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RIGHT-TO-DIE DAMAGE ACTIONS: DEVELOPMENTS IN THE LAW

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This note traces the history of the "right-to-die" damage action. These are cases in which health care providers have been sued for providing unwanted life-sustaining treatment. After briefly describing the development of basic right-to-die law, the principle theories behind damage claims and the cases themselves are discussed, and the primary stumbling blocks are analyzed.

I. RIGHT-TO-DIE CASES AND THE POSITION OF HEALTH CARE PROVIDERS

Fifteen years ago right-to-die lawsuits were infrequently encountered. What cases could be found generally involved religiously motivated refusals of blood transfusions.[1] However, today right-to-die lawsuits are becoming more commonplace. Most often these new cases involve demands for the removal of life-sustaining treatment, typically respirators or feeding tubes. Approximately one half of the states have decisions dealing with demands for the termination of life-sustaining treatment.[2] These cases run the gamut from competent adult non-terminal patients personally asserting their rights,[3] to family members or friends insisting that permanently vegetative or otherwise severely disabled patients be taken off life-support.[4] The majority of these cases seek court orders directing uncertain or unwilling health care providers simply to turn off the machines.

The fact that these issues frequently arise should come as no surprise. In our society death has become a matter for negotiation between doctor, patient and family. For eighty percent of Americans death occurs while hospitalized.[5] It is estimated that 5,000 to 10,000 patients are

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1. *See* Paris, *Compulsory Medical Treatment and Religious Freedom: Whose Law Shall Prevail?*, 10 U.S.F. L. REV. 1 (1975); Note, *The Right of a Patient To Refuse Blood Transfusions: A Dilemma of Conscience and Law For Patient*, 3 U. S. F. V. L. REV. 91 (1974).

2. *See* Society for the Right to Die, Right to Die Court Decisions (1988) (available at 250 W. 57th St., New York, NY 10107).

3. *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (successful petition for removal of feeding tube).

4. *See, e.g.*, Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986) (spouse successfully petitioned for removal of feeding tube from husband in persistent vegetative state); *In re* Peter, 108 N.J. 365, 529 A.2d 469 (1987) (friend successfully petitioned for guardianship and order removing feeding tube).

5. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICAL AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT OF THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 17-18 (1983) [hereinafter PRESIDENT'S COMM'N].

maintained in some kind of vegetative state while tens of thousands more receive life-support in the form of respirator treatment or artificial nutrition and hydration through tubes inserted into their bodies. Under these circumstances, it is surprising that more cases do not result in litigation.[6] Were there an established set of rules to guide these negotiations fewer problems might arise. To that end, some thirty-nine states have "living will" or "natural death" statutes.[7] These laws permit a person to provide a binding instructions to health care providers concerning the use of life-sustaining treatment in cases of later incompetency. As more and more of the population utilizes these statutes, and as judicial decisions clarify existing uncertainties, the law and medical practices involving life-sustaining treatment will stabilize.[8] That time, however, has not come.[9]

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6. As the boundaries of medical technology expand and the mean population age increases, the most important issue may well become the right of access to life-sustaining treatment in the face of scarce resources. *See* PRESIDENT'S COMM'N, *supra* note 5, at 98-100.

7. *See* Alabama Natural Death Act, ALA. CODE §§ 22-8A-1 to -10 (Supp. 1983); Alaska Act Relating to the Rights of the Terminally Ill, ALASKA STAT. §§ 18.12.010-.100 (1986); Arizona Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1985); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, 1987 Ark. Acts 713; California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West 1988); Colorado Medical Treatment Decision Act, COLO. REV. STAT. §§ 15-18-101 to -113 (1987); CONN. GEN. STAT. ANN. § 19a-504-a (West 1986); Delaware Death with Dignity Act, DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); District of Columbia Natural Death Act of 1981, D.C. CODE ANN. §§ 6-2421 to -2430 (1987); Florida Life Prolonging Procedure Act, FLA. STAT. §§ 765.01-.15 (1986); Georgia Living Wills Act, GA. CODE ANN. §§ 31-32-1 to -12 (1985); Hawaii Act, 1986 Haw. Sess. Laws 338; Idaho Natural Death Act, IDAHO CODE §§ 39-4501 to -4508 (1985); Illinois Living Will Act, ILL. ANN. STAT. ch. 110 1/2, paras. 701-710 (Smith-Hurd 1987); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE § 16-8-11 (1985); Iowa Life-Sustaining Procedures Act, IOWA CODE §§ 144A.1-.11 (1985); Kansas Natural Death Act, KAN. STAT. ANN. §§ 65-28,101-09 (1979); Louisiana Life-Sustaining Procedures 2A, LA. REV. STAT. ANN. §§ 4D:1299.58.1-.10 (1984); Maine Living Wills Act, ME. REV. STAT. ANN. tit. 22, § 10a (1985); Maryland Life-Sustaining Procedures, MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (1985); Mississippi Natural Death Act, MISS. CODE ANN. §§ 41-41-101 to -121 (1984); Missouri Death-Prolonging Procedures Act, MO. REV. STAT. §§ 459.010-.055 (1985); Montana Living Will Act, MONT. CODE ANN. §§ 50-9-101 to -104, 50-9-111, 50-9-201 to -206 (1985); Nevada Withholding of Life-Sustaining Procedures Act, NEV. REV. STAT. §§ 44g.540-690 (1977); New Hampshire Living Wills Act, N.H. REV. STAT. ANN. § 137H (1985); New Mexico Right To Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (1978); North Carolina Right to Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -322 (1977); Oklahoma Natural Death Act, OKLA. STAT. tit. 63, §§ 3101-3111 (1985); Oregon Rights with Respect to Terminal Illness Act, OR. REV. STAT. §§ 97.050-.090 (1977); South Carolina Death With Dignity Act, S.C. CODE ANN. § 44-77-10-160 (1986); Tennessee Right to Natural Death Act, TENN. CODE ANN. §§ 32-11-101 to -111 (1983); Texas Natural Death Act, TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon 1977); Utah Choice and Living Will Act, UTAH CODE ANN. §§ 75-2-1101 to -1118 (1985); Vermont Terminal Care Document Act, VT. STAT. ANN. tit. 18, §§ 5251-5262, tit. 13, § 1801 (1982); Virginia Natural Death Act, VA. CODE ANN. §§ 54-325.8:1-13 (1983); Washington Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010-.905 (1979); West Virginia Natural Death Act, W. VA. CODE §§ 16-30-1 to -10 (1984); Wisconsin Natural Death Act, WIS. STAT. § 154.01 (1984); Wyoming Living Will Act, WYO. STAT. §§ 33-26-144 to -152 (1984). *See also* COLO. REV. STAT. § 12-36-117 (1987).

8. Hospitals will soon be forced to address life-sustaining treatment issues whether they wish to or not. In its 1989 Accreditation Manual for Hospitals, the Joint Commission on the Accreditation of Hospitals is requiring that hospitals have in place a policy governing implementation of "Do Not Resuscitate" orders. PERSPECTIVES, Jan. 1988.

9. A recent physician poll conducted in Colorado discloses disturbing information. Twenty-four percent of all doctors surveyed were unfamiliar with the state's three-year old

There are general rules known to those who deal with bioethical issues. Yet the nostrum that a competent adult has the right to refuse unwanted medical treatment is of little help when competency is disputed, when someone is never competent to make their own decision, or when an incompetent without a living will is the focus of attention. Moreover, many institutions have no policies governing *how* to terminate, let alone *when* to terminate, treatment.[10] In the absence of widespread policies and commonly accepted principles, and in light of the ability of medical technology to maintain the mechanics of life long after death would otherwise occur, it is no wonder that the courts have become deeply involved in right-to-die issues.[11]

The courts do not look forward to involvement in right-to-die cases. The vast majority of opinions make it clear that treatment decisions ideally should be made by patients and families in conjunction with health care providers under legislatively formulated guidelines.[12] Only a small minority of jurisdictions encourage judicial involvement in approving certain treatment termination procedures.[13] The fact is that scores of patients are taken off life-support every day without court involvement.[14]

The right to be free from such treatment may seem to have sprung up quickly over the last dozen years.[15] In fact, common law rights to bodily integrity and freedom from medically invasive procedures have a long history.[16] As a result of the general recognition of these rights the overwhelming majority of cases result in a court order directing the cessation of treatment.[17] For competent adult patients the right is clear

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living will statute. CENTER FOR HEALTH, ETHICS AND POLICY, GRADUATE SCHOOL OF PUB. AFFAIRS, UNIV. OF DENVER, WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT: A SURVEY OF OPINIONS AND EXPERIENCES OF COLORADO PHYSICIANS 10 (1988).

