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# Hospice: The Legal Ramifications of a Place to Die

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# NOTES

## Hospice: The Legal Ramifications of a Place to Die

The word "hospice," which means a home for the sick,<sup>1</sup> is the name given a recent development in the area of health care and treatment for the terminally ill. Unlike hospital care which focuses on curing the patient, hospice care is palliative; it seeks to alleviate the patient's symptoms rather than cure the disease or prolong the patient's life.<sup>2</sup> Pain and misery often face dying patients and hospice care concentrates not only on easing patients' physical discomfort but also on providing support for the psychological, social and spiritual needs of patients and their families, so that they "may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them."<sup>3</sup> Serious legal issues are raised by the unorthodox approach to patient care typical of hospice treatment. This note examines the potential tort or criminal liability of the hospice care provider, the effect of natural death acts and living wills on the hospice care provider's liability, and the patient's right to refuse curative treatment and receive palliative care in a hospice. Natural death acts provide more uncertainty than protection for the hospice and, while some recent case law favors allowing patients to refuse curative treatment, hospices remain in a legally tenuous position. The note outlines recommendations for admission and treatment procedures designed to alleviate any potential legal liability of the hospice and staff, and it suggests that present legislation be amended in order to protect hospice care providers.

### THE HOSPICE

The concept of the hospice is an ancient one; Fabiola, a disciple of Saint Jerome, established one in the port of Rome nearly 2,000 years ago.<sup>4</sup> Since that time the concept of establishing a center which provides hospitality, refreshment and fellowship to the sick and the needy has existed throughout Europe.<sup>5</sup> The modern hospice movement began in Great Britain<sup>6</sup> with the establishment of Saint Joseph's Hospice and Saint

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<sup>1</sup> See WEBSTER'S NEW INTERNATIONAL DICTIONARY 678 (2d ed. 1957).

<sup>2</sup> See Potter, *A Challenge for the Hospice Movement*, 302 NEW ENG. J. MED. 53, 53 (1980).

<sup>3</sup> National Hospice Organization, Standards of a Hospice Program of Care 3 (1979) [hereinafter cited as Standards].

<sup>4</sup> S. STODDARD, THE HOSPICE MOVEMENT 7-8 (1978).

<sup>5</sup> See *id.*

<sup>6</sup> S. LACK & R. BUCKINGHAM, FIRST AMERICAN HOSPICE 9 (1978).

Christopher's Hospice.<sup>7</sup> The first American hospice was the Hospice at New Haven, Connecticut,<sup>8</sup> and now it is estimated that between 700 and 1,000 hospice programs exist throughout the United States in various stages of development.<sup>9</sup>

A hospice may be located in a designated wing or unit of a hospital, or in a separate facility. In addition, some hospices operate exclusively through home visits by the hospice staff.<sup>10</sup> Hospice care is provided by an interdisciplinary team which generally includes doctors, pharmacists, nurses, social workers, clergy and volunteers.<sup>11</sup> A humanistic approach characterizes the hospice philosophy, which requires that members of the hospice staff direct their professional training toward the special needs of the terminally ill.<sup>12</sup>

Hospice care providers distinguish between "ordinary" and "extraordinary" treatment. Ordinary treatment includes "all medicines, treatments, and operations which offer a reasonable hope of benefit, and which can be obtained and used without excessive expense, pain or other inconvenience."<sup>13</sup> Extraordinary treatment consists of "medicine, operations, or other treatment which cannot be obtained and employed without considerable expense, pain or other inconvenience, and which provide no reasonable hope of lasting benefit to the patient."<sup>14</sup> A hospice provides ordinary treatment but will not administer extraordinary care; it will not make heroic efforts to prolong the patient's life.

The ordinary care provided by a hospice is largely concerned with easing the pain which accompanies many terminal illnesses, particularly cancer. To alleviate or control such pain, hospice care providers administer analgesics as a prophylactic measure according to a schedule, rather than on demand after pain occurs.<sup>15</sup> After the patient's pain is under continuous

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<sup>7</sup> *Id.*

<sup>8</sup> *Id.* at 3.

<sup>9</sup> Telephone interview with Margaret Duncan, Public Information Officer for the National Hospice Organization, McLean, Virginia (April 8, 1981).

<sup>10</sup> See generally S. LACK & R. BUCKINGHAM, *supra* note 6.

<sup>11</sup> *Id.* at 4, 25.

<sup>12</sup> See *id.* at 4.

<sup>13</sup> Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1209 (1973).

<sup>14</sup> Note, *Euthanasia: The Physician's Liability*, 10 J. MAR. J. PRAC. & PROC. 148, 149 (1976).

<sup>15</sup> These analgesics are frequently referred to as "Brompton's Mixture." Jaffe & Martin, *Opioid Analgesics and Antagonists*, in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 494, 512 (6th ed. A. Gilman, L. Goodman & A. Gilman eds. 1980).

Regular administration of narcotics does not imply repetitive overdosage of the patient. Instead, drug dosage can be titrated or adjusted to establish the minimal dosage level at which the patient is freed from pain. "Such titration produces the optimal clinical result—a patient who is free from pain but who is also alert enough to enjoy the benefits of pain-free survival." Potter, *supra* note 2, at 54. In Britain heroin is an analgesic alternative to morphine for the relief of intractable pain. See Shapiro, *The Right of Privacy and Heroin Use for Painkilling Purposes by the Terminally Ill Cancer Patient*, 21 ARIZ. L. REV. 41, 43

control, the hospice staff turns its attention "to the psychological, social and spiritual needs of the patient."<sup>16</sup> A hospice

offers a carefully designed regimen of "loving care" based in an environment sensitively attuned to recognizing the needs and even the "rights" of the dying. It addresses these needs and rights with a caring regimen of pain relief, personal and family counselling, attractive surroundings and sees to all those things which will put the patient in charge of his own dying as much as possible.<sup>17</sup>

Furthermore, many hospices counsel and train the patient's family to help care for the patient while he lives and send a bereavement team to the family's home after the patient dies.<sup>18</sup>

No standard procedures are required for admitting patients or running a hospice facility.<sup>19</sup> Since each hospice sets up its own procedures according to its particular needs, a variety of admission requirements has been imposed. Presumably, hospices will only admit patients who have been diagnosed as terminally ill and have a limited life expectancy;<sup>20</sup> a prognosis of six months or less is common. Some hospices limit admission to patients who are suffering from cancer.<sup>21</sup> Others require that the patient live within

(1979). Research conducted in St. Christopher's Hospice in London has shown that in advanced cases of pain, when injections of medication rather than oral dosages are necessary, "heroin possess[es] important advantages over morphine, especially where large doses [are] required." *Id.* at 44. Such studies have provoked the view that the scheme of state and federal law in the United States which prohibits the use of heroin as an analgesic "sweep[s] unnecessarily broadly," *id.* at 58 (quoting *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965)), and "might well constitute an abridgement of the right of privacy," Shapiro, *supra*, at 42.

<sup>16</sup> Holden, *Pain, Dying and the Health Care System*, 203 *Sci.* 984, 985 (1979). In the past 10 years chronic pain has been recognized as a disease in itself, "a debilitating condition generally accompanied by serious psychological problems and often caused by them." *Id.* at 984. Many hospice patients suffer from cancer and endure a special variety of pain: "[T]he imminence of death, the sense of isolation, the fear of worse things to come, and the distress of family members can make the pain far more agonizing than it would be otherwise." *Id.* at 985.

<sup>17</sup> P. ROSSMAN, *HOSPICE* 7 (1977). The persons who receive hospice treatment are not all elderly; a large percentage of the people receiving care in hospices are under 50 years old and many terminally ill children receive hospice care as well. *Id.* at 16. Because the cost of the intense personal attention received in a hospice offsets the money saved by not utilizing the high technology curative therapies offered in hospitals, the cost of inpatient hospice care is often at least as expensive as inpatient hospital care, *Supporting Hospice Care*, 207 *Sci.* 160, 160 (1980). However, patients who are able to receive home hospice care save money since the hospice care enables them to live out their final days at home rather than in an institution. *Id.* At present, health insurance such as Medicare and Medicaid does not cover hospice care. *Id.* However, a two-year demonstration project in which patients in certain hospices will have all of their expenses paid by Medicare and Medicaid was begun during the spring of 1980. *Id.*

<sup>18</sup> S. LACK & R. BUCKINGHAM, *supra* note 6, at 76-78, 97-99.

<sup>19</sup> Telephone interview with Margaret Duncan, *supra* note 9. The National Hospice Organization has outlined standards and principles to be used as guidelines for those setting up a hospice, however. See Standards, *supra* note 3.

<sup>20</sup> See generally S. LACK & R. BUCKINGHAM, *supra* note 6, at 75.

<sup>21</sup> See *id.*

a particular area, obtain consent and cooperation from his personal physician, obtain consent from his family and designate a friend or family member who will serve as primary care person.<sup>22</sup> Hospices may require the patient to sign a form stating that he consents to admission to the hospice and agrees to palliative rather than curative treatment.<sup>23</sup>

### LIABILITY OF THE HOSPICE CARE PROVIDER

Before one can evaluate and discuss advisable admission and treatment procedures, one must discuss the legal liability involved in administering hospice care. Because hospice care could be viewed as a form of passive euthanasia, the hospice management and physician may be subject to civil and criminal liability. Malpractice actions based on the claims that extraordinary treatment could have saved the hospice patient and that the failure of the hospice care provider to administer such treatment constitutes a form of euthanasia could be instigated by the patient himself while he is still living or by an unhappy family member after the patient's death.<sup>24</sup> Theoretically, a tort action could also be brought against the hospice facility itself under a theory of respondeat superior since the hospice physicians may be employees under the control of the hospice.<sup>25</sup> In addition, the hospice physician could face a criminal prosecution for homicide.<sup>26</sup>

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<sup>22</sup> See *id.*

<sup>23</sup> See generally *id.* at 76.

<sup>24</sup> Hospice care providers may also face the problem of negligence for misdiagnosis. Diagnosing a patient as terminally ill may be an uncertain matter; doctors may disagree as to whether a patient is terminally ill. For a discussion of this matter, see note 81 *infra*. Misdiagnosis in this case is extremely serious since the resulting negative effects of inappropriate treatment may be irreversible.

<sup>25</sup> See generally *Brown v. Moore*, 247 F.2d 711 (3d Cir.), *cert. denied*, 355 U.S. 882 (1957); Annot., 69 A.L.R.2d 305 (1960). In fact, it has been argued that a hospital could be held independently liable, in addition to its liability under agency law. See *Darling v. Charleston Community Memorial Hosp.*, 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964), *aff'd*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965). Under this theory, a hospice could be sued for its failure to adequately supervise the use of its facility by nurses, doctors and other health care professionals. It should be noted that in some cases, charitable or state immunity might protect the hospice if it is connected with a facility that is so protected, see generally *W. WADLINGTON, LAW AND MEDICINE* 203-52 (1979).

