1-1-1998

Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment

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BEYOND MISGUIDED PATERNALISM: RESUSCITATING THE RIGHT TO REFUSE MEDICAL TREATMENT

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The author focuses on the failure of the courts to provide a remedy for the right to refuse medical treatment. Health care providers, for a number of reasons, often ignore patient requests to forgo certain life-extending medical procedures. The courts have generally allowed medical professionals complete discretion in deciding whether to honor patients' requests. When patients or their estates sue health care providers for violation of the right to refuse treatment, courts have refused to award damages. By failing to provide a remedy, the courts effectively make the right a meaningless one. While acknowledging the importance of physician autonomy, the author argues that the courts' one-sided approach to this dilemma is unsound. To implement the right, the author advocates and describes a new approach under which courts would consider not only the special context in which this issue generally arises but also the important autonomy interests inherent in the right to refuse medical treatment.

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INTRODUCTION

The common law has long recognized an individual's right to self-determination over her own body, free from interference by others.[1] This right of self-determination expresses the principles, or value choice, of personal autonomy. It includes decisions such as those relating to the medical care that we choose to receive.

Today new biomedical technologies such as respirators, cardiac pacemakers, and kidney dialysis units have greatly increased medicine's capacity to extend human life.[2] Although in many cases these technologies extend life, often they only extend the process of dying.[3] Modern medicine frequently permits individuals to live with what were previously fatal diseases, but it often cannot cure or reverse those illnesses entirely.[4] Consequently, a person is not restored to a

1. For a general discussion of the principles of self-determination and autonomy, see H. TRISTRAM ENGELHARDT, JR., THE FOUNDATIONS OF BIOETHICS 264 (1986), which states that "[o]ne of the ancient presumptions of English law is that individuals should be secure in their bodies against the unauthorized touching of others," and Sylvia A. Law, *Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions*, 21 N.Y.U. REV. L. & SOC. CHANGE 279, 285 (1994-1995), which comments that "[p]atients' rights to self-determination and autonomy in medical decision-making have deep historic roots and command broad respect as abstract principles."

2. According to one historian, "[n]inety percent of the medicine being practiced today did not exist in 1950." John Steele Gordon, *How America's Health Care Fell Ill*, AM. HERITAGE, May-June 1992, at 49, 49.

3. *See* LIFE CHOICES: A HASTINGS CENTER INTRODUCTION TO BIOETHICS 134 (Joseph H. Howell & William Frederick Sale eds., 1995) (discussing the new array of ethical issues that arise from advances in medical technology). Justice Brennan noted that:

> The timing of death—once a matter of fate—is now a matter of human choice. Of the approximately 2 million people who die each year, 80% die in hospitals and long-term care institutions, perhaps 70% of those after a decision to forego life-sustaining treatment has been made. Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying.

Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 302 (1990) (Brennan, J., dissenting) (citations omitted).

4. *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 3 (1983). The study states:

fully functioning life. Unfortunately, many patients who have had their lives extended by modern medical advancements find their physical and psychological existence to be unsatisfactory.[5] Beginning in the early 1900s, some patients attempted to avoid that outcome by "asserting a right to die a natural death, without undue dependence on medical technology or . . . a right to 'die with dignity.'"[6] In recent years, a legal consensus has evolved that competent patients have a near absolute right to refuse medical treatment.[7] This right also rests with the legal surrogates of incompetent patients, who may decline treatment on the incompetent patients' behalf.[8]

> The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken, just as such choices provide the basis for other decisions about medical treatment. Health care institutions and professionals should try to enhance patients' abilities to make decisions on their own behalf and to promote understanding of the available treatment options.

Id. The median life expectancy is now 79 for women and 72 for men. *See* BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1995, at 86 (115th ed. 1995).

5. As Jonathan Swift observed, "[e]very Man desires to live long; but no Man would be old." JONATHAN SWIFT, *Thoughts on Various Subjects, in* SATIRES AND PERSONAL WRITINGS 406, 414 (William Alfred Eddy ed., 1932). Both public opinion polls and scientific studies show that many people prefer not to be placed on life-support systems. *See* James Lindgren, *Death by Default*, 56 L. & CONTEMP. PROBS. 185, 197-99 (1993) (reviewing medical opinion polls and discussing the individual's fear of being placed on life support and losing the ability to make medical decisions for him or herself).

6. *In re* Conroy, 486 A.2d 1209, 1220 (N.J. 1985); *see also* Judith C. Areen, *Bioethics and the Law: The Second Stage: Balancing Intelligent Consent and Individual Autonomy*, 31 ARIZ. L. REV. 447, 449-51 (1989) (recognizing that until the 1900s there was no recognition of informed consent). For a history of the patient autonomy movement, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 389-93 (1982).

7. *See Cruzan*, 497 U.S. at 278 (indicating that competent persons have a "constitutionally protected liberty interest in refusing unwanted medical treatment"); *In re* Quinlan, 355 A.2d 647, 662-64 (N.J. 1976) (recognizing that the right to privacy includes the right to refuse medical treatment). Every state and the District of Columbia have enacted statutes that enable patients to make end-of-life decisions in the form of advance directives. *See The New DNR Laws: Pros and Cons*, CHOICE IN DYING (National Council for the Right to Die, New York, N.Y.), Spring 1993, at 1 (listing and discussing advance directive statutes in the various states); *see also* GUIDO CALABRESI & PHILIP BOBBIT, TRAGIC CHOICES 16-17, 56 (1978) (coining the term "tragic choice" to describe situations in which a legal system must allocate burdens and benefits involving great suffering or death); 2 ALAN MEISEL, THE RIGHT TO DIE, § 12.25, at 171 n.135 (2d ed. 1995) (presenting a comprehensive account of practices and laws governing the foregoing of life-sustaining treatment and surrogate decision-making); Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on* Roe, Casey, *and the Right to Die*, 44 AM. U. L. REV. 803, 841 (1995) (discussing the policies behind the right to refuse treatment).

8. *See Conroy*, 486 A.2d at 1227-28.

As the right to refuse treatment gained social acceptance, more people chose to exercise that right.[9] It is clear, however, that physicians have not accorded the same respect to the right as has society.[10] Some evidence suggests that many physicians are keeping patients alive against their wishes.[11] Some physicians are motivated to keep patients alive because of liability concerns, the promise of new life-sustaining technology, or even financial considerations.[12] As a result, physicians frequently will override patient decisions to refuse medical treatment because of a belief that respecting the patient's request would not be in the patient's or the doctor's best interest.[13]

Due to the medical profession's failure to honor consistently the right to refuse medical treatment, a growing number of patients (or their estates) have filed lawsuits alleging that patients who received unwanted life-sustaining treatment suffered a compensable injury.[14]

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9. *See* Robert L. Jayes et al., *Do-Not-Resuscitate Orders in Intensive Care Units: Current Practices and Recent Changes*, 270 JAMA 2213, 2215 (1993) (discussing a recent study showing that, from 1988 to 1990, almost twice as many intensive care unit patients had do not resuscitate ("DNR") orders as did patients from 1979 to 1982); *see also* Areen, *supra* note 6, at 449 (commenting that the emergence of a patient's rights movement over the past few decades has reduced the traditional autonomy of the medical profession).

10. *See* David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101, 2102 (1992) (noting that physicians' values dominate end-of-life decision-making although physicians' do a poor job of eliciting patient values and preferences and are unaware of what the patient really wants); *see also* Susan Gilbert, *Study Finds Doctors Refuse Patients' Requests on Death*, N.Y. TIMES, Nov. 22, 1995, at A1 (quoting Dr. William Kraus as saying, "[although] [p]eople think advance directives are solving the problem . . . [w]e have very good information that they aren't, that nothing has changed—the amount of pain at the end of life, the number of people dying alone attached to machines").

11. *See* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 1-29 (1984) (noting that, historically, medical practitioners treated patients paternalistically and resisted efforts by courts and patients to increase patient participation in medical decision-making).

12. *See, e.g.*, DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 160-64 (1987) (discussing the influence of advanced medical technology); Merrijoy Kelner et al., *Advance Directives: The Views of Health Care Professionals*, 148 CANADIAN MED. ASS'N J. 1331, 1335-36 (1993) (discussing the reservations that physicians have about advanced directives); Tony Smith, *Cheap Managed Death*, 310 BRIT. MED. J. 744 (1995) (stating that doctors have ethical and financial incentives to keep patients alive).

13. *See* Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 886 (1991). An advance directive study tried to discover why living wills are sometimes disregarded by physicians. *See id.* at 882-87. Researchers concluded that physicians override advance directives when they disagree with the patient's choices and feel that the undesired treatment is appropriate. *See id.*

14. *See, e.g.*, Ross v. Hilltop Rehab. Hosp., 676 F. Supp. 1528, 1530 (D. Colo. 1987); McVey v. Englewood Hosp. Ass'n, 524 A.2d 450, 452 (N.J. Super. Ct. App. Div. 1987); Strachan v. John F. Kennedy Mem'l Hosp., 507 A.2d 718, 719 (N.J. Super. Ct. App. Div. 1986); Elbaum v. Grace Plaza, Inc., 544 N.Y.S.2d

The majority of these suits have relied on traditional tort theory.[15] Generally, these suits claim that the patient suffered a diminished quality of life after receiving undesired medical treatment, which violated a personal autonomy interest.[16]

To date, no courts have permitted recovery for violation of the right to refuse treatment.[17] Many courts have not even permitted such causes of action to proceed.[18] The reasons for this lack of remedy are complex and varied. Some courts have been willing to overlook the harm caused to a person kept alive against his or her will if the court finds that he or she is not experiencing pain—especially those patients who never regain consciousness.[19] Under-

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840, 845-48 (App. Div. 1989); Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 226 (Ohio 1996); 1 MEISEL, *supra* note 7, § 3.4, at 51.

15. For a discussion of theories advanced in cases seeking damages for failure to honor patients' refusal of treatment, see M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499, 504-12 (1992), David H. Miller, *Right-to-Die Damage Actions: Developments in the Law*, 65 DENV. U. L. REV. 181, 185-97 (1989), and Steven I. Addlestone, Note, *Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy*, 46 VAND. L. REV. 1255, 1267-73 (1993).

16. *See, e.g.*, *Elbaum*, 544 N.Y.S.2d at 847; *Anderson*, 671 N.E.2d at 226.

17. *See* Elena N. Cohen, *Death and Dying*, 1 BioLaw (Univ. Pub. Am.) § 12, at R:262 (July 1989) (reporting no significant damages awards have been won by patients in the United States). Although no reported cases exist in which the court awarded damages for the unwanted imposition of life-sustaining treatment, there have been some jury verdicts and settlements in which the plaintiff recovered damages. *See* Gasner, *supra* note 15, at 504-12 (discussing the dismissal and settlement of various cases and contemplating alternative theories of recovery which may prove successful in future litigation); Miller, *supra* note 15, at 197-98 (stating that plaintiffs fair poorly in front of judges). In addition, one court has recognized the potential for a cause of action. *See* Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984) (recognizing the potential for a battery action when a patient is resuscitated against her wishes). Another case awarded an injunction so that the plaintiff could have the life-sustaining treatment removed. *See* Bouvia v. Superior Court, 225 Cal. Rptr. 297, 307 (Ct. App. 1986) (granting injunction to patient who wished to have medical care terminated).

18. *See* Gasner, *supra* note 15, at 504-12 (discussing the failure of plaintiffs to recover for violations of their right to refuse treatment); Miller, *supra* note 15, at 185 (reviewing the dismal prospects for patients in such damage actions).

19. These courts focus on the fact that many who are suffering from terminal illnesses may be experiencing little or no pain, or have lost consciousness. The courts thus reason that an individual in such a state suffers no harm if he or she is kept alive. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 301, 320 (1990) (Brennan, J., dissenting) (voicing complaint that the majority failed to realize the harm to individual autonomy when an individual, even one in a persistent vegetative state is kept alive against his or her wishes); *see also* RONALD DWORKIN, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 184, 191 (1993) (arguing that an individual can be harmed by being kept alive against his or her will, or, if the individual lacks consciousness, against whatever values informed his or her active life); JOEL FEINBERG, *An Unpromising Approach to the "Right to Die," in* FREEDOM AND FULFILLMENT: PHILOSOPHICAL ESSAYS 260, 278 (1992) (discussing

standably, judges are also reluctant to provide a remedy (i.e., award damages) because to do so would ostensibly mean that the court favored death over life.[20] To avoid this dilemma, courts have manipulated tort concepts to validate life-prolonging measures under almost any circumstances, even when a competent patient has decided to refuse treatment.[21] In so doing, the courts render ineffective the right to refuse treatment.[22] Physicians can sustain life, sometimes for months or even years, for people who are near death (or horribly diseased), sedated into near oblivion, and connected to dozens of machines that do most of the individual's "living."[23] Understandably, many of these patients have expressed a wish to die.[24]

In addition to thwarting an individual's autonomy, violation of the right to die with dignity has other repercussions, including the emotional and financial toll on a patient's family and loved ones.[25] Moreover, society has an interest in making sure that people are not kept alive against their wishes. Most people think that the way they die and their attitude towards death bear crucially on the value of their lives.[26] As legal philosopher Ronald Dworkin has ob-

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the harm to an individual's autonomy rights when his or her last wishes are not respected).

20. *See, e.g.*, *Anderson*, 671 N.E.2d at 228 (holding that life is not a compensable injury and refusing to recognize wrongful living as a cause of action).

21. *See, e.g.*, Addelstone, *supra* note 15, at 1268-71 (discussing the courts' failure to provide a remedy for violation of the right to refuse treatment using ordinary tort principles).

22. *See* Barry Friedman, *When Rights Encounter Reality: Enforcing Federal Remedies*, 65 S. CAL. L. REV. 735, 735-36 (1992) (arguing that a tight fit between rights and remedies does not exist for many constitutional rights). William Blackstone recognized that "it is a general and indisputable rule, that where there is a legal right, there is also a legal remedy, by suit or action at law, whenever that right is invaded." 3 WILLIAM BLACKSTONE, COMMENTARIES *23. Furthermore, Blackstone noted that "it is a settled and invariable principle in the laws of England, that every right when with-held must have a remedy, and every injury it's [sic] proper redress." *Id.* at *109; *see also* Marbury v. Madison, 5 U.S. (1 Cranch) 137, 162-63 (1803) (stating the general maxim that for every right there is a remedy).

23. *See* DWORKIN, *supra* note 19, at 61 (providing an elegant and powerful restatement of the view that in a pluralistic society individuals should have rights against governmental interference with deeply personal "private choices," such as abortion and euthanasia).

24. *See* Nicholas G. Smedira et al., *Withholding and Withdrawal of Life Support from the Critically Ill*, 322 NEW ENG. J. MED. 309, 311 (1990); *see also Cruzan*, 497 U.S. at 339 (Stevens, J., dissenting) ("Medical advances have altered the physiological conditions of death in ways that may be alarming: Highly invasive treatment may perpetuate human existence through a merger of body and machine that some might reasonably regard as an insult to life rather than as its continuation.").

25. *See* Roger B. Dworkin, *Medical Law and Ethics in the Post-Autonomy Age*, 68 IND. L.J. 727, 737 (1993).

26. *See* DWORKIN, *supra* note 19, at 199 (stating that individuals worry about the impact of "life's last stage on the character of [their] life as a whole, as we might worry about the effect of a play's last scene or a poem's last stanza on the entire creative work").

served, "[m]aking someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."[27]

My conclusion is that respect for individual autonomy should be the primary (but not the only) factor in deciding whether to afford a remedy for violations of the right to refuse medical treatment. People have a right to forgo treatment—without financial or legal penalty to themselves or those they love—because this decision is one central to personal autonomy.[28] A society that allows the refusal of medical treatment is a better one.[29] Of course, greater autonomy in this area is not without cost, such as an increased risk of involuntary death,[30] and perhaps an implicit financial pressure on ailing patients to die sooner than they might otherwise wish.[31] On balance, however, freedom to make this decision, and to see that the choice is respected by the medical profession, seems worth the price.[32] Thus, the courts can best serve what people perceive as their critical interests by deferring to their autonomous choices, even when the court disagrees with these choices.[33] To do this,

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27. *Id.* at 217.

28. *See Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting). In his dissent, Justice Stevens notes:

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own morality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental," and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator.

Id. (Stevens, J., dissenting) (citation omitted).

29. *See* Dworkin, *supra* note 25, at 727 (discussing the importance of autonomy in American culture).

30. *See Cruzan*, 497 U.S. at 280-81 (1990) (holding that state interest in preventing error and abuse in the right to refuse treatment arena justified its clear and convincing evidence standard). *See generally* Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958) (arguing against any expansion of the right to refuse treatment, on the ground that it would be impossible to devise safeguards that are both workable and adequately protective).

31. *See* David Myland Kaufman & Richard B. Lipton, *The Persistent Vegetative State: An Analysis of Clinical Correlates and Costs*, 92 N.Y. ST. J. MED. 381, 383 (1992) (finding that the bills for 13 patients in a persistent vegetative state averaged $170,000 and the length of stay at the hospital averaged almost 200 days). For a discussion of health care payment alternatives, see Ezekiel J. Emanuel, *Cost Savings At the End of Life: What Do the Data Show?* 275 JAMA 1907 (1996), and David E. Joranson, *Are Health Care Reimbursement Policies a Barrier to Acute and Cancer Pain Management?*, 9 J. PAIN & SYMPTOM MGMT. 244 (1994).

32. *See* Eric Rakowski, *The Sanctity of Human Life*, 103 YALE L.J. 2049, 2100-01 (1994) (book review).

33. *See, e.g.*, Ronald J. Krotoszynski, Jr., Cohen v. California: *"Inconsequential" Cases and Larger Principles,* 74 TEX. L. REV. 1251, 1252-54 (1996) (citing cases where various United States Supreme Court Justices up-

courts must be prepared to provide a remedy when a patient has effectively exercised his or her right to refuse treatment.

To accommodate these interests properly, the court's focus must shift from a philosophical discourse about the value and sanctity of life to a greater understanding and appreciation of the aftermath of a violation of one's right to refuse treatment. Keeping individuals alive after they have made a competent determination to refuse medical treatment has a huge impact and does a great deal of damage to their autonomy right, their loved ones, the medical profession, and society. Sharpening the focus leads to two preliminary conclusions about the current application of tort rules that proscribe liability for failing to follow a patient's wishes. First, courts should not view the patient's decision to forgo life-sustaining treatment as one that a physician or hospital may ignore without consequence. By failing to impose liability when a patient has decided to refuse treatment, the courts ignore a patient's autonomy interests and impose their own moral judgment on the situation, determining paternalistically that the choice to forgo treatment was incorrect or at least unworthy of respect by the legal system.[34] Second, although the current legal structure provides the necessary doctrine to which plaintiffs can turn for remedy, legislative action might be necessary if plaintiffs are to receive compensation for such injuries.

This Article argues that the courts, and if necessary the legislatures, should ensure that patients have a remedy for violation of the important right to refuse medical treatment.[35] First, this Article explores the importance of an individual's autonomy interests in being allowed to make certain medical decisions. Part I considers relevant state and federal statutes and case law that have defined the right to refuse medical treatment. Part II discusses a recent case involving a violation of the right to refuse treatment and examines the court's rationale for refusing to provide a remedy.

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held the principles of fundamental freedoms even though they themselves felt the exercise of those freedoms to be "absurd" or "immature").

34. *See* Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 228 (Ohio 1996) (holding that no "wrongful living" cause of action exists for the improper administration of life prolonging medical treatment). *But see* Bouvia v. Superior Court, 225 Cal. Rptr. 297, 301 (Ct. App. 1986) (holding that "[t]he right to refuse medical treatment is basic and fundamental," and its exercise may not be "overridden by medical opinion").