10. *See, e.g.*, Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988) (failure to have policy for procedure to terminate life-sustaining treatment is not negligence). However, some health care facilities have developed their own procedures and policies. *See, e.g.*, Carlson, Derich & Frank, *Development of a Comprehensive Supportive Care Team for the Hopelessly Ill on a University Hospital Medical Service*, 259 J. A.M.A. 378 (1988).

11. A review of right to die cases and law is outside the scope of this note. The best capsule summaries are provided in J.W. SMITH, HOSPITAL LIABILITY § 13 (Supp. 1987) and M.G. MACDONALD, K.C. MEYER & B. ESSIG, HEALTH CARE LAW: A PRACTICAL GUIDE § 18 (Supp. 1987).

12. *See In re* Farrell, 108 N.J. 335, 338, 529 A.2d 404, 407-08 (1987) (calling for legislative guidelines).

13. *See, e.g., In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 458 U.S. 858 (1981).

14. *See In re* Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (Ten life-support systems are disconnected weekly in Minnesota without court involvement.).

15. Recent cases include *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976), the landmark case which upheld a parent/guardian's right to refuse life-sustaining (respirator) treatment for his daughter who lay in a permanent vegetative state. The *Quinlan* holding was modified by *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

16. *See* Oddi, *The Tort of Interference with the Right To Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 628 (1986).

17. Only on very rare occasions have courts refused to approve a termination order. In New Mexico v. Fort, No. 14768 (N.M. 1983), the court found no authority in the New Mexico Right To Die Act ("Act") to terminate the treatment of an incompetent without a prior directive. This decision was quickly reversed by the state legislature which amended

and fundamental.[18] For patients becoming incompetent or who were never competent, the right is becoming ever more clearly established, so long as family members in good faith agree, and there is little chance for significant patient improvement from a terminal or vegetative condition.[19]

Health care providers have generally taken the position that, in cases of disagreement, it is the patient's obligation to go to court and obtain the order for termination of treatment. While the case law indicates a few instances where doctors or hospitals have gone into court first,[20] the more usual situation involves a patient or family member who petitions the court. Why this has been so is easy to understand. The health care industry is particularly sensitive to the potential for liability claims. Until a few years ago, health care providers may have had more reason to fear not only civil but also criminal penalties for failing to provide life-sustaining treatment. In *Barber v. Superior Court of the State of California* two California doctors were charged with murder after they bowed to family requests and withdrew life support.[21] However, the decision in *Barber* clearly established that health care providers in California need not continue "useless" therapy and that no criminal liability would result so long as the usual standards of the profession were not violated.[22] No cases since have found to the contrary, and no cases have been found where a doctor's termination of life support resulted in even civil liability.[23]

If health care providers face any real danger it is that continuation of unwanted treatment may itself result in liability.[24] Given the competent patient's right to refuse treatment and the more recently developed right for family members to refuse treatment for incompetents, health care providers might be advised to go to court themselves if they disagree with an order to cease treatment. Certainly, almost any court would grant a preliminary order allowing the continuation of treatment, pending a full hearing on allegations challenging the patient's compe-

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the Act to allow physician termination of life-sustaining treatment if family members agree that the patient would have wished treatment to stop. 1984 N.M. Laws ch.99, § 6 (codified as N.M. STAT. ANN. § 24-7-8.1 (Supp. 1986)). *See also* Newman v. Beaumont Army Medical Center, No. EP 86 CA 276 (W.D.Tex. Oct. 30, 1986) (evidence of isolated statement of intent is insufficient to establish patient wishes, and so treatment must continue).

18. *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137-38, 225 Cal. Rptr. 297, 300-01 (Ct. App. 1986).

19. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (never competent patient in terminal condition); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (incompetent patient in persistent vegetative state).

20. *See, e.g.*, John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Beth Israel Medical Center, 136 Misc. 2d 931, 519 N.Y.S.2d 511 (Sup. Ct. 1987); *In re* Lydia E. Hall Hosp., 116 Misc. 2d. 477, 455 N.Y.S.2d 706 (Sup. Ct. 1984).

21. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983).

22. *Id.* at 1017-18, 195 Cal. Rptr. at 490-91.

23. In one case, a surviving family member sued health care providers for withdrawing treatment without a written directive. The case was dismissed. Camp v. White, 501 So. 2d 166, 169-70 (Ala. 1987). *See also* Morgan v. Olds, 417 N.W.2d 232 (Iowa Ct. App. 1987) (incompetent patient's spouse has no cause of action against doctors who withheld life support without spouse's consent).

24. *See* Cohen, *Civil Liability for Providing Unwanted Life Support*, 2 BIOLAW 499 (1987).

tency or asserting that the wishes of the family were in conflict.[25] However, such has not been the practice. Health care providers generally seem to have taken a passive position, requiring patients or families to make the first move. Given developments in the law that tack may not be so wise today.

II. RIGHT-TO-DIE DAMAGE ACTIONS

The 1980's saw the first attempts to impose civil liability upon health care providers for the failure to terminate life-sustaining treatment. Few of these cases have been successful. In some, the courts have stated that the individual's rights were not clearly enough defined to establish liability.[26] In others, the courts found that the duty of the doctor was not clear.[27] Such statements suggest that as the right to refuse life-sustaining treatment becomes more clear, the potential for civil liability for refusing to respect termination demands will grow.[28] While generally so far having been unsuccessful, as a group these cases point in the direction in which the plaintiffs' bar, if not yet the law, is moving.

A. *The Precursors*

1. *In re Spring*[29]

One of the earliest cases to discuss the civil liability issue was *In re Spring*. Decided four years after *Quinlan*, it involved an incompetent 70-year old patient suffering from organic brain syndrome and end-stage kidney disease and undergoing hemodialysis. While continued treatment possibly could have prolonged his life for up to five years, there was no hope of any improvement. The son, who had been appointed temporary guardian, petitioned, along with the spouse, for an order terminating treatment. A guardian ad litem was appointed and the case worked its tortured way through the courts. One month after the patient died, while still undergoing hemodialysis, the Massachusetts Supreme Judicial Court issued its decision.[30]

25. Practical suggestions for health care providers and their attorneys are in a short supply. An excellent resource, however, is M. MACDONALD, K. MEYER & B. ESSIG, HEALTH CARE LAW: A PRACTICAL GUIDE § 18 (1987).

26. *See, e.g.*, Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 961, 969, 229 Cal. Rptr. 360, 363 (Ct. App. 1986).

27. *See, e.g.*, McVey v. Englewood Hosp. Ass'n, 216 N.J. Super. 502, 506, 524 A.2d 450, 452 (App. Div. 1987).

28. For a discussion of the theoretical basis for such claims see Oddi, *supra* note 16, and Comment, *Damage Actions For Nonconsensual Life-Sustaining Treatment*, 30 ST. LOUIS U.L.J. 895 (1986). *See also* Cohen, *supra* note 24.

29. 380 Mass. 629, 405 N.E.2d 115 (1980).

30. The son's guardianship petition was filed in November, 1978. Appointment was made in January, 1979. The parties immediately petitioned to terminate life-sustaining treatment. The probate court appointed a guardian ad litem who filed a report in February, 1979. A hearing was held in April and the judge issued his opinion in May, 1979. The order was stayed. An appeal was filed and a new probate court order was issued in July, 1979. The case was argued in the Massachusetts Supreme Court in January, 1980 and decided that same month by order initially reversing and remanding the case back to the probate court for further hearings. In April, 1980 Mr. Spring died while still being treated.

