. See *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. 1978); *In re Conroy*, 486 A.2d 1209 (N.J. 1985); 1 MEISEL, *supra* note 3, §§ 2.4-5.

115. See, e.g., *Satz*, 362 So. 2d at 160; *In re Jobes*, 529 A.2d 434, 451 (N.J. 1987); 1 MEISEL, *supra* note 3, § 2.4, at 51-52; 2 MEISEL, *supra* note 3, § 8.2, at 468-70.

116. See 2 MEISEL, *supra* note 3, § 10.9, at 22; § 10.11, at 24; § 11.1, at 82 (commenting that almost all states have living will statutes and that advance directives are enforceable in other states even without legislation); *id.* § 10.11, at 23 (noting that states lacking statutory authority for living wills allow health care powers of attorney).

such as family members, guardians, and persons appointed under a durable power of attorney to make that decision when the patient's wishes are not known.¹¹⁷

The distinction between end-of-life cases and wrongful life cases is most apparent when the patient has personally directed that life-sustaining treatment cease.¹¹⁸ For obvious reasons, wrongful life cases contain no equivalent exercise of patient autonomy. The sanctity of life argument is, therefore, qualitatively weaker in the end-of-life cases. Autonomy also distinguishes those cases in which a patient has personally chosen the proxy she wishes to make decisions about her life-extending care.

The analogy to wrongful life is stronger, however, when the treatment decision is made by a proxy who has neither been chosen by the patient nor received clear guidance from the patient. In the many states that permit proxies to make decisions under these circumstances,¹¹⁹ the treatment decision cannot be characterized as an exercise of the patient's autonomy. Superficially at least, these third-party decisions about the value of continued life-sustaining care resemble decisions made by parents to avoid the birth or conception of a child whom they fear will have birth defects.

Despite this similarity, however, proxy decisions about life-sustaining care are quite different. First, parents making a decision whether or not to conceive are not necessarily making a decision that the future child would be better off dead. As a result, juries evaluating wrongful life claims are forced to make that assessment on their own. By contrast, decisions at the end of life reflect a family member's heartfelt belief that further life support would be contrary to the patient's best interests.

Second, it seems incongruous to authorize families to make decisions that end a patient's life and enforce those decisions with injunctive relief while simultaneously maintaining that compensatory damages would offend public policy. Courts regularly enforce the decision-making power

117. See 1 MEISEL, *supra* note 3, § 7.7, at 371 (describing how most states permit patient representatives, like guardians, family members, and other proxies, to make decisions for incompetent patients even if there is no clear and convincing directive from the patient, using a substituted judgment standard); *id.* § 12.4, at 133 (noting that all states except Alabama have legislation authorizing patients to appoint proxies); *id.* § 14.1, at 249 (observing that states are beginning to enact surrogate decision-making statutes).

118. See *Walker by Pizano v. Mart*, 790 P.2d 735, 740 (Ariz. 1990) (en banc) ("Children . . . have neither the ability nor the right to determine questions of conception, termination of gestation, or carrying to term."); Knapp & Hamilton, *supra* note 79, at 258.

119. See 1 MEISEL, *supra* note 3, §§ 7.12–.13, at 395–405.

of patients and their proxies with declaratory and injunctive relief.¹²⁰ These judicial orders result in death. Certainly, the threat to respect for life posed by recognition of a damages action is trivial compared to the impact of a judicial order terminating life-extending care. From this perspective, both kinds of relief are defensible because each gives substance to the legal rights of patients and their proxies. This conclusion is clearest in states whose advance directive statutes explicitly authorize civil liability,¹²¹ but it also seems reasonable in states whose legislation is silent on the issue of liability.

However, opponents of recovery are likely to point out that courts can award equitable relief without directly participating in the underlying treatment decision. Instead, courts need only enforce the decision of the patient or proxy. Suits for damages, on the other hand, require the judicial factfinder to decide independently whether the unwanted extension of life was harmful. Unless the damages calculation is restricted in some fashion (as explored in Part V),¹²² the factfinder must then place a dollar value on the harm.

This difference between equitable and legal relief has already been noted in the wrongful life cases. In *Smith v. Cote*,¹²³ for example, the court distinguished wrongful life actions from right-to-die cases because the former requires an objective calculation of harm by the court whereas the latter does not. “[T]he courts of this State,” it reasoned, “should not become involved in deciding whether a given person’s life is or is not worthwhile.”¹²⁴ In right-to-die cases, by contrast,

[t]he court avoids making an objective judgment as to the value of the plaintiff’s life; it strives, instead, to protect the individual’s subjective will. Even when the plaintiff is an incompetent, “the court does not arrogate to itself the individual’s choice,” but instead allows the plaintiff’s guardian or surrogate to make that choice on his behalf.¹²⁵

In a wrongful life case, the court continued, a court must determine “whether legal injury has occurred.”¹²⁶ Courts, it said, “have no business

120. See *supra* note 117; see also *Brophy v. New England Sinai Hosp., Inc.*, 487 N.E.2d 626 (Mass. 1986); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Ct. App. 1986).

121. See *supra* note 71.

122. See *infra* text accompanying notes 210–237.

123. 513 A.2d 341 (N.H. 1986).

124. *Id.* at 352.

125. *Id.* (citations omitted).

126. *Id.*

declaring that among the living are people who never should have been born."¹²⁷ This difference between equitable enforcement and compensatory redress has led one commentator to conclude that the right-to-die cases protect individual dignity while the wrongful life cases offend it.¹²⁸

This argument insightfully identifies a genuine factual difference between equitable and legal remedies. However, the normative conclusion that the court draws from it, in my view, is mistaken. To be sure, courts awarding damages cannot wash their hands of the underlying treatment decision. But the significance of that involvement is minor when compared with judicial willingness to recognize and enforce a right to refuse life-sustaining care. Judicial orders providing equitable or declaratory relief lead to a person's death; damages do not. These orders have far more symbolic and practical significance than an award of damages, and they do far more to destroy the legal presumption that all life is beneficial. Although calculating damages involves courts more deeply in the burden-benefit calculus than most rulings about equitable relief, it seems foolish to suggest that damages calculations have even a fraction of the societal significance of judicial decisions recognizing and enforcing a right to die.

Furthermore, judicial rulings on requests for equitable relief often involve the court quite deeply in an "objective" evaluation of the treatment decision.¹²⁹ Judicial supervision of proxy decisions for error or abuse inescapably requires judicial monitoring of the treatment decision itself, especially when the patient's probable wishes are unknown and the treatment decision is based on the patient's best interests.¹³⁰

It is easy to understand the desire of judges to affirm the worth and sanctity of "less-than-perfect life."¹³¹ Nevertheless, this desire does not provide a sufficient basis for rejecting the actions of patients who are kept alive against their wishes. When unconsented care is administered, the patient, not the court, suffers the agony of prolonged death, the impover-

127. *Id.* at 353.

128. See Patrick J. Kelley, *Wrongful Life, Wrongful Birth, and Justice in Tort Law*, 1979 WASH. U. L.Q. 919, 938-39.

129. Professor Milani notes the potential in these equitable cases for abuse of disabled patients. See Milani, *supra* note 79, at 203-15. He suggests that this bias provides a reason to reject damages actions for unconsented life support. But the cure for judicial abuse in cases seeking equitable relief is better decision making, not rejection of an action for damages.

130. See 1 MEISEL, *supra* note 3, §§ 7.12-.13, at 395-405.

131. *Turpin v. Sortini*, 643 P.2d 954, 961 (Cal. 1982).

ishment of further medical and support expenses, and the frustration and indignity of lingering beyond her time and burdening her family. Only an action for damages will fully redress these injuries, protect the financial welfare of the patient, and deter future misconduct.¹³²

Injunctive relief is not likely to be an adequate substitute. For many patients, the need for injunctive relief will not become apparent until the damage has been done.¹³³ For others, a restriction to equitable relief would place the burden of litigation on patients and their families, most of whom will be unsophisticated about legal matters, many of whom will lack resources to litigate, and all of whom will be struggling with a family medical crisis. In addition, only damages will deter future misconduct. Under these circumstances, well-intentioned presumptions about the value of life should yield to the legitimate requests of wrongfully treated patients for redress.

To summarize, a crucial factor distinguishing many unconsented care cases from all wrongful life cases is the dying patient's personal exercise of autonomy. This factor definitively distinguishes those end-of-life cases in which the patient has articulated her preferences regarding treatments or proxies. Even in those cases in which the patient's wishes are unclear, many states have authorized proxies to make treatment decisions on the patient's behalf. When proxies properly exercise this authority, their decisions are enforceable with injunctive relief. Under those circumstances, it stretches credulity to suggest that enforcement of these decision-making rights with compensatory damages offends public policy. To be sure, judges and juries will be obliged to ratify the treatment decision. But that is quite similar to enforcing a treatment decision with equitable or declaratory relief. After all, those remedies lead to the death of the patient.

In truth, both our law and our social norms support the freedom of patients and their proxies to make these decisions.¹³⁴ Enforcing their wishes will send a message that patient rights must be respected, not a message that other patients with a similar prognosis must decline care.

132. In Part V, I explore the suggestion that the wrongfully treated patient's recovery should be limited to extraordinary support costs, similar to the parental recovery allowed in wrongful birth actions. See *infra* text accompanying notes 210–237.

133. One irony of rejecting recovery is that the loss of deterrence could increase the number of patients who might seek physician-assisted suicide as a way of mitigating their injury.

134. See 1 MEISEL, *supra* note 3, § 1.5, at 12–13 (reviewing surveys finding popular sentiment favorable to the rights of patients and their families to refuse some forms of life-sustaining care).

IV. CALCULATING DAMAGES

Under traditional tort analysis, a plaintiff seeking compensatory damages must prove that she has been harmed by the defendant's tortious conduct.¹³⁵ Although a plaintiff who can prove intentional misconduct can recover nominal¹³⁶ and sometimes even punitive damages¹³⁷ without any proof of harm, she cannot recover compensatory damages without this proof.

To meet this burden, the plaintiff must demonstrate that the defendant's misconduct has made her worse off than she would have been "but for" the tort.¹³⁸ In an action for unconsented life support, the patient must prove that she would have been better off if she had been allowed to die. This comparison between life and death is likely to trouble the courts, just as the comparison between life and nonexistence troubled the courts faced with wrongful life claims.

In the wrongful life cases, courts assumed that the child bringing the action would have to prove that her life was worse than never existing at all. Many of them also believed that it would be logically impossible or, at least, beyond human capacity to compare life with "the utter void of non-existence."¹³⁹ Justice Weintraub of the New Jersey Supreme Court expressed his concerns in this way:

Ultimately, the infant's complaint is that he would be better off not to have been born. Man, who knows nothing of death or nothingness, cannot possibly know whether that is so. . . . To recognize a right not to be born is to enter an area in which no one could find his way.¹⁴⁰

In another much quoted paragraph, Judge Jasen of the New York Court of Appeals stated the problem in this way:

Whether it is better never to have been born at all than to have been born with even gross deficiencies is a mystery more properly to

135. See, e.g., *Nelson v. Krusen*, 678 S.W.2d 918, 925 (Tex. 1984); see also RESTATEMENT (SECOND) OF TORTS § 903, at 453 (1965).

136. See, e.g., RESTATEMENT (SECOND) OF TORTS § 907 cmt. b; see also KEETON ET AL., *supra* note 77, § 9, at 40.

137. See, e.g., RESTATEMENT (SECOND) OF TORTS § 908 cmt. c; see also KEETON ET AL., *supra* note 77, § 9, at 40.

138. See *Turpin v. Sortini*, 643 P.2d 954, 957 (Cal. 1982); KEETON ET AL., *supra* note 77, § 41, at 266.

139. *Gleitman v. Cosgrove*, 227 A.2d 689, 692 (N.J. 1967); see also *Stewart v. Long Island College Hosp.*, 296 N.Y.S.2d 41, 44-45 (1968), *modified*, 313 N.Y.S.2d 502 (App. Div. 1970); G. Tedeschi, *On Tort Liability for "Wrongful life,"* 1 ISR. L. REV. 513, 529 (1966); Bonnie Steinbock, *The Logical Case for "Wrongful Life,"* HASTINGS CENTER REP., Apr. 1986, at 15, 17-18.