35. Some commentators support the recovery of damages when a physician interferes with the patient's right to refuse treatment. *See, e.g.*, *Developments in the Law, Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1673 (1990); William C. Knapp & Fred Hamilton, *"Wrongful Living": Resuscitation as Tortious Interference with a Patient's Right to Give Informed Refusal*, 19 N. KY. L. REV. 253, 254-59 (1992); A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 665 (1986); Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 430 (1988); Tricia Jones Hackleman, Comment, *Violation of an Individual's Right to Die: The Need for a Wrongful Living Cause of Action*, 64 U. CIN. L. REV. 1355 (1996).

In addition, the Article will review the treatment of other fundamental rights (such as abortion) and compare remedies for violations of these rights with the lack of remedy for the right to refuse medical treatment.[36] When denials and violations of these other rights occur, both state and federal courts have not hesitated to protect the individual's exercise of the right, even if it finds the exercise distasteful or disagrees with the choice.

Finally, Part III of the Article suggests how courts and legislatures could enforce remedies for this right by seeking a creative approach to this difficult problem.

I. THE IMPORTANCE OF PERSONAL AUTONOMY AND THE RIGHT TO REFUSE TREATMENT

Respect for individuality and autonomy have long been central values in our society and legal system.[37] Personal autonomy requires recognition of one's rights to hold certain views, to make one's own choices, and to act on the basis of one's personal values and beliefs, even when others may believe you were mistaken.[38] In general, the more intense and personal the consequences of a choice and the less direct or significant the impact of that choice on others, the more compelling the claim to autonomy in the making of a given decision.[39] Under this criterion, the case for respecting patient autonomy in decisions about individual health[40] and bodily fate is

36. *See infra* notes 232-39 and accompanying text.

37. *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

38. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 62, 82-87 (3d ed. 1989) (providing a full discussion of the new emphasis on patient autonomy concerns in bioethics); Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 222 (1985) (arguing that medical treatment choices are vital to a person's individual autonomy interests). For an overview of the informed consent doctrine, see RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986).

39. The claim to autonomy was most compellingly expressed by John Stuart Mill:

> [T]he only purpose for which power can be rightfully exercised over any member of a civilised [sic] community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. . . . [T]he conduct from which it is desired to deter him must be calculated to produce evil to some one else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

JOHN STUART MILL, ON LIBERTY 12-13 (Alfred A. Knopf, Inc. 1989) (1859).

40. In Western medicine, deference to the patient's interest is rooted in the Hippocratic tradition and in the doctor's status as a fiduciary. *See* ROBERT M. VEATCH, A THEORY OF MEDICAL ETHICS 21-25 (1981). Under these principles, the doctor's interest in income, prestige, and convenience, as well as in his or her own professional opinions and references, constitutes a less immediate and compelling claim to authority than that which derives from the patient's status

very strong.[41] Indeed, the Supreme Court has stated that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[42]

Central to the right to bodily integrity is the common law doctrine of consent.[43] Strictly speaking, every unauthorized touching of a person may constitute a battery,[44] and only the fact of consent renders the touching lawful.[45] Consequently, in the medical context, the administration of medical treatment which involves any touching without the consent of the patient is prima facie unlawful[46] and may give rise to civil liability.[47] Because the unlawfulness stems

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as the bearer of the consequences. *See* Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972) (recognizing the physician's duty to keep a patient informed of medical procedures); *In re* Conroy, 486 A.2d 1209, 1222 (N.J. 1985) ("The doctrine of informed consent is the primary means developed in the law to protect this personal interest in the integrity of one's body."); *see also* Danuta Mendelson, *Historical Evolution and Modern Implications of Concepts of Consent to, and Refusal of, Medical Treatment in the Law of Trespass*, 17 J. LEGAL MED. 1, 4 (1996) (noting that in bioethics, the terms "autonomy" and "respect for autonomy" are associated with several ideas, such as privacy, voluntariness, choosing freely, and accepting responsibility for these choices).

41. The classic statement of bodily value, in the medical context, was expressed by Judge Cardozo, who stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault . . . ." Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914). A more recent statement of the importance of patient autonomy is found in 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 2-4 (1982) (recommending that health care institutions and professionals try to enhance patients' abilities to make decisions on their own behalves and to promote understanding of the available treatment options).

42. *Botsford*, 141 U.S. at 251 (refusing to compel personal injury plaintiff to undergo pretrial medical examination).

43. *See* James Lindgren, *Death by Default*, 56 LAW & CONTEMP. PROBS. 185, 188-89 (1993) (stating that the common law doctrine of consent embodies following a competent person's treatment decisions).

44. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 9, at 41 (5th ed. 1984).

45. *See id.* § 9, at 42.

46. There are some exceptions, for example, in cases of emergency where treatment is necessary to save the patient's life but the patient is unable to give consent to that treatment. *See, e.g.*, Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1052 (Ohio Ct. App. 1984) (holding that medical treatment will be lawful under the doctrine of implied consent when a medical emergency requires immediate action to preserve the health or life of the patient). Some statutory exceptions have also been created regarding the requirement of consent through public health and mental health legislation. *See, e.g.*, Jacobson v. Massachuetts, 197 U.S. 11, 37-38 (1905) (upholding compulsory vaccination laws).

47. To sustain an action for battery, two elements must be satisfied: 1) intent to cause harmful, or offensive touching to another; and 2) the harmful con-

from the fact of the non-consensual touching itself, the contact to the patient need not be harmful to give rise to liability, nor is there any requirement that the touching be done with hostility.[48] It is therefore no defense that the treatment or procedure was skillfully performed, or that it was medically necessary and actually benefited the patient.[49] When, however, a patient with decision-making capacity has given a legally effective consent to the particular intervention,[50] the patient's consent is a complete defense to any action for damages based on the tort of battery.[51]

The common law doctrine of "informed consent" has evolved from these fundamental principles and provides a firm basis for legal recognition of the right of a patient with decision-making capacity to refuse treatment.[52] Pursuant to this doctrine, a doctor must make full disclosure to a patient of all proposed medical procedures, the material risks of those procedures, and alternative courses of ac-

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duct must occur. *See* Love v. City of Port Clinton, 524 N.E.2d 166, 167 (Ohio 1988) (citing RESTATEMENT (SECOND) OF TORTS § 13 (1965)). Any intentional, unwanted, harmful or offensive touching constitutes battery. *See* KEETON ET AL., *supra* note 44, § 9, at 41.

48. *See* RESTATEMENT (SECOND) OF TORTS § 15 cmt. a; *see also, e.g.*, Cobbs v. Grant, 502 P.2d 1, 7-8 (Cal. 1972) (en banc) (holding an operation without consent is battery, but an operation where the patient consents to one type of treatment and receives another is negligence); Lacey v. Laird, 139 N.E.2d 25, 31 (Ohio 1956) (holding that a battery occurs when a doctor performs treatment in the absence of consent).

49. *See* KEETON ET AL., *supra* note 44, § 9, at 41 ("[T]he defendant is liable not only for contacts which do actual physical harm, but also for those relatively trivial ones which are merely offensive and insulting."). A battery may be committed "even though the procedure is harmless or beneficial." *Shapiro*, 469 N.E.2d at 1051. Thus, even actions such as placing a patient on a machine which enables the patient to breathe or receive nutrition, or resuscitating a patient's heart, could give rise to a plausible cause of action for battery if the treatment was not desired.

50. For a consent to medical treatment to be legally effective the medical procedure or treatment must be one to which the person can give a legally valid consent, have the legal capacity to give a valid consent, and be a real consent—i.e., it must be voluntarily given with respect to the particular procedure or treatment performed by a particular individual, and the person must be aware, in broad terms, of the nature and purpose of the treatment to which he or she is consenting. *See* Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 352 n.218, 379-80 (1994).

51. *See Lacey*, 139 N.E.2d at 32.

52. The doctrine of informed consent is founded on the common law tort of battery. *See* KEETON ET AL., *supra* note 44, § 9, at 39-42. The doctrine of informed consent affirms a patient's right to determine his or her own destiny in medical matters, promotes autonomy, guards against overreaching on the part of the physician, protects physical and psychic integrity and thus privacy, and compensates both from affronts to dignity and from some of the unintended consequences of modern medical care. *See* Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 414-15; *see also*, Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 147-50 (1977) (discussing the history of the informed consent doctrine).

tion.[53] On the basis of the information received from the doctor, the patient may then choose among the available treatment options.[54] The doctrine therefore establishes an obligation of health care professionals to respect patients' rights in making treatment decisions.[55] This right of a patient with decision-making capacity to give consent to treatment, after having been fully informed as to the material risks of the proposed treatment, logically involves a corresponding right to refuse treatment.[56]

These common law background principles provided the foundation for courts that faced the task of addressing and defining an individual's right to refuse medical treatment, including life-sustaining treatment.[57] The doctrine of informed consent, which in-

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53. *See* Canterbury v. Spence, 464 F.2d 772, 776, 782 (D.C. Cir. 1972) (permitting action against surgeon and hospital for paralysis resulting from back operation without adequate disclosure of risks); Payne v. Marion Gen. Hosp., 549 N.E.2d 1043, 1050 (Ind. Ct. App. 1990) (holding that a physician has a duty to obtain informed consent before implementing a DNR order); *Lacey*, 139 N.E.2d at 31 (requiring proper consent from a patient even where a beneficial or harmless operation is performed).

54. *See* Parkins v. United States, 834 F. Supp. 569, 574 (D. Conn. 1993) ("[Doctors] must disclose all the treatment options and the risks associated therewith in order to ensure that the patient has sufficient information to make an intelligent choice.").

55. *See In re* Conroy, 486 A.2d 1209, 1222 (N.J. 1985) ("'Under this doctrine, no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies.'" (quoting Norman L. 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))); *see also* Law, *supra* note 1, at 285-88 (defining the right to self-determination and autonomy as characterizing the doctrine of informed consent).

56. *See* Shultz, *supra* note 38, at 232 ("If the key issue is knowledge and choice regarding the fate of one's body, there is no meaningful difference between a decision that will be implemented by touching the body and one that will [not]."); *see also* Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300-03 (Ct. App. 1986) (holding that an adult of sound mind has the right, in the exercise of control over his body, to determine whether or not to submit to medical treatment, and thus it follows that such a patient has the right to refuse any medical treatment even that which may save or prolong life); *Payne*, 549 N.E.2d at 1050 (holding that a physician has a duty to obtain informed consent before implementing a DNR order). *See generally* Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607, 610 (providing a doctrinal analysis of informed consent). In addition to the common law right to refuse treatment, a limited right for competent patients to refuse treatment exists under state statutes. *See infra* note 97 and accompanying text.

57. Several cases have discussed the right to privacy and presented constitutional support for the right to refuse treatment. *See, e.g.*, Rasmussen v. Fleming, 741 P.2d 674, 681-82 (Ariz. 1987) (en banc); Bartling v. Superior Court, 209 Cal. Rptr. 220 (Ct. App. 1984); Severns v. Wilmington Med. Ctr., 425 A.2d 156 (Del. Ch. 1980); *In re* A.C., 573 A.2d 1235 (D.C. 1990) (en banc); *In re* Browning, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989); *In re* Quinlan, 355 A.2d 647 (N.J. 1976); *In re* Colyer, 660 P.2d 738 (Wash. 1983) (en banc). For a thor-

cludes the patient's choice to refuse life-sustaining medical treatment, is well accepted today in certain contexts.[58] The jurisprudence that has developed is a mixture of common law, statutes, and federal and state constitutional glosses.[59] From these sources of law, culminating with *Cruzan v. Director, Missouri Department of Health*,[60] the first "right to die" case to come before the United States Supreme Court, the existence of a fundamental legal right to make choices about one's medical treatment is now firmly established.[61]

A. *Supreme Court Recognition of the Right to Refuse Treatment*

In the 1990 decision, *Cruzan v. Director, Missouri Department of Health*,[62] the United States Supreme Court, for the first time, found a constitutional dimension to the right to refuse medical treatment and held that the constitutional right to liberty is implicated by providing medical treatment without the patient's consent.[63]

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ough discussion of the right to die decisions, see Rebecca Morgan & Barbara Harty-Golder, *Constitutional Development of Judicial Criteria in Right-to-Die Cases: From Brain Dead to Persistent Vegetative State*, 23 WAKE FOREST L. REV. 721 (1988).

58. There were at least 84 appellate decisions addressing the right to die issued prior to the Supreme Court's decision in *Cruzan*. *See* George J. Annas, *The "Right to Die" in America: Sloganeering from* Quinlan *and* Cruzan *to* Quill *and Kevorkian*, 34 DUQ. L. REV. 875, 882 (1996); *see also* Cruzan v. Harmon, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (en banc) (listing 54 reported decisions from 1976 to 1988).

In a number of the earlier cases, the courts denied the right of a patient to refuse treatment and ordered that treatment be administered against the patient's expressed wishes. *See, e.g.*, *In re* President of Georgetown College, Inc., 331 F.2d 1000, 1010 (D.C. Cir. 1964); United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965). However, the clear trend emerging from more recent case law is that the patient's right to refuse treatment, even life-saving treatment, will be upheld. *See In re* Farrell, 529 A.2d 404, 410-11 (N.J. 1987).

59. Some states recognize a right to refuse treatment based on a liberty or privacy interest. *See, e.g.*, Rasmussen, 741 P.2d at 682 (privacy interest); *In re* Barry, 445 So. 2d 365, 370 (Fla. Dist. Ct. App. 1984) (same); *In re* Lawrence, 579 N.E.2d 32, 39 (Ind. 1991) (liberty interest). The Supreme Court has recognized that a competent person has a constitutionally protected liberty interest, grounded in the Fourteenth Amendment, in refusing unwanted medical treatment, including life-sustaining treatment. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990). Thus, following *Cruzan*, it is clear that patients have a liberty interest in refusing resuscitation. Whether this liberty interest is violated, however, is determined by weighing the liberty interest against the relevant state interests. *See id.* at 279.

60. 497 U.S. 261 (1990).

61. *See* MARGARET OTLOWSKI, VOLUNTARY EUTHANASIA AND THE COMMON LAW 35-44 (1997); Alan Meisel, *A Retrospective on* Cruzan, 20 LAW MED. & HEALTH CARE 340, 342 (1992).

62. 497 U.S. 261 (1990).

63. *Id.* at 278-79. The United States Supreme Court stated:

In 1983, Nancy Cruzan suffered severe and irreversible brain damage in a car accident.[64] Although doctors aggressively treated Ms. Cruzan, she was ultimately diagnosed as being in a persistent vegetative state—"a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function."[65] After six years without any sign of recovery, Ms. Cruzan's parents asked the state hospital to discontinue life support and allow her to die.[66] The hospital refused the request without a judicial order supporting such an action.[67] Although Ms. Cruzan's parents obtained a court order from the state probate court permitting the discontinuation of life-sustaining treatment,[68] the Missouri Supreme Court overturned the order.[69] The state supreme court determined that life-sustaining treatment could be removed only on clear and convincing evidence of the patient's desire to have the particular treatment in question removed under the circumstances faced by the patient.[70] The Cruzans petitioned the United States Supreme Court for review.[71]

Writing for the majority, Chief Justice Rehnquist held that the Missouri requirement of "clear and convincing evidence" that the patient would want life-sustaining treatment discontinued before permitting termination of such care did not violate the Due Process Clause of the United States Constitution.[72] First, the Court recognized that one of the primary means of protecting the notion of bodily integrity is the informed consent doctrine.[73] As a result, the majority decided that the "logical corollary of the doctrine of informed

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> This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die."
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> . . . .
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> The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

Id. at 277-78 (citations omitted).

64. *See id.* at 265.

65. *Id.* at 266.

66. *See id.* at 267.

67. *See id.* at 268.

68. *See* Cruzan v. Harmon, 760 S.W.2d 408, 411-12 (Mo. 1988) (en banc), *aff'd sub nom.* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

69. *See id.* at 427.

70. *See id.* at 419.

71. *See* Cruzan v. Director, Mo. Dep't of Health, 492 U.S. 917 (1989) (granting petition for writ of certiorari to the Supreme Court).

72. *See Cruzan*, 497 U.S. at 280-82. The Supreme Court found that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Id.* at 282.

73. *See id.* at 269.

consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."[74] The *Cruzan* Court observed that "most courts have based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right."[75] Here, the Court dismissed the notion that the constitutional right of privacy includes a right to refuse treatment, and instead stated that the issue is more properly analyzed in terms of Fourteenth Amendment liberty interest.[76] All nine Justices agreed on the existence of this liberty interest, disagreeing only on how it should be balanced with the state's expressed interests in the protection and preservation of human life.[77]

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74. *Id.* at 270. Several earlier state court decisions had based their recognition of the "right to die" solely on the common law. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 489 (Ct. App. 1983); *In re* Estate of Longeway, 549 N.E.2d 292, 297 (Ill. 1989); *In re* Gardner, 534 A.2d 947, 951 (Me. 1987); *In re* Peter, 529 A.2d 419, 422-23 (N.J. 1987); *In re* Storar, 420 N.E.2d 64, 70 (N.Y. 1981).

Among the prior decisions discussed in the majority opinion were several cases which held that patients have an interest in refusing to submit to specific medical procedures. *See, e.g.*, Washington v. Harper, 494 U.S. 210, 229 (1990) (holding that Washington's procedures for administrating anti-physchotic medication to prisoners were sufficient to satisfy due process concerns, but stating that "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"); Jacobson v. Massachusetts, 197 U.S. 11, 27-33 (1905) (balancing an individual's interest in declining smallpox vaccine against the state's interest in preventing disease).

75. *Cruzan*, 497 U.S. at 271.

76. *See id.* at 271, 278; *cf.* Ronald J. Krotoszynski, Jr., *Fundamental Property Rights*, 85 GEO. L.J. 555 (1997) (arguing that bodily integrity should be conceptualized as a fundamental property right rather than a liberty interest).

77. *Cruzan*, 497 U.S. at 278. The fact that the four dissenters and Justice O'Connor all explicitly recognized that there is such a protected constitutional interest has led some to say that the *Cruzan* case was the first to find a constitutional right to die. This contention extends the majority opinion beyond its explicit terms. *See* BARRY R. FURROW ET AL., HEALTH LAW § 17-3, at 694 (1995) (noting that the majority rejected a right to die and focused instead on a right to refuse treatment). In her concurrence, Justice O'Connor stated:

> I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions and that the refusal of artificially delivered food and water is encompassed within that liberty interest.
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> . . . .
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> Requiring a competent adult to endure [procedures for artificial hydration and nutrition] against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

Cruzan, 497 U.S. at 287, 289 (O'Connor, J., concurring).

The majority balanced Ms. Cruzan's right to refuse medical treatment against the state's interest in the protection and preservation of human life.[78] The Court determined that Missouri had permissibly sought to advance its interests by adopting "a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state."[79] It reasoned that imposition of this procedural requirement was justified both by the importance of the rights involved and by the appropriateness of placing the risk of error on those attempting to terminate treatment, as an erroneous decision to withdraw treatment is more permanent than an erroneous decision not to withdraw treatment.[80]

The notion that the state has an interest in the preservation of human life independent of the patient's own interests led Justice Brennan[81] and Justice Stevens[82] to write spirited dissents. Justice Brennan, joined by Justices Marshall and Blackmun, rejected the clear and convincing evidence standard as unduly burdensome on

78. Although a patient does have a liberty interest in the right to refuse medical treatment, *see Cruzan*, 497 U.S. at 278, this right is not absolute according to the Court, *see id.* at 279. The state's asserted interests were "the protection and preservation of human life," *id.* at 280, and the safeguarding of personal choice on the decision to refuse life support, *see id.* at 281.

The interests most commonly asserted by states in right-to-die cases are: "(1) [T]he preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977) (distilling these four interests from other cases). The court in *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990), identified a fifth state interest: "[E]ncouraging the charitable and humane care of those whose lives may be artificially extended under conditions which have the prospect of providing at least a modicum of qualify living." *Id.* at 621.