Whether the hospice facility itself could be sued is an important consideration given the nature of hospice care itself. The hospice could be perceived by some as a place which not only condones but actively promotes euthanasia and it could therefore become an object of scorn from those who view euthanasia as evil or immoral.

Some groups such as the California Pro-Life Council view granting a person the right to die as a step toward eliminating the useless and infirm. Marian Banducci, a representative of the Friends of Mothers and Babies and the Helpless Aged, contended that "the real target is to get rid of the people who cost too much to keep alive." *Courier-J. (Louisville)*, Jan. 15, 1978, § G, at 10, col. 3.

<sup>26</sup> Though unlikely, it is nevertheless possible that a criminal action could be brought against the hospice facility for aiding and abetting a murder.

Physicians<sup>27</sup> and policymakers<sup>28</sup> recognize two types of euthanasia: passive and active. Passive euthanasia results from the failure to take affirmative life-prolonging measures.<sup>29</sup> Active euthanasia requires an affirmative act resulting in the patient's death,<sup>30</sup> such as injecting a patient with a lethal drug.<sup>31</sup> Hospice care could be viewed as a form of passive euthanasia since doctors using palliative treatment, by definition, take no affirmative measures to save or prolong the patient's life. However, hospice care could not be characterized as active euthanasia since it does not seek to prematurely end the patient's life.<sup>32</sup>

### *Tort Liability*

A patient could sue the hospice care provider in tort under two separate theories: the first approach is a malpractice action based on negligent treatment; the second is based on the doctor's failure to obtain the patient's informed consent to the treatment. The issue of negligent treatment must be discussed first because if the treatment—in this case terminating all life-prolonging or curative therapy and providing only palliative care—is found to be negligent, the question of informed consent does not arise. A patient ordinarily cannot consent to negligent treatment.<sup>33</sup> If the treatment is found to be negligent, a court is likely to conclude that due to some policy consideration such as the differential status or bargaining positions of the physician and his patient,<sup>34</sup> the patient's consent to the

<sup>27</sup> Rachels, *Active and Passive Euthanasia*, 292 N. ENG. J. MED. 78, 78 (1975).

<sup>28</sup> "Mercy killing" (active euthanasia) is specifically distinguished in seven natural death acts. See ALA. CODE § 22-8A-10 (1981); CAL. HEALTH & SAFETY CODE § 7195 (West Supp. 1981); KANS. STAT. ANN. § 65-28,109 (1980); NEV. REV. STAT. § 449.670 (1979); OR. REV. STAT. § 97.085(1) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h § 10 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.100 (West Supp. 1981).

<sup>29</sup> Note, *supra* note 14, at 148. Turning off a respirator switch is also considered passive euthanasia, but one could argue that only a semantic distinction exists between this and active euthanasia. See Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1650 (1974) [hereinafter cited as *Informed Consent*].

<sup>30</sup> Note, *supra* note 14, at 148.

<sup>31</sup> See *Informed Consent*, *supra* note 29, at 1650.

<sup>32</sup> See Standards, *supra* note 3, at 3. At least one physician argues that the distinction between passive and active euthanasia is not a logical or even an ethical distinction and that active euthanasia may be more humane than passive euthanasia in some cases. See Rachels, *supra* note 27. However, with regard to the hospice care provider, this distinction is important. Public policy is generally more favorably disposed to passive rather than active euthanasia. See notes 25 & 28 *supra*.

<sup>33</sup> See *Tunkl v. Regents of Univ. of Cal.*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963) (exculpatory provision found in agreement signed by patient did not render hospital immune from liability on basis of wrongful acts or omissions of its employees); *Olson v. Molzen*, 558 S.W.2d 429 (Tenn. 1977) (exculpatory agreement signed by patient did not render doctor immune from liability based on negligence in performing abortion).

<sup>34</sup> See *Tunkl v. Regents of Univ. of Cal.*, 60 Cal. 2d 92, 99-101, 383 P.2d 441, 445-46, 32 Cal. Rptr. 33, 37-38 (1963); *Olson v. Molzen*, 558 S.W.2d 429, 431-32 (Tenn. 1977).

treatment is void as against public policy and will not absolve the physician's negligence in providing the unacceptable treatment. In cases involving the discontinuation of life-prolonging treatment at the request of a terminally ill patient, the standard of care to be applied should evaluate whether the physician used that reasonable degree of care and skill which physicians and surgeons ordinarily exercise in the treatment of their patients.<sup>35</sup> Recent studies along with other evidence indicate that a substantial percentage of physicians are inclined to discontinue life-prolonging treatment for their terminally ill patients.<sup>36</sup> In fact, courts have been willing to order the discontinuation of treatment in cases brought by the patient's guardian where the patient is terminally ill and incompetent.<sup>37</sup> Therefore, a court could find evidence to support the contention that discontinuing life-prolonging treatment for terminally ill patients constitutes reasonable care under the circumstances.<sup>38</sup>

<sup>35</sup> See *Nolan v. Dillon*, 261 Md. 516, 534, 276 A.2d 36, 46 (1971); *Anderson v. Johns Hopkins Hosp.*, 260 Md. 348, 350, 272 A.2d 372, 373 (1971); *Dashiell v. Griffith*, 84 Md. 363, 380-81, 35 A. 1094, 1096 (1896); *Janney v. Housekeeper*, 70 Md. 162, 171, 16 A. 382, 384 (1889). If the hospice care provider holds himself out as a specialist, such as an oncologist, he is held to a higher standard of knowledge and skill than a general practitioner: the standard of care required of physicians in the same speciality practiced by the defendant physician. *Kronke v. Danielson*, 108 Ariz. 400, 403, 499 P.2d 156, 159 (1972); *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968). Some courts have applied the "respectable minority" standard. See, e.g., *Leech v. Bralliar*, 275 F. Supp. 897, 902 (D. Ariz. 1967). Under a similar standard, a physician will not be held liable for negligent treatment "[w]here competent medical authority is divided . . . [and] he followed the course of treatment advocated by a considerable number of his professional brethren in good standing in his community." *McHugh v. Audet*, 72 F. Supp. 394, 400 (M.D. Pa. 1947).

<sup>36</sup> See D. CRANE, *THE SANCTITY OF SOCIAL LIFE* 40-46 (1975); Cantor, *Law and the Termination of an Incompetent Patient's Life-Preserving Care*, in *DILEMMAS OF EUTHANASIA* 69, 70 (J. Behnke & S. Bok eds. 1975).

<sup>37</sup> See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

<sup>38</sup> It is possible, however, that a court would be reluctant to find that, as a general rule, discontinuing life-prolonging treatment for terminally ill patients constitutes reasonable care. A court might fear that such a decision would be against public opinion. See the discussion of sentiment against euthanasia, note 25 *supra*. If the court refuses to acknowledge that discontinuing life-prolonging treatment is reasonable care ordinarily exercised by physicians, one could argue in the alternative that even if most physicians do not practice passive euthanasia in the case of terminally ill patients, discontinuing extraordinary treatment is the only appropriate treatment for terminally ill patients who request it and therefore such treatment *should* be the standard of care in this area. In *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974), the court found that administering a particular eye test was not the standard of care ordinarily practiced by doctors in defendant's speciality, *id.* at 518, 519 P.2d at 982, but nevertheless applied an objective evaluation to conclude that applying the test should be the standard of care, regardless of whether it was ordinarily administered by physicians in defendant's speciality. *Id.* at 519, 519 P.2d at 983. Finally, it is possible that a court would be unwilling to hold that discontinuing life-prolonging treatment is ever nonnegligent care for the reason that such a decision might be construed as dangerous in that it is one step toward the legalization of mercy killing. See the discussion of sentiment against euthanasia, note 25 *supra*. In such a case, one could argue that while it is generally negligent to discontinue such treatment, an exception should be made in the case of hospices.

If a court does find that this treatment constitutes reasonable care, it may then consider the issue of whether the patient made an informed consent to the treatment.<sup>39</sup> If a doctor performs treatment without the informed consent of the patient, he may be found liable for not having first obtained this consent before treating the patient—even if the treatment is successful.<sup>40</sup> Treatment administered without the consent of the patient is “viewed as an intentional interference with the person—a battery.”<sup>41</sup> When a doctor performs a medical procedure without any consent whatsoever, many courts allow battery as the theory of recovery.<sup>42</sup> However, when a “patient consents to a treatment but an undisclosed risk materializes, courts have been reluctant to find that the physician has committed an intentional tort.”<sup>43</sup> Instead, courts will find that the physician failed to exercise due care in advising his patient regarding the risks of and alternatives to the treatment.<sup>44</sup> A standard of due care corresponds better doctrinally with a theory of negligence than with the theory of battery<sup>45</sup> and the trend has been to view malpractice in this area as a tort of negligence rather than one of battery.<sup>46</sup>

Irrespective of the doctrinal foundation of the informed consent concept, the doctor is absolved from liability for administering a particular treatment if he obtains an informed consent from the patient before he administers the treatment and performs the consented-to treatment nonnegligently.<sup>47</sup> In order for the doctor to obtain an informed consent from his patient he must first give the patient all material information regarding the risks involved in the treatment<sup>48</sup> and then obtain the patient’s consent to the treatment.<sup>49</sup> The principle of informed consent is

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Hospices promote a valuable public policy in providing patient autonomy and the possibility of death with dignity for terminally ill patients, while also protecting the interests of the patients. Therefore, while consent is ordinarily not a defense to administering negligent treatment, theories such as contributory negligence and assumption of an unreasonable risk could be asserted as defenses against patients who have consented to the termination of extraordinary treatment in a hospice. *See Carmichael v. Reitz*, 17 Cal. App. 3d 958, 991-92, 95 Cal. Rptr. 381, 402 (1971) (patient who used drug despite knowledge from previous experience that it caused thrombophlebitis assumed risk of adverse reaction).

<sup>39</sup> Medical malpractice cases in which patients received treatments to which they had not consented gave rise to the doctrine of informed consent. *Informed Consent*, *supra* note 29, at 1635-36.

<sup>40</sup> *See Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

<sup>41</sup> *Informed Consent*, *supra* note 29, at 1635.

<sup>42</sup> *Id.* at 1636.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> *See generally* W. PROSSER, *LAW OF TORTS* 101, 162 (1971).