140. *Gleitman*, 227 A.2d at 711 (Weintraub, C.J., dissenting in part).

be left to the philosophers and the theologians. Surely the law can assert no competence to resolve the issue, particularly in view of the very nearly uniform high value which the law and mankind has placed on human life, rather than its absence.¹⁴¹

Because of the difficulty of the task, the New Hampshire Supreme Court doubted that wrongful life claims could be resolved in a reasonable, even-handed, and fair way. Instead, it feared "markedly disparate and, hence, unpredictable outcomes."¹⁴²

Indeed, even the three states that allow partial recovery in wrongful life actions have refused to allow general damages.¹⁴³ Instead, they have limited recovery to the extraordinary expenses associated with the child's birth defects.¹⁴⁴ In *Turpin v. Sortini*,¹⁴⁵ for example, the California Supreme Court concluded that "it would be impossible to assess general damages in any fair, nonspeculative manner."¹⁴⁶

The same objection has now been directed against actions seeking damages for unwanted life support.¹⁴⁷ However, there are several reasons why courts should not assume that damages in cases of unconsented life support exceed the jury's capacity. First, factfinders do not need to compare life with death in order to calculate damages. Instead, the jury need only compare the benefits of extended life with the burdens. That is a more manageable assignment and it has some analogs in existing practice. Second, the expressed wishes of the patient and her proxy can inform the jury's determination of harmfulness; no equally probative evidence is available in a wrongful life case. Third, the jurors' ability to empathize with the patient's predicament may enable them to calculate damages more fairly than they could calculate damages for a child who claims that she should never have been born. Fourth, defendants who have forced unwanted "benefits" upon a patient are in a weak position to insist that the patient's cause of action be dismissed if the benefits officiously conferred are difficult

141. *Becker v. Schwartz*, 386 N.E.2d 807, 812 (N.Y. 1978).

142. *Smith v. Cote*, 513 A.2d 341, 353 (N.H. 1986).

143. See *Turpin v. Sortini*, 643 P.2d 954 (Cal. 1982); *Procanik v. Cillo*, 478 A.2d 755 (N.J. 1984); *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483 (Wash. 1983).

144. See *Turpin*, 643 P.2d at 961-64; *Procanik*, 478 A.2d at 760-64; *Harbeson*, 656 P.2d at 494-97. By permitting this recovery without a determination that the child has been harmed by being born, the courts exposed themselves to criticism that they were unprincipled. See *infra* text accompanying notes 224-237 (discussing this charge).

145. 643 P.2d 954 (Cal. 1982).

146. *Id.* at 963-64.

147. See, e.g., *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 228 (Ohio 1996); *Milani*, *supra* note 79, at 221-22.

to measure. Finally, our limited judicial experience with these cases does not justify a fear of wild or irrational verdicts.

A. Balancing Burdens and Benefits

Although judicial doubts about the damage calculus in wrongful life cases have been eloquently expressed and are undoubtedly sincere, they overstate the problem. Life need not be compared to death to determine if the prolongation of life is harmful. Instead, the harmfulness of an unwanted life-extending treatment can be ascertained by comparing the benefits conferred by the prolongation of life to the harm that it inflicts.¹⁴⁸ No knowledge of death or nothingness is necessary to perform this calculation. This knowledge was not necessary for the patient or her proxy when making the treatment decision and it is not necessary for the jury when determining damages.

All personal injury cases require the jury to speculate to some extent about the harm caused to the plaintiff. Alexander Capron notes that "jurors can never actually experience a plaintiff's life in its 'normal' state before an injury or in the injured state that resulted from a defendant's actions."¹⁴⁹ Thus, juries must always use their imaginations to evaluate the burdens suffered by the plaintiff. The amount of imagination required grows with the severity of the injury. We tolerate this speculative leap in order to provide redress for a proven wrong.¹⁵⁰

Wrongful treatment cases would take this task a step further. In cases alleging unconsented life support, the emotional, physical, and financial

148. Numerous articles make this point in the context of wrongful life claims. See, e.g., Michael D. Bayles, *Harm to the Unconceived*, 5 PHIL. & PUB. AFF. 292 (1976); Nora K. Bell & Barry M. Loewer, *What Is Wrong with "Wrongful Life" Cases*, 10 J. MED. & PHIL. 127, 138 (1985); Joel Feinberg, *Wrongful Life and the Counterfactual Element in Harming*, 4 SOC. PHIL. & POL'Y 145, 158-59, 161-67 (1986); Michael B. Kelly, *The Rightful Position in "Wrongful Life" Actions*, 42 HASTINGS L.J. 505, 518 n.58 (1991); see also Philip G. Peters, Jr., *Protecting the Unconceived: Nonexistence, Avoidability, and Reproductive Technology*, 32 ARIZ. L. REV. 488, 502 (1989). This is true whether nonexistence is assigned a utility of zero or is assigned no utility at all. See *id.* at 502 n.83 (collecting citations). Because courts lack knowledge about the patient's afterlife, if any, they cannot make assumptions about a patient's fate in the hereafter. Instead, it seems reasonable to view death (or nonexistence) as a state with an unknown value. See *id.* at 502; see also Kelly, *supra*, at 518 n.58. When patients and their proxies have chosen to make a decision based on the information that they do have about the benefits and burdens of heroic care, it seems reasonable for courts to honor this choice and use a similar calculus.

149. Alexander Morgan Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 658 (1979).

150. Indeed, fears of bias would probably lead most attorneys to exclude from the jury a potential juror who had actually suffered the same injury as the plaintiff. See Knapp & Hamilton, *supra* note 79, at 270-71.

burdens of prolonged life in a debilitated state must be compared to the benefits of a longer life. The first part of this calculation poses no unique difficulties. Adducing the burdens suffered by the patient due to the prolongation of life, such as continued pain and financial loss, should be a straightforward task for tort juries. However, calculating the benefit of being kept alive appears to be a novel assignment.¹⁵¹ Nevertheless, even this task has analogs in existing practice.

Juries routinely place a value on the benefits of life in ordinary tort cases. They do so whenever the defendant's conduct has deprived the plaintiff of pleasures, such as reading, recreation, or interacting with family.¹⁵² What distinguishes the unauthorized treatment cases, consequently, is not the need to place a monetary value on the pleasures of life, but the way in which this valuation is used to compute damages. In routine tort cases, the jury *adds* the value of any lost pleasures to the plaintiff's award. In unauthorized treatment cases, however, juries must *subtract* the value of the benefits conferred upon the plaintiff from the plaintiff's award.¹⁵³ As a result, the mathematical use of these values differs, but the underlying project of assigning values to the benefits of life is surprisingly similar.

B. Standing in the Patient's Shoes

The task of calculating damages in the unconsented care cases is also made more manageable by the jury's ability to draw upon their own family and community experiences with end-of-life decision making. That shared experience will better enable them to stand in the shoes of the patient. While few of us would seriously question whether we should have been born, most of us have watched relatives die and all of us understand that our own time will come. With that knowledge, we can anticipate and empathize with decisions that patients make about their own life-sustaining

151. See Kelly, *supra* note 148, at 518, 526 (making this point regarding wrongful life actions).

152. See, e.g., Thompson v. National R.R. Passenger Corp., 621 F.2d 814, 824–25 (6th Cir. 1980); Yusuf v. United States, 642 F. Supp. 432, 438–42 (M.D. Pa. 1986); Kenton v. Hyatt Hotels Corp., 693 S.W.2d 83, 97 (Mo. 1985); DOBBS, *supra* note 80, at 653; Annotation, *Loss of Enjoyment of Life as a Distinct Element or Factor in Awarding Damages for Bodily Injury*, 34 A.L.R.4th 293 (1984).

153. Some courts may feel that this methodology is flawed because life has an intrinsic value that is greater than the sum of its parts. These courts may phrase their objections to recovery as concerns about the calculability of damages. In my view, however, this is really a sanctity of life objection to recovery, not an objection to the jury's capacity to calculate the harm actually experienced by the patient. If, as suggested above, the sanctity of life presumption must yield in cases of unconsented life support, then the actual experiences of the patient should serve as the basis for the damages calculation.

care. Wrongful treatment cases, therefore, allow the judge and the jury to draw on their own experiences with illness, aging, death, and the withholding of life-sustaining medical care.

C. The Value of Patient and Proxy Preferences

In an action for unconsented treatment, the jury's task is aided by their knowledge that the patient or her proxy felt certain enough about the harmfulness of the unwanted treatment to forego the chance of a longer life.¹⁵⁴ No equally probative evidence of harmfulness is available in wrongful life cases. A parent's decision not to conceive a child or even to abort a fetus does not reliably reflect a belief that the future child would be better off dead. When parents make reproductive decisions in advance of conception or during the early part of pregnancy, they are free to make it on any ground, including their emotional and financial resources and their hope of having or adopting another child without birth defects. Under these circumstances, one cannot assume that the parents who chose not to conceive have concluded that any future child's life would be worse than death. Furthermore, choosing not to conceive a child is simply not the same decision as letting a living person die.¹⁵⁵ Indeed, the wrongful life cases themselves illustrate this difference; they are pursued on behalf of children whose parents have chosen not to let them die.

Admittedly, a jury hearing an unconsented care case must still determine whether the patient has suffered as badly as she feared she would. And the jury will have to place a value on the harm, if any, that it believes occurred. But the jury's ability to perform this task should be enhanced by the context in which it is asked to do it.

D. Unclean Hands and Limits on Offset

To reach the issue of damages, the patient must prove that the defendant has violated the patient's rights and that the plaintiff has suffered as a result. If the plaintiff can meet this burden, then it seems reasonable to assign to the tortfeasor, rather than the plaintiff, the burden of proving that the tortious conduct also contained some benefits. If those benefits are too

154. See DOBBS, *supra* note 80, § 1.9, at 37 n.26 (recommending deference to the subjective valuations of the plaintiff if this can be done without unfairness to the defendant and so long as practical proof so permits).

155. For a further exploration of the difference, see Peters, *supra* note 148, at 536-47.

speculative or difficult to calculate, then the resulting failure of proof should rest on the shoulders of the defendant, not the plaintiff.¹⁵⁶

Courts already allocate the burden of proof this way in ordinary tort actions. In *Morris v. St. Paul City Railway Co.*,¹⁵⁷ for example, the plaintiff suffered a miscarriage due to the defendant's negligence. The defendant claimed that she had been spared the pain of childbirth. The court refused to take this "benefit" into account because the benefit was too speculative.¹⁵⁸ Courts could handle unconsented care cases in a similar manner, permitting the cause of action to proceed as long as the harms suffered by the plaintiff are properly proven and giving the defendant credit only for the pleasures of life that are similarly proven.

In fact, a plausible argument can be made that unwanted benefits should not be considered at all, especially if the provider has intentionally ignored the patient's instructions. Under the rules governing restitution, for example, reimbursement is not ordinarily required for benefits bestowed against the recipient's wishes.¹⁵⁹ This rule reflects the belief that individuals should not be forced to accept and pay for benefits that they do not want.¹⁶⁰ While the recipient may have been enriched, that enrichment is not regarded as unjust under the circumstances.¹⁶¹

Tort law is not as harsh on defendants. In tort, the defendant's liability can sometimes be reduced to reflect benefits tortiously conferred upon the plaintiff. Nevertheless, significant restrictions are placed on this process to protect against injustice. Section 920 of the Restatement (Second) of Torts permits offset only if the defendant has conferred a benefit similar

156. See Kelly, *supra* note 148, at 520 ("To deny recovery because the defendant cannot produce exculpatory evidence seems backwards."); Melinda A. Roberts, *Distinguishing Wrongful from "Rightful" Life*, 6 J. CONTEMP. HEALTH L. & POL'Y 59, 69 (1990). Kelly acknowledges that a child may enjoy some benefits from life. See Kelly, *supra* note 148, at 518. But, he suggests that: (1) these "unwanted" benefits should not be "thrust" upon the child; (2) to the extent that these benefits are uncertain and are hard to compare against the (more certain) losses, the party that seeks to benefit from them should bear the burden of proof and the consequences of failure of proof; (3) benefits should only be offset against losses to the same interest; and (4) the benefits rule should not apply to child support. See *id.* at 519-25.