The courts balance the states' interests against the patients' right to refuse treatment, irrespective of whether the patient bases the right to refuse treatment on informed consent, liberty interest, or both. *See, e.g., In re* Conroy, 486 A.2d 1209, 1221-22 (N.J. 1985) (right to refuse treatment based on informed consent); *Storar*, 420 N.E.2d at 71 (right to refuse treatment based on Constitution); *In re* Colyer, 660 P.2d 738, 743 (Wash. 1983) (en banc) (right to refuse treatment based on informed consent and the Constitution).

79. *Cruzan*, 497 U.S. at 284.

80. *See id.* at 283.

81. *See id.* at 301 (Brennan, J., dissenting).

82. *See id.* at 330 (Stevens, J., dissenting). In his dissent, Justice Stevens opined that the Constitution required the "State to care for Nancy Cruzan's life in a way that gives appropriate respect to her own best interests." *Id.* at 331 (Stevens, J., dissenting). He concluded that the "best interests of the individual, especially when buttressed by the interests of all related third parties, must prevail over any general state policy that simply ignores those interests." *Id.* at 350 (Stevens, J., dissenting). As Missouri had only an "abstract, undifferentiated interest in the preservation of life[,]" Ms. Cruzan's best interests would allow a decision to terminate nutrition and hydration. *Id.* at 331 (Stevens, J., dissenting).

patients and their families.[83] In dissent, Justice Brennan asserted that the majority had undervalued the liberty interest at stake and had given too much deference to the state interest, permitting the state to develop procedural law inconsistent with the effective exercise of the right to forgo life-sustaining treatment.[84] "[T]he State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment."[85]

Justice Brennan contended that a state could not interfere with an individual's fundamental right to forgo unwanted medical treatment unless the state employed means narrowly tailored to a sufficiently important state interest.[86] Although he recognized that Missouri had a legitimate state interest in Ms. Cruzan's welfare, Justice Brennan refused to recognize that this included a generalized interest in the protection of life.[87] Likewise, Justice Stevens observed:

> However commendable may be the State's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in abstraction from persons, and to pretend otherwise is

83. *See id.* at 302 (Brennan, J., dissenting); *see also* DWORKIN, *supra* note 19, at 216-17 (suggesting that the alleged intrinsic value of prolonging somebody's life cannot justify the government's preventing him or her from meeting death sooner if he or she reasonably prefer that course, and arguing that personal autonomy prevails if its exercise would not offend any rights or interest, but only detached values).

84. *See Cruzan*, 497 U.S. at 330 (Brennan, J., dissenting) ("Missouri and this Court have displaced [the patient's] own assessment of the processes associated with dying. They have discarded evidence of her will, ignored her values, and deprived her of the right to a decision as closely approximating her own choice as humanly possible.").

85. *Id.* at 313 (Brennan, J., dissenting). Disagreeing with the evidentiary standard as adopted and applied in the case, Justice Brennan addressed the claim that the state was justified in its allocation of the "risk of error" in a way that favored "the status quo," stating:

> An erroneous decision [that is, one that did not reflect the patient's true wishes] to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem, and result in complete brain death. An erroneous decision not to terminate life support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted. Even a later decision to grant him his wish cannot undo the intervening harm.

Id. at 320 (Brennan, J., dissenting).

86. *See id.* at 303 (Brennan, J., dissenting) (citing Zablocki v. Redhail, 434 U.S. 374, 388 (1978)).

87. *See id.* at 313 (Brennan, J., dissenting).

> not to honor but to desecrate the State's responsibility for protecting life.[88]

Although the Court recognized that the right to refuse treatment was not absolute, the *Cruzan* majority emphasized the important autonomy interest at stake in personal decisions concerning medical care and required the government to have some justification for burdening that decision-making.[89]

Cruzan strongly supports the proposition that the state and federal courts should robustly protect the right to refuse medical treatment, even if they are not constitutionally obliged to do so.[90] In fact, during the post-*Cruzan* era, virtually all courts have affirmed

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88. *Id.* at 356-57 (Stevens, J., dissenting). Justice Stevens further added that such a position is both "patently unconstitutional" and "dangerous" because it would allow states to prefer death for the incompetent in the same way that Missouri prefers life. *Id.* at 354 (Stevens, J., dissenting).

89. Because the state of Missouri was paying for Ms. Cruzan's care, and did not dispute its ability to do so, the Court never addressed whether the cost of the care was a relevant consideration. As one commentator has noted:

> The decision does not explain whether the person paying for the care . . . has any special status in determining what treatment should be provided. As a consequence, it does not determine whether a patient's family might be required to pay for extremely costly care believed to be entirely repugnant, but which the state requires as a matter of state law. In addition, the *Cruzan* decision does not determine whether a state may discontinue treatment of some patients, or choose not to commence it initially, because the state wishes not to pay for that treatment.

FURROW ET AL., *supra* note 77, § 17-2, at 692.

90. Chief Justice Rehnquist, writing for the *Cruzan* Court, conceded: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Cruzan*, 497 U.S. at 278. He repeatedly framed the protected interest as one in refusing treatment, and stated that it was "the forced administration of . . . treatment" that implicated the interest. *Id.* at 279.

Justice O'Connor's concurrence similarly stated that "the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the . . . Due Process Clause." *Id.* at 287-88 (O'Connor, J., concurring).

Justice Brennan, in dissent, joined by Justices Marshall and Blackmun, also emphasized a "fundamental right to be free of unwanted" treatment. *Id.* at 302 (Brennan, J., dissenting). He found an individual has "a right to evaluate . . . treatment . . . and . . . [decide] whether to subject oneself to the intrusion." *Id.* at 309 (Brennan, J., dissenting).

Likewise, Justice Stevens' dissent emphasized, too, that at stake was "[h]ighly invasive treatment." *Id.* at 339 (Stevens, J., dissenting). His broader language about "the liberty to make . . . choices constitutive of private life," *id.* at 341 (Stevens, J., dissenting), and his assertion that "[c]hoices about death touch the core of liberty," *id.* at 343 (Stevens, J., dissenting), is married to language on "rights pertaining to bodily integrity" and the right to be free from "physically invasive" procedures, *id.* at 342 (Stevens, J., dissenting).

the right of competent and incompetent patients to terminate medical treatment.[91]

B. Further Recognition of the Right to Refuse Medical Treatment—The Legislative Response

The publicity and concern generated by the *Cruzan* case brought public focus to the inadequacy of protection for the right to refuse treatment.[92] In response, Congress and state legislatures passed a variety of laws.[93] In 1990, the same year *Cruzan* was decided, Congress enacted the Patient Self Determination Act ("PSDA"),[94] a federal law requiring every hospital and nursing home to provide information about advance directives to all patients upon admission.[95] The PSDA further required institutions to develop policies addressing advance directives and to notify patients of the substance of these policies.[96]

State legislatures also began passing laws to help safeguard the right to refuse medical treatment.[97] Today, all states and the Dis-

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91. For a discussion of courts' recognition of the right to terminate medical treatment, see Larry Gostin, *Life and Death Choices After* Cruzan, 19 LAW MED. & HEALTH CARE 9 (1991), L. Gregory Pawlson, *Impact of the* Cruzan *Decision on Medical Practice*, 19 LAW MED. & HEALTH CARE 69 (1991), and Fenella Rouse, *Advance Directives: Where Are We Heading After* Cruzan?, 18 LAW MED. & HEALTH CARE 353 (1990).

92. *See* Elizabeth McCloskey, *Between Isolation and Intrusion: The Patient Self-Determination Act*, 19 LAW MED. & HEALTH CARE 80, 81 (1991).

93. For a comprehensive account of practices and laws governing the forgoing of life-sustaining treatment and surrogate decision-making, see 2 MEISEL, *supra* note 7, §§ 14.1-.10, at 349-69.

94. 42 U.S.C. §§ 1395cc(f), 1396a(w) (1994) (requiring health care providers participating in Medicaid or Medicare programs to inform competent adult patients, no matter what their reason for admission, about state laws on advance directives and to record any advance directives the patients may have). For further information on the PSDA, see, for example, McCloskey, *supra* note 92, and Margot L. White & John C. Fletcher, *The Patient Self Determination Act: On Balance, More Help Than Hindrance*, 266 JAMA 410 (1991).

95. *See* White & Fletcher, *supra* note 94, at 410.

96. Specifically, the PSDA requires that health care providers "maintain written policies and procedures" applicable to "all adult individuals receiving medical care" concerning "an individual's rights under State [statutory and common] law . . . to make decisions concerning such medical care, including the right to accept or refuse . . . treatment and the right to formulate advance directives." 42 U.S.C. §§ 1395cc(f)(1)(A)(i), 1396a(w)(1)(A)(i). Furthermore, at the time of admission to the health care facility, providers must give patients written information about their own policies concerning such directives. *See* Kelly C. Mulholland, *Protecting the Right to Die: The Patient Self-Determination Act of 1990*, 28 HARV. J. ON LEGIS. 609, 610 (1991). Although the PSDA does not create any substantive rights concerning medical decision-making, it recognizes that such rights exist independent of the Act, and more specifically that state law has created and acknowledged the existence of such rights. *See id.* at 628.

97. *See* 2 MEISEL, *supra* note 7, § 10.12, at 27 n.100 (collecting statutes); *id.* at 29 n.107 (collecting cases); Adam A. Milani, *Better Off Dead Than Disabled?:*

trict of Columbia have recognized the right to refuse treatment through the enactment of a variety of natural death statutes, including living will laws,[98] durable power of attorney for health care laws,[99] do not resuscitate ("DNR") order laws,[100] and health care surrogate laws.[101] In addition, medical organizations, such as the Joint Commission on Accreditation of Health Care Organizations ("JCAHO") now require that health care facilities create a mechanism to assist patients in the development of advance directives.[102]

Should Courts Recognize a "Wrongful Living" Cause of Action When Doctors Fail to Honor Patients' Advance Directives?, 54 WASH. & LEE L. REV. 149, 228 n.48 (1997) (providing a list of state living will and advance directive statutes); *see also* Charles P. Sabatino, *Death in the Legislature: Inventing Legal Tools for Autonomy*, 19 N.Y.U. REV. L. & SOC. CHANGE, 309, 313 (1991-1992) (discussing typical advance directive statutes).

98. Living wills are a misnomer in that they have nothing to do with donative transfers at death. Living wills are documents in which individuals state whether they desire life-sustaining treatment during the final stages of life, and if so, which treatments can be provided and under what circumstances. *See* David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1258 (1994). Generally living will statutes apply only to patients who are terminally ill or permanently unconscious and limit the patients' treatment withdrawal orders to artificial nutrition and hydration. *See id.* at 1259; *see also* Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 796-97 (stating that many such statutes were enacted in states that already created the same rights by judicial decision and the statutes merely provided a procedure for channeling these rights).

99. The durable power of attorney in health care statutes allow a patient to appoint an individual to make medical decisions on the patient's behalf in the event that the patient is unable to make medical decisions for his or herself. *See* Orentlicher, *supra* 98, at 1259.

100. DNR statutes allow patients to state that they do not want to receive cardiopulmonary resuscitation ("CPR") if they suffer cardiac arrest. *See id.* at 1260. CPR can be defined as measures "to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest." N.Y. PUB. HEALTH LAW § 2961(4) (McKinney 1993). These statutes limit the patient's treatment withdrawal orders to one kind of treatment, CPR. *See* Orentlicher, *supra* note 98, at 1260.

101. Health care surrogate laws give authority to family members and friends to make end-of-life decisions for permanently unconscious patients. *See* Orentlicher, *supra* note 98, at 1260-61. Patients can combine a living will and a durable power of attorney appointment. *See id.* at 1259. The patient instructs the appointed surrogate to follow the patient's instructions regarding treatment. *See id.* If the instructions in the living will fail to give enough guidance to the surrogate, the surrogate has the authority to make his or her best judgment concerning the patient's preferences. *See id.* These statutes often apply to patients with any medical condition and are less likely to restrict the types of treatments that the surrogate can order to be withdrawn. *See id.* at 1260. *See generally* Colleen M. O'Connor, *Statutory Surrogate Consent Provisions: An Overview and Analysis*, 20 MENTAL & PHYSICAL DISABILITY L. REP. 128 (1996) (analyzing issues common to many surrogate consent provisions).

102. *See* 1 JOINT COMM'N ON ACCREDITATION OF HOSPS., 1994 ACCREDITATION MANUAL FOR HOSPITALS 157 (1993); *see also* AMERICAN MED. ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS § 2.19 (1986) ("The preference of the individual should prevail when determining whether extraor-

The JCAHO designed directives such as living wills to give physicians information about an individual's treatment preferences.[103] All of the statutes and regulations demonstrate acceptance by a majority of the public of the right to refuse treatment.

One primary failing of these statutes is that most people, for understandable reasons, fail to complete formal advance directives.[104] A recent study estimates that between ten and twenty-five percent of the adult population in the United States has completed formal advance directives (with some estimates as low as five percent).[105] Additionally, as noted earlier, even if a patient is one of the few who has completed an advance directive, no guarantee exists that the doctor will obey the directive.[106] Indeed, some commenta-

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dinary life-prolonging measures should be undertaken in the event of terminal illness.").

103. To be accredited by the JCAHO, a health care institution must have a mechanism for facilitating the family or legal guardian's participation in making decisions for the patient throughout the course of treatment. *See JCAHO Requires Hospitals to Address Ethical Issues*, 7 MED. ETHICS ADVISOR 121, 123 (1991). This mechanism might be an ethics committee or an ethics consultant. *See id.* at 122; *see also* Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 886 (1991) (finding that the presence of advance directives did not increase likelihood that an individual's treatment wishes would be followed); Rhoden, *supra* note 35, at 430 ("The judiciary's reaction to those few cases in which patients or their families have sued for damages for nonconsensual treatment represents another instance of the legal system's uncritical endorsement of the medical profession's activist approach."). *See generally* Ezekiel J. Emanuel & Linda L. Emanuel, *Living Wills: Past, Present, and Future*, 1 J. CLINICAL ETHICS 9, 10 (1990) (discussing the history of the living will).

104. *See* DAVID W. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 277-78 (1981) (noting that most persons do not like to dwell on the prospect of their own death).

105. *See* HEALTH, EDUC. & HUMAN SERVS. DIV., U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO/HEHS-95-135, PATIENT SELF-DETERMINATION ACT: PROVIDERS OFFER INFORMATION ON ADVANCE DIRECTIVES BUT EFFECTIVENESS UNCERTAIN 8 (1995). The GAO study also reported that only 9% of patients under age 30 had an advance directive, but 35% of those over age 75 had one. *See id.* at 9; *see also* Elizabeth R. Gamble et al., *Knowledge, Attitudes, and Behavior of Elderly Persons Regarding Living Wills*, 151 ARCHIVES INTERNAL MED. 277, 278-79 (1991) (finding that although 39 of 75 elderly persons knew about living wills, none had executed one and only two had discussed their preference for limiting treatment with their physician); Martha Terry & Steven Zweig, *Prevalence of Advance Directives and Do-Not-Resuscitate Orders in Community Nursing Facilities*, 3 ARCHIVES FAM. MED. 141, 141 (1994) (reporting that in a study of eight rural community nursing facilities, less than one-third of patients had advance directives).

106. *See* Orentlicher, *supra* note 98, at 1281. To support his thesis that legislation has not changed physician behavior, Orentlicher cites several studies that found physicians often overrode living wills when they disagreed with the patients' choices, including providing undesired treatment when the physician felt it was appropriate. *Id.* at 1281-83; *see also* Panagiota V. Caralis & Jeffrey S. Hammond, *Attitudes of Medical Students, Housestaff, and Faculty Physicians Toward Euthanasia and Termination of Life-Sustaining Treatment*, 20 CRITICAL CARE MED. 683, 686-90 (1992) (discussing findings that medical personnel are

tors have noted that a financial incentive may keep certain people—those with health insurance—alive despite their wishes.[107] Finally, many of these statutes actually provide immunity to the physician who fails to obey an individual's living will or advance directive.[108] Thus, although these statutes buttress the ideal of patient autonomy, they do not adequately protect the patient's right to refuse treatment, and they fail to provide an incentive for the medical profession to respect a patient's considered exercise of the right to refuse treatment. Thus, the statutes fail to address the real problem—physician ability to ignore a patient's wishes.

C. *Physician Responses to the Right to Refuse Medical Treatment*

Despite the general acceptance of the right to refuse medical treatment shared by the public, the courts, and the legislatures, a large disjunction exists between what the law requires and the actual practice in the health care community.[109] Commentators have

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more likely to comply with passive euthanasia by failing to take action to prolong life, than with active euthanasia by taking deliberate action that causes death); Danis et al., *supra* note 103, at 886-87 (noting that a continuing problem with living wills is the unwillingness of many physicians to honor them).

The existence of physician resistance to living wills has also been a source of concern for the nurses who work with them. Two nursing journals have discussed nurses' responsibilities when physicians fail to honor patients' wishes. *See* Barbara Springer Edwards, *When a Living Will Is Ignored*, AM. J. NURSING, July 1994, at 64, 64-65; Cindy Hylton Rushton, *Ask the Experts*, CRITICAL CARE NURSE, Feb. 1993, at 61, 61-62.

107. *See generally* Bobinski, *supra* note 50, at 301-09 (discussing the theories underlying the relationship between economic incentives and the behavior of physicians); Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708 (1986) (discussing the loss to physician autonomy under managed care); Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 22-41 (1993) (discussing utilization review, financial risk-shifting, and effects of cost containment on quality of care).

108. *See* Gelfand, *supra* note 98, at 771-72 (noting that legislation providing for living wills frequently contains no penalty for physicians who do not honor them); Maggie J. Randall Robb, *Living Wills: The Right to Refuse Life-Sustaining Medical Treatment—A Right Without A Remedy?*, 23 U. DAYTON L. REV. 169, 173-77 (1997) (discussing the various types of immunity provided to physicians who fail to obey a patient's living will). In addition, all state living will and health care proxy statutes confer some sort of immunity from civil or criminal liability on health care providers who in good faith comply with a properly executed living will or the instructions of a proxy acting in accordance with the patient's wishes or in the patient's best interest. *See id.*

109. *See, e.g.*, Rhoden, *supra* note 35, at 420-29 (discussing the combination of factors that influence doctors to intervene on behalf of life); Sidney H. Wanzer et al., *Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 956 (1984) ("The physician's schooling, residency training, and professional oath emphasize positive actions to sustain and prolong life . . . ."); *see also* JAMES F. CHILDRESS, WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE 162-72 (1982) (discussing the conflicts between patients and phy-

examined this disjunction and have provided several reasons to explain physicians' reluctance to obey a patient's decision to exercise his or her right to refuse medical treatment.[110] First, some commentators have argued that fear of liability[111] affects physicians' willingness to follow advance directives which ask that life-sustaining treatment be withheld.[112] In addition, some commentators have noted that while physicians fear liability for failing to provide sufficient treatment, either no sanctions, or only mild sanctions, potentially apply to a physician who fails to abide by a patient's treat-

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sicians that arise when patients refuse medical treatment); KATZ, *supra* note 11, at 183-84 (discussing the pervasiveness of medical uncertainty); Joel M. Zinberg, *Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives*, 13 VT. L. REV. 445, 472 (1989) (reporting that 85% of California physicians surveyed knew no details about the state's living will statute).

110. *See* Zinberg, *supra* note 109, at 452. Zinberg, a physician and an attorney, interviewed 18 physicians in Vermont and 39 physicians in and around Los Angeles concerning their experiences with, and understanding of, advance directives. *Id.* He identified three reasons for physician failure to honor patients' advance directives regarding the withholding of treatment: "(1) [F]ear of liability; (2) the perception that directives interpose an unnecessary additional control over, and interfere with, the physicians' professional actions; and (3) the perception that directives implicitly question the physicians' judgment of the patients' best interest." *Id.* at 482.