<sup>48</sup> The court in *Wilkinson v. Vesey*, 110 R.I. 606, 627-28, 295 A.2d 676, 689 (1972), defined “material” as all facts which a reasonable man would regard as significant in light of “the severity of the risk and the likelihood of its occurrence.” *Id.* at 628, 295 A.2d at 689. The more severe or likely the risk, the more probable it is to be material. *Id.*

<sup>49</sup> *Informed Consent*, *supra* note 29, at 1636; *Survey*, *supra* note 13, at 1222.



based on the premise that the patient "know[s] best his own value preferences, capacity for pain and suffering, and uncompleted business and social obligations,"<sup>50</sup> and is therefore in a better position than the doctor to decide whether to undergo the treatment. This reasoning applies to the terminally ill patient as well as the curable patient,<sup>51</sup> even though the risks and alternatives that must be disclosed to the terminally ill patient are different from those disclosed to the curable patient. For example, compared with the curable patient, the terminally ill patient may not be as concerned with the risk of death involved in a certain medical procedure, since death is inevitable for the terminal patient. Instead, he may be more concerned with the discomfort involved in a particular treatment and the probability that the treatment would significantly prolong his life. Nevertheless, the terminally ill patient's decision in choosing one treatment over another is logically no different from that of a curable patient;<sup>52</sup> the terminally ill patient is still in the best position to determine his own preferences and capacity to endure pain and suffering.<sup>53</sup> Therefore, the principle of informed consent is no less applicable for the terminally ill patient than for the curable patient.

This principle of informed consent implies that the patient also has a right to an informed refusal.<sup>54</sup> The patient is only in a position to exercise an informed consent to one treatment if, after having been informed of the risks and alternatives involved with that treatment, he can refuse the treatment should he feel the risks are too great or that an alternative treatment is preferable. If the patient cannot refuse treatment, his choice with regard to an informed consent to that treatment is meaningless. Therefore, a doctor may be found liable for failing to obtain an informed consent or an informed refusal—even if the treatment performed was appropriate, was performed nonnegligently and the patient benefited from the treatment.<sup>55</sup>

Furthermore, the estate of the hospice patient might bring an action under a "survival act"<sup>56</sup> on the basis that the actions of malpractice for

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<sup>50</sup> *Informed Consent*, *supra* note 29, at 1648.

<sup>51</sup> *Id.* at 1649.

<sup>52</sup> *Id.*

<sup>53</sup> *See id.*

<sup>54</sup> Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973).

<sup>55</sup> In fact, correspondence with various hospice facilities indicates that many hospices do not require incoming patients to sign any agreement specifying that they consent to palliative care. Letters from Parkview Memorial Hospital, Horizon Hospice and Highland Park Hospice in response to a survey dated March 27, 1980 (letters on file with the *Indiana Law Journal*).

<sup>56</sup> Every state has some sort of statutory remedy which either arises independently at the patient's death, such as a wrongful death act, or preserves the cause of action vested in the deceased patient, such as a survival act. W. PROSSER, *supra* note 47, at 902. Beneficiaries of the action are often specifically designated by the respective statute in ac-

discontinuing life-prolonging treatment or lack of informed consent which could have been brought by the patient are preserved for the patient's descendants. Alternatively, the estate of the hospice patient might pursue a statutory remedy for wrongful death<sup>57</sup> which arises as a separate cause of action upon the death of the patient. Both the survival and the wrongful death acts typically provide that an action can be brought for "any wrongful act, neglect or default" which causes death,<sup>58</sup> so the estate could sue pursuant to a negligent as well as an intentional tort.<sup>59</sup> In fact, an action for wrongful death based on the doctor's liability under the criminal law could also be brought since any act which constitutes criminal conduct would ordinarily constitute "wrongful" conduct under a wrongful death theory.

### *Criminal Liability*

Criminal liability is unclear in the area of discontinuing treatment for a terminally ill patient, and it is possible that a hospice physician could find himself facing criminal prosecution. Euthanasia is viewed as a clear violation of criminal law<sup>60</sup> such that even those practicing passive euthanasia theoretically could be prosecuted for murder.<sup>61</sup> Moreover, the doctrine of informed consent provides no defense for the defendant physician because a victim's consent is no defense to the crime of murder.<sup>62</sup>

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cordance with the purpose underlying such a statute—which is to compensate family members who perhaps had expectations of continuing support from the deceased if he had lived. *Id.* at 904. Under the survival acts, damages recoverable for the patient's death "will include not only the pain and suffering, medical expenses and loss of earnings of the decedent during his lifetime, but further compensation to the estate itself for loss of prospective economic benefit in the form of future earnings or savings." *Id.* at 905. Under a wrongful death act, however, the beneficiaries of the estate may recover only "the loss of economic benefit which they might have expected to receive from the decedent in the form of support, services or contributions during the remainder of his lifetime" had he lived. *Id.* at 906. Because recovery is ordinarily limited to pecuniary benefits, courts have not adopted the notion that no human life is without value. *Id.* at 907. Therefore, in the case of the terminally ill hospice patient who would not have been able to render any sort of economic benefit upon his family had he not died (in fact, he is likely to be costing his family great expense), his beneficiaries would be able to recover little.

<sup>57</sup> See *id.* at 903.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> Collester, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304, 309 (1977). "Thus one who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief." *People v. Conley*, 64 Cal. 2d 310, 322, 411 P.2d 911, 918, 49 Cal. Rptr. 815, 822 (1966). Murder is defined as "the killing of another human being with malice aforethought." *Survey, supra* note 13, at 1204. Motive for the killing is irrelevant since malice is now defined as intent to kill or cause serious bodily harm. *Id.*

<sup>61</sup> See generally *Turner v. State*, 119 Tenn. 663, 671, 108 S.W. 1139, 1141 (1908).

<sup>62</sup> *Survey, supra* note 13, at 1205.

In fact, all of the special factors which "arguably distinguish euthanasia from more reprehensible forms of killing—a humanitarian motive, the consent of the victim, and the victim's hopeless condition"—are irrelevant under the criminal law.<sup>63</sup>

Although evidence indicates that the practice is widespread,<sup>64</sup> there have been few instances of criminal convictions for euthanasia.<sup>65</sup> Even where prosecution has been undertaken, both judges and juries hesitate to be too harsh on defendants.<sup>66</sup> Nevertheless, hospice care providers by no means are immune from prosecution under criminal law. Homicide may result from a failure to act as well as from positive action.<sup>67</sup> A person is liable for a failure to act when a clear duty to act was present,<sup>68</sup> so that a physician is liable for failing to provide life-prolonging treatment only when his relationship with his patient imposes a duty on him to continue treatment.

This relationship between physician and patient may be construed as contractual in that the patient seeks services from the doctor and the doctor is free to accept or refuse the patient's offer of employment.<sup>69</sup> However,

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<sup>63</sup> *Id.*

<sup>64</sup> *Id.* at 1213.

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* In fact, recent case law regards death following euthanasia as "expiration from existing natural causes," and not as criminal homicide. See *In re Quinlan*, 70 N.J. 10, 51, 355 A.2d 647, 670, cert. denied, 429 U.S. 922 (1976). Furthermore, the court in *Quinlan* stated that if such a death were considered a homicide, it would not be an unlawful homicide, since the right of privacy allows treatment to be terminated in certain cases, so that any resulting death would not come within the scope of criminal homicide statutes. This is because the termination of treatment pursuant to the constitutionally protected right of privacy would be a lawful activity and such an exercise of a constitutional right is protected from criminal prosecution. *Id.* at 51-52, 355 A.2d at 670. The court stated that the state's power to punish the taking of human life "does not encompass individuals terminating medical treatment pursuant to their right of privacy." *Id.* at 52, 355 A.2d at 670. The court added: "There is a real and in this case determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination." *Id.* In fact, one could argue that interpretation of a homicide statute to encompass passive euthanasia is an unconstitutional interpretation of the statute since it deprives an individual of his constitutionally protected right of privacy in deciding whether to refuse medical treatment. See notes 108-70 & accompanying text *infra*.

There is a standing problem here since the person prosecuted under the homicide statute is the physician and the person who has the right of privacy to refuse medical treatment is the patient. However, holding the physician liable for murder clearly has a "chilling effect" on the patient's exercise of his constitutional right. The physician is in charge of carrying out the patient's decision to refuse or accept treatment, and because of his possible liability may be unwilling to act in accordance with the patient's decision.

<sup>67</sup> *People v. Beardsley*, 150 Mich. 206, 211, 113 N.W. 1128, 1130 (1907).

<sup>68</sup> See *id.*

<sup>69</sup> *Survey*, *supra* note 13, at 1207. Of course, if the physician is discharged or withdraws with proper notice to the patient, the contractual relationship ends and the physician is thereafter not liable should life-prolonging treatment be discontinued. Nevertheless, a physician may not terminate the relationship by abandoning his patient. *Murray v. United States*, 329 F.2d 270, 272 (4th Cir. 1964); *Vann v. Harden*, 187 Va. 555, 565, 47 S.E.2d 314, 319 (1948). Criminal liability arises where the physician-patient relationship still exists, not having been terminated by discharge or withdrawal with sufficient notice. *Survey*, *supra* note 13, at 1208.

once the patient-physician relationship commences, the physician has a contractual duty to provide treatment "so long as the case requires."<sup>70</sup> This duty requires the physician to exercise some judgment and take reasonable steps in terminating the relationship.<sup>71</sup> On the basis of this duty, many commentators conclude that criminal liability may be imposed "on a physician who fails to take all action necessary to prolong the life of a dying patient."<sup>72</sup>

The confusion in the area of a physician's criminal liability for discontinuing life-prolonging treatment lies in the definition of the duty that exists between the physician and his patient. Certainly, if the physician's act of discontinuing treatment were found to be acceptable as falling under the standard of due care for terminally ill patients under certain circumstances, and therefore found to be nonnegligent treatment, the criminal law would not impose a duty on the doctor to continue life-prolonging treatment under all circumstances. However, thus far it is not clear that providing treatment "so long as the case requires" gives the physician the discretion to terminate treatment when he has determined that further life-prolonging treatment will render no lasting benefit. Therefore, the patient-physician relationship in the hospice context could conceivably render hospice care providers criminally liable for omitting to provide life-prolonging treatment to their patients. It has been argued, however, that the duty to treat a terminal patient "so long as the case requires" will be interpreted by the courts as meaning "until the patient's condition becomes hopeless,"<sup>73</sup> instead of "until death finally occurs."<sup>74</sup> Such an interpretation would absolve hospice care providers from liability for terminating life-prolonging treatment for their patients found to be terminally ill. However, hospice care providers cannot be certain that courts will apply this more flexible interpretation. While public opinion seems to be moving in the direction of allowing physicians to discontinue treatment for their terminally ill patients who request it, as the criminal law presently stands, hospice care providers still face the possibility of being prosecuted for homicide.