157. 117 N.W. 500 (Minn. 1908).

158. See *id.* at 502.

159. See DOBBS, *supra* note 80, § 4.9, at 467; John W. Wade, *Restitution for Benefits Conferred Without Request*, 19 VAND. L. REV. 1183 (1966); see generally RESTATEMENT OF RESTITUTION §§ 2, 112, 116(c) (1937) (recommending restitution for emergency care only if "the person supplying [services to prevent bodily harm or pain] had no reason to know that the other would not consent to receiving them, if mentally competent"); *id.* § 114 cmt. b, illus. 7 (precluding compensation for services rendered against a patient's religious beliefs).

160. See DOBBS, *supra* note 80, § 4.9(2), at 470.

161. See RESTATEMENT OF RESTITUTION § 2 cmt. a.

to the harm she has caused and only if doing so is equitable.¹⁶² According to comment b, "Damages resulting from an evasion of one interest are not diminished by showing that another interest has been benefited."¹⁶³ Thus, damages for the pain caused by an unconsented surgery may be reduced to reflect any future relief from pain resulting from the surgery.¹⁶⁴ However, damages for the patient's pain and suffering are not diminished by proof that the surgery has increased the patient's earning capacity.¹⁶⁵ This restriction on offset attempts to minimize the risk of an unfair windfall to the plaintiff while protecting the plaintiff from a forced trade for an unwanted benefit.¹⁶⁶

The compromise approach reflected in section 920 should probably be applied to disputes over unconsented life support. An absolute refusal to take officiously conferred benefits into account would often be unfair to defendants. It would permit plaintiffs whose extended lives have brought joy or financial windfalls to recover damages for harm that they have not suffered.¹⁶⁷ Refusal to offset would also add an unnecessary chill to the "chilling effect" that liability could produce on emergency decisions and would be inconsistent with the public policy of acknowledging the benefits of life. However, the defendant should bear the burden of proving any

162. The Restatement (Second) of Torts states the rule as follows:

When the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred a special benefit to the interest of the plaintiff that was harmed, the value of the benefit conferred is considered in mitigation of damages, to the extent that this is equitable.

RESTATEMENT (SECOND) OF TORTS § 920.

163. *Id.* at cmt. b.

164. *See id.* at illus. 1.

165. *See id.* at cmt. b, illus. 6.

166. *See id.* at cmt. f. The good or bad faith of the defendant also plays a role in the extent of offset. *See* *Mohr v. Williams*, 104 N.W. 12, 16 (Minn. 1905), *overruled on other grounds by* *Genzel v. Halvorson*, 80 N.W.2d 854 (Minn. 1957) (permitting the jury to consider the "good faith" of the defendant along with the beneficial nature of the unconsented ear surgery). Comment f to section 920 of the Restatement (Second) of Torts also confirms that good faith matters. It states that

when a person has land or chattels that he has devoted to a particular purpose, he is entitled to continue to use them for that purpose, and the person who interferes with the use is not entitled to have damages mitigated by the fact that he has added to their market value. In these cases the good faith, and reasonableness of the attitudes, of the parties are factors in determining the measure of recovery.

RESTATEMENT (SECOND) OF TORTS § 920 cmt. f.

167. Because of the risk of windfall, offset is ordinarily permitted in cases involving unconsented care that is not life sustaining. *See* *Maben v. Rankin*, 358 P.2d 681 (Cal. 1961); *Mohr*, 104 N.W. at 12; *Rolater v. Strain*, 137 P. 96 (Okla. 1913).

purported benefits, and offset should be limited to like interests.¹⁶⁸ In cases like *Anderson*, therefore, a jury calculating intangible harm should be permitted to consider the gratitude that Mr. Winters had expressed to the nurse who resuscitated him and the many visits and outings that he had with his family.¹⁶⁹ But these intangible benefits should not be used to reduce recovery of his medical expenses. In addition, courts performing this calculus should recognize a separate interest in self-determination that is not subject to offset by other intangible benefits.¹⁷⁰ This would permit a Jehovah's Witness, for example, to recover a reasonable award for the violation of her religious beliefs, even if she has suffered neither net financial loss nor pain and suffering.¹⁷¹ The Uniform Health Care Decisions Act endorses this approach and suggests a minimum award of \$500 for intentional misconduct, but that figure is far too low.¹⁷²

E. Past Jury Verdicts

Although only a few jury verdicts have been reported in the years since the *Quinlan* case created the field of death and dying law, they do not provide any basis for concluding that trial judges and juries are unable to reach defensible verdicts. Instead, they reveal intuitively sound differen-

168. Limitations on offset are desirable for another reason as well. The physician who keeps a patient alive unwillingly is morally responsible for the continued life of the patient and, consequently, has a responsibility (much like that of parents who bring children into the world) to share in the financial support of the patient. That moral obligation justifies a legal duty to help support the unwittingly resuscitated patient if doing so is necessary for the humane care of the patient. See Kelly, *supra* note 148, at 521–25 (suggesting that support expenses should not be subject to offset); Peters, *supra* note 80, at 435–37 (suggesting a duty to share in all expenses that exceed the parents' ability or obligation to pay). Consequently, a physician's liability for proven economic harm should not be reduced to reflect any intangible benefits conferred. However, courts may wish to consider any collateral sources of support available to the patient in deciding whether to reduce the physician's liability for economic harm.

169. See *Anderson v. St. Francis–St. George Hosp., Inc.*, 671 N.E.2d 225, 226–28 (Ohio 1996).

170. Several scholars have proposed a similar "dignitary tort" to protect patients whose right to informed consent has been violated. See 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, 211–14 (1988); Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607, 655; Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749, 763–64 (1986).

171. See, e.g., *Malette v. Shulman*, [1987] D.L.R. 4th 18 (Can.) (awarding \$20,000, which was affirmed on appeal).

172. UNIF. HEALTH-CARE DECISIONS ACT § 10, 9 U.L.A. 258–59 (Supp. 1997). New Mexico substituted a \$2500 minimum award. See *id.* at 259.

tiations between those cases in which a small sum should be given, such as cases in which the only harm inflicted was the violation of patient autonomy, and those cases in which unmistakable suffering resulted or especially egregious misconduct occurred.

In *Malette v. Shulman*,¹⁷³ for example, a Canadian court awarded \$20,000 in general damages to a Jehovah's Witness whose instructions not to administer blood transfusions had been ignored. Because the treatment might have saved her life and the treatment had not impaired her hope for eternal salvation, the trial court limited her recovery to damages for her mental distress. The appellate court found that her \$20,000 award was within "the range of damages appropriate to a tortious interference of this nature."¹⁷⁴ In a similar case in California, the *Atlanta Journal* reports that the jury was more generous, awarding \$500,000.¹⁷⁵

Some cases have been resolved by settlement or dismissal. In *Leach v. Shapiro*,¹⁷⁶ for example, a suit was brought on behalf of a woman with amyotrophic lateral sclerosis ("Lou Gehrig's disease"). She had told her physicians not to keep her alive by machines.¹⁷⁷ Nevertheless, she was kept on a respirator after suffering a cardiac arrest and remained alive in a persistent vegetative state. Her physician refused to disconnect her respirator, contending that it would be murder. He persisted in his refusal even after the family had obtained a court order permitting the termination of life support.¹⁷⁸ Eventually, the family located an out-of-town doctor and waited for him to be granted hospital privileges so that he could disconnect the respirator.¹⁷⁹ They then sued the hospital and the unwilling physician. The hospital reportedly settled prior to trial for \$50,000. Thereafter, the trial court dismissed the patient's action against the physician for lack of sufficient evidence on the issue of informed consent and damages to her family.¹⁸⁰

173. [1987] D.L.R. 4th 18 (Can.).

174. *Malette v. Shulman*, [1990] D.L.R.4th 321, 339 (Can.).

175. Mark Curriden, *Jehovah's Witness Sues Hospital After Transfusion*, ATLANTA J., June 19, 1990, at D1; see also SHAPIRO & SPECE, *supra* note 68, at 328 (citing *Transfusion Dispute Nets Family \$500,000*, ARIZ. BUS. GAZETTE, Apr. 4, 1990, at 28 (discussing an unconsented blood transfusion to a child during a kidney transplant)). That award was being appealed at the time of the report.

176. 469 N.E.2d 1047 (Ohio Ct. App. 1984).

177. See *id.*

178. See *Akron Doctor Goes on Trial in "Right to Die" Case*, N.Y. TIMES, Sept. 18, 1985, at A17; *Judge Clears Doctor Who Refused Death Plea*, N.Y. TIMES, Sept. 19, 1985, at A24.

179. See *Judge Clears Doctor Who Refused Death Plea*, *supra* note 178, at A24.

180. See *id.* If the issue was noneconomic harm to the patient, a reasonable argument can be made that vegetative patients suffer neither harm nor pleasure from life. Cf. McDougald v.

A claim was also dismissed for lack of damages in *Foster v. Tourtellotte*.¹⁸¹ In that case, a competent patient had withdrawn consent to his respirator and had asked for medications to comfort him prior to his death. The veterans hospital in which he was being treated refused to remove the respirator, citing concerns about complicity in suicide and objections by his wife and son.¹⁸² Sixteen days later, he suffered a heart attack and entered into a coma. Within twenty days he was brain dead. At trial, the trial court granted the defendant's motion for summary judgment on the question of damages.¹⁸³

In *Galvin v. University Hospital of Cleveland*,¹⁸⁴ Mr. Galvin had checked into the hospital because of heart problems. He told his physicians that he did not want heroic efforts made to resuscitate him. Nevertheless, he was resuscitated using electric shock after he had an irregular heartbeat. After he was stabilized, he checked himself out of the hospital against medical advice and died at home a short time later. At the trial, the jury returned a verdict in favor of the defendants.

The startling award of damages occurred in 1996 in *Osgood*. The plaintiff, Brenda Young, had been diagnosed with abnormal blood vessels in her brain that were causing seizures. She had been warned that her seizures would eventually become so severe that they would leave her profoundly disabled. As a result, she had given her mother a power of attorney to terminate health care if she became incapacitated.¹⁸⁵ After her next seizure, she went into a coma. The jury concluded that her physicians then lied to her mother in order to get her mother's initial consent to heroic care.¹⁸⁶ As a result, Brenda was kept alive against her wishes. During the four years that elapsed prior to trial, Brenda "spent her days in torment, rhythmically screaming and thrashing in her mother's home."¹⁸⁷ Although she occasionally managed a few intelligible words, like "water" or "bury me," mostly she screamed for five or six hours at a time. Her father was unable to cope and left the home after thirty years of marriage. No convalescent home would take her, so her mother shouldered the burden of

Garber, 536 N.E.2d 372 (N.Y. 1989) (refusing to permit an unconscious plaintiff to recover damages for the lost enjoyment of life).

181. 704 F.2d 1109 (9th Cir. 1983) (per curiam).

182. See *id.* at 1110.

183. See *id.*

184. No. 115873 (Ohio Ct. of Com. Pleas, filed Sept. 8, 1986), summarized in Miller, *supra* note 65, at 197.

185. See Lewin, *supra* note 3, at 1.

186. See *Osgood v. Genesys Reg'l Med. Ctr.*, No. 94-26731-NH (Mich. Cir. Ct. Mar. 3, 1997).

187. Lewin, *supra* note 3, at 1.

caring for her alone. The jury awarded Brenda, by then thirty-eight years old, nearly \$15 million and her mother over \$1 million. The trial court reduced Brenda's award to \$325,000 (her anticipated future medical expenses) because it would not permit her to recover general damages for the prolongation of life.¹⁸⁸

These cases provide significant evidence that juries and the courts supervising them can manage the task of calculating damages in these cases. Indeed, trial judges may be too hesitant to give the issue to jurors. Only the jury award in *Osgood* stands out as a possible exception, and its combination of deceit and unimaginable, long-term suffering suggest that the jury got it right. Furthermore, even if that case is considered an outlier, there is no reason to believe from the overall pattern of outcomes that excessive verdicts are more common for these cases than for other torts or that they are less amenable to judicial control.