111. *See* Renee M. Goetzler & Mark A. Moskowitz, *Changes in Physician Attitudes Toward Limiting Care of Critically Ill Patients*, 151 ARCHIVES INTERNAL MED. 1537, 1538 (1991) (finding that physicians were concerned about malpractice liability in deciding how to treat critically ill patients). The courts have been clear that liability should not be a serious concern for physicians and others who participate in a decision to forgo life-sustaining treatment if they act reasonably and in good faith. *See, e.g.*, *In re* Farrell, 529 A.2d 404, 415-16 (N.J. 1987) ("[N]o civil or criminal liability will be incurred by any person who, in good faith reliance on the procedures established in this opinion, withdraws life-sustaining treatment at the request of an informed and competent patient who has undergone the required independent medical examination described above.").

112. Physicians fear liability from withdrawing treatment even though there has never been a successful suit or prosecution against a physician or faculty member for removing treatment in accordance with the instructions of the patient or the instruction of the family. *See* Alexander Morgan Capron, *Legal and Ethical Problems in Decisions for Death*, 14 LAW MED. & HEALTH CARE 141, 142 (1986) ("If patients behaved as irrationally about treatment as physicians do about liability, the patients would be labeled incompetent."); Alan Meisel, *Legal Myths About Terminating Life Support*, 151 ARCHIVES INTERNAL MED. 1497, 1497-98 (1991) (stating that the small number of lawsuits brought involving termination of life support have all been resolved in favor of the physician); David Orentlicher, *The Right to Die After* Cruzan, 264 JAMA 2444, 2446 (1990) ("No person has ever been found liable for withdrawing life-sustaining treatment without court permission."); Robert F. Weir & Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients: Ethical Standards and Legal Liability for Physicians after* Cruzan, 264 JAMA 1846, 1852 (1990) ("Every court of final decision in every jurisdiction that has addressed the question of physician liability . . . has found physicians participating in the cases to be free from civil or criminal sanctions.").

ment decision.[113] Others have further speculated that physicians' failure to abide by refusal of treatment decisions reflects a basic reluctance to abandon the paternalistic model of decision-making.[114]

The commentators state that many physicians simply do not want to allow their patients to share actively in decision-making, or do not trust the patients to make these choices because the physicians believe that medical training and expertise should be required for every treatment decision.[115] In addition, many physicians mor-

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113. *See* Orentlicher, *supra* note 98, at 1293; Ben A. Rich, *The Values History: A New Standard of Care*, 40 EMORY L.J. 1109, 1117 (1991). For example, many advance directive statutes have severe penalties, including felony convictions, for those who might falsify or destroy a living will, but the actions of a physician who refuses to follow the terms of a patient's living will (or to refer the patient to another physician who is willing to comply with the directive) are only designated to be unprofessional conduct potentially subject to sanction by the State Medical Board. *See, e.g.*, COLO. REV. STAT. § 15-18-113 (1997). Although every state and the District of Columbia have enacted Natural Death Acts, only approximately seventeen states have any sanctions against physicians for a violation of a Natural Death Act, and of those, approximately six provide that the physician may be civilly or criminally liable. *See, e.g.*, ALASKA STAT. § 18.12.070(a) (Michie 1996); ARK. CODE ANN. § 20-17-209(a) (Michie 1991 & Supp. 1997); MONT. CODE ANN. § 50-9-206(1) (1997); TENN. CODE ANN. § 32-11-108(a) (1984 & Supp. 1997).

114. Hard paternalism accepts the proposition that it is morally justifiable for others to protect competent adults, against their will, from the harmful consequences of their fully voluntary choices. *See* Rich, *supra* note 113, at 1118 n.34. Joel Zinberg also reports:

> One interviewee volunteered that a substantial number of his colleagues dislike directives because they believe directives would curtail doctors' control of treatment. This observation is partially confirmed by the fact that many interviewees strongly opposed the interposition of formal ethics committees. Only three interviewees in each state agreed that other physicians or an ethics committee should be consulted.

Zinberg, *supra* note 109, at 482-83 (citations omitted). *See generally* KATZ, *supra* note 11 (explaining that hard paternalism is causing resistance to patient efforts to exercise some degree of autonomy in decisions about their medical treatment). For a detailed analysis of this type of physician behavior and the implications for patient autonomy, see David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101 (1992), and Ben A. Rich, *The Assault on Privacy in Health Care Decisionmaking*, 68 DENV. U. L. REV. 1 (1991).

115. Research studies have concluded that a significant number of physicians question the ability of patients to make decisions at the end of life. *See, e.g.*, Kent W. Davidson et al., *Physicians' Attitudes on Advance Directives*, 262 JAMA 2415, 2416 tbl.3 (1989) (indicating that 58.8% of responding doctors strongly agreed that "[a] potential problem with advance directives is that patients could change their minds about 'heroic' treatment after becoming terminally ill," and 32.4% strongly agreed that "[t]he training and experience of physicians gives them greater authority than patients in decisions about withholding 'heroic' treatment").

Certain members of society receive less respect for their decisions regarding medical treatment than others. Specifically, in assessing terminally ill patients' wishes to die, women's views are considered less credible. *See* Lisa C.

ally believe that they should not be engaged in helping people die.[116] However, as several legal commentators have observed, life-sustaining treatment decisions are value-based and do not require medical knowledge.[117]

Ikemoto, *Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487, 507 n.112 (1992). Professor Ikemoto quotes a study of appellate decisions in right to die cases that uncovered the following differences in the treatment of men and women:

> "The first difference is the courts' view that a man's opinions are rational and a woman's remarks are unreflective, emotional, or immature. Second, women's moral agency in relation to medical decisions is often not recognized. Third, courts apply evidentiary standards differently to evidence about men's and women's preferences. Fourth, life-support dependent men are seen as subjected to medical assault; women are seen as vulnerable to medical neglect."

Id. (quoting Steven H. Miles & Allison August, *Courts, Gender and "The Right to Die,"* 18 LAW MED. & HEALTH CARE 85, 87 (1989)); *see also* JOHN M. SMITH, WOMEN AND DOCTORS 9 (1992) (observing that whether it is "unnecessary surgery, inappropriate treatment or testing, lack of preventive care, lack of consideration in research, allocation of dollars, or simply being milked for dollars by physicians, women[,]" regardless of their race, wealth, or career, are abused by doctors more often than similarly situated men); Law, *supra* note 1, at 295 ("[T]he tradition of medical paternalism is particularly strong in relation to women patients; doctors often assume authority to determine what is in women's best interest without soliciting their views."); Lisa Napoli, *The Doctrine of Informed Consent and Women: The Achievement of Equal Value and Equal Exercise of Autonomy*, 4 AM. U. J. GENDER & L. 335, 338-39 (1996) ("Historically, experiments and operations have been performed on women without their consent. When consent is sought, women must often overcome gender-based stereotypes that impact on a doctor's decision to perform a procedure . . . ."). *See generally Black-White Disparities in Health Care*, 263 JAMA 2344 (1990) (discussing disparities in the treatment of blacks and whites); *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991) (discussing disparities in the treatment of men and women).

116. The literature is saturated with discussions on the moral aspects of helping people die. *See* Andrew Benton, *Personal Autonomy and Physician Assisted Suicide: The Appropriate Response to a Modern Ethical Dilemma*, 20 OHIO N.U. L. REV. 769, 778-86 (1994); Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—And Why These Reasons Are Not Convincing*, 12 ISSUES L. MED. 113 (1996); Alan A. Stone, *The Right to Die: New Problems for Law and Medicine and Psychiatry*, 37 EMORY L.J. 627 (1988); Eugenie Anne Gifford, Comment, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 UCLA L. REV. 1545, 1554-58 (1993).

117. *See* Orentlicher, *supra* note 98, at 1293; *see also* Bouvia v. Superior Court, 225 Cal. Rptr. 297, 305 (Ct. App. 1986). The court in *Bouvia* stated that:

> Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's [sic] alone.

Id.

Thus, from the viewpoint of a patient, or the patient's family, the right to refuse medical treatment is easily ignored.[118] Broad judicial proclamations and state statutory protections have failed to guarantee patients an effective right to medical self-determination.

II. ASSESSING THE FAILURE TO REMEDY BREACHES OF PATIENTS' TREATMENT REFUSALS

Because of the medical profession's failure to honor consistently the right to refuse treatment, patients have been kept alive against their wishes. At the same time, however, it has been very difficult for patients to recover damages for the violation of that right.[119] As noted earlier, a significant incentive for physician compliance with a patients' right to decisional autonomy has been the fear of litigation.[120] Various forms of tort law, including battery, medical malpractice, and the doctrine of informed consent (rather than administrative enforcement), have been the favored methods of enforcing patient treatment decisions.[121]

Although complaints alleging violation of the right to refuse treatment are in all other respects ordinary tort actions,[122] they pose a problem with regard to the issues of injury and damages.[123] Dam-

118. Realizing the difficulty of having a patients right to refuse treatment respected, some commentators have suggested some rather creative measures so that physicians will be unable to ignore the patients' request. *See, e.g.*, Marian Haglund Juhl, *A Tattoo in Time: I Want My Last Wish To Be Clearly Visible So It Will Be Honored by the Doctor Who Treats Me*, NEWSWEEK, Oct. 13, 1997, at 19, 19 (suggesting a DNR tattoo be placed on the body so that physicians cannot ignore a patients' wishes).

119. *See* Gasner, *supra* note 15, at 499 (stating, in 1992, that to date, no final monetary judgment had ever been awarded).

120. *See supra* notes 111-12 and accompanying text; *see, e.g.*, Oddi, *supra* note 35, at 634 (recognizing that physicians may be civilly or criminally liable if they withhold treatment); Rhoden, *supra* note 35, at 420, 422-23 (discussing how the fear of liability may effect medical decision-making). *But cf.* Hackleman, *supra* note 35, at 1362-63 (arguing that Ohio physicians disregard patient advance directives because Ohio law provides sanctions only when they act in bad faith and provides loopholes for those physicians who are prosecuted).

121. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 269 (1990) (finding that the "notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment," and that informed consent is a component of American tort law). In his dissent, Justice Brennan remarked that the right "to determine what shall be done with one's own body" is grounded in American tort law. *Id.* at 305 (Brennan, J., dissenting).

122. For a discussion of theories advanced in cases seeking damages for failure to honor a patient's refusal of treatment, see Gasner, *supra* note 15, at 504-12, and Addlestone, *supra* note 15, at 1267-72.

123. On the issue of damages, the plaintiff must allege that had the health care provided not been negligent nor willful, the plaintiff's right to refuse treatment would have been respected and the plaintiff would have died. *See* Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 227 (Ohio 1996). Thus, the person's injury is in living. To conclude that a plaintiff suffered an

ages in tort actions for violating the right must be based on the premise—unacceptable to many courts—that in some circumstances death is preferable to life, and that a life continued warrants damages.[124] A recent case demonstrates some of the difficulties that patients have in vindicating the right to refuse treatment.

In *Anderson v. St. Francis-St. George Hospital,*[125] the Ohio Supreme Court held that "there is no cause of action for 'wrongful living'" against a hospital for failure to follow a patient's DNR order.[126] In *Anderson*, Edward Winter, eighty-two, was admitted to the hospital in 1988, complaining of chest pain.[127] While in the hospital, Mr. Winter discussed the type of treatment he was to receive with his family doctor, Dr. Russo.[128] Dr. Russo understood Mr. Winter to say that "he wanted no extraordinary life-saving measures in the event of further illness."[129] Despite the fact that Dr. Russo recorded "no code blue" on his chart,[130] when Mr. Winter developed a potentially fatal irregular heart rhythm a nurse revived him by using a cardiac defibrillator.[131] Mr. Winter survived the ventricular fibrillation, but two days later suffered a stroke that left him permanently

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injury cognizable in tort, and to determine the measure of compensatory damages, the factfinder would have to compare the relative benefits of nonexistence to a life with disabilities. Courts have deemed this task impossible, refusing to make such calculations of injury (and the resulting valuations of life with and without disabilities), and thus have denied the availability of wrongful living suits to plaintiffs. *See* Hackleman, *supra* note 35, at 1369.

124. *See, e.g.*, Lininger v. Eisenbaum, 764 P.2d 1202, 1212 (Colo. 1988) (en banc) (concluding that "life, however impaired and regardless of any attendant expenses, cannot rationally be said to be a detriment" when compared to the alternative of nonexistence); Cockrum v. Baumgartner, 447 N.E.2d 385, 389 (Ill. 1983) (finding that human life cannot be a compensable harm, and stating that "the benefit of life should not be outweighed by the expense of supporting it"); Becker v. Schwartz, 386 N.E.2d 807, 812 (N.Y. 1978) (finding courts unequipped to handle the task of comparing the value of life in an impaired state and nonexistence).

125. 671 N.E.2d 225 (Ohio 1996).

126. *Id.* at 228.

127. *Id.*

128. *See* Anderson v. St. Francis-St. George Hosp., No. C-930819, 1995 WL 109128, at *1 (Ohio Ct. App. Mar. 15, 1995), *rev'd*, 671 N.E.2d 225 (Ohio 1996).

129. *Id.* During his conversation with Dr. Russo, Mr. Winter was competent and alert. *See id.* In addition, Mr. Winter's daughter "told Dr. Russo how such [life-saving] measures had been given to Winter's wife, which resulted in great misery and suffering for the remainder of her life." *Id.* While she was in intensive care, Mr. Winter's wife had "had her heart shocked and her chest beat and that Winter was very upset about those actions." *Id.* at *1 n.1. Winter subsequently told his daughter "'never to let anybody do that to him.'" *Id.*

130. *Id.* at *1. In his deposition testimony, Dr. Russo defined a "no code blue" order as "an organized process of resuscitating a patient and anything that would initiate that or any procedure that would be, that would occur during that process would be a resuscitative procedure, whether you whap them on the chest or whether you give medicine or whether you give an IV." *Id.*

131. *See id.*

paralyzed on his right side.[132] Mr. Winter incurred significant medical expenses for the constant medical attention that he required before his death nearly two years later.[133] Mr. Winter's estate alleged battery, negligence, and wrongful living claims,[134] asserting that by keeping Mr. Winter alive, the hospital caused him pain, suffering, emotional distress, disability, and medical damages, as well as other expenses.[135]

Chief Justice Moyer, writing for a majority of the Ohio Supreme Court, concluded from the facts that Mr. Winter had not suffered a compensable injury from the hospital's failure to follow his treatment request.[136] In his decision, Justice Moyer did not question Mr. Winter's right to make the treatment decision or his competency to do so. On the contrary, the court noted the constitutional significance of his right to make such a decision.[137] Justice Moyer stated:

> The plaintiff asserts a right to enforce an informed, competent decision to reject life-saving treatment. This claim is inextricably linked to, and arises directly out of, the right to die recognized in *Cruzan*. . . . Thus, in a "wrongful living" action, the plaintiff is asserting a liberty interest in refusing unwanted medical treatment. It is the denial of this liberty interest, when the medical professional either negligently or intentionally disregards the express wishes of a patient, that gives rise to the wrongful living cause of action.[138]

The court, however, concluded that Ohio did not recognize a tort claim for wrongful living.[139] Rather than examining Mr. Winter's

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132. *See id.* After his stroke, Mr. Winter, although aware of what was going on, "was unable to walk, was incontinent of urine, had difficulty speaking, and needed assistance in bathing and dressing." *Id.*

133. *See id.* at *2.

134. *See id.*

135. *See id.*

136. Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 228 (Ohio 1996).

137. *See id.* at 227 (noting that in a wrongful living action the plaintiff is asserting a constitutional liberty interest in refusing medical treatment).

138. *Id.*

139. *See id.* at 228. The wrongful living cause of action was first coined by A. Samuel Oddi. Oddi, *supra* note 35, at 637-43. The tort is essentially a battery or negligence claim associated with doctors who perform life-sustaining treatment against the wishes of a patient. *See id.* at 644. The wrongful living claim should be distinguished from claims for wrongful life, wrongful birth, and wrongful pregnancy. *See Anderson*, 671 N.E.2d at 227.

A wrongful life claim is brought by a child seeking damages against a health care provider for negligently failing to inform the parents of a possible hereditary defect, *see* Turpin v. Sortini, 643 P.2d 954, 955 (Cal. 1982) (en banc), or for failure to properly sterilize a parent, *see* Johnson v. University Hosp., 540 N.E.2d 1370, 1372 (Ohio 1989). A wrongful birth claim is brought by parents of an impaired child. WILLIAM L. PROSSER ET AL., CASES AND MATERIALS ON TORTS 441 (8th ed. 1998). Wrongful pregnancy deals specially with the failure of ei-

autonomy interest, the court focused on the difficulty of determining damages under a wrongful living cause of action, stating that "[t]here is perhaps no issue that better demonstrates the outer bounds of liability in the American civil justice system than this issue."[140]

In determining if damages should be awarded for the life-prolonging treatment, Justice Moyer stated that the issue presented was whether "'continued living' [is] a compensable injury."[141] The court held that life is not a compensable injury,[142] even if the plaintiff could show a breach of a duty resulting in prolongation of life.[143] The court noted that it had previously recognized the "'impossibility of a jury placing a price tag' on the benefit of life"[144] and concluded that: "There are some mistakes, indeed even breaches of duty or technical assaults, that people make in this life that affect the lives of others for which there simply should be no monetary compensation."[145]

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ther a birth control method or a sterilization procedure that led to the birth of an unwanted, albeit healthy, child. *See Johnson*, 540 N.E.2d at 1372.

140. *Anderson*, 671 N.E.2d at 228 (noting that damages, if any, must be based on a theory of negligence or battery). In rejecting the wrongful living tort, the Ohio Supreme Court reversed the appellate court's decision to allow recovery for all foreseeable consequences of the treatment, including pain, suffering, and emotional distress beyond that which Winter would have suffered had he not been resuscitated. *See id.* The difficulty in comparing death to a life with disabilities arises in the "wrongful life" suits as well. *See* Barry R. Furrow, *Impaired Children and Tort Remedies: The Emergence of a Consensus*, 11 LAW MED. & HEALTH CARE 148, 152 (1983); Horace B. Robertson, Jr., *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injures and Wrongful Life*, 1978 DUKE L.J. 1401, 1456.

141. *Anderson*, 671 N.E.2d at 227. In his concurring opinion, Justice Douglas stated:

> [If one] [a]ppl[ied] the positive connotation to an act which continues life, where death would have occurred without intervention, what damage could possibly ensue?
>
> . . . Assuming, for purposes of argument only, that the action of the hospital through its staff was negligence and, assuming further, that "damages" should be assessed as a result of the negligence, how could they be computed? Can the preservation of life (furthering life) even be amenable to the "damages" concept. I think not!

Id. at 229 (Douglas, J., concurring).

142. *See id.* at 228. Overall, it appears that the court did not believe that Mr. Winter had suffered any cognizable injury from the wrongful resuscitation.

143. *See id.* One could apply this reasoning to a person who interferes with the right to have an abortion. Indeed, in that case, the argument is stronger because the life saved is of one who did not assert a right to die.

144. *Id.* (quoting *Johnson*, 540 N.E.2d at 1378). Even the court's language reflects complete disregard for patient choice; life is a "benefit," regardless of the patient's view of the matter.

145. *Id.* For a critique of the view that an individual does not suffer harm by being kept alive against his will, see 1 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO OTHERS 91 (1984), which argues that it is reasonable to believe a person may be harmed by something even if he is unaware of it, like a man who does not know his wife is having an affair.