#### THE EFFECT OF LIVING WILLS AND NATURAL DEATH ACTS

Fearing subsequent civil or criminal liability, physicians may be reluctant to comply with their patients' requests to terminate life-prolonging treatment.<sup>75</sup> In response to this reluctance, many people have drafted living wills to prevent being kept alive in a state of incapacitation and misery.

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<sup>70</sup> Survey, *supra* note 13, at 1208.

<sup>71</sup> See generally *id.* at 1207-08.

<sup>72</sup> *Id.* at 1207.

<sup>73</sup> *Id.* at 1208.

<sup>74</sup> *Id.*

<sup>75</sup> See Kutner, *The Living Will: Coping with the Historical Event of Death*, 27 BAYLOR L. REV. 39, 46 (1975).

The living will is a directive written by a patient to his physician stipulating that it is the patient's wish that the physician refrain from administering life-prolonging treatment should the patient become terminally ill.<sup>76</sup> Drafting such a document has been viewed as "a contribution to the responsibility a thinking individual owes to himself to rationally approach death without terror or anxiety anticipating the event when his life processes may be, and are, irreversibly disabled."<sup>77</sup> A living will is unenforceable absent enabling legislation and to insure that such directives can be enforced eleven states have enacted natural death acts thus far.<sup>78</sup> These statutes are designed to increase patients' legal control of treatment decisions and eliminate the uncertainty surrounding the legality of complying with a terminally ill patient's wish that treatment be stopped.<sup>79</sup> These statutes permit hospices to cease life-prolonging treatment and administer palliative care when they act pursuant to a patient's valid directive. Each of the eleven statutes provides that neither the physician nor the medical facility is criminally or civilly liable for complying with a patient's directive to terminate life-prolonging treatment.<sup>80</sup>

A directive must meet various requirements to be valid under the acts. Although the language of the statutes is unclear, in four states the terms of the statutes require that the patient be terminally ill at the time of execution.<sup>81</sup> Hospices are intended to provide health care to terminally ill patients. However, these four acts protect the hospice care provider

<sup>76</sup> See *id.* at 47.

<sup>77</sup> *Id.* at 39.

<sup>78</sup> ALA. CODE §§ 22-8A-1 to -10 (1981); ARK. STAT. ANN. §§ 83-3801 to -3804 (West Supp. 1977); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1981); IDAHO CODE §§ 39-4501 to -4508 (West Supp. 1978); KAN. STAT. ANN. §§ 65-28,101 to ,109 (1980); NEV. REV. STAT. §§ 449.540-.690 (1979); N.M. STAT. ANN. §§ 24-7-1 to -11 (1978); N.C. GEN. STAT. §§ 90-320 to -323 (1981); OR. REV. STAT. §§ 97.050-.090 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 1-11 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. §§ 70.122.010-.905 (West Supp. 1981). As of Spring 1981, the District of Columbia and 19 states are considering natural death bills: Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York, Ohio, Rhode Island, South Carolina, Tennessee and Vermont. Society for the Right to Die Newsletter, Spring 1981.

<sup>79</sup> See ALA. CODE § 22-8A-2 (1981); CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1981); WASH. REV. CODE ANN. § 70.122.010 (West Supp. 1981).

<sup>80</sup> ALA. CODE § 22-8A-7 (1981); ARK. STAT. ANN. § 82-3804 (West Supp. 1977); CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1981); IDAHO CODE § 39-4507 (West Supp. 1978); KAN. STAT. ANN. § 65-28,106 (1980); NEV. REV. STAT. § 449.630 (1979); N.M. STAT. ANN. § 24-7-7 (1978); N.C. GEN. STAT. § 90-321(h) (1981); OR. REV. STAT. § 97.065(2) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 6 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.050 (West Supp. 1981).

<sup>81</sup> CAL. HEALTH & SAFETY CODE §§ 7187(e), 7188 (West Supp. 1981); IDAHO CODE §§ 39-4503(3), 39-4504(2) (West Supp. 1978); OR. REV. STAT. §§ 97.050(5), 97.055(1) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 2(5), 3 (Vernon Supp. 1980-1981). Only six states require written certification that the patient is terminally ill before life-prolonging treatment may be legally discontinued: ALA. CODE § 22-8A-6 (1981); CAL. HEALTH & SAFETY CODE § 7187(e) (West Supp. 1981); KAN. STAT. ANN. § 65-28, 102(e) (1980); N.M. STAT. ANN. § 24-7-5(A) (1978); TEX. REV. CIV. STAT. ANN. art. 4590h, § 2(5) (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.020(6) (West Supp. 1980). Unless the certification is in writing, evidentiary problems could arise in a hospice setting should a relative of a patient later challenge the admission of the patient to a hospice facility. However, many hospices require no written certification that the patient has been diagnosed as terminally ill. Letters from Hazel E. Etzler, Hospice Nurse Coordinator of Parkview Memorial Hospital and T. Margaret Difrancesca of Highland Park

only if the patient was terminally ill at the time he executed the directive. Therefore, the hospice is not protected under these acts with regard to patients who executed a directive before they became terminally ill, even if they are terminally ill at the time they enter the hospice.<sup>82</sup>

Another requirement common to eight of the natural death acts is that the patient be an adult at the time he executes a directive.<sup>83</sup> Only two acts outline procedures whereby designated persons may execute a directive on behalf of a minor.<sup>84</sup> Thus, the acts that stipulate that a valid directive may only be executed by an adult will not protect a hospice with regard to minors receiving palliative care. A similar problem arises under five of the acts which stipulate that a valid directive may not be executed by a pregnant woman where her physician has knowledge of the pregnancy.<sup>85</sup> Hospices located in these states are likewise not protected under the acts with regard to their patients who are pregnant.<sup>86</sup>

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Hospice, and unsigned response from Horizon Hospice in response to a survey dated March 27, 1980 (letters on file with the *Indiana Law Journal*).

It should be noted that the definition of a "terminal" condition is not at all clear. Patients who have been termed incurable by one physician may be considered treatable with the expectation of cure or prolonged palliation by another physician. "[P]atients with extensive cancer of the cervix with local involvement in the pelvis have been termed incurable when actually, by means of aggressive surgical procedures such as exenteration, they may have prolonged periods of palliation and a certain number may be cured." Potter, *supra* note 2, at 53. Furthermore, there is also the problem of determining what length of prognosis will qualify as terminal. Seven states use the word "imminent" in determining whether the patient qualifies as one who may draft a valid directive: ALA. CODE § 22-8A-3(6) (1981); CAL. HEALTH & SAFETY CODE §§ 7187(c), 7188 (West Supp. 1981); IDAHO CODE §§ 39-4503, 39-4504 (West Supp. 1978); NEV. REV. STAT. § 449.610 (1979); OR. REV. STAT. § 97.055(1) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 2(3), 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. §§ 70.122.020(4), 70.122.030(1)(a) (West Supp. 1981). None of these states, however, define "imminent." The National Hospice Organization states that hospice care is oriented toward persons with a prognosis of six months or less. Standards, *supra* note 3, at 11. The problem of determining when a patient is terminal may be a serious flaw in the natural death act procedure since the statutes cannot be applied with certainty in all cases.

<sup>82</sup> The four states with statutes which require that the patient be terminally ill *at the time* he executes a directive do not cover situations where the patient is comatose as a result of an injury or sudden illness, even if the patient is terminally ill and would wish to discontinue treatment. See CAL. HEALTH & SAFETY CODE §§ 7187(e), 7188 (West Supp. 1981); IDAHO CODE §§ 39-4503(3), 39-4504(2) (West Supp. 1978); OR. REV. STAT. §§ 97.050(5), 97.055(1) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 2(5), 3 (Vernon Supp. 1980-1981).

<sup>83</sup> ALA. CODE § 22-8A-4(a) (1981); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39-4503(3) (West Supp. 1978); KAN. STAT. ANN. § 65-28,103(a) (1980); NEV. REV. STAT. § 449.600 (1979); OR. REV. STAT. § 97.050(5) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1981).

<sup>84</sup> ARK. STAT. ANN. § 82-3803 (West Supp. 1977); N.M. STAT. ANN. § 24-7-4 (1978). North Carolina is silent with regard to whether one must be an adult in order to execute a valid directive. It could be argued that in those states that fail to provide a procedure whereby life-prolonging treatment may be terminated for minors, the legislature did not intend for minors to receive palliative care. This interpretation would have serious implications for hospices which admit minor patients.

<sup>85</sup> CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); KAN. STAT. ANN. § 65-28,103 (1980); NEV. REV. STAT. § 449.610 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1981).

<sup>86</sup> In the states which prohibit pregnant women from drafting valid directives, a strong presumption may be made that the legislature intended to prohibit pregnant women from receiving palliative care. This interpretation puts a hospice in a precarious position if it

Furthermore, nine acts require that the patient be competent at the time he executes a directive.<sup>87</sup> Only one act allows designated third persons to execute the directive for any patient who is "physically or mentally unable . . . or otherwise incapacitated"<sup>88</sup> from executing the directive and another act outlines a procedure whereby designated third persons may execute a valid directive for a patient who is comatose.<sup>89</sup> Although hospices are primarily intended for persons who are alert enough to benefit from the various counselling services, personal care and pleasant surroundings which hospices provide,<sup>90</sup> a patient could be capable of appreciating the homelike atmosphere and virtually unlimited visitation procedures which a hospice provides while still being legally incompetent. Given that no definition of "competent" is provided in these acts<sup>91</sup> and

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admits pregnant patients. However, it should be noted that these provisions may be found unconstitutional, at least if the woman is in the first trimester of pregnancy. See *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>87</sup> Each of the directive forms reads, "I, \_\_\_\_\_, being of sound mind" ALA. CODE § 22-8A-4(c) (1981); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39-4504 (West Supp. 1978); KAN. STAT. ANN. § 65-28,103(c) (1980); NEV. REV. STAT. § 449.610 (1979); OR. REV. STAT. § 97.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030(1) (West Supp. 1981); accord, N.M. STAT. ANN. § 24-7-3 (1978) (section does not contain a directive, but requires the person to be "of sound mind" before executing a directive).

<sup>88</sup> ARK. STAT. ANN. § 82-3803 (West Supp. 1977). Many persons in Arkansas are drafting "Right to Life" directives in fear that their family or others might cut off life-prolonging treatment pursuant to this section. SOCIETY FOR THE RIGHT TO DIE, 1979-1980 MANUAL 24 [hereinafter cited as SOCIETY].

Interesting problems arise when a third party is allowed to decide to end extraordinary treatment for a terminally ill or comatose patient. For example, in Denver, Colorado, a mother charged with felony child abuse won a temporary restraining order from the Colorado Supreme Court preventing doctors from turning off a respirator that sustained the breathing of her 17-month-old abused son. Rosalie Lovato, on trial for child abuse, sought to continue the respirator because without the respirator her son might die and she could then be charged with a more serious offense. *Courier-J.* (Louisville), Sept. 13, 1979, § A, at 4, col. 2.