The court upheld the family's order to stop treatment, recognizing that "substituted judgment" decisions made on an incompetent's behalf should control if they both reflect what the patient would want if he were competent, and if the patient's interest in self determination outweighed the state's interests.[31] The Court went on to list ten general factors which would control the issue of whether a court order was necessary in such cases. While making it clear that judicial intervention was not always needed, it was found to be appropriate here, especially given the uncertainty in the state of the law.[32] In reviewing that law, the court in *dicta* addressed the issue of civil liability. While recognizing that treating competent patients against their will would result in a battery, the court had more problem with that analysis when applied to incompetents.[33] This limitation is somewhat difficult to reconcile with the court's earlier finding that a "person has a strong interest in being free from nonconsensual invasion of his bodily integrity, and a constitutional right of privacy that may be asserted to prevent unwanted infringements of bodily integrity."[34] The only way this limitation of the right of incompetents can be explained is to emphasize the medical profession's strong *parens patriae* position toward incompetents, regardless of the assertion of the incompetent's rights by family or guardians.

2. *Foster v. Tourtellotte*[35]

The case of *Foster v. Tourtellotte* appears to have been the first reported case directly related to a damage claim in a right-to-die case. It involved a competent patient's withdrawal of consent to respiratory treatment. He had been dependent on such treatment for almost a year. When the hospital and doctors refused to stop the machine, Foster sued, not only for an injunction but for damages and attorneys fees as well . The lower court granted the injunction on the ground that Foster's "constitutional rights of privacy and dignity" were being violated.[36] The injunction was stayed pending appeal, but Foster died before the order became effective or an appeal was taken.

In May, 1980 the Supreme Court issued its final written opinion affirming the probate court decision. *Id.* at 632-33, 405 N.E.2d at 117-18. While the courts moved conscientiously, this case serves as an example of how judicial involvement—especially in the earlier right to die cases—could lead to lengthy and troublesome delays.

31. *Id.* at 634, 405 N.E.2d at 120. Typically, the courts have identified four state interests in continuing life-sustaining treatment: (1) preserving life; (2) preventing suicide; (3) protecting incompetents and dependent third parties; and (4) protecting the integrity of the medical profession. These interests are then balanced against the patient's right to refuse treatment. Oddi, *supra* note 16, at 632-35. Given the facts, in some cases the strongest state interest is protecting third parties. *Id.* at 635. In *Spring*, the court identified the preservation of life as the primary state interest. *Spring* at 634, 405 N.E.2d at 119. These four state interests were first set out by the same court in *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977), and have been widely cited ever since. *See* PRESIDENT'S COMM'N, *supra* note 5, at 31-32.

32. *Spring* at 634, 405 N.E.2d at 121-22.

33. *Id.* at 638, 405 N.E.2d at 119.

34. *Id.*

35. 704 F.2d 1109 (9th Cir. 1983).

36. *Id.* at 1110.

Subsequently, the plaintiff's damages action for violation of Foster's constitutional right to privacy under 42 U.S.C. § 1983[37] was voluntarily dismissed with prejudice and the motion for attorney's fees was denied by the district court in an unpublished opinion. The reported opinion, while referring to the district court's dismissal of the damage action, only addresses whether the district court abused its discretion in denying Foster's fee application under the Equal Access to Justice Act.[38]

The Ninth Circuit, however, found that, even if one assumed an absolute constitutional privacy right to refuse treatment, the government had acted reasonably in requiring a court order.[39] The court held that Foster's request for an injunction raised troublesome and disturbing questions in a matter quite literally of life and death. Also "the government faced a complete absence of helpful precedent in the Supreme Court or the courts of appeal on the application of the right to privacy to a patient's desire to terminate life sustaining treatment."[40] No fees were awarded.

3. *Tune v. Walter Reed Army Medical Hospital*[41]

In this case a competent 71 year-old terminal cancer patient in respiratory distress petitioned the court, through her son, for an order terminating use of a respirator. Army policy precluded withdrawal of life-sustaining treatment once placed in operation. Relying on the constitutional right to privacy for a competent's refusal of unwanted medical treatment, the court granted the petition and Mrs. Tune's respirator was disconnected.[42]

In discussing the precedents, the court acknowledged the "well-established rule of general law" that a competent patient, not the physician, is the one who decides whether treatment is to be given.[43] To support this proposition the court cited to a case involving a damage action for medical negligence and breach of informed consent require-

37. The Civil Rights Act of 1871, 42 U.S.C. § 1983 (1986), states:
Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

38. *Foster*, 704 F.2d at 1111-12. The Equal Access to Justice Act requires a court to award fees to a prevailing party in non-tort cases unless the position of the United States was substantially justified. Fees may also be denied if "special circumstances make an award unjust." 28 U.S.C. § 2412(d)(l)(A) (Supp. 1987). While Foster did not prevail on his damage claim he did receive the requested injunction. That served as the basis for the fee request. 704 F.2d at 1112-13.

39. *Foster*, 704 F.2d at 1112. Foster's wife and one of his children opposed his wish and even Foster had equivocated on his decision during hospitalization. *Id.* at 1110.

40. *Id.* at 1113.

41. 602 F. Supp. 1452 (D.D.C. 1985).

42. *Id.* at 1456.

43. *Id.* at 1455.

ments.[44] This can be read as an indication that breach of a physician's duty in right-to-die cases could result in a damage award under negligence or informed consent doctrines.[45]

The three decisions in *Spring*, *Foster* and *Tune* provide only the barest of support for later right-to-die damage actions. *Spring* hinted at the possibility of civil liability but shied away from applying traditional battery analysis to such an area. *Foster* had actually included a damage claim under civil rights law. However, that privacy-based claim was voluntarily dismissed at the trial level and the appellate court never reached the issue. Further, in denying plaintiff's fee motion the court made it clear that the law was so uncertain at the time that no established right of the plaintiff supported an award. Finally, while *Tune* tacitly acknowledged the potential for damage claims in right-to-die cases, the issue was not presented to the court by the pleadings. The importance of the court's citation to common medical malpractice cases in *dicta* is therefore difficult to assess.

B. *Right-to-die Damage Actions*

Lack of a clearly developed line of precedent makes the first case examined in this section all the more significant. The case arose in a state with no right-to-die precedent, except the lower court decision in the same case.

1. *Estate of Leach v. Shapiro*[46]

This is the first case which resulted in a damage recovery through settlement in the context of a right-to-die action. In *Leach*, the estate and family of a woman who was hospitalized while suffering from amyotrophic lateral sclerosis (ALS or "Lou Gehrig's disease," a terminal illness for which there is no treatment) sued her hospital and attending physician for placing and maintaining Mrs. Leach on life support against the wishes of herself and her family. Previously, a successful action had been brought to obtain an order terminating life sustaining treatment. The order was based on the constitutional right to privacy in refusing unwanted medical care.[47] The defendants in the subsequent damage action moved to dismiss for failure to state a claim upon which relief might be granted. The trial court granted the motion.[48]

The complaint pled five causes of action: (1) the estate's claim to

44. *Id.* at 1455 (citing Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.) (action against surgeon and hospital for paralysis resulting from back operation without adequate disclosure of risks), *cert. denied*, 409 U.S. 1064 (1972)).

45. Where treatment is performed without consent the appropriate tort model is battery, not negligence. *See* Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (en banc). Medical battery claims have a recognized place in American tort law. *See, e.g.*, Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

46. 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984).

47. Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (Ct. Com. Pl. 1980).