Justice Moyer then examined the possibility that Mr. Winter might have a claim based upon theories of negligence or battery.[146] He concluded, however, that causation was lacking for both a negligence and a battery claim.[147] In reaching this conclusion, the court applied an extremely narrow version of the "but for" causation test,[148] finding that the defibrillation did not cause Mr. Winter's subsequent stroke.[149] Even though the record indicated that Mr. Winter would have died without resuscitation and that a stroke was a foreseeable event,[150] the court held that "the record is devoid of any evidence that the administering of the resuscitative measures caused the stroke."[151]

Not surprisingly, the court also narrowly interpreted the battery claim to provide compensatory damages only if the patient had suffered physical harm.[152] Because Mr. Winter had suffered no physical damage due to defibrillation, "i.e., no tissue burns or broken bones,"[153] and because his estate had conceded that it was not seeking nominal damages,[154] the court concluded that there was no issue for the trial court to decide on remand and entered judgment for the hospital.[155]

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146. *See Anderson*, 671 N.E.2d at 227.

147. *See id.* at 229. For a discussion of how courts will often confuse the concepts of valuation and causation in tort cases involving preexisting conditions, see Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353, 1353-64 (1981).

148. *Anderson*, 671 N.E.2d at 227. Under an ordinary tort analysis, application of the "but for" test in a case where a doctor ignores a DNR order is straightforward. The plaintiff must demonstrate that the doctor's actions proximately caused the subsequent injury. *See* Anderson v. St. Francis-St. George Hosp., No. C-930819, 1995 WL 109128, at *5 (Ohio Ct. App. Mar. 15, 1995) (holding that a patient is entitled to compensation for foreseeable injuries proximately caused by the unwanted medical treatment), *rev'd*, 671 N.E.2d 225 (Ohio 1996). The appropriate test should be that but for the resuscitation, the injury would not have occurred. Without intervention from the doctors, the patient would have died and would not have been subjected to the pain and loss of dignity associated with her medical condition. *See id.* These conditions are foreseeable.

149. *See Anderson*, 671 N.E.2d at 229.

150. *See id.* at 228.

151. *Id.* ("Winter suffered the stroke because the nurse enabled him to survive the ventricular tachycardia. Because the nurse prolonged Winter's life, numerous injuries occurring after resuscitation might be foreseeable, but would not be caused by the defibrillation.").

152. *See id.* at 229. The court reasoned that Mr. Winter did not suffer a battery because any nonconsensual medical treatment the nurse performed was physically harmless. *See id.* The courts unduly narrow definition of harm results from its failure to find any harm from continued living. *See id.* at 228.

153. *Id.* at 229.

154. *See id.*

155. *See id.*

In addressing whether the lack of a remedy would have a detrimental impact on the important right to refuse medical treatment, Justice Moyer noted that this decision should not encourage unwanted life-saving treatment:

> Where a patient clearly delimits the medical measures he or she is willing to undergo, and a health care provider disregards such instructions, the consequences for that breach would include the damages arising from any battery inflicted on the patient, as well as appropriate licensing sanctions against the medical professionals.[156]

Three judges dissented and argued that Winter's estate should have been given an opportunity to prove that the hospital was negligent and that the health care providers violated Mr. Winter's constitutional rights.[157] The dissenters specifically argued that, "[c]ontrary to the assertion of the majority opinion, the plaintiff was not seeking to recover because Winter's life was prolonged. He was seeking to recover because the hospital staff failed to follow the instructions Winter had given them."[158] Furthermore, the dissent noted that Mr. Winter's estate might be able to prove that the hospital's negligence increased the likelihood that he would suffer a stroke,[159] and that his estate had sufficient evidence to survive summary judgment.[160] An expert witness had offered to testify that a stroke was immediately foreseeable if resuscitation occurred.[161] Therefore, the dissent asserted, the majority incorrectly granted summary judgment in favor of the defendant hospital.[162]

The *Anderson* court never explicitly questioned Winter's right to make the DNR decision or his competency to do so, nor did it examine the appropriateness of the hospital authorities' determinations.[163] Rather, the court focused on the difficulty or inappropri-

156. *Id.* at 229. Chief Justice Moyer apparently ignored the fact that under the *Anderson* holding, the court failed to provide any remedy.

157. *See id.* at 230 (Pfeifer, J., dissenting).

158. *Id.* (Pfeifer, J., dissenting).

159. *See id.* (Pfeifer, J., dissenting) (noting that Mr. Winter's experts should have been given an opportunity to testify about causation because a factual dispute existed about what had caused his stroke).

160. *See id.* (Pfeifer, J., dissenting).

161. *See id.* (Pfeifer, J., dissenting) ("Medical experts were prepared to testify on behalf of [Mr. Winter's estate] that 'it was medically foreseeable that he [Mr. Winter] would suffer a stroke during the days immediately following defibrillation.'").

162. *See id.* (Pfeifer, J., dissenting).

163. Indeed, the appellate court had specifically found that there could have been a violation of Mr. Winter's right and believed that, if such a violation was found, the only issue left to determine was whether the resuscitation caused his harm. *See* Anderson v. St. Francis-St. George Hosp., No. C-930819, 1995 WL 109128, at *3 (Ohio Ct. App. Mar. 15, 1995), *rev'd*, 671 N.E.2d 225 (Ohio 1996). The court stated, "To be more precise, Edward Winter gave express directives for his medical care which were ignored, either negligently or intentionally.

ateness of assigning a dollar amount for this type of harm,[164] at least partly because of the view that life is always preferable to death. As a result, the court thus undermined Winter's fundamental right.

Mr. Winter's case reveals the fatal flaw inherent in the right to refuse treatment. *Anderson* illustrates that failing to provide a remedy for the right to refuse medical treatment renders that right almost a complete nullity.[165] If physicians are given the power to administer life-saving or life-sustaining medical care, despite a patient's express refusal of that treatment within an advance directive, then the physician could subject the individual to any number of various medical treatments without consent.[166]

The court's deference results from its failure to fully acknowledge the scope and importance of the individual autonomy interest involved.[167] People make the decision to refuse or accept life-sustaining medical treatment for many reasons. Some want to avoid the final agony of a terminal illness; others want to press on, despite pain or disability, for myriad reasons.[168] Some people may have religious views for rejecting or accepting life-sustaining treat-

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His right to refuse treatment was expressly violated." *Id.* The Ohio Supreme Court never disputed this finding. Rather, it reversed the appellate court based on its bizarre application of the causation rules to Mr. Winter's case, resulting in the plaintiff's failure to show any connection between the defibrillation and Winter's subsequent stroke. *See Anderson*, 671 N.E.2d at 228.

164. *See Anderson*, 671 N.E.2d at 228.

165. *See* Rhoden, *supra* note 35, at 430 (arguing that the judiciary's unresponsiveness to wrongful living suits reflects "the legal system's uncritical endorsement" of the medical profession and its reluctance to sanction the medical profession's interventionist instincts).

166. Taking this argument to its logical end, an individual would have no cause of action even if the medical provider maliciously refused to withdraw treatment. Why should the law allow for such an abuse of medical authority on the sanctity of human life, particularly when the rest of society must account for similar conduct in other contexts, and may even be called on to support the individual's existence? The consequences of this argument are unreasonable. *See, e.g.*, United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965) (holding that physicians could provide blood transfusions to a hospitalized patient who was refusing them on religious grounds and concluding that "[t]he patient may knowingly decline treatment, but he may not demand mistreatment").

It is hard to imagine a case in which a patient's refusal of medical treatment that is necessary to save his life would not come within the court's definition of mistreatment. *See* SMITH, *supra* note 115, at 19 (noting that doctors have been granted tremendous power by society, including, perhaps, most importantly, the power to control the "flow of information").

167. *See, e.g.*, Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992) ("[C]hoices central to personal dignity and autonomy . . . [that] define one's own concept of existence, of meaning, of the universe, and of the mystery of human life . . . [also] define the attributes of personhood . . . ."); Michael H. v. Gerald D., 491 U.S. 110, 141 (1989) (Brennan, J., dissenting) (noting that in our system of government, "'liberty' must include the freedom not to conform").

168. *See* Rakowski, *supra* note 32, at 2094.

ment, or strong philosophical beliefs.[169] Others reject life because of the conditions on which it is offered: either in chronic and uncontrolled pain, in helpless dependence on other people, or in other ways considered degrading.[170] "Of course, people often have reasons other than self-interest for not wanting to live as long as [technologically] possible"[171]—they fear becoming an unnecessary burden on their family or friends, or perhaps they want to leave a larger estate.[172] Also present is some notion of dignity or self-respect.[173] "None of us," as Ronald Dworkin says, "wants to end our lives out of character."[174]

Part of the courts' deference to physicians appears to stem from a misplaced appreciation of the strong incentives already existing within the medical profession that support continued treatment of

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169. *See id.*

170. *See id.* at 2094. Some of these fears, as noted above, are well justified. Physicians do ignore the documented wishes of patients and all too often allow patients to live with uncontrolled pain. *See A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591, 1591-92 (1995). Studies of cancer patients have shown that over 50% suffer from unrelieved pain. *See* NEW YORK STATE TASK FORCE ON LIFE AND LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT at x-xi (1994). The New York Task Force also reports that "[d]espite dramatic advances in pain management, the delivery of pain relief is grossly inadequate in clinical practice. . . . Studies have shown that only 20 to 60 percent of cancer pain, is treated adequately." *Id.* at 43.

171. Rakowski, *supra* note 32, at 2094.

172. *See id.* at 2094-95; *see also* Gasner, *supra* note 15, at 514 ("Permitting payment for unwanted treatment provides a serious disincentive to honor patient choice. . . . If the provider is allowed to treat now, and decide later whether it was appropriate, and get paid in the interim, there is little incentive to expedite the court proceedings.").

173. *See* Rakowski, *supra* note 32, at 2095. Professor Meisel makes the point that the proclivity of the courts in treatment refusal cases to assert the state interest in an adversarial fashion against the liberty interest of the individual erroneously suggests that the state has no concern for the autonomy, self-determination, privacy, and bodily integrity of its citizens. 2 MEISEL, *supra* note 7, § 8.14, at 502. Personal dignity is a part of one's right of privacy. The right of bodily privacy led the United States Supreme Court to hold that it shocked its conscience to learn that a state, even temporarily, had put a tube into the stomach of a criminal defendant to recover swallowed narcotics. *See* Rochin v. California, 342 U.S. 165, 172 (1952).

174. DWORKIN, *supra* note 19, at 213. Dworkin observes:

> Decisions about life and death are the most important, the most crucial for forming and expressing personality, that anyone makes; we think it crucial to get these decisions right, but also crucial to make them in character, and for ourselves. Even people who want to impose their convictions on everyone else through the criminal law, when they and like-minded colleagues are politically powerful, would be horrified, perhaps to the point of revolution, if their political fortunes were reversed and they faced losing the freedom they are now ready to deny others.

Id. at 239.

the patient.[175] There is also the courts' discomfort with punishing a physician for saving a life.[176] However, an unbalanced inquiry that heeds only the rights of the medical profession does great harm to patient autonomy interests. Because health care for end-of-life treatment is expensive,[177] claimants have tried to refuse payment to nursing homes and hospitals when health care providers have ignored their right to refuse treatment and thus have subsequently accrued large medical bills.[178] As in *Anderson*, these claims have not been successful.[179] Monetary considerations,[180] current statutes, and case law do not supply incentives for hospitals and doctors to pro-

175. *See supra* notes 107-08 and accompanying text; *see also* Danis et al., *supra* note 13, at 884 (noting six instances where patients received more aggressive care than requested); Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455, 460-66 (1996) (reviewing the financial incentives for physicians to overtreat patients).

176. *See* Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 229 (Ohio 1996) (Douglas, J., concurring) ("Short of ignoring a living will or a durable power of attorney for health care, medical professionals should not be subjected to liability for carrying out the very mission for which they have been trained and for which they have taken an oath." (citations omitted)).

177. *See generally* Katharine R. Levit et al., *National Health Expenditures, 1993*, 16 HEALTH CARE FIN. REV. 247 (1994) (providing data on health care expenditures in the United States and noting, in particular, the high cost of end-of-life care).

178. *See, e.g.*, Grace Plaza, Inc. v. Elbaum, 588 N.Y.S.2d 853, 855 (App. Div. 1992). In *Grace Plaza*, a long-term care facility admitted Jean Elbaum in September, 1986, following hospital treatment for a stroke. *Id.* at 855. Approximately one year later, Mr. Elbaum informed Grace Plaza that his wife did not want to live in her present state and he demanded her feeding tube be withdrawn. *See id.* When Grace Plaza refused Mr. Elbaum's request, he stopped paying and Grace Plaza sued to recover payment for services it had rendered to Mrs. Elbaum. *See id.* In holding that Grace Plaza could recover, the court acknowledged that, "in light of our decision today, all health care providers in charge of competent patients will have an additional financial incentive to prolong the lives of such patients over the objections of the patients' families." *Id.* at 860. The court then stated:

> This may be true, and the potential evil which we see is that some beleaguered families may, regrettably, be forced to litigation . . . . What is not noted is that, if Mr. Elbaum's conduct in this case were condoned, health care providers would have an additional financial incentive to obey, without question, the orders of those conservators who might prematurely despair of their conservatee's recovery, or the orders of those conservators whose judgment might be tainted by motives less altruistic than Mr. Elbaum's. The potential evil we see resulting from this, i.e., the possible death of even one patient whose life might have been saved, is infinitely greater, in our view.

Id.

179. *See Anderson*, 671 N.E.2d at 228; *see also Grace Plaza*, 588 N.Y.S.2d at 860.

180. *See* Gilbert, *supra* note 10, at A1 (quoting Dr. Bernard Lo, director of the program of medical ethics at the University of California at San Francisco, as stating that doctors have strong financial incentive to put patients in intensive care rather than talk with them about alternatives.)

vide appropriate care to a patient who chooses to refuse medical treatment.[181] As one dissenting judge put it, such rulings "allow[ ] a nursing home to profit financially, while ignoring a patient's wishes, as it imposes its own ethical standards upon her."[182]

To be sure, some judges have indicated dissatisfaction with the lack of protection accorded the right to refuse treatment.[183] These jurists, however, are in the minority.[184] In most post-*Cruzan* decisions, courts, by denying a remedy, have effectively expanded the discretion of hospital authorities to ignore the patient's right to refuse medical treatment. At least arguably, these decisions have reduced the right to refuse treatment to a mere catch-phrase.

III. BEYOND THE CURRENT LAW: A NEW APPROACH

The prevailing judicial attitude does not adequately protect the right to refuse medical treatment. A new approach is necessary to ensure that in balancing the competing interests that underlie this dilemma, more respect is accorded the patient's autonomy interests.

A. *Autonomy Rights and Misguided Paternalism*

Notably absent from current jurisprudence in this area is the notion that protecting a patient's autonomy serves important social and civic values. Autonomy is firmly grounded in the Constitution's

181. *See* Wolf, *supra* note 175, at 457-58 (discussing how some commentators have remarked on the potential problems caused by the current system, which favors treatment over nontreatment); *see also* Don Colburn, *The Grace of a "Good Death" Escapes Many; Despite Living Wills and Other Innovations, Doctors Often Ignore or Don't Know Patients' Wishes*, WASH. POST, Dec. 5, 1995, at Z7 (quoting Joanne Lynne, director of the Center to Improve Care of the Dying, stating that one of the problems with the current system is that "it doesn't hold itself accountable for badly handled deaths. 'If I, as a doctor, do it badly, nothing comes down on me . . . . I get paid well. The family is left behind in grief and goes away. The patient's suffering counts for nothing.'").

182. *Grace Plaza*, 588 N.Y.S.2d at 862 (Rosenblatt, J., dissenting) (expressing great concern that Grace Plaza had "'ignored Mr. Elbaum's demands while simultaneously insisting upon payment for their undesired services.'" (quoting Elbaum v. Grace Plaza, 544 N.Y.S.2d 840, 847 (App. Div. 1989))).

183. *See, e.g., id.* at 868 (Rosenblatt, J., dissenting) ("The advancement of professional ethics to support the preservation of life has epitomized the medical profession, to the public benefit. However powerful those interests may be, they should not serve as a platform to afford compensation for unwanted services, rendered adversely to the patient's declared right to autonomy."); *Anderson*, 671 N.E.2d at 230 (Pfeifer, J., dissenting) (noting that the patient's administrator should have been allowed to show that the hospital failed to follow the patient's instructions with regard to his medical care).

184. In case law, it is the *dissenting* judges who have indicated dissatisfaction with the lack of protection accorded patients who refuse treatment. *See, e.g., Grace Plaza*, 588 N.Y.S.2d at 868 (Rosenblatt, J., dissenting); *Anderson*, 671 N.E.2d at 230 (Pfeifer, J., dissenting).

protection of individual liberty.[185] The Supreme Court has interpreted the Constitution to provide protection for liberty interests ranging from freedom of conscience and religion,[186] to autonomy in decisions affecting marriage, reproduction, and the raising of children.[187] The Court extrapolated from these liberty and autonomy interests to support a constitutional right to withdraw life support.[188]

Judicial decisions involving the right to refuse medical treatment do not demonstrate respect for individual autonomy.[189] Rather, the decisions reflect a misguided paternalism on the part of judges to allow doctors to extend life under almost any circumstances. Unfortunately, this view holds that the medical professional knows better than the patient, what is really in the patient's

185. The Supreme Court has frequently employed autonomy in constitutional jurisprudence. For example, it recognized the autonomy of the individual to choose the editorial content of publications in *Herbert v. Lando*, 441 U.S. 153, 178 (1979) (Powell, J., concurring), to represent themselves in court in *Faretta v. California*, 422 U.S 806, 817 (1975), and to control unwanted mail in *Rowan v. United States Post Office Department*, 397 U.S. 728, 736 (1970). In all these instances, the Court could have substituted liberty for autonomy without altering the import of these rights. In *Planned Parenthood v. Casey*, the Court also used liberty and autonomy indistinguishably, claiming "[t]he woman's constitutional liberty interest also involves her freedom to decide matters of the highest privacy and the most personal nature," and "[d]ecisional autonomy must limit the State's power to inject into a woman's most personal deliberations its own view of what is best." 505 U.S. 833, 915-16 (1992) (Stevens, J., concurring in part and dissenting in part).

In constitutional jurisprudence, both liberty and autonomy protect a woman's right to make important personal decisions for herself. *See id.* at 920 (Stevens, J., concurring in part and dissenting in part). Thus, the Court has identified autonomy with liberty for many decades, and recently has employed it to ground important personal rights.

186. *See, e.g.*, Wallace v. Jaffree, 472 U.S. 38, 52 (1985) (reaffirming that individual freedom of conscience protected by the First Amendment embraces the right to select any religious faith or none at all); West Virginia State Bd. of Educ. v. Barnette, 319 U.S. 624, 642 (1943) (holding that requiring school children to salute the flag "invades the sphere of intellect and spirit" protected by the First Amendment).

187. *See, e.g.*, Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (privileging "matters so fundamentally affecting a person as the decision whether to bear or beget a child"); Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925) (protecting the right of parents "to direct the upbringing and education of children under their control"); Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (defining liberty to include the right to choose an occupation to "acquire useful knowledge, to marry," and to raise children).

188. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring) ("[A] protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions and . . . the refusal of artificially delivered food and water is encompassed within that liberty interest.").

189. *See supra* Part II.

best interest.[190] Perhaps because the stakes are so high, the government intervenes on the side of the medical professional to ensure that the individual does not make a horrible mistake.

This Article maintains that the medical profession should not be trusted to make these fundamental choices for individuals.[191] The medical provider is not any wiser or more knowledgeable about how a person chooses to exercise fundamental liberties than the person him or herself.[192] Likewise, the government, including the judiciary, should not automatically side with the doctor when making a determination in the right to die cases. Even though the legislatures and courts are often inept at determining what is truly in a person's best interest,[193] they should not rely solely on the medical profession to make that determination. There is a natural tendency to belittle the costs we inflict on others in pursuing our values or interests. As Rochefoucauld warned, "[w]e are all strong enough to endure the misfortunes of others."[194] Permitting the medical profession to dictate decisions about fundamental liberty interests for the majority of citizens violates individual autonomy.[195]

Moreover, because the right to refuse medical treatment is such a deeply personal choice that implicates each person's philosophical or religious views on life and death,[196] medical providers should not

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190. *See, e.g.*, Grace Plaza, Inc. v. Elbaum, 588 N.Y.S.2d 853, 861-64 (App. Div. 1992) (Rosenblatt, J., dissenting) (reasoning that in maintaining medical treatment, Grace Plaza was not acting out of fear of liability because the patient's wishes were unclear; rather, it was imposing its own ethical beliefs on the patient).