The more likely problem with damage awards is that they will be small.¹⁸⁹ They will be small because most patients, unlike Brenda Young, will be old and critically ill and may not be conscious of any suffering. In that event, the awards for compensatory damages may be too small to serve as an effective deterrent. Punitive damages could help correct this in the most egregious cases.¹⁹⁰

F. Summing Up Calculability

The task of calculating general damages in cases of unconsented life support will be more difficult than it is in traditional tort cases because juries must place a value on the benefits of prolonged life. As a result, courts and commentators can reasonably ask whether the jury is capable of calculating damages fairly. However, there are several reasons to believe that juries will be able to do so. First, the presence and severity of any harm done to the patient can be determined by balancing the benefits of prolonged life against the burdens. Knowledge of death or nonexistence is not needed. Second, jurors will be able to call on both their own experiences and also the considered decisions of the patients and their families to help them make reasoned judgments. No equivalent information is available in wrongful life cases. Third, the only aspect of the damages calculation that will be novel is the measurement of life's benefits, an issue on which the tortfeasor, not the patient, should bear the burden of proof and

188. See *Osgood*, No. 94-26731-NH.

189. See 2 MEISEL, *supra* note 3, § 17.1, at 352, § 17.25, at 437.

190. See *infra* text accompanying notes 216-218.

suffer the consequences of failure. In addition, those benefits should be offset only against the pain and suffering of prolonged life, not the pecuniary costs. Finally, our limited experience with these cases does not support the speculation that juries and the supervising trial judges cannot reach defensible verdicts. In fact, the small size of jury verdicts is likely to make punitive damages an important tool for deterring the most egregious misconduct.

V. CORRECTIVE JUSTICE

As the ethicist Robert Veatch has observed:

If competent patients have a valid moral and legal right to refuse medical treatment, it stands to reason that they should have some recourse if they are treated against their consent. Real harms are incurred Patients suffer physical pain Hospital bills will still have to be paid.¹⁹¹

Basic fairness requires that physicians who usurp the legal decision-making power of patients or their legally authorized proxies compensate those patients for any harm caused by their misconduct. Assuming that damages can be calculated and that doing so is consistent with public policy (assumptions that I have tried to defend in Parts III and IV), then justice mandates compensation.¹⁹²

However, several judicial and academic critics of a cause of action for unconsented life support have suggested that the goals of just compensation and deterrence can be adequately advanced even if courts reject an action for full compensatory damages. Instead, they propose that courts recognize a battery action for limited damages, such as the extraordinary expenses caused by the prolongation of life. Although a compromise of this sort would be preferable to a denial of recovery altogether, partial recovery would be decidedly inferior to general damages as a matter of both justice and deterrence. Given the weaknesses in the arguments against full recovery, that sacrifice would be inappropriate.

191. Veatch, *supra* note 65, at 6.

192. Liability would also advance the compensation goals of tort law by shifting the losses to a party better able to spread the costs. See KEETON ET AL., *supra* note 77, § 4, at 24–25; Hackleman, *supra* note 85, at 1371. It would also place responsibility on the least cost avoider—that is, the party best positioned to insure that patient and proxy wishes are respected. See generally Guido Calabresi & Jon T. Hirschoff, *Toward a Test for Strict Liability in Torts*, 81 YALE L.J. 1055 (1972) (proposing a strict liability test “to accomplish a minimization of the sum of accident costs and of accident avoidance costs”).

A. Compensation for Wrongful Treatment

All states currently have legislation recognizing in some form a right to refuse life-sustaining care.¹⁹³ Courts have extended this right even further. In fact, the preeminent treatise in the field characterizes the right of currently competent patients as “virtually absolute.”¹⁹⁴ Every state also permits proxies to refuse life-sustaining care for incompetent patients under some circumstances, although the precise requirements for doing so vary widely.¹⁹⁵

States confer this decision-making power on patients in order to protect patient autonomy. They confer decision-making power on proxies to protect patient welfare. These interests in autonomy and welfare are jeopardized whenever physicians disregard the instructions of patients and their legally authorized proxies.

The law of battery protects patients against this harm by making unconsented treatment actionable.¹⁹⁶ Indeed, under the law of battery, the patient is entitled to recover nominal damages whether or not the treatment is harmful and to receive punitive damages if the misconduct is egregious.¹⁹⁷ Not surprisingly, several state statutes regulating advance directives specifically contemplate a civil action for damages.¹⁹⁸ And the Uniform Health Care Decisions Act contemplates a minimum recovery to insure that the injury to autonomy and dignity is compensated even if the treatment is otherwise beneficial.¹⁹⁹

Failure to enforce these rights with an action for damages would leave injured patients uncompensated, no matter how catastrophic their suffering

193. See Hackleman, *supra* note 85, at 1355, 1361.

194. I MEISEL, *supra* note 3, § 2.4, at 51. It also concludes that incompetent patients have a nearly absolute right to have appropriate medical decisions made on their behalf. See *id.* § 2.4, at 54.

195. See *id.*, at ch. 7 (surveying the standards by which courts permit surrogates to make treatment decisions for incompetent patients).

196. Most of the current cases allege battery as the underlying breach of duty. Traditionally, a physician commits a battery whenever she performs a medical procedure without the patient's consent, unless the treatment is rendered in an emergency and it is impossible to obtain consent. See RESTATEMENT (SECOND) OF TORTS §§ 13, 15, 892–892D cmt. a, illus. 4 & 5, cmt. b. The consent can be either actual (subjective) or apparent (objective). See *id.* §§ 49–50. As a matter of traditional tort law, the emergency treatment exception disappears when the physician knows in advance that consent has been refused. See *id.* § 892D cmt. a, illus. 5; see also *Malette v. Shulman*, [1990] D.L.R. 321 (Can.) (holding that the emergency doctrine of necessity does not allow a physician to disregard a patient's advance directive); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984).

197. See *supra* notes 136–137.

198. See *supra* note 71.

199. See *supra* note 172.

nor how much they depend upon tort recovery to pay the medical and support expenses engendered by the unwanted care. As between the patient who has been wrongfully kept alive and the physician who has wrongfully administered the treatment, corrective justice would certainly seem to require that the physician compensate the patient for any harm caused by the breach of duty.

Furthermore, an independent action for damages is more important to a wrongfully treated patient than a wrongful life action is for a child who is conceived due to provider negligence. The welfare of wrongfully conceived children is partially protected by judicial recognition of parental actions for wrongful birth. Through their wrongful birth actions, parents can recover the extraordinary costs of raising a child with a disability²⁰⁰ and, in some states, their ordinary child support costs as well.²⁰¹ This indirect protection of the child makes recognition of an independent wrongful life action in the name of the child less essential. The supreme courts of New Hampshire and Arizona, for example, both explicitly noted that "recognition of a wrongful life action would make a substantial difference only in limited circumstances, as when the statute of limitations bars the parents' claim . . . or when the parents are unavailable to sue."²⁰²

Several factors make it unlikely that courts will recognize an equivalent cause of action at the end of life.²⁰³ Most importantly, the harms suffered by the wrongfully treated patient and her family arise out of a breach of duty to the patient, not to the family. In wrongful birth actions, by contrast, the physician breaches a duty owed first to the parents.²⁰⁴ As a result of this difference, a cause of action by family members for compensatory damages more closely resembles a bystander claim for the negligent infliction of emotional distress or, more rarely, a claim for the intentional infliction of emotional distress, than it resembles a wrongful birth action. Not surprisingly, that is how many of the family

200. See, e.g., *Fassoulas v. Famey*, 450 So. 2d 822, 824 (Fla. 1984) (allowing recovery of extraordinary upbringing costs); *James G. v. Caserta*, 332 S.E.2d 872 (W. Va. 1985).

201. See *Phillips v. United States*, 508 F. Supp. 544 (D.S.C. 1981); *Ochs v. Borrelli*, 445 A.2d 883 (Conn. 1982); *KEETON ET AL.*, *supra* note 77, at 372-73.

202. *Walker by Pizano v. Mart*, 790 P.2d 735, 740-41 (Ariz. 1990) (en banc); *Smith v. Cote*, 513 A.2d 341, 354 (N.H. 1986).

203. *But see Osgood v. Genesys Reg'l Med. Ctr.*, No. 94-26731-NH, at 18-19 (Mich. Cir. Ct. Mar. 3, 1997) (analogizing the mother's action for the value of her care to a wrongful birth claim).

204. See, e.g., *Walker*, 790 P.2d at 740 (stating that "any wrong that was done was a wrong to the parents, not the fetus"); *Morgan v. Olds*, 417 N.W.2d 232, 235-36 (Iowa App. 1987) (noting that physicians owe the patient a duty to seek proxy consent, but not the family); *Young v. Oakland Gen. Hosp.*, 437 N.W.2d 321, 326 (Mich. Ct. App. 1989) (same).

claims have been litigated.²⁰⁵ So characterized, they face substantial doctrinal obstacles.²⁰⁶ Furthermore, these actions do not entirely sidestep the policy issues presented by a claim that life is harmful. As Adam Milani points out, resolution of these claims requires that the benefits to the family from the patient's survival be compared to the burdens.²⁰⁷

Parents of minor children and spouses may be entitled to sue in their own name for reimbursement of any of the patient's expenses that they have been required to pay under the "necessaries" doctrine.²⁰⁸ However, other family relationships will not give rise to either the obligation to pay or the right to reimbursement. Furthermore, this doctrine does not make the wrongdoer responsible for financial costs incurred personally by the patient or her insurer. Nor does it compensate the patient for the intangible harm done to the patient. Accordingly, wrongfully treated patients need a cause of action in their own name.

The fairness of imposing liability in particular cases will, of course, depend upon the facts of the case.²⁰⁹ Courts will have to determine, for

205. See *Ficke v. Evangelical Health Sys.*, 674 N.E.2d 888, 893 (Ill. App. Ct. 1996) (rejecting an action by the family because extending such an action to bystanders would raise serious practical problems, such as where to draw the line); *Benoy v. Simons*, 831 P.2d 167, 170 (Wash. 1992) (denying recovery because the plaintiff had not proven intent or recklessness, extreme and outrageous conduct, or objective physical injury); 2 MEISEL, *supra* note 3, § 17.6 (reviewing the cases and the doctrinal requirements).

206. See *supra* note 205.

207. See Milani, *supra* note 79, at 225 n.355.

208. See, e.g., *Hulse v. Warren*, 777 S.W.2d 319 (Mo. Ct. App. 1989); *St. Joseph Hosp. v. Rizzo*, 676 A.2d 98, 100 (N.H. 1996).

209. The most compelling claim for damages will arise when a health care provider knowingly disregards clear patient preferences in a case that presents no unique legal issues. A powerful claim for recovery will also arise whenever an advance directive is contained in the patient's chart and the patient's nurse or physician unreasonably fails to read it. See *Oddi*, *supra* note 78, at 661 n.160; see also Milani, *supra* note 79, at 225-26 n.355 (supporting liability, but for expenses only). Strong claims for recovery will also arise when a hospital negligently fails to place a patient's advance directive in the chart. See *id.* (concluding that liability "may encourage better record-keeping practices"). Congress's enactment of the PSDA, imposing certain obligations on hospitals for the handling of patient advance directives and for educating staff about patient rights, might even provide a basis for alleging that the hospital's conduct was negligent or even negligent per se. See *Gasner*, *supra* note 65, at 518-19; *Addlestone*, *supra* note 84, at 1278-79; but see *Asselin v. Shawnee Mission Med. Ctr.*, 894 F. Supp. 1479, 1485 (D. Kan. 1995) (finding no private cause of action for violating the PSDA). Liability would also be appropriate when a physician disregards the clear instructions of a legally authorized surrogate.