48. *Estate of Leach*, 13 Ohio App. 3d at 393, 469 N.E.2d at 1051.

recover medical expenses totalling over $60,000 for treatment without consent; (2) the estate's claim that Mrs. Leach's constitutional right to privacy was violated; (3) the estate's claim that Mrs. Leach was subjected to pain and suffering; (4) the family members' individual claims that the hospital and doctor had wrongfully subjected them to mental pain and suffering; and (5) the plaintiffs' collective claim for punitive damages.[49]

The court of appeals noted that the dismissal could only be upheld if, from the pleadings, it appeared beyond doubt that the plaintiffs could prove no set of facts entitling them to relief.[50] Applying this test the court reversed and reinstated the case. The court made it clear at the outset that treatment without consent constituted a battery even though the procedure might be harmless or beneficial.[51] Additionally, the court stressed the importance of informed consent and held that failure to disclose under appropriate circumstances could constitute fraud.[52]

Plaintiffs alleged that health care providers had been expressly advised by Mrs. Leach, when competent, that she did not wish to be kept alive by machines. These wishes were echoed by all of her family members. Further, the family members alleged that for two months, while Mrs. Leach was on life support, the health care professionals had failed to inform them of her true condition and had administered experimental drugs to her without consent. The court concluded that these allegations raised questions of fact that could, at trial, support all of the claims except the invasion of privacy claim. That claim failed as a matter of law since the right to privacy was held to be a personal right which lapsed on the death of Mrs. Leach.[53] On remand, prior to trial, the defendant hospital settled for $50,000. The case against the doctor was dismissed when the trial court found the evidence inadequate to submit the case to the jury—a ruling which was not appealed.

2. *Bartling v. Glendale Adventist Medical Center*[54]

Seventy year-old Mr. Bartling had many serious illnesses, including cancer. In April 1984, he was admitted to the defendant hospital. His lung collapsed during a biopsy and he was placed on a ventilator. Because he kept trying to remove the ventilator tubes, his wrists were placed in "soft restraints." The hospital admitted that Mr. Bartling was competent. Despite his repeated demands, the hospital and his doctors refused to disconnect the ventilator.[55]

In June 1984, Mr. Bartling and his wife brought an action for injunctive relief to restrain the defendants from providing the unwanted

49. *Id.* at 395-98, 469 N.E.2d at 1051-53.
50. *Id.* at 395, 469 N.E.2d at 1051.
51. *Id.*
52. *Id.* at 398, 469 N.E.2d at 1054.
53. *Id.* Application of survival statutes have an unusual result in right-to-die damage actions. *See infra* pp. 59-63.
54. 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986).
55. *Id.* at 966, 229 Cal. Rptr. at 361.

treatment.[56] The suit also included several damage claims. The Bartlings pled five tort theories: (1) battery; (2) violation of state and federal constitutional rights; (3) breach of fiduciary duty; (4) intentional infliction of emotional distress; and (5) conspiracy. General and punitive damages as well as attorney's fees were sought.[57]

On the first appeal, the court in *Bartling v. Superior Court*[58] (*Bartling I*) granted the order to discontinue the unwanted treatment. *Bartling I* remanded the case to consider the issue of attorney's fees, which the trial court denied.[59] On the second appeal, the court reversed and remanded a second time.[60] On the second remand, the trial court sustained a demurrer to the third amended complaint, denied leave to amend and dismissed the damages case. The third appeal in *Bartling v. Glendale Adventist Medical Center* (*Bartling II*) followed.[61]

In reviewing the background to the damages case the *Bartling II* court reiterated the holding in *Bartling I* that, on balance, Mr. Bartling's right to discontinue unwanted treatment outweighed the interests of the state in keeping him alive against his will.[62] That, however, did not mean that defendants' refusal to terminate life support was tortious under the circumstances. The court held that because the state of the law was unclear at the time, and since the defendants' conduct was based on what they believed in good faith was their duty to preserve life in accordance with prevailing medical standards, no liability would attach.[63]

The court then went claim by claim through the pleadings and disposed of each of plaintiff's theories. Mr. Bartling's claims for pain and suffering were held not to survive his death.[64] Since defendants did not violate plaintiffs' clearly established rights their actions could neither have evinced a "conscious disregard" for plaintiffs' rights nor be considered extreme or outrageous.[65] The conspiracy claim under 42 U.S.C. § 1985(3) was insufficient because there was no allegation of racial or class based discriminatory animus, and the other common law conspiracy claims were not supported by sufficient factual allegations.[66] The trial court's dismissal with prejudice was accordingly affirmed[67].

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56. Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

57. Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d at 967, 229 Cal. Rptr. at 362.

58. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

59. 184 Cal. App. 3d at 967, 229 Cal. Rptr. at 362.

60. Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 97, 228 Cal. Rptr. 847 (1986).

61. 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986).

62. *Id.* at 969, 229 Cal. Rptr. at 363. The court in *Bartling I* restated and weighed the commonly accepted governmental interests in such cases, first set out seven years earlier in *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977). 163 Cal. App. 3d at 193-95, 209 Cal. Rptr. at 224-25.

63. 184 Cal. App. 3d at 968-69, 229 Cal. Rptr. at 363.

64. *Id.* at 969-70, 229 Cal. Rptr. at 364. *See infra* pp. 59-63 for a discussion of the survival of claims in right-to-die cases.

65. *Id.* at 970, 229 Cal. Rptr. at 364.

66. *Id.* at 972, 229 Cal. Rptr. at 365-66.

67. *Id.* at 973, 229 Cal. Rptr. at 366.

3. The *Bouvia* Cases

In 1983, 25 year-old Elizabeth Bouvia sought a court order which would allow her to starve to death in a California public hospital. She was quadriplegic and suffered from severe cerebral palsy and crippling arthritis. Her condition was not terminal, but she suffered constant pain and experienced great difficulty eating. The trial court denied the relief she requested. Subsequently, Ms. Bouvia abandoned her appeal.[68]

Two years later, with her condition deteriorating, she checked into another public hospital which implanted a morphine dispensing pump in her chest to help relieve her pain. Stabilized, she was transferred to High Desert Hospital (HDH), a county medical facility. There her treating physician ordered the placement of a nasogastric feeding tube against her will.[69]

Ms. Bouvia responded by filing a lawsuit seeking injunctive relief and damages. The trial court refused to grant a preliminary injunction. Ms. Bouvia petitioned the state court of appeal for a writ of mandamus and other extraordinary relief. In *Bouvia v. Superior Court*[70] (*Bouvia I*), a precedent-setting and dramatic opinion, the court of appeals confirmed her constitutionally based right to refuse forced tube feeding regardless of the fact that she was not terminal.[71]

The tube was removed pursuant to the court of appeal decision, but Ms. Bouvia's doctor then informed her that the morphine pump was not medically indicated and would be removed after she was "detoxified." Ms. Bouvia once again responded with a lawsuit seeking injunctive relief and more damages in *Bouvia v. County of Los Angeles*[72] (*Bouvia II*).

To date, the two underlying damage actions have still not been tried. The complaints in both of Ms. Bouvia's actions state identical claims for relief even though the facts are different. Three substantive claims are made: (1) battery; (2) violation of constitutional and civil rights (privacy and due process liberty interests); and (3) intentional in-

68. *See* Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1136, 225 Cal. Rptr. 297, 300 (1986).

69. *See* Bouvia v. County of Los Angeles, 195 Cal. App. 3d 1075, 241 Cal. Rptr. 239 (1987).

70. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

71. *Id.* at 1138-39, 225 Cal. Rptr. at 302. The holding in *Bouvia I* was an expansion of the doctrine announced in *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), in that the court emphasized for the first time the unconditional right of a competent adult to decide his or her own fate regardless of what the motives were behind the decision. 179 Cal. App. 3d at 1135, 225 Cal. Rptr. at 306.

72. 195 Cal. App. 3d 1075, 241 Cal. Rptr. 239 (1987). The trial court granted plaintiff's request for a temporary restraining order to preserve the status quo. Court appointed experts suggested, and the court ordered, that Ms. Bouvia be transferred to a different facility where she might be weaned from her dependence on morphine. *Id.* at 1080-81, 241 Cal. Rptr. at 241-42.