191. As Justice Brandeis observed: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding." Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

192. *See, e.g.*, Planned Parenthood v. Casey, 505 U.S. 838, 920 (1992) (Stevens, J., concurring in part and dissenting in part) ("Part of the constitutional liberty to choose is the equal dignity to which each of us is entitled.").

193. For example, the Court has upheld cases in which the judiciary has denied certain autonomy and moral choices to individuals. *See, e.g.*, Buck v. Bell, 274 U.S. 200 (1927) (upholding state-forced sterilization); Plessy v. Ferguson, 163 U.S. 537 (1896) (upholding the separate but equal doctrine), *overruled by* Brown v. Board of Educ., 347 U.S. 483 (1954); Dred Scott v. Sandford, 60 U.S. (19 How.) 393 (1856) (invalidating the congressional act freeing slaves in certain territories), *superseded by* U.S. CONST. amends. XIII, XIV.

194. DUKE DE LA ROCHEFOUCAULD, THE MAXIMS OF THE DUKE DE LA ROCHEFOUCAULD ¶19, at 35 (Constitutine FitzGibbon trans. 1957).

195. *See* Philip G. Peters, *The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy*, 45 UCLA L. REV. 673, 693 (1998) ("When unconsented care is administered, the patient, not the court, suffers the agony of prolonged death, the impoverishment of further medical and support expenses, and the frustration and indignity of lingering beyond her time and burdening her family.").

196. *See* DWORKIN, *supra* note 19, at 215 (noting that the idea that "human life is sacred or inviolable is both more complex, and open to different and com-

interfere and attempt to impose their own view regarding life's absolute sanctity.[197] Again, the courts must uphold the patients' autonomy interests in cases in which doctors have ignored their wishes. Instead, the courts have acted to uphold the values and viewpoints of the medical profession.[198] Under the Constitution, transient majorities may not impose their own moral choices on others, absent a compelling governmental reason for doing so, if the legislation implicates a fundamental liberty interest.[199] The Founders believed that government should not define popular morality or displace the citizenry's ability to make moral decisions.[200] Indeed, the belief was that individuals would become better citizens if they had the freedom to make difficult moral choices about how to live their lives.[201] As Professor Martin Diamond suggests, the Founders

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peting interpretations"); *see also* BEAUCHAMP & CHILDRESS, *supra* note 38, at 157 ("Any attempt to make life—understood as a set of vital logical processes—unconditionally good in itself is a 'vitalism' that should be rejected in favor of a view that life is only conditionally good."). As another commentator has aptly recognized:

> [L]ife is not merely a matter of being alive in some purely biological or bio-physical sense of the term. Something can be alive or be capable of life in the latter sense, yet not alive or capable of life in the sense implied in or by the expressions mentioned above . . . . [A] full life . . . is one full of significant experience and activity, and we apply it in the first instance only to human beings.

Henry David Aiken, *Life and Right to Life*, *in* ETHICAL ISSUES IN HUMAN GENETICS 173, 173 (Bruce Hilton et al. eds., 1973).

197. *See* Casey, 505 U.S. at 851 ("[T]he most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."); Michael H. v. Gerald D., 491 U.S. 110, 141 (1989) (Brennan, J., dissenting) (arguing that "[i]n a community such as ours, 'liberty' must include the freedom not to conform").

198. *See supra* notes 17-24 and accompanying text.

199. *See Casey*, 505 U.S. at 850 ("Our obligation is to define the liberty of all, not to mandate our own moral code.").

200. *See* Richard Hofstadter, *The Founding Fathers: An Age of Realism*, *in* THE MORAL FOUNDATIONS OF THE AMERICAN REPUBLIC 73, 76 (Robert H. Horwitz ed. 1977) ("One thing that the Fathers did not propose to do, because they thought it impossible, was to change the nature of man to conform with a more ideal system."); Kimberly Sharron Dunn, Note, *The Prize and the Price of Individual Agency: Another Perspective on Abortion and Liberal Government*, 1990 DUKE L.J. 81, 88 (noting that the original 13 colonies rejected the Aristolean view of government and based the legitimacy of their revolution on a belief taken from John Locke's political philosophy that "when political power inappropriately intrudes on individual liberty the people have the right to abolish it"). For another discussion of the necessary role of the state in making people more autonomous, see Jennifer Nedelsky, *Reconceiving Autonomy: Sources, Thoughts and Possibilities*, 1 YALE J.L. & FEMINISM 7 (1989).

201. *See* RUTH W. GRANT, JOHN LOCKE'S LIBERALISM 194 (1987) ("And to be truly free, he must be guided by his own reason. It is not enough to do the reasonable thing. A man must have reached the conclusion on his own that it is the reasonable thing to do."); JOHN STUART MILL, ON LIBERTY 3-19 (Currin V. Shields ed., Bobbs-Merrill Co. 1956) (1859) (distinguishing between moral and political power in the project of making human beings good, and carving out a

were confident that at least among some people, "the full range of the higher human virtues would have suitable opportunity to flourish . . . from religion, education, family upbringing, and simply out of the natural yearnings of human nature" but not by use of the law.[202] Thus, the government generally should remain neutral to competing views of the good or of morality.[203]

The pluralism of American society provides a third argument against government paternalism.[204] Because of the differing beliefs that underlie each person's value system, it is essential that an individual's choice be respected.[205] Decisions about when to die, just

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large domain of individual liberty that should not be disturbed by coercion or moral condemnation); *see also* United States v. Eichman, 496 U.S. 310, 318-19 (1990) ("We are aware that desecration of the flag is deeply offensive to many . . . . [But p]unishing desecration of the flag dilutes the very freedom that makes this emblem so revered, and worth revering."); Texas v. Johnson, 491 U.S. 397, 419 (1989) ("The way to preserve the flag's special role is not to punish those who feel differently about these matters. It is to persuade them that they are wrong.").

202. Martin Diamond, *Ethics and Politics: The American Way*, *in* THE MORAL FOUNDATIONS OF THE AMERICAN REPUBLIC, *supra* note 200, at 39, 71; *see also* H.L.A. HART, LAW, LIBERTY, AND MORALITY 58 (1963) ("[W]hat is valuable here [in the domain of morality] is *voluntary* restraint, not submission to coercion, which seems quite empty of moral value."). There is very little evidence to support the idea that morality is best taught by fear of legal punishment. Morality is certainly taught and sustained without legal punishment, and where morality is taught with it, there is the standing danger that fear of punishment may remain the sole motive for conformity.

203. *See* RONALD DWORKIN, A MATTER OF PRINCIPLE 191 (1985) ("[E]quality supposes that political decisions must be, so far as is possible, independent of any particular conception of the good life, or of what gives value to life. . . . [T]he government does not treat [citizens] as equals if it prefers one conception to another . . . ."); JOHN RAWLS, POLITICAL LIBERALISM 191-94 (1993) (defining the necessity of neutrality much more vigorously than Dworkin, as well as, offering a more philosophical understanding of neutrality).

204. *See* James Madison, Debates (June 12, 1788), *in* 3 THE DEBATES IN THE SEVERAL STATE CONVENTIONS ON THE ADOPTION ON THE FEDERAL CONSTITUTION, AS RECOMMENDED BY THE GENERAL CONVENTION AT PHILADELPHIA, IN 1787, at 328, 330 (Jonathan Elliot ed., William S. Hien & Co., 2d ed. 1996) (1891) ("[T]he utmost freedom . . . arises from that multiplicity of sects which pervades America, . . . for where there is such a variety of sects, there cannot be a majority of any one sect to oppress and persecute the rest."). Other writers have added that the maintenance of multiple faiths is the best protection of the core guarantee of liberty of conscience. *See, e.g.*, ELISHA WILLIAMS, THE ESSENTIAL RIGHTS AND LIBERTIES OF PROTESTANTS: A SEASONABLE PLEA FOR THE LIBERTY OF CONSCIENCE, AND THE RIGHT OF PRIVATE JUDGMENT, IN MATTERS OF RELIGION, WITHOUT ANY CONTROUL FROM HUMAN AUTHORITY 7 (n.p. 1744).

205. *See, e.g.*, THE FEDERALIST NO. 10, at 32 (James Madison) (John P. Kaminski & Richard Leffler eds., Madison House 1989). Madison stated that in a federalist republic:

> The influence of factious leaders may kindle a flame within their particular States, but will be unable to spread a general conflagration through the other States: a religious sect, may degenerate into a political faction in a part of the Confederacy; but the variety of sects

as surely as decisions about conception,[206] should often reside outside the domain of majoritarian legislative bodies.

Although medical professionals may have legitimate reasons for rejecting a patient's decision to refuse medical treatment, this does not justify abandoning the values and principles articulated in *Cruzan*[207] and *Casey*.[208] The medical profession should not be permitted to act with impunity.[209] Doctors and other care-givers should recognize that patients have the right to exercise choice in these matters, and the courts should ensure that health care professionals respect patients' values and preferences when making treatment decisions.[210]

Notwithstanding the deficiencies of the paternalistic approach reflected in the *Anderson* decision, a deferential approach towards physicians has some support in the academic community. A number of scholars have argued that medical doctors must be given wide latitude in their administration of a patient's care.[211] They argue that medical professionals are in the best position to judge what care patients should receive and, therefore, should not be overly inhibited in exercising their discretion.[212] Defenders of the status quo

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> dispersed over the entire face of it, must secure the national Councils against any danger from that source . . . .

Id.

206. *See* Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 541 (1942) (holding that the Constitution forbids a state from sterilizing certain criminals not only because the proposed punishment would do "irreparable injury" to bodily integrity, but because "[m]arriage and procreation" concern "the basic civil rights of man").

207. 497 U.S 261 (1990); *see supra* Part I.A.

208. 505 U.S. 833 (1992); *see also* Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984) (stating that carrying deference to a physician's best medical judgment to its extreme "could effectively nullify those privacy rights recognized in *In re Quinlan*," and permit a "physician [to] circumvent the express wishes of a terminal patient by waiting to act until the patient was comatose and critical"). *But see* Barnes v. Glen Theater, Inc., 501 U.S. 560, 575 (1991) (Scalia, J., concurring) (arguing that moral opposition to nudity supplies a rational basis for permitting a state to prohibit it).

209. *See* Grace Plaza, Inc. v. Elbaum, 588 N.Y.S.2d 853, 860-61 (App. Div. 1992) (Rosenblatt, J., dissenting) ("Grace Plaza is on record as having discounted utterly the patient's wishes to die naturally, proclaiming itself to be the transcendent arbiter of the patient's artificial life support.").

210. Obviously, just as medical professionals should not be allowed to completely discount a patient's decision to accept or refuse medical treatment, not all patient decisions should automatically receive protection from the courts. For example, if a provider insists on treatment because the patient might get better and the patient or the patient's family objects with no basis, this might present a circumstance when a physician might be permitted to displace the patient or his or her family as decision-maker. Instead, each patient's situation should be evaluated on a fact-specific basis, providing balanced protection for patient wishes.

211. *See* Milani, *supra* note 97, at 168 & n.85 (citing scholars who suggest that physicians are in the best position to make decisions for patients).

212. *See id.*

may argue that cases like *Anderson* provide needed flexibility to health professionals, allowing them to best determine what care the patient should receive.[213]

On the other hand, several academicians have questioned the minimal protection accorded to patients under the current test and have put forth a variety of proposals for reform. Some commentators have advocated providing patients with new common law actions.[214] Others have suggested that legislative action may be the only hope for increased protection of patient autonomy.[215]

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213. *See id.*

214. *See generally* Gasner, *supra* note 15 (arguing for the need for a tort remedy to impose financial penalties for the failure to respect a patient's right to refuse treatment); Knapp & Hamilton, *supra* note 35 (arguing for a need for a legal remedy if a patient's right to refuse treatment is violated); Milani, *supra* note 97, at 223 n.348 (1997) (interpreting Willard Pedrick as "suggesting that the use of tort principles will be more successful in assuring the right to die than the enactment of statutes"); Miller, *supra* note 15 (arguing that courts must give broader recognition to right-to-die damage actions); Oddi, *supra* note 35 (arguing for the need for a wrongful living tort to permit compensation for violations of the right to refuse treatment); Willard H. Pedrick, *Dignified Death and the Law of Torts*, 28 SAN DIEGO L. REV. 387, 390 (1991) (noting that the "familiar principles of tort law can be enlisted to better assure that unwanted life support measures either will not be used, or will be withdrawn when that is the wish of the patient or the patient's agent"); Peters, *supra* note 195, at 731 (arguing that a right to compensatory damages will foster respect for patients' wishes); Addlestone, *supra* note 15, at 1267-72 (noting that "[a]s a matter of common sense, noncompliance with a patient's wishes should give rise to some type of liability"); Richard P. Dooling, Comment, *Damage Actions for Nonconsensual Life-Sustaining Medical Treatment*, 30 ST. LOUIS U. L.J. 895 (1986) (arguing that a physician or hospital that fails to respect a patient's right to die should be liable in damages); Hackleman, *supra* note 35 (noting the need for a wrongful living cause of action if a patient's right to die is violated).

215. Several commentators have suggested that the Patient Self-Determination Act ("PSDA") might give rise to a cause of action when a hospital fails to inform a patient of his rights under state law or of its policy regarding the removal of life support. *See* Gasner, *supra* note 15, at 518; Addlestone, *supra* note 15, at 1278-79. *But see* Mulholland, *supra* note 96, at 627 n.81 (1991) (arguing that by delegating to health care providers the role of information distributor, and not information advocate, the PSDA eliminates the possibility of malpractice suits).

The only case to date on the issue, however, held that the PSDA does not include a private right of action. *See* Asselin v. Shawnee Mission Med. Ctr., 894 F. Supp. 1479, 1485 (D. Kan. 1995). Some states classify the failure of a health care provider to comply with an advance directive, and to transfer a patient to a facility where treatment will be withdrawn, as a criminal misdemeanor, but such a failure must be willful or in bad faith. *See, e.g.*, ARK. CODE ANN. § 20-17-209(a) (Michie 1991); CAL. HEALTH & SAFETY CODE § 7191(a) (Deering 1998); MONT. CODE ANN. § 50-9-206(1) (1997); NEB. REV. STAT. § 20-411(1) (1997); NEV. REV. STAT. ANN. § 449.660(1) (Michie 1996). Other states classify the failure to comply with a directive as unprofessional conduct, allowing state licensing authorities to penalize a health care provider. *See, e.g.*, D.C. CODE ANN. § 6-2427(b) (1995); HAW. REV. STAT. § 327D-11(c) (1993); MO. ANN. STAT. § 459.045(1) (West 1992); N.J. STAT. ANN. § 26:2H-78(a) (West 1996); OKLA. STAT. ANN. tit. 63, § 3101.11(a) (West 1997); R.I. GEN. LAWS § 23-4.11-

Many of these scholars have noted that fear of civil or criminal actions for suspending treatment provides a strong incentive for health care providers to resuscitate patients at all costs.[216] They argue that a similar fear of legal liability for unwanted treatment might counterbalance this effect because the only legally prudent thing to do would be to act in good faith, consistent with the patient's wishes, and in accordance with good medical practice.[217] Thus, they assert that courts and legislatures should provide greater protection for the individual autonomy interest.[218]

B. Resuscitating the Right to Refuse Treatment

Plaintiffs bringing actions for a violation of the right to refuse treatment have relied on a plethora of theories, ranging from intentional infliction of emotional distress to constitutional violations.[219]

9(a) (1996); S.C. CODE ANN. § 44-77-100 (West 1976 & Supp. 1997); TENN. CODE ANN. § 32-11-108(a) (1984 & Supp. 1997); UTAH CODE ANN. § 75-2-1112(3) (1993); WIS. STAT. ANN. § 154.07(1)(a)(3) (West 1997).

216. *See, e.g.*, George J. Annas, *Reconciling* Quinlan *and* Saikewicz*: Decision Making for the Terminally Ill Incompetent*, 4 AM. J.L. & MED. 367, 386 n.48 (1979). A few living will statutes expressly provide the basis for a civil cause of action, but either limit the damages available or require that the health care provider's refusal to follow the advance directive be in bad faith. *See* ALASKA STAT. § 18.12.070(a) (Michie 1994) (allowing "civil penalty not to exceed $1000 plus the actual costs associated with the failure to comply with the order or declaration, and this shall be the exclusive remedy at law"); NEB. REV. STAT. § 20-402(1) (1997) ("Unjustifiable violation of a patient's direction shall be a civil cause of action maintainable by the patient or the patient's next of kin. Remedy in law and equity may be granted by a court of competent jurisdiction."); TENN. CODE ANN. § 32-11-108(a) (1984 & Supp. 1997) ("Any health care provider who fails to make good faith reasonable efforts to comply with the preceding procedure as prescribed by the attending physician shall be civilly liable and subject to professional disciplinary action . . . .").

Additionally, section 10 of the Uniform Health-Care Decisions Act ("UHCDA") includes a provision on "statutory damages." UNIF. HEALTH-CARE DECISIONS ACT § 10, 9 U.L.A. 309 (1988 & Supp. 1998). Damages are available only for an intentional violation of the act and can range from $500 to "actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees." *Id.* § 10(a). A comment to the section indicates that the drafters chose civil damages rather than criminal penalties "out of a recognition that prosecutions are unlikely to occur." *Id.* § 10 cmt. It also indicates that the statutory damages "do not supersede but are in addition to remedies available under other law." *Id.*

217. *See* Annas, *supra* note 216, at 386 n.48.

218. *See id.*

219. *See, e.g.*, Ross v. Hilltop Rehab. Hosp., 676 F. Supp. 1528, 1530-31 (D. Colo. 1987) (claiming civil rights violations under 42 U.S.C. § 1983 and a private cause of action under section 504 of the Rehabilitation Act); Bouvia v. County of Los Angeles, 241 Cal. Rptr. 239 (Ct. App. 1987) (claiming violation of civil rights); Bartling v. Glendale Adventist Med. Ctr., 229 Cal. Rptr. 360 (Ct. App. 1986) (pleading five damage theories including battery, violation of state and federal constitutional rights, breach of fiduciary duty, intentional infliction of emotional distress and conspiracy); McVey v. Englewood Hosp. Ass'n, 524

Despite this, few complaints have been successful.[220] It appears that the courts,[221] and not existing tort law,[222] have been the principal roadblock to recovery. Courts have been reluctant to extend existing tort principles from other cases to this area.[223] Although many decisions acknowledge the existence of these principles, courts have not generally applied them in the same fashion as they would in other personal injury cases.[224] This has occurred because the courts

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A.2d 450, 452 (N.J. Super. Ct. App. Div. 1987) (claiming negligent infliction of emotional distress).

A discussion of the § 1983 cause of action in the context of refusal of treatment is outside the scope of this Article, but can be found in SHELDON H. NAHMOD, CIVIL RIGHTS AND CIVIL LIBERTIES LITIGATION: THE LAW OF SECTION 1983, 156-57 (3d ed. 1991).

220. *See* Gasner, *supra* note 15, at 499 (noting that no reported cases exist in which damages have been awarded for the unwanted imposition of life-sustaining treatment).

221. Nancy Rhoden argues that the courts have adopted the medical presumption of continued treatment: "Although it may seem like folly to question the near-sacrosanct medical and legal injunction to 'err on the side of life,' . . . the medical presumption for treatment incorporates not only the overt and noble commitment to saving life, but also covert and highly questionable psychological, technological, and professional drives." Rhoden, *supra* note 35, at 420. Rhoden describes the professional self-concept of physicians: "Persons intensively socialized to be decisive, action-oriented healers may find it extraordinarily difficult to refrain from taking action." *Id.* at 421.