In other cases, the fairness of allowing recovery will be less clear. In the past, for example, courts have been protective of physicians who continued to treat because the law governing their legal obligations was unclear. See, e.g., *Grace Plaza of Great Neck, Inc. v. Elbaum*, 623 N.E.2d 513, 514-15 (N.Y. 1993) (refusing to authorize relief from hospital bills despite an earlier ruling that the evidence of Mrs. Elbaum's wishes was adequate); compare *Bartling v. Superior Ct.*, 209 Cal. Rptr. 220 (1984) (ruling posthumously that the patient's wishes should have been honored), with *Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360 (Ct. App. 1986) (denying

example, whether the physician reasonably believed that consent had been given, or whether the physician had a legally sufficient basis for providing treatment over the objections of the patient or proxy.²¹⁰ But in those cases in which the physician has neither consent nor a legally sufficient justification for treatment, the fairness arguments for allowing the recovery of compensatory damages are powerful.

B. Partial Recovery

The courts and scholars who oppose recognition of a cause of action for the prolongation of life are not convinced that patients need a cause of action for full compensatory damages. In their view, patients can receive sufficient protection with an action for limited damages. Under one approach, the patient would only recover damages for injuries “directly” inflicted by the unwanted treatment. Under a second approach, patients would only recover the extraordinary expenses that they incur due to the prolongation of their lives.

The first of these approaches was proposed in *Anderson*. In that case, the Ohio Supreme Court concluded that unwanted life-saving treatment would not go undeterred because the provider would be liable for any damages “directly” caused by the battery, such as “tissue burns or broken bones,” resulting from an unwanted defibrillation.²¹¹

damages for unwanted medical treatment). Deciding the fairness of liability under these circumstances ultimately requires a decision whether physicians or families should be obliged to initiate judicial proceedings when they disagree. This question is discussed further in Part VI.

210. Adherence to moral or religious scruples is one justification that may be offered. Many state living-will statutes and a few judicial opinions permit providers to transfer the patient if the withholding of life-sustaining care would violate their moral beliefs. See 2 MEISEL, *supra* note 3, § 11.18, at 112–13, § 17.23, at 420–26. However, moral crises do not appear to be the typical explanation for overuse of life support. Instead, physicians seem to assume that they know what is best for their patients. See, e.g., Danis et al., *supra* note 36, at 1815 (noting that physicians assume that patients share their views). As a consequence, they either fail to acquaint themselves with patient wishes or they ignore what they have learned. Even in those occasional cases in which a physician’s resistance arises out of genuine moral qualms, the physician should be required to give timely notice to the patient of the physician’s moral objections so that the patient’s family can quickly locate another provider. In addition, the physician should cooperate with transfer of the patient. The Uniform Health Care Decisions Act would impose these requirements of notice and assistance. See UNIF. HEALTH-CARE DECISIONS ACT § 7, 9 U.L.A. 236 (Supp. 1997). Failure to do so should deprive the physician of this defense to tort liability.

211. See *Anderson v. St. Francis–St. George Hospital, Inc.*, 671 N.E.2d 225, 229 (Ohio 1996) (noting that Winters had no damages due to defibrillation). Although Winters suffered a stroke subsequent to the resuscitation, the life-saving efforts had not precipitated the stroke except by prolonging his life. The court felt this distinction was crucial. See *id.* The trial court’s opinion in *Osgood* appeared to follow *Anderson* on this issue. See *Osgood v. Genesys Reg’l Med. Ctr.*, No. 94-26731-NH (Mich. Cir. Ct. Mar. 7, 1997).

The second method of limiting damages would permit patients to recover the extraordinary expenses caused by the prolongation of life. That is the same measure of damages used in the minority of states that permit wrongful life actions.²¹² Professor Milani, who opposes actions for general damages, has endorsed the recovery of extraordinary expenses.²¹³ And the trial court in *Osgood* also concluded that the patient's medical expenses were compensable even though her wrongful living claim was not.²¹⁴ This also may be the remedy contemplated in Alaska, where the living will statute authorizes the recovery of \$1000 plus the costs incurred due to the wrongful conduct.²¹⁵

Because partial recovery of this kind is possible, Professor Milani has concluded that direct recognition of an action for wrongful living is unnecessary. "Courts need not take on the task of deciding whether a plaintiff's life is worth living," he writes, "because there are adequate remedies available under familiar tort principles for those whose refusal of life-sustaining care has not been honored."²¹⁶ Patients, he suggests, can bring battery actions for their extraordinary expenses.²¹⁷ This, he concludes, would satisfy "the basic rule of tort compensation" and would provide adequate deterrence.²¹⁸

These proposals for partial recovery contain two important similarities. First, they share the assumption that patients who are treated against their wishes should receive some recovery. The significance of that concession cannot be overstated. It markedly differentiates the debate over unconsented life support from the debate over wrongful life. In the wrongful life setting, the great majority of courts rejected the cause of action altogether. Thus far, no court or commentator has suggested a similarly draconian resolution of damages actions for unconsented life support. As a result, the axis of the debate at the end of life is quite different than it was in the reproductive torts. In the wrongful life setting, the debate ultimately was between limited recovery and none at all. With actions for unconsented life support, however, the current debate is

212. See *supra* text accompanying note 144. In addition, most states permit parents to recover the extraordinary costs of caring for a child born due to provider negligence in a wrongful birth action. See *supra* text accompanying note 200.

213. See Milani, *supra* note 79, at 228; see also Hackleman, *supra* note 85, at 1369 (advocating the recovery of extraordinary expenses).

214. See *Osgood*, No. 94-26731-NH, at 15.

215. See ALASKA STAT. § 18.12.070(a) (Michie 1996).

216. Milani, *supra* note 79, at 228.

217. See *id.*

218. See *id.* at 226, 228. It would also be consistent with the protections provided by wrongful birth actions. See *id.* at 225.

between partial recovery and full recovery. Although future judicial opinions may retreat from this concession, the current tenor of the debate is notably more receptive to claims by wrongfully treated patients. This difference is probably explained by the many factors that differentiate the two settings (explored above in Parts III and IV), including the absence of a wrongful birth analogy in end-of-life disputes.²¹⁹

The second similarity between these proposals is the shared assumption that wrongfully treated patients would have an action for battery even if their “wrongful living” claims were dismissed. This assumption is likely to cause a regrettable amount of unnecessary confusion. The thorny issues posed by unwanted life support turn on the damages requested, not the precise breach of duty alleged to have caused them. In this sense, William Knapp and Fred Hamilton are correct when they suggest that “[t]here is no more a ‘cause of action’ for ‘wrongful living’ than there is a cause of action for a ‘wrongful broken leg’ or a ‘wrongful whiplash.’”²²⁰ To recover compensatory damages for harm caused by unwanted treatment, a patient must prove both a traditional breach of duty, such as battery or negligence, and the presence of compensable harm. The difficult issues are raised by the harm or damages alleged, not by the theory of recovery; recasting the theory of recovery will not avoid these damages issues.

Despite this unfortunate detour, the proposals for limiting damages do have an important potential advantage. A properly fashioned limitation on damages has the potential to sidestep or minimize judicial concerns about respect for life and the calculability of damages. However, only one of the two proposed ways of shaping a partial recovery fulfills this promise. And both proposals are vulnerable to the criticism that they inadequately compensate wrongfully treated patients.

The first proposal would distinguish between injuries “directly” caused by tortious life support and those that are merely a product of the prolongation of life. This approach does not survive close scrutiny. If an unwanted life-saving treatment is competently performed²²¹ and successfully extends the patient’s life,²²² then recovery for injuries inflicted during

219. See *supra* text accompanying notes 200–208.

220. Knapp & Hamilton, *supra* note 79, at 261; see also *Anderson v. St. Francis–St. George Hosp., Inc.*, 671 N.E.2d 225, 227 (Ohio 1996) (using the same examples as Knapp & Hamilton).

221. If incompetence results in a worse recovery than should have occurred, then the patient would have an ordinary negligence claim for the unnecessary injuries.

222. If an unwanted life-sustaining treatment causes extra pain or injury and yet fails to extend the patient’s life (as might occur with unwanted chemotherapy), then the patient has a traditional action for unnecessary pain and suffering, not for the unwanted extension of life. See Oddi, *supra* note 78, at 641 n.76 (giving the example of a transfusion with incompatible blood).

the resuscitation raises precisely the same issues as any other claim for wrongful living. Contrary to the assumptions of the court, these issues are not escaped when the post-resuscitation suffering results from injuries inflicted during the resuscitation itself. If the alternative to life with these injuries was death, then the patient has not been harmed by their infliction unless the benefits conferred by the prolongation of life are outweighed by the burdens. The fact that the patient's suffering results from injuries inflicted during life-saving care, rather than during the weeks or months thereafter, is irrelevant. As a result, courts cannot escape the controversial implications of a claim for wrongful life support by limiting recovery to the injuries "directly" inflicted during life support.

In addition, the distinction between direct and indirect harm has another shortcoming. It would arbitrarily favor the patient who deteriorates during the course of resuscitation over both the patient whose condition was catastrophic at the time of resuscitation and also the patient who foreseeably deteriorates after resuscitation.²²³ Because the distinction between direct and indirect injuries does not withstand analysis, most courts will probably reject it.

The second proposal would permit wrongfully treated patients to recover only the extraordinary costs that they suffer by virtue of the unwanted treatment. The two most powerful potential criticisms of this measure of recovery are, first, that it provides inadequate compensation and deterrence and, second, that it represents an unprincipled compromise. While the first of these criticisms is accurate, the second is not. As a result, recovery of pecuniary harm represents a respectable second-best remedy—one that should be considered in those jurisdictions unwilling to allow full recovery.

The most damning weakness of partial recovery is its inadequacy. Restricting recovery to extraordinary pecuniary expenses would unfairly undercompensate both those patients who endure tragic physical and emotional suffering and also those patients, like Jehovah's Witnesses receiving unwanted blood transfusions, whose primary grievance is their loss of autonomy or religious liberty. In addition, restriction of recovery to *extraordinary* expenses would leave unprotected those patients whose welfare requires assistance with the *ordinary* expenses of their prolonged lives, including shelter, food, and clothing. Contrary to Professor Milani's contention, truncated relief of this kind is *not* consistent with traditional

223. When the patient's subsequent deterioration is unforeseeable, traditional proximate cause notions could limit recovery.

notions of tort recovery, which seek to make the injured person whole.²²⁴ Compensating wrongfully treated patients this parsimoniously is simply not necessary given the weaknesses in the arguments against full recovery.

Nevertheless, some courts are likely to reject full recovery. In those states, recovery of either extraordinary pecuniary expenses or, more generously, both extraordinary and ordinary pecuniary expenses offers a promising second-best remedy.²²⁵ So limited, the calculation of damages will be relatively simple and the court will not need to determine the ultimate value of the patient's extended life. Although damages will be incomplete, partial recovery will provide patients with some protection against financial catastrophe and will give physicians some incentive to respect patient wishes. In this way, a limited right to recovery would protect these patients in much the same way that a parental wrongful birth action protects children born due to provider negligence. Consequently, it is far superior to denial of the claim altogether.

The second criticism likely to be advanced against partial recovery is one that was leveled against the courts that allowed partial recovery in wrongful life cases. In those cases, partial remedy was immediately criticized as internally inconsistent by both advocates and critics of recovery.²²⁶ As Roger Dworkin noted, "It seems odd to . . . admit simultaneously that an injury has been inflicted on the child while denying full compensation for it."²²⁷ From this perspective, partial recovery was inadequate. On the other hand, the Texas Supreme Court viewed this compromise as too generous. In its view, courts allowing partial recovery were discarding the requirement of a legally cognizable injury in order to reach the "right result."²²⁸ The primary deficiency of this compromise, said the New Hampshire Supreme Court, is "that it imposes liability even if the defendant has caused no harm."²²⁹

Despite these criticisms, however, partial recovery is a defensible outcome in states that conclude that general damages are incalculable. As

224. See RESTATEMENT (SECOND) OF TORTS § 901 & cmt. a (stating that damages are intended to restore the plaintiff to the position he would occupy "but for" the tort); DOBBS, *supra* note 80, § 8.1, at 647 (noting that compensatory damages seek to compensate the plaintiff for all losses, including pain and suffering).