Believing Ms. Bouvia had been successful in *Bouvia I*, which resulted in the writ ordering removal of the feeding tube, and in *Bouvia II*, which resulted in the temporary restraining order, plaintiff's counsel filed for attorney's fees, thus resulting in the consolidated fees opinion in *Bouvia II*. *Id.*

fliction of emotional distress. Additionally, each complaint states a claim for conspiracy to commit the alleged torts and seeks injunctive relief, punitive and compensatory damages, attorney' s fees and costs.[73]

4. *McVey v. Englewood Hospital Association*[74]

The adult children of Elizabeth Palermo, a stroke victim received by the hospital in a deep coma, sued the hospital, its administrator and treating doctors for maintaining their mother on a respirator against the family's and Ms. Palermo's previously expressed wishes.[75] The defendants took the position that Ms. Palermo had been properly attached to the respirator upon admission and could not thereafter be disconnected because, even though her condition was "without hope", she was not completely brain dead. Further, the defendants refused to have the matter reviewed by the hospital ethics committee. Plaintiffs were forced to go to court, and approximately one month later received an order appointing them guardians of Ms. Palermo with the power to make medical treatment decisions. Plaintiffs ordered the respirator removed. That was done, and four days later Ms. Palermo died. This damage action followed.[76]

Plaintiffs' amended complaint contained sixteen claims. Plaintiffs sued for themselves individually and for Ms. Palermo's estate. The claims asserted were based upon theories of (1) negligence; (2) negligent infliction of emotional distress; (3) breach of fiduciary duties, (4) breach of physician-patient relationship; (5) assault and battery;

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73. In *Bouvia II* the court of appeals granted attorney's fees for the writ obtained in *Bouvia I*, citing the state private attorney general law, CAL. CIV. CODE § 1021.5 (West 1976), which allows for an award of fees if an action vindicates an important right or confers a significant benefit on the general public. However, the court denied fees in both cases under the Civil Rights Attorney's Fees Award Act of 1976, 42 U.S.C. § 1988 (1982), which allows for an award of reasonable fees to the prevailing plaintiff in a federal civil rights action. 195 Cal. App. 3d at 1086, 241 Cal. Rptr. at 246.

In a poorly worded opinion the court threw together a variety of reasons why § 1988 was not applicable as the record then stood: plaintiff's injuries were not proximately caused by the execution of a government policy or custom, the doctors were not guided by any such policy or customs, and no showing was made that defendants proximately caused Ms. Bouvia to suffer a violation of civil rights. Then, before concluding that the case was "simply not the type of situation which that act was designed to encompass," the court put into doubt the constitutional analysis of its two earlier precedent-setting cases with this paragraph:

> While it is true that in both *Bartling I* and *Bouvia II* the author of the majority opinion alluded to a constitutional basis for the right vindicated, it seems clear that the right primarily is a development of the common law, and for that reason applies to patients in private as well as governmental facilities and to patients being treated by private as well as publicly-employed medical practitioners.

Id. at 1088, 241 Cal. Rptr. at 248. (citation omitted).

74. 216 N.J. Super. 502, 524 A.2d 450 (App. Div.), *cert. denied*, 108 N.J. 182, 528 A.2d 12 (1987).

75. Ms. Palermo, age 91, suffered a severe stroke at her home and was discovered approximately three hours later. She was transported to the hospital and immediately attached to a respirator. Shortly thereafter, Ms. Palermo's daughter arrived and immediately instructed one of the doctors that neither Ms. Palermo nor any family member wanted a respirator to be used. First Amended Complaint at 10-13, McVey v. Englewood Hosp. Ass'n, No. L-090901-85 (Bergen County, N.J. Ct. filed Jan. 28, 1986).

76. 216 N.J. Super. at 505, 542 A.2d at 452.

(6) conspiracy to violate and violation of constitutional and common law rights to privacy, liberty, freedom from unlawful seizure and bodily self-determination; and (7) violation of 42 U.S.C. § 1981 (equal rights under law) and 42 U.S.C. § 1985 (conspiracy to interfere with civil rights) . Plaintiffs sought punitive and compensatory damages for pain and suffering, including reimbursement of over $21,000 in medical expenses and over $5,500 in legal expenses incurred in the guardianship proceedings.[77] The amended complaint was dismissed and the plaintiffs appealed.

In a very brief opinion, the appellate court upheld the dismissal. It noted the responsibility of the medical profession to preserve life, especially in an emergency situation. Most importantly, the court rejected the theory that the health care providers had some duty of their own to "determine the existence, veracity and effect of an incompetent's orally expressed treatment decision,"[78] and found that the guardianship proceeding was an appropriate—though not always required—way for such decisions to be effected.[79]

5. *Ross v. Hilltop Rehabilitation Hospital*[80]

This case involved Hector Rodas, a 34 year-old Guatemalan, who suffered a drug-induced stroke on February 10, 1986. The stroke left him in a "locked-in" state in which his mind was essentially intact but his body was virtually paralyzed. He could not speak or swallow, so a feeding tube had been inserted into his stomach. He could respond reliably to "yes or no" questions by nodding his head. This limited movement also allowed him to spell out messages with the help of a therapist pointing to a letter board. Mr. Rodas was not terminal but had a severely reduced life expectancy, and there was no real hope for significant improvement.[81]

On June 17, 1986, Mr. Rodas spelled out a message demanding that he not be fed and hydrated through the gastrostomy tube. The defendant hospital and doctor refused to comply but immediately informed Mr. Rodas' lawyer. On August 22, 1986, the hospital and doctors filed a petition in state probate court requesting appointment of a guardian and a declaration as to whether Mr. Rodas had the right to refuse nutrition and hydration at the defendant hospital.[82]

After a thirteen-day trial, which Mr. Rodas attended daily, the state

77. While these numerous theories were asserted, the essence of the claims sounded in malpractice or negligence. *See* Brief and Appendix of Amicus Curiae Society For The Right To Die at 11-13, McVey v. Englewood Hosp. Ass'n, 216 N.J. Super. 182, 524 A.2d 452 (App. Div. 1987).

78. 216 N.J. Super. at 506, 524 A.2d at 452.

79. *Id. See* Annotation, *Judicial Power to Order Discontinuance of Life-Sustaining Treatment*, 48 A.L.R. 4th 67 (1986).

80. 676 F. Supp. 1528 (D. Colo. 1987).

81. *Id.* at 1530.

82. *Id.*

probate court issued a far-reaching order.[83] Among other things, the court held that, utilizing any of the suggested tests, Mr. Rodas had the mental capacity to decide his own treatment. Further, the court held that Mr. Rodas had a constitutionally-protected right of privacy to refuse medical treatment and that gastrostomy tube feeding and hydration constituted such treatment. Finally, the court held that because of the circumstances of the case Mr. Rodas would be permitted to remain at Hilltop and receive general nursing care while dying through refusal of nutrition and hydration. Defendants did not appeal the order and on February 6, 1987, Mr. Rodas died at Hilltop.[84]

Just prior to his death, Mr. Rodas filed a damage action in federal court against the hospital, its administration, its staff and his doctors. The suit stated numerous claims, including negligence, breach of contract, breach of fiduciary duty, battery, negligent and intentional infliction of emotional distress, civil rights violations under 42 U.S.C. § 1983[85] and a private cause of action under § 504 of the Rehabilitation Act of 1973.[86] Shortly after his death Mr. Rodas' attorneys amended the complaint and abandoned all state tort claims, having concluded that damages for pain and suffering under such claims were personal to Mr. Rodas and did not survive his death.[87]

On cross motions for summary judgment on the remaining federal claims, the district court entered a decision for defendants. The court held that Hilltop and the defendant doctor were private, not governmental actors whose conduct was not fairly attributable to the state. Since state action is a required element under 42 U.S.C. § 1983, that claim was dismissed.[88]

The district court also ruled against Mr. Rodas' Rehabilitation Act (the "Act") claim. Mr. Rodas alleged that defendants had discriminated against him in violation of the Act in two ways. First, Mr. Rodas alleged the defendants discriminated against him by incorrectly treating him as mentally handicapped, and therefore unable to decide to forego treatment. Second, Mr. Rodas alleged the defendants discriminated against him because of his actual physical handicap by failing to obtain court authorization for treatment—treatment he did not want but physically

83. *In re* Hector O. Rodas, No. 86-P-139, slip. op. (Dist. Ct. of Colo., Grand County, April 3, 1987, superseding order of January 22, 1987).