Further, with the increased availability of technology that can have some effect, the medical ethic more than ever includes an attitude that "it is always better to over-diagnose and over-treat than to fail to intervene." *Id.* This sentiment, in turn, is supported by faith in medical power and fear of litigation. *See id.* at 422-23. Therefore, the impact of technology itself on the practice of medicine breeds a technological imperative. *See id.* at 423-27; *see also* Daniel Callahan, *Can We Return Death to Disease?,* 19 HASTINGS CENTER REP. supp. at 4 (1989) ("We will need a dampening of the push for medical progress, a return to older traditions of caring as an alternative to curing, and a willingness to accept decline and death as part of the human condition (not a notable feature of American medicine).").

222. *See* Peters, *supra* note 195, at 675 (arguing that a doctrinal difficulty exists for courts adopting the wrongful living tort due to the development and rejection of the prenatal tort remedy, wrongful life). *But see,* Hackleman, *supra* note 35, at 1359 (arguing that wrongful life tort provides support for the further development and adoption of the wrongful living tort).

223. *See, e.g.,* Grace Plaza, Inc. v. Elbaum, 588 N.Y.S.2d 853, 860-61 (App. Div. 1992) (Rosenblatt, J., dissenting) (stating that Grace Plaza completely ignored the patient's wishes, believing that it knew what was best for the patient). While courts have failed to provide a remedy, they have not been entirely forthcoming as to why the plaintiff does not deserve a recovery. Instead, as noted above, the courts manipulate tort principles so that it appears the plaintiff has no legal case. *See supra* note 21 and accompanying text. For a discussion of a judge's duty to make the reasoning behind his or her decisions and assumptions in those decisions explicit, see Katharine T. Bartlett, *Feminist Legal Methods,* 103 HARV. L. REV. 829, 862-63 (1990).

224. For example, in *Anderson v. St. Francis-St. George Hospital,* 671 N.E.2d 225, 228 (Ohio 1996), the court applied an incorrect causation analysis in order to find that the hospital's defibrillation did not cause Mr. Winter's injury. *See supra* notes 148-55 and accompanying text.

have discounted patients' right to refuse treatment[225] and have failed to find harm when the patients remain alive.[226] The courts' timidity effectively renders the right to refuse treatment a nullity.

To be sure, potential liability acts as a strong incentive for the medical profession to respect an individual patient's autonomy rights. Perhaps new theories, such as the wrongful living tort,[227] will be used to vindicate patients for the violation of this right. Like its predecessors, however, a new tort theory will do nothing if courts are not willing to implement fully the tort principles that already exist in the medical area.

As noted above, courts appear to take questionable positions concerning the autonomy interest involved and the power of the medical profession.[228] Some courts may object to remedying a denial of the right to refuse treatment based on a religious belief that life is the gift of a higher power, and thus individuals have no right to dispose of their lives.[229] In addition, courts may be reluctant to provide a remedy when they are unsure that the individual properly exercised the right to refuse treatment.[230] This last concern, however, confuses the required procedural protections that may be necessary to protect all patients from overly cost-conscious health care provid-

225. *See, e.g., Grace Plaza*, 588 N.Y.S.2d at 861-64 (Rosenblatt, J., dissenting) (reasoning that in maintaining medical treatment, Grace Plaza was not acting out of fear of liability because the patient's wishes were unclear; rather, it was imposing its own ethical beliefs on the patient).

226. *See, e.g., Anderson*, 671 N.E.2d at 229 (holding that the prolongation of life cannot be a legal detriment).

227. For commentators who argue for the acceptance of a wrongful living cause of action, see, for example, Knapp & Hamilton, *supra* note 35, at 261-63, Oddi, *supra* note 35, and Hackleman, *supra* note 35.

228. *See supra* notes 17-24 and accompanying text.

229. *See* JOHN LOCKE, TWO TREATISES OF GOVERNMENT 375 (Peter Laslett ed., Cambridge Univ. Press 1963) (1690) (arguing that the will of God is the preservation of mankind and that human sanctions are not valid against this); PAUL RAMSEY, ETHICS AT THE EDGES OF LIFE: MEDICAL AND LEGAL INTERSECTIONS 146 (1978) (characterizing life as a gift from God, a perception based on the Judeo-Christian heritage that has influenced medicine toward a pro-life stance, and that choosing any course of action or inaction that results in death would be to throw the gift of life back in the face of the giver). *But see* Webster v. Reproductive Health Servs., 492 U.S. 490, 563-72 (1989) (Stevens, J., concurring in part and dissenting in part) (asserting that a state's religious reasons for a law are inappropriate considerations).

230. Courts have legitimate fears that some patients might be killed against their wishes or that some patients might be coerced into consenting to the removal of care. *See* Yale Kamisar, *On the Meaning and Impact of Physician-Assisted Suicide Cases*, 82 MINN L. REV. 895, 906 (1998) (citing Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 287-92 (1990) (O'Connor, J., concurring)).

ers[231] with the legal remedy that should be provided to any patient who properly exercises her right and is ignored.

1. The protection of fundamental liberties

A review of other fundamental rights shows that courts have upheld the protection of individual liberties and autonomy rights, even when they disagree with how the individual exercises those rights or see potentially harmful consequences following such an exercise.[232] For example, imagine the case of a woman who goes to her doctor and requests an abortion. If the doctor, because of a moral objection to abortion, deceived the woman into believing that an abortion would endanger her life, surely the woman would have a cause of action for malpractice or fraud.[233] This would be true even though the doctor may have been right in the sense that, after the fact, the new mother proves to be quite happy to have the child. In the abortion context, the physician is not permitted to overrule a patient's decision, even if the physician feels the patient's decision is morally wrong.[234]

The right to vote belongs to all individuals.[235] An individual can vote for whomever he or she pleases, even if a person votes for a candidate who objectively does not appear to serve his or her best interests.[236] Similarly, we protect freedom of speech even though it

231. *See Cruzan*, 497 U.S. at 280 (upholding the imposition of a clear and convincing evidence standard as a legitimate procedural protection on the right to refuse medical treatment).

232. *See, e.g.*, Cohen v. California, 403 U.S. 15, 25 (1971) ("We cannot lose sight of the fact that, in what otherwise might seem a trifling and annoying instance of individual distasteful abuse of a privilege, these fundamental societal values are truly implicated.").

233. *See, e.g.*, McCandless v. State, 162 N.Y.S.2d 570, 575-76 (App. Div. 1957) (awarding $2000 in damages for an abortion performed on mental patient without her consent, though pain was less than labor would have been and mental condition was improved as a result of abortion).

234. *See* Lawrence J. Nelson et al., *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest"*, 37 HASTINGS L.J. 703, 724 (1986); Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1990-94 (1986).

235. *See* Reynolds v. Sims, 377 U.S. 533, 562 (1964) (recognizing the right to vote as fundamental and as one of those rights that is "preservative of other basic civil and political rights"); Wayne v. Venable, 260 F. 64, 66 (8th Cir. 1919) (holding that the right to vote "is so valuable that damages are presumed from the wrongful deprivation of it").

236. For example, suppose that Kathleen Willey, a women who has publicly stated that President Clinton sexually assaulted her, voted for him in the 1996 Presidential election. Knowingly voting for a person whom you believe has attempted to take advantage of you might appear to be irrational and wrong. However, no government official judges a person's vote and determines whether it is in his or her best interest.

may lead to violence,[237] and we protect freedom of religion even though some will join cults.[238]

Thus, even when courts disagree with the manner in which people exercise some of their most valuable rights, and view the exercise as harmful, the courts do not limit the individual's ability to make these choices. Nor do courts withhold a meaningful remedy from persons denied these rights. Part of an individual's autonomy interest is the ability to make what, with twenty-twenty hindsight, proves to be a poor, or even wrong, decision.[239] Obviously, the consequences of making an incorrect choice with regard to the right to refuse medical treatment are tremendous. A necessary incident of freedom and individual liberty, however, is permitting individuals to make mistakes, even life and death mistakes.

2. Applying tort principles

Application of basic tort principles to remedy a violation of the right to refuse medical treatment is straightforward if one respects the autonomy interests at stake. A battery action for unauthorized medical treatment has existed for many years. The *Cruzan* Court noted its potential availability as a remedy for violation of a patient's right to refuse medical treatment.[240] A physician who knowingly ignores a patient's advance directive would be liable for battery and should be subject to damages for the harm caused by the wrongful resuscitation or failure to obey the patient's desire for treatment to be withdrawn.[241] Depending on the jurisdiction, the

237. *See, e.g.*, DOUGLAS A. HIBBS, JR., MASS POLITICAL VIOLENCE: A CROSS-NATIONAL CAUSAL ANALYSIS 8 (1973) (commenting that unpopular political speeches have caused riots in which people have died); WILLIAM W. VAN ALSTYNE, INTERPRETATIONS OF THE FIRST AMENDMENT 34-35, 107 n.38 (1984) (citing several Supreme Court political speech cases to support the theory that extreme and offensive speech is valuable because of its ability to grab attention and force debate on difficult issues).

238. *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205, 214 (1972) (setting forth the general test to be applied in First Amendment free exercise challenges). *See generally*, Leon Wieseltier, *Strait Was the Gate*, NEW REPUBLIC, Apr. 21, 1997, at 42 (discussing the Heaven's Gate cult and the death of its members who believed that they would find their maker on a comet).

239. *See* DWORKIN, *supra* note 19, at 222. Although the contribution that autonomy gives to the value of a person's life is undisputed, it is a separate question whether that value is enhanced by a liberty interest to make immoral or wrong choices. Joseph Raz argues forcefully that in many cases it is not. JOSEPH RAZ, THE MORALITY OF FREEDOM 380-81, 410-12 (1986).

240. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 269 (1990) (discussing the common law view that a physician's nonconsensual touching may constitute a battery).

241. *See* Anderson v. St. Francis-St. George Hosp., No. C-930819, 1995 WL 109128, at *5 (Ohio Ct. App. Mar. 15, 1995), *rev'd*, 671 N.E.2d 225 (Ohio 1996). This holding was reversed on appeal because of a failure to show any connection between the defibrillation and Winter's subsequent stroke. *See Anderson*, 671 N.E.2d at 228; *see also* Marcus L. Plante, *An Analysis of "Informed Con-*

plaintiff may have to show that she has suffered harm to recover compensatory damages,[242] but should be entitled to nominal damages and even punitive damages without such proof.[243] Some jurisdictions will presume harm and award damages even though no physical harm has been shown.[244] Under either analysis, the damages resulting from battery when a patient specifically has asked not to be resuscitated should include all future medical expenses: If the patient had not been resuscitated, she would not be alive to incur these expenses.[245] Even if no evidence exists that the resuscitation caused the subsequent medical problems, by definition, those problems can be said to have resulted from the health care provider's actions. In addition, the plaintiff should be permitted to recover for any costs related to end-of-life care, emotional damages (including the deprivation of the right to make a refusal of treatment choice and the pain and suffering of the current illness), and perhaps even the continued anguish and indignity of remaining alive but grossly impaired without hope of recovery.[246]

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sent", 36 FORDHAM L. REV. 639, 666 (1968) (stating that in order to recover damages the plaintiff only need show that what was done was substantially different from that to which consent was given); Leonard L. Riskin, *Informed Consent: Looking For the Action*, 1975 U. ILL. L. FORUM 580, 583-84 (stating that in medical informed consent cases, the "plaintiff may recover damages for the wrongful touching, for all injuries flowing from the touching, and if the court or jury considers it appropriate, for punitive damages").

242. *See* 2 DAN B. DOBBS, DOBBS LAW OF REMEDIES, § 7.3(2), at 305 (2d ed. 1993) (discussing torts, such as battery, and noting that some jurisdictions permit recovery of presumed damages in situations where one of these torts has been committed but little or no economic or physical harm results); *see, e.g.*, Sutherland v. Kroger Co., 110 S.E.2d 716, 724 (W. Va. 1959) ("[D]amage flows from the wrongful act, itself injurious to another's rights, although no perceptible loss or harm accrues therefrom . . . .").

243. *See* 2 DOBBS, *supra* note 242, § 7.3(2), at 305 (discussing that some jurisdictions do not use the presumed damages rule and, thus, may leave the plaintiff without a substantial recovery, but that these jurisdictions generally will emphasize other immeasurable damages, such as emotional distress or punitive damages, to ensure a full recovery).

244. *See, e.g.*, Carey v. Piphus, 435 U.S. 247, 266-67 (1977) (holding that students who were deprived of their procedural due process rights may collect nominal sums in the absence of proof of damages); Wayne v. Venable, 260 F. 64, 66 (8th Cir. 1919) (noting that substantial damages are presumed in voting rights cases); Lamb v. Cartwright, 393 F. Supp. 1081, 1085 (E.D. Tex. 1975) (allowing recovery for unlawful arrest); Miles v. F.E.R.M. Enters., 627 P.2d 564, 568 (Wash. Ct. App. 1981) (holding that in a civil rights action for race discrimination damages are presumed).

245. To prove compensatory damages in a battery action, a plaintiff must demonstrate that "but for" the defendant's tortious conduct, she would not have suffered the harm or offense. *See* KEETON ET AL., *supra* note 44, § 41, at 205.

246. Likewise, if a health care provider negligently fails to respect a patient's right to refuse treatment, he or she should be held liable if the patient can prove the elements of a negligence cause of action. *See, e.g.*, WILLIAM L. PROSSER, HANDBOOK ON THE LAW OF TORTS § 18, at 102 (4th ed. 1971) (stating that a doctor is liable if he acts without the consent of the patient or a court order). In a negligence case, the analysis requires the identification of a duty and

Once courts accept that prolonging life against a person's wishes is a harm, proving damages should not be difficult. As noted above, in many jurisdictions, under either a battery or negligence cause of action, plaintiffs must provide proof of their injuries relating to harm allegedly caused by prolonging an individual's life against his or her will in order to receive compensation.[247] This system is imperfect like any system that attempts to compensate human injury with money.[248] Some deserving plaintiffs may be denied recovery because they cannot prove that their harm is real. Other plaintiffs may be overcompensated in the imprecise process of attaching a monetary value to mental anguish and the loss of dignity. This proof of harm requirement should satisfy those who are worried about speculative damages and the potential harm to the medical profession from the risk of huge liability awards. Moreover, requiring proof of damages or harm helps to weed out unmeritorious cases at an early stage. If the plaintiffs cannot plead specifically the type of harm they have suffered, they may have failed to state a cause of action and their suit should be dismissed.[249] In addition, providing proof of injury provides appellate courts with a record against which they can independently evaluate the merits of any award.[250] Rather than speculate about possible damages, or the lack

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breach of that duty, as well as proof of causation and damages. *See* Menifee v. Ohio Welding Prods., 472 N.E.2d 707, 710 (Ohio 1984).

A breach of duty arises when a health care provider negligently interferes with a person's right to refuse medical treatment. Consider first the factual scenario in *Anderson* where the nurse negligently failed to read the plaintiff's DNR order on his medical chart. *Anderson*, 671 N.E.2d at 226. A reasonable person employed as a nurse should be familiar with a patient's chart; thus, the nurse has a duty to read the chart. Once the nurse should have known of the patient's wish to refuse life-sustaining treatment, the nurse's duty shifts to abide by the patient's wishes. Her negligence in resuscitating the plaintiff constitutes a breach of that duty.

Furthermore, causation and damages should not be complicated to assess. As Professor Oddi stated when describing a negligence cause of action for the right to refuse treatment, "the loss to the patient asserting the right to die is the prolongation of life. Expressed in terms of causation, the question becomes: But for the . . . interference with the right to die, that is, the rendering of treatment, was the life of the patient prolonged?" Oddi, *supra* note 35, at 661. Thus, the measure of damages should be reflective of how long the life was prolonged after the time when death would be expected to occur had no treatment been rendered. *See id. See generally* CHARLES T. MCCORMICK, HANDBOOK ON THE LAW OF DAMAGES 260-74 (1935) (discussing the standard of proximate cause in torts).

247. *See supra* note 242 and accompanying text.

248. *Cf.* Friedman, *supra* note 22, at 741-42 (asserting that the familiar notion that money can make someone whole is somewhat dubious where physical injuries are concerned).

249. *See* Jones v. Clinton, 990 F. Supp. 657, 678-79 (E.D. Ark. 1998) (dismissing Paula Jones' sex discrimination and outrage claims for failure to show harm from alleged unwelcome sexual advances from the then-Governor of Arkansas).

250. *See* Miller, *supra* note 15, at 189.

thereof, appellate courts will have proof of actual damages and thus be unable to impose their viewpoint of what damages should be awarded.

Awarding financial damages in these cases would better balance the power relationship among the patient, family, and health care provider.[251] In addition, in a traditional tort action for battery, plaintiffs are entitled to a trial by jury.[252] The public abhorrence of such over-treatment of patients, and the widespread public fear of being kept alive against one's will, are likely to make the possibility of trial by jury extremely unattractive to the medical profession.[253]

Thus, in contrast to the current approach that denies a tort recovery for violations of the right to refuse medical treatment,[254] courts should apply basic tort principles without flinching at the fact that a person has chosen death over an undesirable existence. For example, in *Estate of Leach v. Shapiro*,[255] the court held that Ms. Leach's estate could recover on the basis of a battery theory for her wrongful resuscitation.[256] The court analogized the case to other battery cases and treated Ms. Leach's claim like all other medical batteries.[257]

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251. *See* Peters, *supra* note 195, at 693 (arguing that providing compensation to the plaintiff can ensure greater protection of the plaintiff's right to refuse treatment); Stephanie S. Gold, Note, *An Equality Approach to Wrongful Birth Statutes*, 65 FORDHAM L. REV. 1005, 1011 (1996) (noting that the denial of a patient's right to sue and collect damages for the wrongful birth tort relives the doctor from "the threat of liability and the corollary burden of full disclosure").

252. *See* Knapp & Hamilton, *supra* note 35, at 270-71 (discussing the benefits to the plaintiff of a trial by jury in a wrongful living cause of action).

253. The recent acquittals of Jack Kevorkian demonstrate the public's belief that the law does not reflect the importance of end-of-life decisions. In 1994 and 1996, Michigan juries acquitted Jack Kevorkian for his participation in assisted suicides of terminally ill individuals. *See* Kelly L. Anderson, *Kevorkian Acquitted for the Second Time*, ASSOCIATED PRESS, Mar. 8, 1996, *available in* 1996 WL 4415582 (discussing Kevorkian's second acquittal); David Margolick, *Kevorkian's Trial Has Come to an End but Debate on Assisted Suicide Hasn't*, N.Y. TIMES, May 4, 1994, at A16 (commenting that Jack Kevorkian was acquitted by a Michigan jury of charges that he illegally assisted the suicides of terminally ill individuals because jury members determined that he had not intended the deaths but only that he intended to relive pain and suffering).

254. *See supra* Part II.B.

255. 469 N.E.2d 1047 (Ohio Ct. App. 1984) (recognizing potential of recovery for non-consensual administration of life-sustaining treatment). In *Leach*, Ms. Leach's estate sued after hospital personnel placed her on a respirator without her or her family's consent following an in-hospital resuscitation which resulted in her being left in a chronic vegetative state. *Id.* at 1052. In reversing the lower court's dismissal of the claim, the appellate court concluded that a patient may recover for violation of her right to refuse medial treatment. *See id.*

256. *Id.* at 1052.