225. See Knapp & Hamilton, *supra* note 79, at 269 n.87 (citing cases allowing extras as a minimum recovery).

226. See Peters, *supra* note 80, at 403 nn.14-15 (collecting authorities).

227. Roger B. Dworkin, *The New Genetics*, in 1 *BIOLAW* 89, 98 (1986).

228. *Nelson v. Krusen*, 678 S.W.2d 918, 930 (Tex. 1984) (Robertson, J., concurring); *accord* *Lininger v. Eisenbaum*, 764 P.2d 1202, 1212 (Colo. 1988) (en banc).

229. *Smith v. Cote*, 513 A.2d 341, 354 (N.H. 1986); *accord* *Walker by Pizano v. Mart*, 790 P.2d 735, 740 (Ariz. 1990) (en banc).

explained above,²³⁰ the elements of damages that are hardest to calculate are the intangible benefits and burdens of life itself, not the extent of pecuniary harm. Courts that decline to permit recovery for intangible harm because they doubt the jury's ability to ascertain such damages may reasonably conclude that the presence or absence of pecuniary harm is demonstrable and, therefore, compensable. In effect, the intangible benefits and burdens of life will be treated as offsetting one another. Although, as Melinda Roberts correctly points out, this approach may overcompensate children with minor birth defects whose lives were clearly beneficial on balance and undercompensate those children with the most catastrophic injuries,²³¹ the presumption seems reasonable in jurisdictions that doubt their ability to perform the larger calculation.

This compromise is also consistent with the rules governing officiously conferred benefits.²³² Tort law traditionally takes them into account only to reduce damages for harms to a similar interest.²³³ This restriction helps to minimize the risk that the defendant will be able to force an unwanted trade upon the plaintiff, while at the same time limiting the risk of a windfall to the plaintiff.²³⁴ In the context of unconsented life support, this approach supports the recovery of damages for pecuniary harm even if the unwanted treatment confers intangible benefits on the patient.

Recovery of pecuniary losses can also be defended by analogy to the laws of child support. The physician who keeps a patient alive against the patient's wishes has effectively breathed new life into the patient and, like a parent who brings a child into the world or a physician whose carelessness results in the birth of a child, this physician has a moral responsibility to protect the well-being of that patient during the patient's extended life.²³⁵ This obligation does not require proof that the patient's extended life is harmful;²³⁶ instead, it arises out of the physician's disrespect for the patient's wishes and his resulting responsibility for the welfare of that

230. See *supra* text accompanying note 151.

231. See Roberts, *supra* note 156, at 70.

232. See *Turpin v. Sortini*, 643 P.2d 954, 965-66 (Cal. 1982).

233. See *supra* text accompanying notes 162-172.

234. Interestingly, this rule limits the extent to which the law of damages is strictly consequentialist or utilitarian in nature. For a further discussion of the nonconsequentialist underpinnings of this approach, see Peters, *supra* note 148, at 524-34.

235. For an elaboration of this thesis in the context of wrongful life actions, see generally Peters, *supra* note 80. Under current family law, child support obligations may arise out of contract, consent, and some kinds of tort-like misconduct, in addition to genetic parenthood. See *id.* at 425-29.

236. See *id.* at 398-99.

patient. In the wrongful life setting, a similar obligation is enforced in three jurisdictions by an action for wrongful life and, in others, through parental actions for wrongful birth.²³⁷

As a result, recognition of a patient's right to recover her pecuniary losses is a defensible compromise. Although it is a second-best remedy, it is not unprincipled.²³⁸ In its ideal form, this limited right to recover would provide compensation for all pecuniary harm, not simply extraordinary expenses. However, credit should be given to the defendant for any pecuniary gains caused by the wrongful conduct, such as continued pension or Social Security benefits.²³⁹

C. Synthesizing the Justice Issues

To summarize, the goal of achieving corrective justice supports the recovery of compensatory damages for all harms caused by the unconsented and unjustified administration of life-sustaining care. The kinds of conduct that will constitute a breach of duty may take a variety of shapes, ranging from patent disregard of known wishes to failure to read the hospital chart. When this misconduct occurs, corrective justice requires compensation from the errant physician for any harm caused by the breach of duty

Surprisingly, the courts and commentators who are hostile to a cause of action for "wrongful living" seem supportive of a right to partial recovery. Their willingness to allow partial recovery markedly distinguishes the unconsented life support cases from the wrongful life cases. However, recognition of a right to partial recovery is less desirable than full recovery. It would undercompensate those patients who suffer severe pain and those whose primary grievance is the loss of religious or personal liberty. This harsh result seems unnecessary given the weaknesses in the arguments against full recovery. However, in states that doubt the ability of juries to calculate general damages, a right to recover for pecuniary harm or, more narrowly, for extraordinary expenses would be preferable to rejection of the action altogether. Courts should resist, however, the temptation to adopt the Ohio Supreme Court's distinction between direct and indirect harms because both types of harm pose the same policy issues.

237. Protection of this interest is incomplete to the extent that courts preclude recovery for ordinary support expenses or reduce parental recovery to reflect the joys of parenting.

238. See Peters, *supra* note 148, at 532.

239. The extent of this recovery will depend on how the collateral source rule is applied to this unique setting. See DOBBS, *supra* note 80, § 3.8(1), at 266-69.

VI. DETERRENCE AND OVERDETERRENCE

Tort liability for unconsented life support could provide a much needed incentive for physicians to respect the wishes of patients and their proxies. Although managed care incentives may eventually eliminate much of the need for this legal leverage, tort liability can currently play a useful role in structuring appropriate physician incentives. Nevertheless, courts should be sensitive to the risk that tort liability could unduly weaken the physician's natural inclination to err on the side of life and should also fashion the physician's substantive duties in a manner that reduces this risk.

A. Providing a Legal Incentive to Respect Patients and Proxies

Liability for compensatory damages would provide a much-needed legal incentive for physicians and hospitals to respect the instructions of patients and their proxies.²⁴⁰ The prospect of liability would encourage physicians and hospitals to internalize the value of self-determination to their patients and, consequently, to expend an appropriate amount of their own time and attention ascertaining and respecting patient wishes. Failure to recognize a cause of action, on the other hand, would substantially weaken—and effectively rewrite—the underlying substantive rights themselves.²⁴¹ Because the threat of damages constitutes the most significant legal sanction that physicians will realistically face for the violation of patient rights,²⁴² removing that threat would go a long way toward immunizing physician misconduct. Absent a court order, physicians would possess a *de facto* right to treat a patient against her wishes—a right of eminent domain over the patient herself. Laws intended to empower patients and their proxies would, instead, have simply deregulated physicians. Obviously, this is inconsistent with the spirit of the legal doctrines recognizing the rights of patients and their proxies to refuse medical care.

Recognition of a cause of action would help to offset the current tendency of the law to encourage overtreatment. Fear of legal liability cur-

240. See, e.g., Gasner, *supra* note 65, at 504; Hackleman, *supra* note 85, at 1371–72; William Prip & Anna Morretti, *Compliance: The Missing Component in Patient Autonomy Laws*, EXPERIENCE, Spring 1996, at 4, 9.

241. See, e.g., DOBBS, *supra* note 80, § 1.7, at 23 (observing that the remedy defines the right); Hackleman, *supra* note 85, at 1381 (concluding that a right with no remedy is worthless); Knapp & Hamilton, *supra* note 79, at 276 (stating that patients would have “no right at all” without an action for damages).

242. See *infra* text accompanying notes 246–251.

rently makes health care providers reluctant to withhold treatment.²⁴³ In the words of the bioethicist Ruth Macklin, "Where it was once physicians who overtreated patients because they believed it was their moral obligation to continue therapy, it is now hospital administrators and risk managers who often insist on overtreatment out of fear of medical-legal liability."²⁴⁴ This picture is fully consistent with the assumptions of Dr. Nancy Dickey, then chairwoman of the board of the American Medical Association, who stated, "The thinking has been that if you do intervene and you shouldn't have, the worst that will happen is that the patient will live a little longer and that you'll never be held accountable if you keep the patient from dying."²⁴⁵

The incentive to ignore the directives of patients and their proxies under these circumstances is obvious. In fact, providers who are paid for these unwanted services are financially rewarded for their misconduct.²⁴⁶ Moreover, the "[a]bsence of penalty provisions in most advance directive laws fosters a belief among health care providers that noncompliance is legally acceptable."²⁴⁷ This unbalanced legal message reinforces the existing preference of many physicians to follow the beat of their own drum and the apparent aversion of many physicians to time-consuming discussions with patients and their families. The losers in this story are the patients and proxies who have their own ideas about the humane limits of life-sustaining care.

The need for deterrence materially distinguishes tort actions for unconsented life support from actions for wrongful life. Courts concerned about the policy implications of actions for wrongful life could reject those

243. See Terri R. Fried et al., *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 153 ARCHIVES INTERNAL MED. 722, 724, 727 (1993) (finding that, when deciding whether to take a patient off a respirator, "a sizable number of respondents [25.6%] cite the question of legality as their primary concern"); S. Van McCrary et al., *Treatment Decisions for Terminally Ill Patients: Physicians' Legal Defensiveness and Knowledge of Medical Law*, 20 LAW, MED. & HEALTH CARE 364, 373 (1992) (finding that physicians' perception of legal risk influences their end-of-life treatment decisions and that these perceptions are often incorrect); Mildred Z. Solomon et al., *Decisions near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 19 (1993) (noting that clinicians' uncertainty about law, ethics, and professional standards manifests itself in decisions to withdraw treatment). These legal fears are greatly exaggerated. Some scholars note that there has never been a successful suit or prosecution against a physician for respecting the wishes of a patient or proxy. See, e.g., Gasner, *supra* note 65, at 504 n.35; Miller, *supra* note 65, at 184; Prip & Morretti, *supra* note 240, at 8.

244. RUTH MACKLIN, *ENEMIES OF PATIENTS* 64 (1993).

245. Lewin, *supra* note 3, at 28.

246. See Milani, *supra* note 79, at 169-73; Prip & Moretti, *supra* note 240, at 9.

247. Prip & Moretti, *supra* note 240, at 10.

actions and rely upon the parental action for wrongful birth to provide at least some deterrence.²⁴⁸ In the context of decisions about life-sustaining care, however, the existing legal alternatives to an action by the patient for compensatory damages have obviously proven inadequate.

Although providers who wrongfully administer life support potentially face a number of sanctions, including forfeiture of their right to payment,²⁴⁹ professional discipline,²⁵⁰ and, in a few states, civil penalties²⁵¹ or liability for attorneys' fees,²⁵² these sanctions have not had a significant effect, perhaps because they are rarely enforced and have few teeth. As a result, they represent a potentially useful supplement to a cause of action for general damages, but not an effective substitute.

Recognition of a limited cause of action by the patient for pecuniary losses would improve upon these options, but it, too, would have less impact than an action for general damages. Similarly, recognition of a family claim for emotional distress or for support expenses could provide some useful deterrence.²⁵³ It would be the functional equivalent of an action for wrongful birth.²⁵⁴ But the level of deterrence provided by the family's claim would fall short of ideal unless patients were also allowed to recover for the harm done to them. Otherwise, tortfeasors would escape liability for some of the harm that they have caused and, thus, would not have to internalize these costs in their decision making.

At the same time, the potential impact of an action for compensatory damages on physician behavior should not be overstated. Because relatively few of the victimized patients are likely to seek compensation and because physician conduct is influenced by many other factors, the deterrent effect of tort liability is likely to fall well short of ideal. Consequently, a lasting solution will require a fundamental change in physician culture, one that prioritizes the communication necessary to inform,

248. See *supra* text accompanying notes 200–208 (discussing the obstacles to recognition of a similar cause of action at the end of life).

249. See ALASKA STAT. § 18.12.070 (Michie 1996); see also Marshall B. Kapp, *Enforcing Patient Preferences: Linking Payment for Medical Care to Informed Consent*, 261 JAMA 1935 (1989).