84. 676 F. Supp. at 1531-32.

85. To establish a claim under § 1983 a plaintiff must establish the following elements: (1) an entity acting under color of state law, (2) who subjects or causes any person to be subjected, (3) to a deprivation of rights secured under the Constitution or law of the United States. *Id.* at 1535.

86. 29 U.S.C. § 794 (1982 & Supp. 1986).

87. First Amended Complaint, Ross v. Hilltop Rehabilitation Hosp., No. 87-F-187 (D. Colo. filed July 29, 1987).

88. 676 F. Supp. at 1535-37. The judge in *Ross* relied heavily on a finding in *Bouvia I* that there had been no state involvement. 676 F. Supp. at 1537. The earliest case to address the issue in the context of a federal civil rights damage claim was a precursor to the *Leach* case, in which an Ohio federal district court judge dismissed plaintiffs' damage claim with a finding of no state action. Leach v. Shapiro, No. C81-2559A (N.D. Ohio June 25, 1982). *See* Oddi, *supra* note 16, at 648 n.101.

was unable to refuse. The court held that the Act does not reach medical treatment decisions of or for handicapped individuals, and that in any event there was no evidence that defendants' treatment of Mr. Rodas was "discriminatory" as defined under the Act.[89]

6. *Strachan v. John F. Kennedy Memorial Hospital*[90]

On April 25, 1980, 20 year-old Jeffrey Strachan shot himself in the head with a .38 caliber handgun. Comatose but still breathing on his own, he was transported to the defendant hospital. Soon after admission he stopped breathing.[91]

Though clinically brain dead, he was placed on a respirator. That afternoon one of the treating physicians asked the parents if they would consider donating Jeffrey's organs for transplant. The parents considered the matter and the next morning informed the attending physician that they were not going to authorize donation. They asked that the respirator be turned off. The doctor advised them to give the matter more thought. That evening the parents repeated their request that the respirator be turned off. The attending physician noted in the chart that he would do so as soon as the hospital instructed him as to the proper procedure. The hospital administrator was contacted.[92]

Never before having been faced with such a situation, the administrator called the hospital's attorney. During confused communications the parents were first informed that the respirator could not be turned off without a court order. Later, the hospital took the position that treatment could be discontinued without judicial involvement if two electroencephalagrams (EEGs) were run 24 hours apart and showed irreversible brain death. After another day's delay the EEGs were performed and brain death was confirmed. The next day the parents were told that if they executed a release requesting cessation of treatment the respirator would be disconnected. They did so. The respirator was stopped and their son was declared dead, four days after arriving at the hospital.[93]

The parents brought suit alleging negligent infliction of emotional distress and wrongful withholding of a dead body. At trial, the jury awarded the parents $70,000 for each of the claims. The intermediate appellate court reversed. Over a lengthy and passionate dissent, the majority held that there had been no dead body to wrongfully withhold since no physician had actually declared death prior to the life support system being turned off.[94]

89. 676 F. Supp. at 1538-39. The district court also rejected plaintiff's assertion that the earlier state probate proceedings had not provided a full and fair opportunity to litigate the claims under the Act, and further ruled that the Rehabilitation Act claim was barred by res judicata and collateral estoppel. 676 F. Supp. at 1538-42.

90. 109 N.J. 523, 538 A.2d 346 (1988).

91. *Id.* at 526, 538 A.2d at 347.

92. *Id.*

93. *Id.* at 527-28, 538 A.2d at 348.

94. Strachan v. John F. Kennedy Memorial Hospital, 209 N.J. Super. 300, 314, 507 A.2d 718, 725 (App. Div. 1986), *aff'd in part and rev'd in part*, 109 N.J. 523, 538 A.2d 346 (1988).

Next, the court turned to the novel question of whether defendants could be liable for failing to have procedures in place for disconnecting life support systems. The jury had found that the defendant hospital and its administrator were negligent in failing to have such procedures in place. The appellate court held that no such duty existed. No legitimate public policy considerations suggested to the court that non-doctors be required to establish termination procedures. Accordingly, failure to have such procedures was not negligence.[95]

On final appeal, the New Jersey Supreme Court affirmed in part and reversed in part. It held that there was but one duty owed to the parents: to act reasonably in the disposition of their son's body.[96] Finding that there was more than enough evidence to support a jury conclusion that Jeffrey was dead soon after arriving at the hospital, the court reinstated the wrongful withholding claim and ordered a new trial on the issue of damages.[97] The court agreed with the appellate division and held, as a matter of law, that no duty existed which required the hospital to adopt life-support termination procedures. Such matters, the court ruled, were the business of the medical community and not the judiciary. Failure to have such procedures might relate to whether the body had been wrongfully withheld, but did not create the basis for an additional and separate negligence claim.[98]

7. *Westheart v. Anaheim Memorial Hospital*[99]

Plaintiff in this case was the spouse of 76 year-old George Westheart, who entered the defendant hospital in a vegetative-like state on February 21, 1985. On admittance, Westheart was suffering from congestive heart failure, pneumonia, chronic organic brain syndrome secondary to previous multiple strokes and dehydration.[100] Against Mrs. Westheart's order that no extraordinary or heroic measures be taken to sustain her husband's life, the defendants inserted a gastrostomy feeding tube. The complaint further alleged that the operation was performed for the purpose of inflating medical expenses, and while it would extend Mr. Westheart's life, would provide him no net benefits since it would not improve his prognosis.[101] In fact, Mr. Westheart died prior to the filing of the complaint.[102]

Mrs. Westheart brought suit in her individual capacity as surviving

95. 209 N.J. Super. at 318, 507 A.2d at 727. The court was extremely concerned about creating new bases for hospital liability while the country was in the "midst of a medical malpractice crisis," and where no previous cases had established such a duty. *Id.*

96. Strachan v. John F. Kennedy Memorial Hospital, 109 N.J. 523, 538 A.2d at 349 (1988).

97. *Id.* at 538, 538 A.2d at 354.

98. *Id.* at 538, 538 A.2d at 349.

99. No. 493416 (Super. Ct., County of Orange, Cal. filed June 26, 1986) (dismissed with prejudice on defendant's demurrer), *appeal filed*, No. G 005933 (Cal. Ct. App. 1987).

100. Complaint at ¶ 9, Westheart v. Anaheim Memorial Hosp., No. 493416 (Super. Ct., County of Orange, Cal. filed June 26, 1986) (dismissed with prejudice on defendant's demurrer), *appeal filed*, No. G 005933 (Cal. Ct. App. 1987).

101. *Id.* at ¶¶ 10-11.

102. *Id.* at ¶ 7.

spouse. The complaint alleged a claim for negligent and intentional infliction of emotional distress. Mrs. Westheart sought compensatory and punitive damages.[103] The case was dismissed by the trial court for failure to state a claim on which relief could be granted. It is currently pending in the California Court of Appeals.[104]

8. *Galvin v. University Hospital of Cleveland*[105]

On June 30, 1985, Mr. Galvin, who was suffering from serious heart problems, checked in to the defendant hospital. As his condition worsened he instructed his doctor that he wished to be allowed to die in peace and wanted no heroic efforts to be employed to resuscitate him. In spite of these directions, Mr. Galvin was subjected to cardioversion, a procedure whereby an electric shock is applied to the exterior chest wall, when he experienced a dangerously erratic heartbeat. Upon being stabilized, Mr. Galvin checked himself out of the hospital against medical advice. He died at home a short time later. This case was then filed by his wife and two adult children.[106]

The case set out one claim on behalf of the estate and one claim on behalf of the surviving family members. The estate's claim sought damages for Mr. Galvin's pain and suffering, emotional distress and unnecessary medical expenses, while generally alleging battery and informed consent violations.[107]

The family's claim was based on theories of negligent and intentional infliction of emotional distress. The case proceeded to a jury trial in April, 1988, where a verdict was returned on behalf of the defendant health care providers.