257. *See id.* at 1052-53. Although the appellate court permitted Ms. Leach's estate to bring her claim, the trial court dismissed the patient's action for lack of sufficient evidence on the issue of informed consent and damages to her family. *See Akron Doctor Goes to Trial in 'Right to Die' Case*, N.Y. TIMES, Sept. 18,

Likewise, in *Bouvia v. Superior Court*,[258] a case requesting only injunctive relief, the court properly noted the importance of the individual's autonomy interest.[259] Ms. Bouvia suffered from cerebral palsy, quadriplegia, and arthritis.[260] Although she was not terminally ill and, in fact, doctors expected her to live for another fifteen to twenty years, her medical condition was not subject to cure and her physical ailments permanently and irreversibly impaired her ability to function.[261] While at the hospital, Ms. Bouvia became so ill that she stopped eating because she could no longer swallow without vomiting.[262] No longer wishing to be in pain or be completely dependent on others for all bodily functions, the plaintiff executed a written instruction stating her unwillingness to undergo further medical treatment.[263] Nonetheless, the hospital, concerned that her weight loss might reach life-threatening levels, intentionally placed her on life-sustaining treatment, inserting a feeding tube into Ms. Bouvia against her express written instructions.[264]

The *Bouvia* court recognized her right to have the nasogastric tube withdrawn and prohibited its replacement on the basis of her right to refuse medical treatment, even that which is life-sustaining.[265] The court reasoned that the decision concerning one's medical treatment belongs to each person.[266] The court correctly stated: "It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. . . . It is a moral and philosophical decision that, being a competent adult, is her's [sic] alone."[267]

1985, at A17; *Judge Clears Doctor Who Refused Death Plea*, N.Y. TIMES, Sept. 19, 1985, at A24.

258. 225 Cal. Rptr. 297 (Ct. App. 1986).

259. *Id.* at 301.

260. *See id.* at 299-300.

261. She was in constant pain, completely unable to care for herself in any manner, and was dependent upon someone for "feeding, washing, cleaning, toileting, turning, and helping her with elimination and other bodily functions." *Id.* at 300.

262. *See id.*

263. *See id.* at 300 n.2.

264. *See id.* at 300.

265. *Id.*

266. *See id.* at 305. After winning the court's approval to have her feeding tube removed, Ms. Bouvia elected not to remove the tube and is presently still alive. *See* WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 586 (5th ed. 1998).

267. *Bouvia*, 225 Cal. Rptr. at 305. The *Bouvia* court goes to great lengths to make sure that Ms. Bouvia's suffering is well-understood. *Id.* at 304 ("In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding.").

I agree that courts must be careful not to permit the refusal of medical treatment only when they agree with it. The decisions should turn on whether

Ms. Bouvia most likely would also have had a battery claim, as the hospital and doctors subjected her to intentional harmful conduct against her written wishes.[268] Specifically, Ms. Bouvia had a right to refuse sustaining medical treatment. She had exercised this right and memorialized her election so that she would not have to endure pain, suffering, and loss of dignity.[269] When health care providers intentionally inserted a feeding tube into Ms. Bouvia's body without her consent, their intentional and nonconsensual touching caused a harmful condition that she had the right to prevent.[270] Thus, a patient in this situation could commence an action for battery and seek monetary damages for medical expenses from unwanted treatment.

The approach provided in the *Leach* and *Bouvia* cases reflects respect for the rights of patient autonomy. A successful tort action results in a court ordering the defendant to pay a certain sum of money to the victim of his negligent or intentional wrongful conduct. This award both compensates the plaintiff for her damages and deters the defendant and others from engaging in tortious behavior.[271]

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the patient was competent to make a decision, or has properly designated a surrogate to make a decision based on the individual's values and beliefs.

Some commentators have asserted that the court permitted Ms. Bouvia to withdraw her life support only after concluding that her decision was rational and "correct." *See generally* Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 281 (1977) (asserting that in situations where the court is looking to the reasonableness of the patient's decision, whether explicitly so or not, "if patients do not decide the 'wrong' way, the issue of competency will probably not arise"); Lois Shepherd, *Sophie's Choices: Medical and Legal Responses to Suffering*, 72 NOTRE DAME L. REV. 103, 124 (1996) (asserting that the recognition of a right to refuse medical treatment "that is based solely in concerns about the individual's liberty or autonomy would not require the court to discuss at length, as this court did, the diminished quality of Bouvia's life").

268. Section 13 of the Restatement (Second) of Torts provides: "An actor is subject to liability to another for battery if (a) he acts intending to cause a harmful or offensive contact with the person of the other or a third person . . . , and (b) a harmful contact with the person of the other directly or indirectly results." RESTATEMENT (SECOND) OF TORTS § 13 (1965). A comment to the Restatement states:

> [A] surgeon who performs an operation upon a patient who has refused to submit to it is not relieved from liability by the fact that he honestly and, indeed, justifiably believes that the operation is necessary to save the patient's life. Indeed, the fact that medical testimony shows that the patient would have died had the operation not been performed and that the operation has effected a complete cure is not enough to relieve the physician from liability.

Id. § 13 cmt. c.

269. *See Bouvia*, 225 Cal. Rptr. at 300 & n.2.

270. *See id.* at 300-01. From the moment that the feeding tube was inserted, Ms. Bouvia experienced pain and a loss of dignity that she would not have endured had she been allowed to die. *See id.* at 299.

271. *See* PROSSER, *supra* note 246, § 4, at 22-23.

Although permitting patients to recover in tort obviously exposes health care providers to more potential risks, health care providers may still be able to assert affirmative defenses.[272] Moreover, health care providers who act in good faith will have no reason to fear a battery or negligence claim because of the protections provided in living will and proxy statutes.[273] This is certainly an improvement over the current approach that protects the rights of the health care provider, permitting the provider to err on the side of life when faced with a request to end life-prolonging treatment with which he or she disagrees.[274] If courts applied this approach to violations of the right to refuse treatment, they would acknowledge the health care provider's duty not to treat without consent and allow the trial process to determine whether the duty was breached.[275] Thus, a damage award in these cases will act as a deterrent to health care providers.

Recognition of patients' rights and corresponding physician duties in this area should expand if courts apply tort principles in the conventional manner to right to refuse treatment cases. Unfortunately, this may take a significant amount of time. As demonstrated by the *Anderson* opinion, many years may pass before such claims routinely survive defendants' summary judgment motions.[276] Thus, some legislative modifications of the current law may be required.[277]

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272. Such affirmative defenses might include, for example, that the health care provider reasonably believed that the patient making the demand was incompetent at the time, or that the decision was being made on behalf of an admittedly incompetent patient by some family members while other family members disagreed. *See, e.g.*, Ross v. Hilltop Rehab. Hosp., 676 F. Supp. 1528, 1533-34 (D. Colo. 1987).

273. All state living will and health care proxy statutes confer some sort of immunity from civil and/or criminal liability to health care providers who in good faith comply with a properly executed living will or the instructions of a proxy acting in accordance with the patient's wishes or in the patient's best interest. *See* 2 MEISEL, *supra* note 7, § 11.17, at 111 n.102 (listing living will statutes); *id.* § 12.46, at 196 n.216 (listing proxy statutes).

274. *See supra* Part II.

275. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 901 cmt. c. (1965) (stating that providing a remedy for legal violations best serves the deterrence function of tort law).

276. *See, e.g.*, Peters, *supra* note 195, at 711-17 (arguing that the popularity of partial recovery for these actions may slow down the progress of providing a full remedy for these violations).

277. A new legislative remedy may be required if courts continue to provide immunity to health care providers who ignore a patient's right to forego medical treatment. This can be accomplished through the modification of the current advance directive statutes to include greater protection for the right to refuse treatment and providing specific guidance on damage awards for those who ignore this important right. By providing immunity from civil liability, the courts have given health care providers the power to override a patient's constitutional right to refuse medical treatment. This result clearly undermines the purpose and goal of that right.

C. *Responses to Those Who Think the Current Scheme Is Fine*

Some commentators argue that the courts should not adopt a new approach to right to refuse treatment damages actions.[278] Even though courts have failed to grant plaintiffs complete relief for violations of their right to refuse treatment, the commentators claim that the partial recovery currently available through the tort law and the potential for professional licensing suspensions are sufficient to protect an individual's right to refuse medical treatment.[279] They oppose the development of new remedies—either a wrongful-living tort or new statutes—because, in their view, courts are not equipped to handle many of the questions posed by these situations (e.g., whether a patient should be permitted to choose death).[280] They also note that awarding damages would be antithetical to "'the very nearly uniform high value which the law and mankind has placed on human life, rather than its absence.'"[281]

Moreover, at least one commentator has expressed concern that any additional "[l]egal recognition that a disabled life is an injury would harm the interests of those most directly concerned, the handicapped."[282] Professor Milani asserts that permitting persons

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Although legislative action can always speed up tort reform, generally it is necessary when the current legal system provides no remedy, or where the courts are reluctant to expand the law to apply to new areas. Neither of these situations applies in the right to refuse treatment cases, so hope exists that courts will apply traditional tort remedies.

278. *See, e.g.*, Milani, *supra* note 97, at 230 (arguing that the current potential for recovery is sufficient for any violation of the right to refuse treatment); Jon L. Spargur, Jr., Note, First Health Care Corp. v. Rettinger: *Are Living Wills Dead in North Carolina?* 32 WAKE FOREST L. REV. 591, 610-11 (1997) (arguing that recent court decisions that permit providers to err on the side of life when a request to end treatment appears ambiguous provide sufficient protection for patient autonomy); *see also* Geoffrey Disston Minott & Vincent Phillip Zurzolo, Comment, *Wrongful Life: A Misconceived Tort*, 15 U.C. DAVIS L. REV. 447, 458-67 (1981) (arguing against the wrongful life tort for many of the same reasons that commentators oppose the wrongful living tort).

279. *See* Milani, *supra* note 97, at 222-27 (asserting that plaintiffs should be permitted to bring tort claims but damages should be limited); Sparger, *supra* note 278, at 610-11 (arguing that a narrow interpretation of living will remedies provides sufficient awards). *But see* Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 229 (Ohio 1996) (awarding only nominal damages for a battery claim for the right to refuse treatment). Clearly, neither the current application of the tort law nor professional sanctions provide adequate compensation to the plaintiff or deterrence to health care providers.

280. *See* Milani, *supra* note 97, at 222; Peters, *supra* note 195, at 715-16.

281. Milani, *supra* note 97, at 154 (quoting Greco v. United States, 893 P.2d 345, 348 (Nev. 1995)).

282. *Id.* at 218. Medical literature suggest that doctors often "estimate the quality of life of chronically ill persons to be poorer than patients themselves hold it to be and give this conclusion great weight in inferring, incorrectly, that such person would choose to forgo life-prolonging treatment." Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786, 1786 (1994); *see also* Lawrence J. Schneiderman et al., *Do Physicians' Own Preferences for Life-Sustaining Treatment Influence Their Perceptions of Patients' Preferences?*, 4 J.

who are on life-sustaining treatment to sue their doctors provides an incentive for doctors not to treat the disabled[283] and encourages a lack of respect for them.[284]

These scholars focus on the potential for a partial remedy under the current system and argue that this is sufficient.[285] However, as noted earlier, the case law demonstrates that the current scheme does not adequately protect the right to refuse treatment.[286] As *Anderson* showed,[287] the court may determine that causation is lacking or that no harm exists due to a simplistic, if not disingenuous, conception of the legally cognizable injuries resulting from failure to respect a patient's wishes.[288] Moreover, *Anderson* permits only nominal damages for a violation of the right to refuse treatment.[289] No incentive currently exists for health care providers to obey the patient's wishes.[290] These scholars must acknowledge that often no

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CLINICAL ETHICS 28, 31 (1993) (suggesting that not only do physicians "often underestimate their patients' perceived quality of life," but also that they may "be influenced by, their own personal preferences").

283. Milani, *supra* note 97, at 218. Medical doctors' perceptions about the quality of life of persons with disabilities may be overly negative. *See* David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 59-60 (1996) (suggesting that doctors, in determining whether a patient is eligible for treatment, use the same cost/benefit analyses as do employers in determining whether to hire a disabled person); Marsha Saxton, *Prenatal Screening and Discriminatory Attitudes About Disability*, 13 WOMEN & HEALTH 217, 223 (1988) ("By working in hospitals, with sick people, doctors generally see only those cases of disability where there are complications, where patients are poorly managed, or patients in terminal stages. Many physicians never have the opportunity to see disabled individuals living independently, productively, enjoyably.").

284. Milani, *supra* note 97, at 218-19; *see* Carol J. Gill, *Suicide Intervention for Persons with Disabilities: A Lesson in Inequality*, 8 ISSUES IN L. & MED. 37, 38-39 (1992) (asserting that when persons with disabilities say they want to die, it is treated as "natural" or "reasonable," while persons without disabilities expressing the same wish are labeled "suicidal").

285. *See, e.g.*, Milani, *supra* note 97, at 223-27 (arguing that nominal damages and recovery for extraordinary medical expenses are an adequate remedy for a violation of the right to refuse medical treatment).

286. *See supra* Part II. For example, in Ohio, offensive conduct only entitles the plaintiff to nominal damages. *See* Anderson v. St. Francis-St. George Hosp., 671 N.E.2d 225, 229 (Ohio 1996). Moreover, professional sanctions, which are rare, do not provide a mechanism to enforce a patient's decision and further do not provide monetary recovery for unwanted medical treatment.

287. See *supra* notes 125-56 and accompanying text.

288. *Anderson*, 671 N.E.2d at 229.

289. *Id.*

290. Living will and other advance directive statutes, as well as professional sanctions, fail to provide an appropriate remedy. *See supra* notes 113, 215-16; *see also* Rich, *supra* note 113, at 1172 n.230 (arguing that the legislation "serves only the interests of healthcare providers and the right to life movement").

Under Ohio law, a physician cannot be subjected to criminal prosecution, professional disciplinary action, tort liability, or other civil action if the physi-

remedy exists for violations of the right to refuse medical treatment. This lack of remedy fails to provide protection for one of our most important rights.

One should also remember that in cases when defendant health care providers administer unwanted life-sustaining treatment, the nature of the intrusion and the corresponding harm to the autonomy interest can be significant. For example, in *Bartling v. Glendale Adventist Medical Center*,[291] health care providers placed a competent and extremely ill patient on a ventilator against his will, with a tube inserted in his throat via a tracheotomy.[292] His hands were restrained to prevent him from pulling out the tube.[293] For a competent but unwilling patient such as Mr. Bartling, that kind of treatment can only be described as a form of torture. He was kept in this state from April through November, 1984 when he died.[294] During the entire time he was in constant pain.[295] The injustice in not allowing Mr. Bartling's estate to recover should be apparent to anyone who takes seriously the concept of informed consent and the right to refuse medical treatment.

Moreover, the elderly and disabled should expect that doctors will respect their medical decisions, even if they do not agree with them.[296] These patients are entitled to receive the same medical treatment as any other person. Health care providers should not refuse treatment to these patients because of high costs or because of a mistaken belief concerning the quality of life of the aged and disabled. Moreover, medical professionals who presume that an elderly or disabled person wants to die should be held liable, even criminally, if they fail to use their best efforts to keep that person alive.

What appears to underlie the anxiety of these commentators is that the health care profession may not appreciate the quality of life

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cian acts in good faith, in reliance on a health care decision, and in compliance with a power of attorney statute. *See* OHIO REV. CODE ANN. § 1337.15(A) (Anderson 1953 & Supp. 1997). A physician or health care facility can also refuse to comply or allow compliance with the instructions of a directive on the basis of conscience or any other basis, as long as they transfer the individual to a physician or health care facility that will comply with the directive. *See id.* § 1337.16(B)(1)-(2)(a). In addition, under Ohio law, a physician or health care facility cannot be forced to provide or withhold health care to an individual during an emergency situation. *See id.* § 1337.16(C).

These provisions make it difficult to determine under what circumstances a physician or health care facility could actually be held liable for acting contrary to an individual's wishes. The provisions may actually provide the physician or health care facility with excuses for acting or not acting.

291. 229 Cal. Rptr. 360 (Ct. App. 1986).

292. *Id.* at 361.

293. *See id.*

294. *See id.*

295. *See id.* at 362.

296. For a discussion of the importance of personal autonomy and the right to refuse medical treatment, see *supra* Part I.

that the aged and disabled lead.[297] They fear that this misunderstanding will be enhanced by large damage awards in right to refuse treatment cases.[298]

The denial of a remedy, however, fails to address their concern. Rather, protection for elderly and disabled patients comes from the procedural mechanisms that guarantee the proper exercise of the right to refuse treatment.[299] Saying that a doctor is legally empowered or required to stop life support for someone who wants it stopped is no justification for allowing a doctor to stop life support for a disabled person who wants to live. The autonomy interest to choose life or death need not devalue life; rather, it should honor the choice for life just as much as, if not more than, it should honor the choice for death. The *Cruzan* case[300] made clear that states may place a burden on the right to refuse treatment to ensure that uncaring physicians or greedy relatives do not take advantage of the ill.[301] However, the *Cruzan* Court recognized that some people would be denied the right to refuse treatment because they failed to assert it in compliance with the law.[302]

Once someone has exercised the right to refuse medical treatment, in accordance with the law, he or she should receive a remedy if a health care professional ignores his or her wishes. The perceived lack of adequate safeguards in the process should not result in the denial of protection, i.e., a remedy, for all those who have lawfully exercised their right. It is better to respect the right of people who have complied with the procedures by allowing a remedy, than to have a right that is meaningless because it is unenforceable. Doctors should not be permitted to displace the patient's exercise of the right to refuse treatment. Each person should be free to make his or her own decisions about the medical care that he or she receives at the end of life and should have his or her choices respected. Protecting an individual's autonomy interest justifies the courts' process of learning to respect each individual's decision about the medical care he or she wishes to receive, particularly with respect to life-sustaining care. As Dworkin has written, "[t]he

297. *See supra* note 282.

298. *See supra* text accompanying note 281.

299. *See* Owen M. Fiss, *Forward: The Forms of Justice*, 93 HARV. L. REV. 1, 2 (1979) ("Judges have no monopoly on the task of giving meaning to the public values of the Constitution, but neither is there reason for them to be silent."); *see also* Donald H. Zeigler, *Rights Require Remedies: A New Approach to the Enforcement of Rights in the Federal Courts*, 38 HASTINGS L.J. 665, 681-82 (1987) (urging the establishment of a new framework for enforcing rights in the federal courts).

300. *See supra* Part I.A.

301. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 281-83 (1990).

302. *Id.* at 284. *See generally* Friedman, *supra* note 22, at 777-80 (discussing the importance of the courts in setting forth and enforcing the remedy for violations of individual liberties).

greatest insult to the sanctity of life is indifference or laziness in the face of its complexity."[303]

CONCLUSION

Advances in medical technology have drastically changed the way physicians treat patients, affecting how, where, and when Americans die. Many people expire only after being subject to heroic life-sustaining measures unheard of a few decades ago. In response to this medical development, courts and legislatures recognized the "right to die," stating that patients have a constitutional or common law interest in refusing unwanted medical treatment.[304]

Despite these attempts to secure the individual's right to refuse medical treatment, the case law indicates that physicians routinely ignore advance directives from patients.[305] Obviously, one important reason for this is the fact that physicians and other health care providers are almost immune from legal sanctions.

The fundamental obstacle to full implementation of the right to refuse medical treatment is not the failure to recognize the right, but the unwillingness of courts to remedy the violation of the right by physicians.[306] This should not be the case. Federal and state law expressly recognize the right to refuse medical treatment. If the right to refuse life-sustaining treatment is to have meaning, the law *must* provide a remedy for intentional or negligent violations of this right.

For understandable reasons, courts show a deep reluctance to assess civil liability against health care providers who choose to preserve life.[307] The courts have not fully explored the fundamental interests involved and have been one-sided in analyzing important constitutional issues. The moral complexity of the issue, however, does not excuse courts from their duty to enforce this fundamental right.

303. DWORKIN, *supra* note 19, at 240.
304. *See supra* notes 92-103 and accompanying text.
305. *See supra* Part I.C.
306. *See supra* Part II.
307. *See supra* notes 175-76 and accompanying text.