250. See, e.g., CAL. HEALTH & SAFETY CODE § 7191 (West Supp. 1997); S.C. CODE ANN. § 44-77-100 (Law Co-op Supp. 1996); UTAH CODE ANN. § 75-2-1112 (1993).

251. See, e.g., ALASKA STAT. § 18.12.070 (Michie 1996) (imposing a civil penalty of \$1000 plus costs).

252. This award would be for the fees incurred by the family in obtaining an order to terminate life support. See, e.g., *Bartling v. Glendale Adventist Med. Ctr.*, 228 Cal. Rptr. 1847 (1986) (awarding \$160,000 in attorneys' fees on remand). However, attorneys' fees are not available in most cases. See 1 MEISEL, *supra* note 3, § 17.26, at 439.

253. Emotional distress claims would face substantial doctrinal obstacles. See *supra* note 205.

254. See *supra* text accompanying notes 204–207.

ascertain, and respect patient wishes. At present, however, the prospects for that change are bleak; the sponsors of the SUPPORT study spent millions of dollars on a sophisticated intervention that had absolutely no impact on physician behavior. While ethicists continue to explore new ideas, none have yet been proven to be either effective or feasible on a large scale. As a result, the law has a role to play.

At the very least, a carefully tailored cause of action for wrongful treatment has the potential both to counterbalance the existing legal incentives to disregard patient wishes and also to reinforce the social norms supporting the rights of patients and their proxies. “[I]t’s going to take a lot to change [this culture],” said Daniel Callahan, a renowned ethicist and former president of the Hastings Center; “one way that may happen is through legal pressure and jury verdicts.”²⁵⁵

Compensatory damages would combine with nominal and punitive damages to provide courts with a sensitive array of tools with which to protect patient interests.²⁵⁶

B. The Risk of Overdeterrence

Juxtaposed against this potential for a desirable impact on physician behavior is the risk that tort liability could have an unwanted “chilling effect,” making physicians reluctant to initiate life support without clear instructions from the patient.²⁵⁷ One hospital lawyer has suggested that liability “would cause health practitioners to be terribly confused about which way to proceed if there was an emergency health-care decision.”²⁵⁸ The threat of tort liability could conceivably cause physicians to delay resuscitation while nurses combed the chart for firm guidance about heroic efforts.

Accentuating the risk of undesirable overdeterrence is the evolution of the health care industry towards managed care. Because managed care organizations place an emphasis on cost control, they will have an obvious incentive to grade hospitals and providers on their respect for advance

255. Lewin, *supra* note 3, at 28.

256. My thanks to David Partlett for bringing this to my attention.

257. Interestingly, this risk of overdeterrence has an analog in the wrongful life cases. Recognition of wrongful life liability could induce some physicians to pressure their pregnant patients to have abortions following unplanned pregnancies. But the similarity between wrongful life and unconsented care cases ends there, as wrongful birth actions would pose this risk even if wrongful life actions were rejected. *But see* Bader v. Johnson, 675 N.E.2d 1119, 1123 (Ind. Ct. App. 1997) (“[R]ecognition of a claim for wrongful birth does not require physicians to counsel abortion.”).

258. Lewin, *supra* note 3, at 28.

directives.²⁵⁹ Conceivably, this movement could make the SUPPORT findings obsolete and eliminate the need for further legal incentives to respect patient wishes. In fact, these financial pressures could ultimately make undertreatment a more serious problem than overtreatment.

Notwithstanding these reasonable fears, there are several reasons for doubting that the risk of overdeterrence requires the immunization of physician misconduct. First, and most importantly, the courts can protect physicians from liability in those circumstances in which "erring on the side of life" is justified, as it will be in the typical emergency, without rejecting liability in cases in which the disregard of a patient's wishes is not justified. Courts can do this by carefully tailoring the underlying cause of action. Second, in nonemergency settings, physicians who have reasonable doubts about the instructions they have received from a patient or proxy can go to court for judicial guidance. Third, it is too soon to assess the ultimate impact of managed care. Thus far, neither prospective payment systems, such as Medicare's diagnosis-related groups, nor managed care have eliminated widespread overtreatment. So long as the danger of overtreatment is pervasive, as it clearly is now, the arguments for a tort deterrent are powerful. And if the danger of undertreatment should worsen, the law can and will provide the victims with a remedy for the unjustified failure to provide requested life support.²⁶⁰ It need not, however, deny a remedy to the victims of overtreatment. Both wrongs deserve legal redress.

C. Tailoring the Cause of Action

Courts can free physicians to err on the side of life by carefully articulating safe harbors in which physicians are free to treat without fear of later second guessing. There are two especially obvious candidates for a safe harbor of this kind. The first involves physicians who render emergency life support and neither know nor should know of a previous refusal of consent.²⁶¹ The second involves physicians who continue life-sustaining care because the instructions that they have received from the patient or proxy

259. See *Blue Cross & Blue Shield v. Marshfield Clinic*, 65 F.3d 1406, 1414 (7th Cir. 1995); 2 MEISEL, *supra* note 3, § 17.13, at 390 (predicting that physicians will face pressure to recommend the termination of care when it appears that there is no hope for recovery).

260. See, e.g., Peters, *supra* note 56 (discussing the protections provided by the Americans with Disabilities Act).

261. See *Allove v. Flower Hosp.*, No. L-96-329 (Ohio Ct. App. June 27, 1997), *reprinted in* 6 BNA HEALTH LAW REPORTER 1124 (1997)

are ambiguous.²⁶² Under both of these circumstances, courts should permit physicians to administer life-sustaining treatment until they receive a clear refusal of consent. By recognizing safe harbors of this kind, courts can provide physicians with the freedom to err on the side of life when doing so is justified, while preserving liability for unjustified conduct, such as the resuscitation of patients whose wishes were well known.

There are two additional scenarios in which physicians might seek the protection of a safe harbor. The wisdom of providing them with immunity in these two situations, however, is a close question. The first involves physicians who must make an emergency treatment decision and who should have been familiar with the patient's refusal of consent. These physicians may contend that immunity would free them to err on the side of life when they never checked or have forgotten the patient's wishes. The second scenario involves physicians who have reasonable doubts about the legal propriety of a request by the patient or proxy to terminate life support. Arguably, they should have the freedom to continue life-sustaining care until the family obtains a court order. However, each of these immunities has potential disadvantages that could outweigh their potential benefits.

1. Unreasonable Failure to Know Patient Wishes

Emergency physicians who have no reason to know about a previous refusal of life-sustaining care have no reason to fear liability.²⁶³ But what about the attending physician who has had ample opportunity to read the patient's directive, but never bothered to do so? Traditional tort principles would support recovery. Physicians are liable when they unreasonably fail to familiarize themselves with clinical information contained in the chart.²⁶⁴ They arguably have a similar obligation to acquaint themselves with the patient's treatment preferences—perhaps even an obligation to

262. Most general advance directives may suffer from this shortcoming. See, e.g., Teno et al., *Do Advance Directives*, *supra* note 2, at 508 (concluding that only 22 of 688 advance directives were specific enough to control the later treatment decisions).

263. Traditionally, a physician does not commit a battery whenever she performs a medical procedure without the patient's consent if the treatment is rendered in an emergency and it is impossible to obtain consent. See RESTATEMENT (SECOND) OF TORTS § 892–892D, cmt. a, illus. 4 & 5, cmt. b.

264. See, e.g., *Larrimore v. Homeopathic Hosp. Ass'n*, 181 A.2d 573 (Del. 1962) (holding a hospital liable when a nurse failed to read the chart); *Killebrew v. Johnson*, 404 N.E.2d 1194, 1197 (Ind. Ct. App. 1980) (finding that a doctor's failure to read x-rays constituted submissible negligence).

inquire about them, just as they would elicit a patient's medical history.²⁶⁵ Yet, physicians routinely fail to do so.

And what of the physician who knew about the patient's preferences and simply forgot? As a matter of traditional tort law, the privilege to render unconsented emergency treatment disappears when the physician knows in advance that the patient would not consent.²⁶⁶

Arguably, the extension of liability this far could put physicians in a tactical quandary if an emergency arises and they have not yet familiarized themselves with the patient's instructions or have forgotten them. Erring in either direction could result in liability. Although it seems unlikely, it is possible that physicians faced with this Hobson's choice would delay life-sustaining treatment while checking the patient's chart. Immunity from tort liability would eliminate this tactical quandary and permit the attending physicians to err on the side of treatment.

Unfortunately, immunity would also remove the provider's incentive to know and respect the wishes of the patient or her proxy. In fact, immunity would create a positive disincentive to learn this information. Once physicians discover that they have more discretion if they are unfamiliar with the governing instructions than if they know them, they will have a powerful incentive not to ask their patients or proxies about their preferences regarding end-of-life treatments, like CPR, and not to read documents memorializing those preferences. Given this risk, immunity ought not be lightly granted.

The choice between immunity and liability ultimately turns on the likelihood that liability would produce a significant chilling effect. My own suspicion is that it is more likely to have a constructive impact, inducing hospitals to place the instructions given by patients or their proxies in the charts, prompting physicians to read those instructions, and motivating risk managers to devise better methods for informing nurses and physicians

265. See Oddi, *supra* note 78, at 662; see also PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 50 (1983) (concluding that the option of nontreatment should be discussed with dying patients). But see *Iafelice v. Luchs*, 501 A.2d 1040, 1049 (N.J. 1985) (holding that physicians owed parents no duty to inform them of a nontreatment option when death was not a legally sanctioned alternative).

266. See RESTATEMENT (SECOND) OF TORTS § 892D cmt. a, illus. 5; see also *Estate of Leach v. Shapiro*, N.E.2d 1047, 1053 (Ohio Ct. App. 1984); *Malette v. Shulman*, [1990] D.L.R. 321 (Can.) (holding that the emergency doctrine of necessity does not allow a physician to disregard a patient's advance directive).

quickly about patient preferences, such as the placement of color coded signals on the charts.

Because we do not know the impact that liability would have, courts and legislatures will have to rely on their instincts, aided in part by the direction in which they prefer to err. That probably means that most courts will deny compensatory damages in cases in which a physician must make an immediate decision and has not read or cannot recall the patient's instructions. But judges who share my belief that liability would induce a more productive response could reasonably impose liability on physicians who should have known better than to administer life-extending care.

2. Reasonable Doubts About the Propriety of a Request to Terminate Treatment

The second category of cases in which the risk of an undesirable chilling effect warrants special consideration involves physicians who continue treatment because they have reasonable doubts about the legal propriety of the request to discontinue treatment. In some states, for example, the obligation of physicians to respect treatment refusals by pregnant patients²⁶⁷ or mature minors²⁶⁸ may be unresolved. In other cases, the legal authority of family members to make the treatment decision may be unclear.²⁶⁹ Sometimes physicians may doubt that the instructions they have received from a legally authorized proxy are consistent with the wishes or the interests of the patient. Absent the threat of tort liability, physicians might err on the side of life in these situations. If they are potentially liable for overtreatment, however, they might be tempted to defer to the disputed request—not because it seems defensible, but because deference is the route most likely to avoid litigation.

Thus far, the courts have been unwilling to impose liability in cases like these.²⁷⁰ Instead, they have limited the patients and their families to equitable relief. By preferring equitable relief to legal redress, these courts have not only reversed the normal (albeit weak) preference for legal relief,²⁷¹ but they have also deviated from the normal tort practice of judging the reasonability of challenged behavior in hindsight. In effect, they

267. See *e.g.*, *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (en banc).

268. See *e.g.*, *In re E.G.*, 549 N.E.2d 322 (Ill. 1989).

269. See, *e.g.*, *Cruzan v. Director, Miss. Dep't of Health*, 110 S. Ct. 2841 (1990); *Grace Plaza of Great Neck, Inc. v. Elbaum*, 623 N.E.2d 513 (N.Y. 1993).