<sup>89</sup> N.C. GEN. STAT. § 90-322 (1981). Interestingly, those persons designated to execute the directive on behalf of the incompetent under both the North Carolina and Arkansas acts are just those persons who are most likely to benefit from the shortened life of the patient. For a discussion of the need for formalities to protect the patient, see note 98 *infra*. Because of these provisions, Arkansas and North Carolina could be criticized for not providing enough protection for the patient. One case study describes a 76-year-old retired man suffering from a terminal illness which rendered him incompetent. This man expressed a strong desire to the medical staff that his life be prolonged. His family, on the other hand, "expressed strong feelings . . . that no 'heroic' measures be undertaken." Jackson & Youngner, *Patient Autonomy and "Death with Dignity,"* 301 NEW ENG. J. MED. 404, 406 (1979). Under the Arkansas act that patient's family could draft a directive for the patient, despite his wish to continue living.

<sup>90</sup> "Hospice exists in the hope and belief that, through appropriate care and the promotion of a caring community sensitive to their needs, patients and families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them." Standards, *supra* note 3, at 3.

<sup>91</sup> However, Arkansas, ARK. STAT. ANN. § 82-3802 (West Supp. 1977), and New Mexico, N.M. STAT. ANN. § 24-7-3(B) (1978), require that a directive be executed with the same formalities as is required of a valid will, which could indicate that at least in those two states a patient must be competent enough to execute a valid will; that is, the patient must be competent

given that under four of these acts the patient additionally must be terminally ill,<sup>92</sup> questions of what constitutes competence with regard to executing a valid directive could become quite acute in the hospice situation.<sup>93</sup> As a result of their illness, terminal patients suffer both physical and psychological symptoms that could arguably render them incompetent.<sup>94</sup>

Along with the requirements discussed above, each statute outlines certain formalities to be followed in executing the directive<sup>95</sup> and may provide a specific form with which the directive must comply.<sup>96</sup> All eleven of the statutes require the signatures of witnesses in addition to that of the patient himself,<sup>97</sup> and set forth certain restrictions regarding who may qualify as a witness.<sup>98</sup> A further formality found in three of the acts is

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enough to understand his business affairs and the nature of his assets and how his distributees will be affected by them. This interpretation of competence to execute a valid directive could be inappropriate in the living will context. Perhaps all that is necessary is that the patient be cognizant enough to know whether he would rather live or die given his present state of life. This would be a much lower standard than requiring that the patient be able to relate his assets to those to whom he may wish to give them. A person who is only semiconscious due to extreme pain and large doses of medicine is likely to understand his present quality of life and what he has to look forward to while unable to explore and uninterested in exploring his financial status and to whom he wishes his assets to be distributed.

<sup>92</sup> CAL. HEALTH & SAFETY CODE §§ 7187(e), 7188 (West Supp. 1981); IDAHO CODE §§ 39-4503(3), 39-4504(2) (West Supp. 1978); OR. REV. STAT. §§ 97.050(5), 97.055(1) (1979); TEX. REV. CIV. STAT. ANN. art. 4590h §§ 2(5), 3 (Vernon Supp. 1980-1981).

<sup>93</sup> Competency may be defined in different ways for different purposes. See *Sieling v. Eymann*, 478 F.2d 211, 214 (9th Cir. 1973) (competency to plead guilty distinguished from competency to stand trial).

One definition of competency to consent to medical treatment was outlined by the Supreme Court of Washington in *Grannum v. Berard*, 70 Wash. 2d 304, 422 P.2d 812 (1967). In that case the court found that competency is presumed; to overcome this presumption, clear, cogent and convincing evidence is necessary. The court used the same test to determine competency that is used to determine the capacity of an individual to execute an agreement: whether the person, at the time of making the agreement, possessed sufficient reason to understand the nature, terms and effect of the agreement. See *id.* at 307, 422 P.2d at 814. For a discussion of mental competency to accept medical treatment, see *Informed Consent*, *supra* note 29.

<sup>94</sup> See also note 98 *infra*.

<sup>95</sup> ALA. CODE § 22-8A-4(a) (1981); ARK. STAT. ANN. § 82-3802 (West Supp. 1977); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39-4504 (West Supp. 1978); KAN. STAT. ANN. § 65-28,103; NEV. REV. STAT. § 449.600 (1979); N.M. STAT. ANN. § 24-7-3 (1978); N.C. GEN. STAT. § 90-321(c) (1981); OR. REV. STAT. § 97.055 (1977); TEX. REV. CIV. STAT. ANN. art. 4590h § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1981).

<sup>96</sup> IDAHO CODE § 39-4504 (West Supp. 1978); NEV. REV. STAT. § 449.610 (1979); OR. REV. STAT. § 97.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h § 3 (Vernon Supp. 1980-1981). However, Alabama, Kansas and Washington allow a patient to add material to the form. The declaration must substantially follow the form, but may also include other specific directions. ALA. CODE § 22-8A-4(c) (1981); KAN. STAT. ANN. § 65-28,103(c) (1980); WASH. REV. CODE ANN. § 70.122.030(1) (West Supp. 1981).

<sup>97</sup> See ALA. CODE § 22-8A-4(a) (1981); ARK. STAT. ANN. § 82-3802 (West Supp. 1977); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39-4504 (West Supp. 1978); KAN. STAT. ANN. § 65-28,103; NEV. REV. STAT. § 449.600 (1979); N.M. STAT. ANN. § 24-7-3 (1978); N.C. GEN. STAT. § 90-321(c) (1981); OR. REV. STAT. § 97.055 (1977); TEX. REV. CIV. STAT. ANN. art. 4590h § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1981).

<sup>98</sup> See ALA. CODE § 22-8A-4(a) (1981); ARK. STAT. ANN. § 82-3802 (West Supp. 1977); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39-4504 (West Supp. 1978);



the requirement that the directive be renewed every five years.<sup>99</sup> This requirement raises no problems in the hospice context since the patient could easily draft a new directive upon entering the hospice and renew it every five years thereafter,<sup>100</sup> although it is unlikely that a hospice patient would live that long.

Unfortunately, while natural death acts could protect the hospice and the hospice physician with regard to all of its patients who qualify to draft a valid directive, under ten of the acts, a hospice may not require a patient to draft a directive as an admission requirement or condition to receiving hospice care.<sup>101</sup> Therefore, unless the patient independently executes a directive on or before entering a hospice, hospices in these ten states have no greater protection than hospices in states which have no natural death act. In fact, hospices have less protection in these jurisdictions, since it is likely that the provisions prohibiting the execution of directives as an admission requirement would also prohibit signatures to informed consent forms as an admission requirement. At least in the other

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KAN. STAT. ANN. § 65-28,103; NEV. REV. STAT. § 449.600 (1979); N.M. STAT. ANN. § 24-7-3 (1978); N.C. GEN. STAT. § 90-321(c) (1981); OR. REV. STAT. § 97.055 (1977); TEX. REV. CIV. STAT. ANN. art. 4590h § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1981). These formalities are important for the protection of the patient since the possibilities of mistake, undue influence and even fraud are present. Beneficiaries of the patients will stand to benefit earlier if life-prolonging treatment is terminated. Similarly, the expense and emotional distress to the patient's family is ended earlier if life-prolonging treatment is terminated. These reasons may color the intentions of the patient's family or other persons who stand to benefit from the patient's timely death with regard to the influence they exert on a patient to draft a directive.

In addition, the formalities are important for the patient's protection from himself; patients are known to change their minds with regard to whether they wish to continue life-prolonging treatment. For example, a patient in a particularly painful stage of his treatment may at first wish to terminate extraordinary efforts to preserve his life, but later change his mind when he enters into a new phase of treatment and the pain subsides. Similarly, patients are known to suffer depression, ambivalence or fear of further treatment during their illness, any of which may cause them to make a premature decision to terminate extraordinary care. See generally Jackson & Youngner, *supra* note 89. Certainly, the patient must be competent enough to understand the implications of the directives; the decision to refuse life-prolonging treatment is serious and must be carefully considered and skillfully recorded.

<sup>99</sup> CAL. HEALTH & SAFETY CODE § 7189(5) (West Supp. 1981); IDAHO CODE § 39-4506 (West Supp. 1978); OR. REV. STAT. § 97.055(4) (1977).

<sup>100</sup> California and Oregon make it harder for a hospice patient to renew the directive since they have special restrictions on who may be a witness for directive of a patient in a skilled nursing facility. CAL. HEALTH & SAFETY CODE § 7188.5 (West Supp. 1981); OR. REV. STAT. § 97.055(3) (1977). Eight of the acts prohibit the hospice physician or staff from being a witness for the directive. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39-4506 (West Supp. 1978); KAN. STAT. ANN. § 65-28,103(a)(4) (1980); NEV. REV. STAT. § 449.600 (1979); N.C. GEN. STAT. § 90-321(c)(3)(iii) (1981); OR. REV. STAT. § 97.055 (1977); TEX. REV. CIV. STAT. ANN. art. 4590h § 3 (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1981).

<sup>101</sup> ALA. CODE § 22-8A-9(c) (1981); CAL. HEALTH & SAFETY CODE § 7192(c) (West Supp. 1981); IDAHO § 39-4508(3) (West Supp. 1978); KAN. STAT. ANN. § 65-28,108(c) (1980); NEV. REV. STAT. § 449.650(3) (1979); N.M. STAT. ANN. § 24-7-8(c) (1978); N.C. GEN. STAT. § 90-321(g) (1981); OR. REV. STAT. § 97.080(2) (1977); TEX. REV. CIV. STAT. ANN. art. 4590h § 8(c) (Vernon Supp. 1980-1981); WASH. REV. CODE ANN. § 70.122.070(3) (West Supp. 1981).

states, hospices could require signatures to such forms to be used as evidence that at the time of admission the patient had been advised of the implications of and alternatives to palliative care.

Furthermore, it has been argued that if the patient fails to draft a directive altogether, hospices have less protection in states which have enacted a natural death act.<sup>102</sup> Given that the natural death acts outline a specific procedure which, if followed by a physician or health care facility, protects the physician or facility from liability, the natural death acts could be interpreted as a statement of public policy implying that unless that specific procedure is followed, the physician or facility is vulnerable to liability in tort or in criminal law. In other words, in eleven jurisdictions, if the physician discontinues life-prolonging treatment without the benefit of a patient's valid directive, he is acting outside the protection of the natural death act and therefore may not be immune from liability.