III. Analysis of the Cases and Claims

A. *Differing State Approaches*

Plaintiffs have been conspicuously unsuccessful in prevailing on damage actions growing out of right-to-die cases. While unreported appellate or trial court successes may possibly exist, the only known award received by a plaintiff occurred as a result of the ruling in the *Leach* case.[108] That case merely reinstated a claim dismissed before trial by the lower court judge. The award was through settlement with the hospital and does not reflect a judicial imposition of liability. In fact, when the non-settling doctor in that case went to trial, the judge directed a verdict on his behalf without allowing the case to go to the jury.[109]

103. *Id.* at ¶ 13.

104. Westheart v. Anaheim Memorial Hosp., No. 493416 (Super. Ct., County of Orange, Cal. filed June 26, 1986) (dismissed with prejudice on defendant's demurrer), *appeal filed*, No. G 005933 (Cal. Ct. App. 1987).

105. No. 115873 (Ohio Ct. of Com. Pleas, Cuyahoga County, filed Sept. 8, 1986).

106. Complaint, Galvin v. University Hospital of Cleveland, No. 115873 (Ohio Ct. of Com. Pleas, Cuyahoga County, filed Sept. 8, 1986).

107. *Id.* at ¶¶ 16-19.

108. *See supra* text accompanying notes 47-54.

109. *Id.*

The *Strachan*[110] and *Galvin*[111] cases are the only cases which have proceeded all the way through trial. *Strachan* is a somewhat unusual case even for the right-to-die area, in that the liability theory approved by the New Jersey Supreme Court involved the mishandling of the dead body of the plaintiffs' son. Presumably, plaintiffs' claim would have been just as valid if defendants had merely refused to release the boy's body for the four days.[112] In this light, the health care providers' application of the futile life-support can be seen as merely aggravating circumstances surrounding the quasi-property right infringement.[113] Nevertheless, *Strachan* did not approve a damage theory common to the more "traditional" right-to-die cases: where the complaint centers around the interference with the right to refuse treatment. While *Galvin* did involve such a claim, no appellate decision resulted from the case.

Therefore, while plaintiffs have been successful in a limited number of cases when they have been able to get to a jury, they have been much less successful in front of judges.[114] That is not to minimize the importance of *Leach*. By holding that a health care provider's conduct in a right-to-die case can support a civil damage action, *Leach* laid the foundation for a case like *Galvin*. Nevertheless, the eight cases reviewed here do not provide immediate encouragement for those urging the recognition of a damage claim in right-to-die cases. Furthermore, five of these cases were handed down from appellate jurisdictions that are leaders in championing patients' rights to refuse treatment.

The New Jersey Supreme Court, which denied *certiorari* in *McVey*[115] and which affirmed the intermediate appellate court reversal of the more "traditional" claim in *Strachan*, issued the country's first modern right-to-die opinion in *Quinlan*.[116] *Quinlan* was a broadly-worded decision confirming a fundamental constitutional right to reject treatment. It applied that right in a situation involving a family member's decision on behalf of an incompetent patient. Since *Quinlan*, the New Jersey appellate courts have continued to be at the forefront in expanding right-to-die jurisprudence.[117]

In the 1985 case of *In re Conroy*,[118] the New Jersey Supreme Court

110. *See supra* text accompanying notes 91-99.

111. *See supra* text accompanying notes 106-08.

112. *See* Annotation, *Liability in Damages for Withholding Corpse From Relatives*, 48 A.L.R. 3d 240 (1973).

113. *See* W. PROSSER & P. KEETON, THE LAW OF TORTS ch.2 § 12 (5th ed. 1984) (property right in dead bodies evolved "out of thin air" to protect feelings of survivors "under a fiction likely to deceive no one but a lawyer"). *Id.* at 63.

114. The appellate decision in *Leach* is certainly significant. In reinstating plaintiff's claims, the Ohio appellate court acknowledged that health care providers may subject themselves to civil liability for not only compensatory but also punitive damages if they provide unwanted treatment. The appellate court approved theories of informed consent, violation of constitutional rights and negligent infliction of emotional distress. *See supra* text accompanying notes 45-50.

115. *See supra* text accompanying notes 76-81.

116. *See supra* text accompanying note 15.

117. New Jersey has more reported and precedent-setting right to die cases than any other jurisdiction. *See* SOCIETY FOR THE RIGHT TO DIE, *supra* note 3, at NJ-1 to NJ-20.

118. 98 N.J. 321, 486 A.2d 1209 (1985).

issued one of the most far-reaching right-to-die decisions of the time. After approving the use of living wills and holding that nasogastric tube feeding was medical treatment which could be refused, the court set out three alternative tests for allowing such decisions to be made for incompetent patients.[119] In 1986, *In re Requena*[120] was one of the first cases ordering an unwilling hospital to care for a patient who had refused tube feeding. Then, in 1987, the New Jersey Supreme Court issued three major right-to-die decisions on the same day.

In re Farrell[121] clarified and applied the rule that a competent terminal individual has the right to refuse life-sustaining treatment. The court was faced with a 37 year-old mother of two, completely disabled with ALS, who was being cared for at home and who was attached to a respirator. In setting out a procedure whereby treatment could be refused, the court stressed that primarily the patient, along with family and doctors—not the courts—should be making treatment decisions.[122] *In re Peter*[123] involved a guardian's request to remove a feeding tube from a 60 year-old nursing home resident who was being maintained in a vegetative state. The New Jersey Supreme Court held that life-sustaining treatment can be withdrawn when there is clear and convincing evidence of the patient's wishes, regardless of the length of life expectancy.[124] The court concluded by urging legislative action in the area.[125] *In re Jobes*[126] held that if certain evidentiary standards were met a young vegetative nursing home patient could reject life-sustaining treatment by having close family members exercise substituted judgment on her behalf, even though the patient herself never spoke directly about the issue when competent.

These decisions put New Jersey at the forefront of right-to-die law. It therefore may be significant that in *McVey* and *Strachan* the New Jersey appellate courts were so inhospitable to plaintiffs' right-to-die damage claims.[127] While the *Strachan* court seemed willing to fit the facts into more traditionally recognized tort theories and subject health care prov-

119. *Id.*

120. 213 N.J. Super. 475, 517 A.2d 886 (Ch. Div.), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (App. Div. 1986) (per curiam).

121. 108 N.J. 335, 529 A.2d 404 (1987).

122. *Id.* at 341-43, 529 A.2d at 413-15.

123. 108 N.J. 365, 529 A.2d 419 (1987).

124. *In re Peter* is the first decision which interpreted a general health-care proxy to reach decisions concerning life-sustaining treatment, even when the state's durable power of attorney statute did not authorize medical proxy decisions. *Id.* at 370, 529 A.2d at 426, 429.

125. At the time, New Jersey was not one of the 39 jurisdictions with living will legislation. *See supra* note 7.

126. 108 N.J. 394, 529 A.2d 434 (1987).