270. See *supra* note 66.

271. See DOBBS, *supra* note 80, § 1.1, at 3.

have ruled that damages are available only when the physician's legal duty at the time was clear.²⁷²

Presumably, the courts have protected physicians from hindsight scrutiny in borderline cases so that physicians can err on the side of life until they receive instructions from a court.²⁷³ However, these physicians could have provided themselves with the same protection by going to court themselves.²⁷⁴ Consequently, the disposition of these cases ultimately turns on whether families or physicians should bear the burden of going to court when physicians balk at the request of a patient or proxy. If physicians should bear this responsibility, then it would be fair to impose liability on those physicians who fail to do so and are later determined to have wrongfully kept the patient alive. If, instead, patients and families should shoulder the obligation of seeking judicial assistance, then physicians who have reasonable doubts should be protected from liability until a court rules on the dispute, even if the court later concludes that the physician's concerns were unfounded.

On whom should this burden be imposed? The answer may turn on the specific factual setting. Because competent patients have a virtually unfettered right to refuse life-sustaining medical care, physicians who doubt the propriety of clear requests made by currently or previously competent patients should either obtain judicial permission to continue treatment or else run the risk of tort liability. As an Ohio appellate court once concluded, "[T]he patient's right to refuse treatment is absolute until the quality of the competing interests is weighed in a court proceeding."²⁷⁵

At the opposite extreme are cases in which the past preferences of a previously competent patient are reasonably in doubt and no legally authorized proxy has been appointed. Under these circumstances, it seems reasonable to ask the family to obtain decision-making authority from a court or to obtain a court order mandating the cessation of treatment. In

272. And, by effectively forcing patients to seek equitable, rather than legal, relief in borderline cases, these courts have also fashioned an exception to the traditional rule that plaintiffs need not mitigate anticipated harm by seeking prior equitable relief. See, e.g., *Robinson v. Carney*, 632 A.2d 106, 108 (D.C. 1993); 2 *MARILYN MINZER ET AL., DAMAGES IN TORT ACTIONS* § 16.22, at 16-34 to -35 (1982).

273. See *Grace Plaza*, 623 N.E.2d at 516; Gasner, *supra* note 65, at 503; Nancy Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 420 (1988) (noting the "near-sacrosanct" injunction to "err on the side of life").

274. See Gasner, *supra* note 65, at 513-14 (suggesting that the underlying issue is who must go to court).

275. *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051-52 (Ohio Ct. App. 1984).

Grace Plaza of Great Neck, Inc. v. Elbaum,²⁷⁶ for example, the patient's wishes were unclear and New York did not recognize independent decisions by family members. As a result, the court concluded that the physician should be free to administer life-sustaining treatments until the family obtained a court order.

A much closer case would be presented, however, if clear instructions have been given by a proxy authorized by state law to make treatment decisions. Depending upon state law, these legally empowered proxies may be family members, judicially appointed guardians, statutorily authorized surrogates, or persons named as an attorney-in-fact under a durable power of attorney.²⁷⁷ On the one hand, these proxies have been given prima facie legal power to make the treatment decision. From this perspective, physicians who object to their decisions should take their objections to court or else exercise any rights of conscience they may have under state law. They should not unilaterally continue unwanted care.

On the other hand, it is the proxy who seeks to end the patient's life. Under these circumstances, the New York Court of Appeals has concluded that there is "nothing unfair in placing the burden of instituting legal proceedings on those seeking to discontinue treatment."²⁷⁸ According to the court, this allocation of responsibility furthers the goal of erring on the side of life and places the burden of going forward on those with best access to evidence of patient preferences.²⁷⁹ As a result, the court concluded that a provider who "entertains doubts about the state of the law" or who "has legitimate professional reservations about the procedure requested" could either "seek a judicial determination of the matter itself or insist that the family do so."²⁸⁰

In addition, proxies will often have conflicts of interest that could color their judgment. The patient's illness may heavily tax the proxy's emotional and financial resources. Ongoing treatment can also threaten the family's inheritance and monopolize the time and emotional energies of caretakers. These competing pressures could affect the judgment of even the most loyal proxy.

276. 623 N.E.2d 513 (N.Y. 1993); see also *McVey v. Englewood Hosp. Ass'n*, 524 A.2d 450 (N.J. 1987) (per curiam) (holding that, absent a legal guardian, the physician had no duty to determine and evaluate the veracity of the patient's purported orally expressed wishes).

277. See generally MEISEL, *supra* note 3, at chs. 5, 12, 14.

278. *Grace Plaza*, 623 N.E.2d at 515.

279. See *id.* at 516.

280. *Id.* at 515 (emphasis added).

Legitimate arguments, therefore, can be made in support of either allocation of the responsibility to go to court. However, a recent study found that the economic hardship on family members did not affect their ability to predict patient preferences.²⁸¹ My own intuition is that courts will usually defer to the proxy when the case goes to court. As a result, forcing surrogates to go to court each time a physician balks at their requests is likely to produce a waste of judicial and private resources. Placing the burden of going forward on physicians, instead, would encourage them to identify those cases in which the surrogate's request is not merely inconsistent with their own preferences, but is also most likely to be deemed inappropriate by a neutral third party.

Placing the obligation on physicians will also assign the burden on the party best positioned to know that a dispute is imminent. Families and patients will often be unaware that their physician is unwilling to respect their wishes until the unwanted heroic efforts have taken place. Physicians, on the other hand, will appreciate the potential conflict from the moment that they receive instructions from the patient or proxy. Placing the burden of initiating litigation on physicians, consequently, will force them, first, to read the treatment directives given by the patient or proxy and, second, to determine whether they have a serious objection to the proxy's instruction. If they do have reservations, they will then have both an incentive and an opportunity to resolve the issue with the proxy or go to court before the actual treatment decision needs to be made.

For patients and their families, furthermore, the right to go to court will often be meaningless. Patients whose proxies are unaware that their instructions will be disregarded cannot be expected to seek a court order. At other times, families will lack the resources, sophistication, or emotional reserves necessary to go to court during a time of family crisis.

Because there are good reasons for assigning the responsibility to physicians as well as good reasons for assigning it to proxies, courts are likely to struggle with this issue. If courts are serious, however, about delegating decision-making power to patients and their proxies, then the burden of seeking judicial guidance should be placed on physicians. Physicians who have a reasonable opportunity to transfer the patient or to obtain judicial guidance should be obliged to use that opportunity or risk later liability. This resolution respects the prima facie allocation of decision-making power to the proxy, rather than to the physician, while

281. See Kenneth Lovinsky et al., *Is Economic Hardship on the Families of the Seriously Ill Associated with Patient and Surrogate Preferences?*, 156 ARCHIVES INTERNAL MED. 1737 (1996).

providing breathing room for physicians who have reasonable doubts about proxy requests.

D. Synthesizing the Deterrence Analysis

To summarize, tort liability for unconsented life support will provide a much needed counterbalance to current legal incentives to overtreat. Nevertheless, courts should be sensitive to the risk that tort liability could unduly weaken the physician's natural inclination to err on the side of life. This risk can be minimized if courts limit tort liability to those circumstances in which the wishes of the patient or her legally authorized proxy are clearly communicated and the physician has had a reasonable opportunity to learn about these wishes. Under those circumstances, physicians should bear the burden of going to court when they disagree with the directions of the patient or proxy.

CONCLUSION

Not surprisingly, the wrongful life analogy provides only a starting point for examining tort claims at the end of life. Although the end-of-life cases are, of course, similar to the wrongful life cases in their contention that life itself is a compensable injury, they also differ in important respects that complicate the analysis.

In the wrongful life setting, for example, courts have worried that they would offend public policy if they endorsed parental allegations that a child born due to provider carelessness would have been better off unborn. At the end of life, on the other hand, public policy clearly supports the right of patients and, in many circumstances, their proxies to refuse life-extending care. Our willingness to permit these decisions reflects the tragic realities of life, not a repudiation of it. Under these circumstances, recognition of a right to compensatory damages would encourage respect for patient rights by doctors, hospitals, and nursing homes who would otherwise have little legal incentive to carefully investigate patient wishes or ardently respect them.

Admittedly, the task of calculating general damages in cases of unwanted life support will be more difficult than it is in traditional tort cases because juries must place a value on the benefits of prolonged life. However, there are several reasons to believe that juries will be able to perform the task fairly. First, the presence and severity of any harm done to the patient can be determined by balancing the benefits of prolonged

life against the burdens. No knowledge of death or nonexistence is needed. Second, jurors will be able to call on their own family experiences and the considered decisions of the patients and their families to help the jury make reasoned judgments. No equivalent information is available in wrongful life cases. Third, the only aspect of the damages calculation that will be uniquely difficult is the measurement of life's benefits, an issue on which the tortfeasor, not the patient, should bear the burden of proof. Finally, our limited experience with these cases does not support the speculation that juries and the trial judges who supervise cannot reach defensible verdicts.

Consequently, the arguments against allowing recovery based on the wrongful life analogy have serious weaknesses. At the same time, the policy objectives of fairness and deterrence support recovery. As between the patient who has been wrongfully kept alive and the physician who has administered treatment without consent or an adequate justification, corrective justice requires that the physician compensate the patient for any harm caused by the breach of duty. An action for unconsented life support is also more badly needed than one for wrongful life. This is because wrongfully resuscitated patients lack the financial protections that wrongful birth actions provide for children whose wrongful life claims are rejected.

Furthermore, rejection of an action for damages would rewrite the substantive law of death and dying, effectively conferring upon physicians a right to treat patients against their wishes until a court has authorized the cessation of treatment. Although patients and their families could theoretically seek equitable relief, this remedy will often be inadequate. Patients and proxies who are unaware that their instructions will be ignored cannot be expected to seek judicial assistance. At other times, families will lack the money, emotional resources, or sophistications necessary to go to court during a time of family crisis.

Nevertheless, courts will understandably be concerned that tort liability could cause physicians to hesitate in emergencies or unduly weaken the physician's natural inclination to err on the side of life. This risk can be minimized if courts limit liability to those cases in which the wishes of the patient or her proxy were clearly communicated and the physician has had a reasonable opportunity to learn about them. This safe harbor should provide physicians with the breathing room that they need. If, however, the instructions from the patient or a legally empowered proxy are clear and the physician has had ample opportunity to ascertain them, physicians and hospitals should bear the burden of going to court for

guidance when physicians and families disagree. Those who do not should shoulder the risk that a court will later conclude that they wrongfully treated the patient.

Current judicial and academic critics of an action for “wrongful living” have suggested, however, that the goals of compensation and deterrence can be adequately advanced by recognizing a battery action for extraordinary expenses. Their willingness to allow partial recovery is noteworthy. By endorsing a remedy permitted in only a tiny minority of the wrongful life cases, these critics have implicitly acknowledged that cases involving unconsented life support cases are materially different from the wrongful life cases.

Unfortunately, partial recovery would be decidedly inferior to general damages as a matter of both justice and deterrence. It would undercompensate those patients who suffer severe pain and those whose primary grievance is the loss of religious or personal liberty. This harsh result seems unnecessary because the arguments against full recovery have serious weaknesses. However, in states that refuse to let the jury place a negative value on life or doubt the ability of juries to calculate general damages, a right to compensation for pecuniary harm or, more narrowly, a right to reimbursement for extraordinary expenses would be preferable to rejection of the action altogether.²⁸²

These conclusions are not meant to suggest that actions for compensatory damages will provide a cure for the plague that prompts them. Many, maybe most, patient and proxy directives are too general or vague to provide the necessary guidance to physicians. In addition, any fundamental change in physician attitudes and behavior will probably have to come from a shift in the culture of medicine. Nevertheless, the law has a proper role to play in these disputes. Tort liability can, at a minimum, provide redress to those patients whose rights have been clearly violated. In addition, it can reinforce the social consensus that the decisions of patients and their proxies matter. More optimistically, it can also provide a more properly balanced set of legal signals and, in so doing, encourage a few more physicians to respect patient wishes.

282. Courts should, however, resist the temptation to adopt the Ohio Supreme Court's distinction between direct and indirect harms because both types of harm pose the same policy issues. See *supra* text accompanying notes 220–222.