If a court makes the assumption that the natural death act is such a statement of public policy, then even if a patient voluntarily drafts a directive, without regard to any admission requirement, the theory of informed consent provides no defense for the physician. When a presumption is made that only designated persons may refuse life-prolonging treatment, a physician may not legally discontinue treatment for those who have not drafted valid directives, regardless of whether they consent to the treatment; the statute would be interpreted as stating that terminating treatment for those who either cannot or do not draft valid directives, constitutes actionable conduct. This would be an unfortunate effect of the statutes. Certainly, these eleven legislatures did not intend their natural death acts to lessen the protection of health facilities like hospices. One of the primary purposes of these acts is to recognize patient autonomy in decisionmaking relating to a patient's own medical care,<sup>103</sup> and the philosophy of hospice care is dedicated to promoting just this sort of patient autonomy.<sup>104</sup>

Three states anticipate this problem and include a provision stipulating that no presumption may be made pursuant to the natural death act regarding the intention of an individual who has not executed a directive to withhold life-prolonging treatment.<sup>105</sup> While courts in these states will not

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<sup>102</sup> See Horan, *The "Right to Die" Legislative and Judicial Developments*, 13 *FORUM* 488, 491 (1978).

<sup>103</sup> See *SOCIETY*, *supra* note 88, at 5.

<sup>104</sup>

The patient and family are the *raison d'être* for Hospice programs. Patient and family participation in the decisions and care giving, to the maximum extent possible, should enable the patient and family to live according to their "style" and with the dignity and respect due all human beings until the moment of the patient's death.

Standards, *supra* note 3, at 7.

<sup>105</sup> ALA. CODE § 22-8A-9(e) (1981); IDAHO CODE § 39-4508 (West Supp. 1978); KAN. STAT. ANN. § 65-28,108(e) (1980). However, North Carolina included a section in its natural death act

make a presumption based on the failure of a person to draft a directive, they may still interpret a statute's specific denial of the ability of a minor or a pregnant woman to draft a valid directive as constituting a statement of public policy that at least those persons have no right to refuse treatment. Seven states include a section providing that the statute will not impair or supersede any previously existing legal right to withhold treatment.<sup>106</sup> These seven sections, although they are quite vague, could arguably be interpreted as negating any presumption that might be made regarding a patient who fails to draft a directive, but they still would not prevent a court from concluding that the legislature intended to make a public policy statement regarding those persons specifically prohibited from refusing life-prolonging treatment. In any case, it is not clear that a physician in fact has the legal right to withhold life-prolonging treatment from his patient, absent protection granted by a natural death act.<sup>107</sup>

In many respects, the natural death acts do not provide adequate protection to hospices and hospice physicians. Not only do most of the acts fail to protect hospices in cases where the patient is a minor or incompetent, but further, they deny hospices the right to require qualified patients to draft a directive before receiving palliative care and may prohibit hospices from requiring informed consent forms as well. As a result of these shortcomings in the natural death acts, hospices must choose either to refuse to admit many patients or risk criminal and civil liability for treating patients who have not executed valid directives. Furthermore, if courts interpret these acts to express the legislative intention that life-prolonging treatment may not be terminated if the patient has not executed a valid directive, the hospice's legal position is weaker in states that have natural death acts than in states that have not enacted such statutes.

#### BALANCING THE STATE'S INTEREST IN PRESERVING LIFE AGAINST THE PATIENT'S RIGHT TO REFUSE TREATMENT

Even though legislation has failed to provide either adequate protection for the hospice or sufficient autonomy for the patient, the common law has long recognized that an individual has a "strong interest in being

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which outlines procedures which may be taken in the absence of a directive. N.C. GEN. STAT. § 90-322 (1981). Therefore, in North Carolina, the presumption is even stronger that the physician is liable should he terminate life-prolonging treatment without following the procedures outlined in the natural death act.

<sup>106</sup> ALA. CODE § 22-8A-9(d) (1981); CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1981); NEV. REV. STAT. § 449.680 (1979); N.M. STAT. ANN. § 24-7-9 (1978); N.C. GEN. STAT. § 90-320 (1981); OR. REV. STAT. § 97.085(2) (1977); TEX. REV. CIV. STAT. ANN. art. 4590h § 11 (Vernon Supp. 1980-1981).

<sup>107</sup> See text accompanying notes 24-74 *supra*.

free from nonconsensual invasion of his bodily integrity."<sup>108</sup> Moreover, the Supreme Court has acknowledged the right to make medical decisions regarding one's own body as among the personal freedoms granted to persons in the United States.<sup>109</sup> As Justice, then judge, Cardozo so succinctly states in *Schloendorff v. Society of New York Hospital*:<sup>110</sup> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."<sup>111</sup>

Moreover, while the Constitution does not explicitly mention a right of privacy, Supreme Court decisions have recognized that a right of privacy exists in the area involving medical matters.<sup>112</sup> In *Griswold v. Connecticut*,<sup>113</sup> the Supreme Court found that an unwritten right of privacy exists in the penumbra of specific guarantees of the Bill of Rights,<sup>114</sup> and interdicted state intrusion into the area of personal decisionmaking with regard to contraception and its relation to family life.<sup>115</sup> In *Roe v. Wade*,<sup>116</sup> the Supreme Court found that the right of privacy extends to a woman's decision to terminate her pregnancy and that the state's intrusion into the area of her personal decisionmaking is significant.<sup>117</sup> While the Court

<sup>108</sup> *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977).

<sup>109</sup> See *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 250 (1891).

<sup>110</sup> 211 N.Y. 125, 105 N.E. 92 (1914).

<sup>111</sup> *Id.* at 126, 105 N.E. at 93; accord, *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Natanson v. Kline*, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960). It should be noted that some philosophers argue that the state has an interest in interfering with an individual's decisionmaking only when it is preventing that individual from harming others. According to John Stuart Mill:

The sole end for which mankind [is] warranted, individually or collectively, in interfering with the liberty of action of any of their number, is [that of] self protection . . . [T]he only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.

J.S. MILL, ON LIBERTY 10 (D. Spitz ed. 1975). Mill's serious skepticism of state paternalism extends to the point that he asserts that such intervention could impair one's humanity:

He who lets the world, or his own portion of it, choose his plan of life for him, has no need of any other faculty than the ape-like one of imitation. Were someone else to make fundamental decisions for him [i]t is possible that he might be guided in some good path, and kept out of harm's way . . . [b]ut what will be his comparative worth as a human being?

*Id.* at 56.

<sup>112</sup> *Doe v. Bolton*, 410 U.S. 179 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Stanley v. Georgia*, 394 U.S. 557 (1969).

<sup>113</sup> 381 U.S. 479 (1965).

<sup>114</sup> *Id.* at 484.

<sup>115</sup> *Id.* at 485-86; accord, *Roe v. Wade*, 410 U.S. 113 (1973) (woman's decision to terminate pregnancy under certain conditions falls within right of privacy).

<sup>116</sup> 410 U.S. 113 (1973).

<sup>117</sup> *Id.* at 153.

in *Roe* acknowledged that the right of privacy "is not unqualified and must be considered against important state interests,"<sup>118</sup> it also found that the right of privacy "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."<sup>119</sup> Surely, the right of privacy is broad enough to encompass a terminally ill patient's right to refuse treatment.<sup>120</sup> As the Court in *Roe* suggested, one must balance the patient's right of privacy, in this case to refuse treatment, against the state's interest in preserving life.<sup>121</sup>

The right of privacy with regard to medical matters entails the right of a patient to refuse treatment when the treatment involves a significant bodily invasion and the circumstances of the case are such that no state interest overrides the right of privacy. In *Roe v. Wade*, the Supreme Court examined factors such as the psychological and physical harm which could result from motherhood in addition to the stigma of unwed motherhood in reaching the conclusion that the state's intrusion into a woman's decision to terminate her pregnancy is significant.<sup>122</sup>

In *In re Quackenbush*,<sup>123</sup> the New Jersey Supreme Court found a significant bodily invasion when a patient was in such a severely gangrenous condition that saving his life required amputating both of his legs below the knee. Even though the patient would have had a positive prognosis had he undergone the amputation, the court found that the right of privacy applied and allowed him to refuse treatment.<sup>124</sup> Denying a terminally ill hospice patient the option to refuse life-prolonging treatment also may be viewed as an instance of significant bodily invasion. In compelling treatment the state would be intruding into perhaps the most important area of an individual's decisionmaking. Only the patient can know best how long he can withstand physical and mental suffering without losing his dignity. Moreover, the state in compelling life-prolonging treatment is likely to be compelling additional pain and an additional financial and emotional burden on the patient and his family. Surely this is a significant and unacceptable intrusion of the state into the private decisionmaking of an individual.

Since disallowing a terminally ill patient the decision to discontinue life-prolonging treatment may be construed as a significant bodily invasion, the right of privacy will apply unless the state has a compelling interest which requires treatment. Court opinions explaining the extent of the state's interest in interfering with a patient's decisionmaking in the area

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<sup>118</sup> *Id.* at 154.

<sup>119</sup> *Id.* at 153.

<sup>120</sup> This has been argued in several state supreme court decisions. *See, e.g.*, text accompanying note 143 *infra*.

<sup>121</sup> 410 U.S. at 152-55. In *Roe*, the Court extended the state's interest in preserving life to preserving prenatal life as well. *Id.* at 150.

<sup>122</sup> *Id.* at 153.

<sup>123</sup> 156 N.J. Super. 282, 383 A.2d 785 (1978).

<sup>124</sup> *Id.* at 290, 383 A.2d at 789.

of medical matters hold that the state may interfere only when it is acting "to prevent grave and immediate danger to interests which the state may lawfully protect."<sup>125</sup> Four state interests usually are raised in opposition to a patient's wish to refuse treatment: first, preserving life; second, protecting the interests of innocent third parties; third, preventing suicide; and fourth, maintaining the ethical integrity of the medical profession.<sup>126</sup> To determine whether a patient has the constitutional right to refuse life-prolonging treatment and submit to a hospice's palliative treatment, each of the countervailing state interests must be examined to determine if the interest is substantial enough to override the individual's right of privacy.

The court in *John F. Kennedy Memorial Hospital v. Heston*<sup>127</sup> noted that the state has an interest in preserving life where the lack of medical treatment could result in death while the risk in the operation with the treatment is not great.<sup>128</sup> Similarly, in *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,<sup>129</sup> the court denied a pregnant woman the right to refuse a blood transfusion on religious grounds. The state's interest in the welfare of the infant justified giving the transfusion against the mother's wishes since the transfusion would save the lives of both mother and child.<sup>130</sup>

However, it may be argued that the state's interest in preserving life is lessened if the patient is terminally ill. The Supreme Court in *Roe* found that the state's interest in restricting a woman's decision to terminate her pregnancy becomes increasingly compelling as the pregnancy progresses.<sup>131</sup> It held that prior to the end of the first trimester, the decision to abort the pregnancy is free from state intervention,<sup>132</sup> while in the second trimester the state may regulate abortions "in ways that are reasonably related to maternal health"<sup>133</sup> and in the third trimester, the state may regulate or proscribe abortions entirely,<sup>134</sup> pursuant to its interest in "the potentiality of human life"<sup>135</sup> represented by a viable fetus.<sup>136</sup>

<sup>125</sup> *Holmes v. Silver Cross Hosp. of Joliet*, 340 F. Supp. 125, 129-30 (N.D. Ill. 1972) (quoting *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943)).

<sup>126</sup> *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978).

<sup>127</sup> 58 N.J. 576, 279 A.2d 670 (1971).

<sup>128</sup> *See id.* at 582-83, 279 A.2d at 673.

<sup>129</sup> 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

<sup>130</sup> *Id.* at 423, 201 A.2d at 538.

<sup>131</sup> 410 U.S. at 162-63.

<sup>132</sup> *Id.* at 163.

<sup>133</sup> *Id.* at 164.

<sup>134</sup> *Id.* at 164-65. The state may not endanger the mother's health, however, in regulating or proscribing abortions.

<sup>135</sup> *Id.* at 164.

<sup>136</sup> It should be noted that the Supreme Court reserved the right of the state to regulate the abortion procedure insofar as such regulation reasonably relates to the preservation and protection of maternal health. *Id.* at 163. For example, the state could require that the person performing the abortion have certain qualifications or that the abortion be performed

Similarly, in the case of a patient who seeks to refuse life-prolonging treatment, it may be argued that the state's interest becomes increasingly compelling as the possibility of preserving life becomes greater, but as the prognosis dims this interest becomes less and less compelling.<sup>137</sup> Preserving life is impossible in the case of a terminally ill patient, and even if it is argued that the state also has an interest in prolonging the life of a patient, such an interest would not be substantial in the case of a terminally ill hospice patient. A hospice patient generally has a prognosis of six months or less,<sup>138</sup> even if he submits to further curative therapy. The progress of his disease is such that it is highly questionable that further treatment offers any sort of lasting benefit. While one could argue reasonably that the state's interest in preserving life extends also to prolonging life in the case of a patient for whom curative or life-prolonging treatment is likely to provide lasting benefit, in the case of a hospice patient, compelling treatment is likely to provide only further pain and expense and is therefore unreasonable. If the state denies the patient the right to refuse extraordinary treatment and denies the physician the discretion to terminate such treatment where to do so is appropriate, it is essentially forcing the patient to choose between undergoing all available curative therapies, however painful and expensive they may be, or dying at home in pain, without the palliative assistance which medical science could provide.

State courts have applied the reasoning that the state's interest is less compelling when preserving life is impossible. In *Superintendent of Belcher-town State School v. Saikewicz*,<sup>139</sup> a Massachusetts court singled out the state's interest in preserving life as the "most significant of the asserted state interests"<sup>140</sup> and limited this interest when the patient is terminally ill. The court found that while the state may intervene to preserve life when the affliction is curable, "it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness."<sup>141</sup> Likewise, the New Jersey court in *In re Quinlan*<sup>142</sup> gave direction to the balancing

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in specified facilities. *Id.* This right to regulate the abortion procedure could be logically extended to the hospice context. For example, it could be found that the state may regulate procedures under which a person can legally refuse life-prolonging treatment; the state could perhaps require that the patient make his decision to refuse treatment under the supervision of and consultation with his attending physician. In any case, state regulation of the procedure need not conflict with hospice practice and philosophy since hospice procedures should be designed to promote patient autonomy while insuring the patient's safety and these procedures could be altered to accommodate state regulation. *See* text accompanying notes 171-74 *infra*.

<sup>137</sup> This has been argued in state supreme courts. *See, e.g.*, *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. at 582-83, 279 A.2d at 673.

<sup>138</sup> Standards, *supra* note 3, at 11.

<sup>139</sup> 373 Mass. 728, 370 N.E.2d 417 (1977).

<sup>140</sup> *Id.* at 741, 370 N.E.2d at 425.

<sup>141</sup> *Id.* at 742, 370 N.E.2d at 426.

<sup>142</sup> 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

between the state's interest and the patient's right of privacy by adding, "the state's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."<sup>143</sup>

Another state interest which may restrict a patient's decisionmaking power is protecting the interests of innocent third parties. This state concern generally arises in situations where the patient has young dependents and the patient's illness is not terminal but instead could be readily cured with the use of the medical treatment which the patient attempts to refuse. In *In re President of Georgetown College, Inc.*,<sup>144</sup> a mother of a seven month old child tried to refuse a blood transfusion on religious grounds. The state as *parens patriae* denied her right to refuse treatment in part because her death would result in the abandonment of her child.<sup>145</sup> However, the state's interest in preserving the rights of innocent third parties is curtailed if it can be shown that the concerned third parties will not be injured by the patient's decision to refuse treatment. The court in *In re Estate of Brooks*<sup>146</sup> noted that the patient's children were all of adult years in concluding that the state's interests in compelling treatment did not override the patient's religious principles.<sup>147</sup> If the children are adults, they are unlikely to be left without means of support upon the patient's death. Many patients who enter hospices are middle-aged or elderly persons and do not have minor children. The state would rarely have an interest in protecting innocent third parties with regard to these hospice patients who refuse extraordinary treatment. More significantly, even if a hospice patient did have minor dependents, because he has a dim prognosis with or without extraordinary treatment, the state's interest in protecting innocent third parties would be slight. Treatment which could extend the patient's life for only a few weeks or months would be unlikely to significantly aid the third parties involved.

While a court may allow the patient to refuse treatment if no dependent third parties will be injured, the patient will not be allowed to commit suicide. The state's interest in preventing suicide has long been recognized in the common law.<sup>148</sup> The traditional definition of suicide is

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<sup>143</sup> *Id.* at 41, 355 A.2d at 664. *Saikewicz, Quinlan* and *In re Dinnerstein*, 1978 Mass. App. Ct. Adv. Sh.736, 380 N.E.2d 134 (1978), all involved situations where a guardian decided to refuse the treatment on behalf of the patient. Therefore, one could argue in these cases that individual choice was not involved at all. Furthermore, *Dinnerstein* is an extension of the *Quinlan* and *Saikewicz* decisions in that the court held a guardian need not obtain a prior court order giving him the power to decide for the patient to stop the resuscitator. If the decision cannot be made by the patient, it is to be made by the physician and family. *Id.* at \_\_\_\_, 380 N.E.2d at 139.

<sup>144</sup> 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

<sup>145</sup> *Id.* at 1008.

<sup>146</sup> 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

<sup>147</sup> *Id.* at 372-73, 205 N.E.2d at 442. *See also* *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978).

<sup>148</sup> *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. at 580, 279 A.2d at 672.



"the intentional, voluntary, nonaccidental taking of one's own life."<sup>149</sup> Courts may determine whether there has been an act of suicide in a particular case by considering first, whether the individual intended to cause his own death, and second, whether he initiated the act which led to his death.<sup>150</sup> Technically, the refusal of life-prolonging treatment by a terminally ill patient falls under this traditional definition, since the patient recognizes that by refusing life-prolonging treatment his life could end earlier than it would if the treatment were accepted. However, refusing treatment when one is terminally ill should not be characterized as an act of suicide. First, the terminally ill patient does not *intend* to cause his own death. There is a distinction between recognizing that death is inevitable and taking no action which will further prolong the suffering accompanying one's illness and taking some independent action which, in and of itself, initiates death.<sup>151</sup> A patient who refuses life-prolonging treatment is allowing the inevitable, imminent event of death to proceed naturally; he is not taking an independent action which results in death where death would not have otherwise occurred.<sup>152</sup>

More importantly, the policies behind the state's interest in preventing suicide do not apply to the case of the terminally ill hospice patient.<sup>153</sup> Aside from the state's interests in preserving life and protecting innocent third parties discussed above, one could assert that the policies of discouraging morally reprehensible acts and protecting persons from themselves do not apply in cases where the patient is terminally ill. While suicide has historically been considered morally reprehensible,<sup>154</sup> the decision of a terminally ill patient to discontinue life-prolonging treatment is recognized and condoned by many doctors<sup>155</sup> and even some religious groups.<sup>156</sup> In other words, the decision of a terminally ill patient is not generally considered a reprehensible act of suicide. Moreover, a terminally ill patient's decision to stop treatment is not a self-destructive decision

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<sup>149</sup> Note, *Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases*, 44 BROOKLYN L. REV. 285, 295 (1978).

<sup>150</sup> *Id.* at 296.

<sup>151</sup> However, the subjective intent of the patient in refusing treatment may not be considered determinative by the court. See *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. at 576, 279 A.2d at 670; *In re President of Georgetown College, Inc.*, 331 F.2d at 1000.

<sup>152</sup> One could also argue that refusing treatment is not an act—a *taking* of one's own life—but merely an omission. However, this distinction is basically semantic. It may be argued that a patient who recognizes that his life will probably end earlier if he refuses life-prolonging treatment is making as much of a decision to shorten his life as one who knowingly injects himself with an overdose of drugs. Of course it could also be argued that the patient did not *initiate* the act which led to his death since it was ultimately the illness which killed him and he did not initiate the illness. However, one may rebut that, in fact, it was the act of refusing treatment which ultimately resulted in his premature death.

<sup>153</sup> See G. WILLIAMS, *THE SANCTITY OF LIFE* 314 (1957).

<sup>154</sup> See Survey, *supra* note 13, at 1206.

<sup>155</sup> Rachels, *supra* note 27, at 78.

<sup>156</sup> *Courier-J.* (Louisville), Dec. 7, 1979, § A, at 3, col. 1; *Courier-J.* (Louisville), Oct. 27, 1979, § A, at 3, col. 1; *N.Y. Times*, Dec. 7, 1979, § A, at 1, col. 4.

made by a mentally disturbed individual. Even if one concedes that considerations of protecting the suicidal person from himself are applicable to cases of actual or attempted suicide under the assumption that one who tries to kill himself may be regarded as maladjusted, depressed or mentally ill, such reasoning will not apply to the terminally ill hospice patient. A terminally ill patient's decision to discontinue treatment is often recognized as a reasoned, well-considered and even logical choice,<sup>157</sup> not one which is irrational or self-destructive such that he must be protected from himself.<sup>158</sup> Finally, the decision of a terminally ill person to terminate treatment cannot be construed as dangerous because it fails to strengthen the will of others to live or because it tends to encourage others to prematurely end their lives,<sup>159</sup> since it involves a restricted situation. The treatment may be foregone for many reasons—religious beliefs, a desire not to prolong pain, the expense of the treatment, or an acceptance of death<sup>160</sup>—but the overriding factor is that a cure is no longer possible; in prolonging treatment the patient merely exacerbates physical, mental and financial suffering. Because the patient's decision to terminate treatment is based on the recognition that further treatment is gratuitous, rather than on some independent desire to die, which is unrelated to his terminal illness, his decision is distinct from a curable patient's decision to terminate treatment and will not tend to encourage such conduct in others.<sup>161</sup> Therefore, while a terminally ill patient's decision may arguably fall under the traditional definition of suicide, this decision to terminate treatment should not be characterized as an act of suicide since it does not violate the policies which the state intends to promote in preventing suicide and may be distinguished from cases which do fall within those policies.

Finally, the state's interest in maintaining the ethical integrity of the medical profession has limited the patient's right to refuse treatment in some cases. In *John F. Kennedy Memorial Hospital v. Heston*,<sup>162</sup> the court considered the burden of the patient's refusal of treatment on the hospital and physicians who are dedicated to preserving life. The court found that

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<sup>157</sup> See, e.g., notes 75-107 & accompanying text *supra*.

<sup>158</sup> See *generally Informed Consent*, *supra* note 29, at 1656.

<sup>159</sup> See also G. WILLIAMS, *supra* note 153, at 272.

<sup>160</sup> *Informed Consent*, *supra* note 29, at 1632.

<sup>161</sup> Another policy against suicide is that a person wrongfully deprives society of his existence and activity. G. WILLIAMS, *supra* note 153, at 264 (1957). This policy also is not applicable to the context of a terminally ill patient refusing treatment because the course of the patient's disease already deprives society of the patient's presence and activity. Practically or economically speaking, a patient dying of cancer within six months is of little benefit to society; in fact, he is likely to be "unnecessarily" expending resources should he accept expensive medical treatment which cannot cure him. In addition, while suicide may be emotionally shocking and traumatic for certain members of society, such as the victim's immediate family, *id.* at 271, death following the termination of life-prolonging treatment is expected and may even evoke relief from grieving family members.

<sup>162</sup> 58 N.J. at 583, 279 A.2d at 673.

if the patient is likely to die without treatment, then physicians may administer treatment and "pursue their functions according to their professional standards,"<sup>162</sup> despite the patient's wishes. In *United States v. George*,<sup>163</sup> a man refused a blood transfusion, but asked to have an operation for his bleeding ulcer without the transfusion. The court said the doctors could not be required to ignore the mandates of their own conscience: "The patient may knowingly decline treatment, but he may not demand mistreatment."<sup>164</sup> In other words, a patient can choose to die at home, ignoring medical treatment altogether, but he cannot demand a treatment which his doctor considers negligent.

Other courts have not permitted the state's interest in protecting the medical profession's standards to override a patient's right of privacy to refuse treatment. Instead, the right to refuse treatment is frequently considered to be consistent with conventional medical ethics. In *Satz v. Perlmutter*,<sup>165</sup> the court stated:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. . . . Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same.<sup>166</sup>

The American Medical Association acknowledges that passive euthanasia is permissible in some cases.<sup>167</sup> "The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family."<sup>168</sup> When a physician can no longer cure a patient, the most appropriate treatment may well be that which alleviates pain and discomfort, rather than the continuation of curative therapy until death.<sup>169</sup>

In the case of a terminally ill hospice patient who requests that life-prolonging treatment be terminated, some state supreme courts have held

<sup>163</sup> 239 F. Supp. 752 (D. Conn. 1965).

<sup>164</sup> *Id.* at 754.

<sup>165</sup> 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

<sup>166</sup> *Id.* at 163. The court added:

It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death.

*Id.* at 164.

<sup>167</sup> Rachels, *supra* note 27, at 78.

<sup>168</sup> *Id.* (taken from a statement adopted by the House of Delegates of the American Medical Association on Dec. 4, 1973).

<sup>169</sup> *See Standards, supra* note 3, at 6.

that the state's interests are outweighed by the patient's right of privacy in deciding to refuse treatment. These interests include preserving life, protecting the interests of innocent third parties, preventing suicide and maintaining the ethical integrity of the medical profession.

### RECOMMENDATIONS

While some state courts have concluded that a terminally ill patient's right of privacy to refuse extraordinary treatment and receive palliative care outweighs the state's interests in preserving life as long as possible, and a few states have enacted natural death acts in an attempt to increase patient autonomy and protect doctors from liability for complying with a patient's wish to discontinue treatment, a hospice's legal position is still far from secure. However, hospices may take precautions in their admission and treatment procedures in order to reduce the risk of any potential legal liability.

First, before a patient is admitted into the hospice, the patient should be certified by at least two physicians as being terminally ill. One of the physicians certifying the patient should be the patient's attending physician since the attending physician is in the best position to evaluate the progress of the patient's illness and his response, or lack thereof, to various treatments previously administered. An outside physician's evaluation would also be useful as an objective opinion but in any case the hospice physician must also examine the incoming patient. If questions should later arise regarding whether the patient was actually terminally ill upon his admission to the hospice, the hospice physician might be charged with negligence for not having verified that at the time of admission the patient's condition was still terminal and not in remission such that curative therapy would have been appropriate. Certification should be in writing and included in the patient's hospice records to avoid any evidentiary problems should questions later arise. This verification that the incoming hospice patient is terminally ill should avoid successful claims later brought against the hospice based on a theory that providing the patient with only palliative treatment was negligent because he was not terminally ill at the time of his admittance.

Second, the hospice should establish an ethics committee or some similar mechanism which would interview and screen all prospective patients and their families regarding the emotional and physical condition of each applicant in an effort to evaluate the likelihood that the patient will benefit from hospice care. Not all patients can benefit from the hospice setting, and not all families will feel comfortable with the unorthodox approach to treatment practiced in a hospice.<sup>170</sup>

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<sup>170</sup> See *id.* at 7.

Third, this committee must counsel the applicant and his family regarding the procedures and implications of palliative treatment. For example, it is possible that a hospice may have a standard practice of not utilizing curative therapy for complications of the terminal illness, such as pneumonia. The committee must disclose the procedures and implications of and alternatives to palliative care in as much detail as possible so that the patient and the family will know exactly what the palliative care in that hospice will and will not entail. Such disclosure is required if the patient is to make an informed consent to hospice care. The hospice will only be protected from an action claiming a lack of informed consent to the treatment if it can document that it in fact made reasonable efforts to explain all procedures, alternative procedures, and the implications of such procedures to the patient, and in addition, received consent from the patient to hospice care after he had been so informed.

Fourth, each new patient should sign a directive modeled after those outlined in the natural death acts, but altered in such a way that the informed consent of the patient to palliative care is evident from the document. The directive should include a section specifying that the patient is aware he is terminally ill, that he desires a termination of all extraordinary care, and further that the patient requests palliative care and is fully aware of the consequences and limitations of such treatment. Although hospices in ten of the jurisdictions which have passed natural death acts are prohibited from making the execution of a directive a condition precedent to receiving hospice care, each patient should be advised of the purposes and procedures for executing a directive and encouraged to execute one.

Finally, a regular procedure for review of the hospice standard of care should be established. Like an acute care hospital, the hospice should review all standards and procedures of clinical care<sup>171</sup> to assure that all appropriate efforts are made for each patient's comfort and well-being.<sup>172</sup> One aspect of this review should be periodic examinations of each patient to ascertain that the patient's condition is not in remission or in any other state which would render palliative care inappropriate. Such periodic examinations should alleviate the possibility of an action being brought against the hospice on the theory that the patient was properly admitted to the hospice but later went into remission such that palliative care

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<sup>171</sup> Potter, *supra* note 2, at 54.

<sup>172</sup> Legislatures may want to set up separate licensing requirements for hospices so that they meet specific standards of care in order to be licensed. *See, e.g.*, FLA. STAT. ANN. §§ 400.601-615 (West Supp. 1981); MICH. COMP. LAWS ANN. §§ 333.21401-21421 (West Supp. 1981); NEV. REV. STAT. §§ 449.001-240 (1979). Such statutory safeguards could be important for the protection of patients since, as in nursing homes, the patients are in an extremely vulnerable position with virtually no bargaining power.

became inappropriate and the hospice was negligent for not transferring the patient to a different facility for full curative therapy.

States which have enacted natural death acts should amend their acts to specifically account for hospice care. The philosophy of hospice care is the same as that reflected in the natural death acts<sup>173</sup> and yet, as the acts presently stand, they deny hospices many of the protections that are afforded to them in states which have not enacted such statutes. If a state determines that specific civil and criminal immunity is desirable for health care providers who are willing to follow the direction of terminally ill patients who desire to discontinue treatment, then the statutes must be amended so that hospices may require a patient to execute a directive as a condition to admission into the hospice. Furthermore, legislators should carefully consider whether they, in fact, wish to deny minors, incompetents and pregnant women the right to draft valid directives to refuse treatment so that uncertainty is eliminated in this area.<sup>174</sup> Meanwhile, hospices in states which presently deny such persons the right to draft valid directives are at risk to accept such persons into their program of care.

### CONCLUSION

Legal uncertainty and therefore the possibility of civil or criminal liability faces the hospice movement. A legislative trend has developed in recent years toward authorizing a patient's right to refuse treatment and toward providing immunity from liability for doctors who choose to follow the directive of their patients to discontinue life-prolonging treatment. However, through oversight, this legislation has not specifically accounted for the hospice situation, and therefore it provides more uncertainty than protection for the legal position of the hospice.

In addition, while a few state supreme courts allow patients the choice to discontinue extraordinary treatment pursuant to their right of privacy, the majority of states have not yet found that a terminally ill patient has a right of privacy to discontinue treatment. Therefore, hospices need to take precautions in their admission and treatment procedures in order to alleviate the possibility of successful lawsuits being brought against them.

Moreover, each state legislature needs to consider whether to promote

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<sup>173</sup> See text accompanying notes 103-04 *supra*.

<sup>174</sup> One could propose that a separate statute be enacted for hospices, similar to the natural death acts. While such a statute might add more protection for the hospice care providers, it would probably inhibit flexibility by imposing restrictions on their methods of care, among other things. Since hospice care emphasizes flexibility in that it develops a homelike atmosphere through, for example, unlimited visitation, the disadvantages of such a statute would likely outweigh the benefits.

patient autonomy and physician immunity through natural death acts, and if so, whether to exclude specific persons such as pregnant women, minors or mental incompetents from the class of patients who are granted such patient autonomy. If a natural death act is approved by a state, it should be written so that it protects the hospice movement since that movement is directed toward just the sort of patient autonomy which the natural death acts promote.

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