127. The *McVey* court ended its opinion by commenting on whether doctors had a duty to obey family requests to remove life-sustaining treatment: "[t]hat time has not come in New Jersey." McVey v. Englewood Hosp. Ass'n, 216 N.J. Super. 502, 506, 524 A.2d 450, 452. In *Strachan*, while the court ruled in plaintiffs' favor on the claim that defendants had wrongfully withheld a dead body, the court held that under existing law the hospital owed no duty to plaintiffs to have procedures or forms for use in terminating life-sustaining treatment. Strachan v. John F. Kennedy Memorial Hosp., No. A-77, slip op. at 8-9. (N.J. Mar. 16, 1988).

iders to liability, the court refused to recognize a duty which could serve as the basis for expanded litigation in the future. Of course, the underlying events in *Strachan* occurred in 1980, when the only reported New Jersey court decision was *Quinlan*, and the law was much less clear than it is today. The underlying action in *McVey* occurred in April, 1985, only three months after New Jersey's second right-to-die case had been decided.[128]

California, another state which has had multiple right-to-die damage claims, is another of the jurisdictions with advanced law in the underlying area. *Barber v. Superior Court*,[129] decided in 1983, was the first case to clear doctors of criminal charges where they had acted to withdraw life-sustaining treatment from an elderly vegetative patient. The decision represented a milestone in approving the discontinuance of artificial nourishment and sanctioning the withdrawal of life-sustaining treatment without a court order.[130] *Bartling v. Superior Court*[131] (*Bartling I*) extended *Barber* and held that the right to reject life-sustaining treatment was not limited to terminal or comatose patients. While the damage claim later brought in this case was unsuccessful,[132] substantial attorney's fees were later ordered to be paid by the doctors and hospital for fees incurred in obtaining the injunctive relief order in the right to refuse treatment part of the case.[133] *Bouvia v. Superior Court*[134] (*Bouvia I*) confirmed the state and federal constitutional and common law right to refuse life-sustaining treatment. In upholding Ms. Bouvia's right to refuse treatment the court found that her motive was immaterial, and that the hospital—a public institution—would be compelled to provide her general care during the effectuation of her decision.[135]

The unsuccessful *Bartling v. Glendale Adventist Medical Center* (*Bartling II*) damage claim was decided by the California appellate courts after the decisions affirming the right to reject life-sustaining treatment in *Barber* and *Bouvia I*. However, the action complained of in *Bartling II* occurred prior to the publication of the decision in *Bouvia I*. Therefore, at the time the *Bartling II* doctors were acting, the only announced decision in the area was *Barber*, and that case dealt with criminal charges against doctors who withdrew treatment from a vegetative patient who was much more disabled than Mr. Bartling. In that context, the appellate court's statement in *Bartling II* that Bartling's survivors' rights were "not legally established or clearly developed in California before [*Bartling*

128. *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).
129. 147 Cal. App.3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983).
130. *Id.* at 1018-1022, 195 Cal. Rptr. at 491-94.
131. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).
132. *See supra* text accompanying notes 56-69.
133. In October 1987, Bartling's attorneys were awarded $160,008 for work performed in *Bartling I*. Bartling v. Glendale Adventist Medical Center, No. C 500735 slip op. (Cal. Super. Ct. Los Angeles County, Oct. 14, 1987). While plaintiffs have not been very successful on their substantive damage claims, an award of attorneys fees against a health care provider can result in the functional equivalent of such a damage award and serve as a powerful warning to other health care providers.
134. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).
135. *Id.* at 1145, 225 Cal. Rptr. at 306.

I],"[136] while neglecting to mention *Barber*, is generally accurate. However, the actions forming the grounds for the pending damage claims in *Bouvia II* and *Westheart* occurred after both *Barber* and *Bartling I* had been decided. Whether that fact will affect the outcome of *Bouvia II* is an open question.

The approach taken by the Ohio courts has been the most "progressive." With absolutely no state precedents in the right-to-die area, an intermediate state court of appeals in *Estate of Leach v. Shapiro* held that claims for relief existed for wrongfully placing a patient on life support.[137] In sustaining the viability of these claims the court cited to Ohio cases outside of the right-to-die area.

In generally sustaining the battery claim in *Leach*, the court cited to an Ohio case which held that a battery was committed when a plastic surgeon performed rhinoplasty on a minor without proper consent.[138] In further analyzing the battery claim under the informed consent theory, the court cited to an Ohio X-ray malpractice case where it was held that a battery claim was stated if a patient's consent to a touching was given without sufficient explanation of the possible effects of the procedure.[139]

Throughout the entire *Leach* opinion only two references to other right-to-die cases were made. In holding that under Ohio law the only way life-support systems could properly be disconnected was pursuant to a court order, the court noted that such a holding was in accord with other jurisdictions which had considered the matter.[140] The only other citation in *Leach* to right-to-die cases was made in generally discussing informed consent doctrine.[141]

The Colorado damages action grew out of treatment in the state's first right-to-die decision. The plaintiff decided to proceed solely on her two federal claims, having abandoned numerous state causes of action.

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136. 184 Cal. App.3d at 970, 229 Cal. Rptr. at 364.

137. 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984). *See supra* text accompanying notes 47-54.

138. 13 Ohio App.3d at 397, 469 N.E.2d at 1051 (citing Lacey v. Laird, 166 Ohio St. 12, 16, 139 N.E.2d 25, 31 (1956)).

139. 13 Ohio App. 3d at 398, 469 N.E.2d at 1052 (citing Belcher v. Carter, 13 Ohio App. 2d 113, 114, 234 N.E.2d 311, 312 (1967)).

140. 13 Ohio App. 3d at 397, 469 N.E.2d at 1052-53 (citing Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Eichner, 73 A.D.2d 431, 426 N.Y.2d 517 (1980), *modified*, *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981)). In fact, the *Leach* court was incorrect in that regard. Just six months after *Saikewicz*, the Massachusetts Appeals Court decided *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978), which substantially cut back the requirement for a court order as set out in *Saikewicz*. *Dinnerstein* was confirmed two years later in the case of *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980). Both cases were decided and reported several years before the decision in *Leach*. New York, on the other hand, continues to be the only jurisdiction which still regularly approves of the parties obtaining such court orders. *See In re* Beth Israel Medical Center, 519 N.Y.S.2d 511, 515 (Sup. Ct. 1987).

141. The court noted that if one carried informed consent doctrine to its extreme and waited to act until a patient was completely disabled the privacy rights recognized in other right to die cases could be circumvented. *Leach*, 13 Ohio App. 3d at 398, 469 N.E.2d at 1053.

Accordingly, the trial court did not have occasion to analyze the state tort claims. The case, therefore, says little about how Colorado courts might view such damage actions in the future.[142]

There is a distinct difference in the way the various courts have addressed these damage claims. The *Leach* court took the approach that such a claim was already well-founded in existing state tort law. By extending these common law tort principles, the court was willing to allow the jury to decide whether defendants had violated the rights of the patient or the family. California and New Jersey have taken a very different approach. They have extended great deference to the medical profession—almost to the point of allowing the health care providers to define what course of conduct is reasonable in these cases. The difference between these two approaches comes down to the question of what duty a particular court is willing to impose on health care providers.

B. *The Duty a Health care Provider Owes Patients and Families*

The right-to-die damage actions which have gone to court have relied on numerous theories. Some cases, like *Westheart* have pled a single claim (infliction of emotional distress on a surviving spouse). Others, like *McVey*, pled well over a dozen claims, split between the decedent's estate and the surviving family members. Given the lack of substantive success, and the great variety of fact situations involved, no key to what a properly pled complaint should look like can be offered.[143]

While commentators have examined some of the cases and suggested numerous damage claim theories, plaintiffs' lawyers have been even more creative in just the few cases reviewed here.[144] It certainly has not been for lack of trying that successful theories have not yet been crafted. Rather, with the exception of Ohio courts, the courts which have considered these damage claims seem reluctant to extend tort law principles which have been established in other medical practice cases into the right-to-die area. While their decisions acknowledge the existence of these principles, so far the courts have failed to apply them. This has been either because the right of the plaintiff to refuse the treatment was not clearly established, or because the court failed to find that the health

142. Ross v. Hilltop Rehabilitation Hospital, 676 F. Supp. 1528 (D.Colo. 1987). The remaining federal claims presented a novel question of the applicability of § 504 of the Rehabilitation Act of 1973, which the court rejected. The court also addressed the extremely important issue of state action under 42 U.S.C. § 1983, discussed at length below. *See infra* text accompanying notes 82-92.

143. Charting the claims in the various damage cases clearly demonstrates which causes of action were most frequently pled. Only *Westheart* and *Bouvia* did not include a survival action made on behalf of the decedent's estate (Ms. Bouvia is still alive). All other cases included claims on behalf of surviving family members, except *Ross*, in which the sole plaintiff was the decedent's estate.

144. Comment, *Damage Actions For Nonconsensual Life-Sustaining Treatment*, 30 ST. LOUIS U.L.J. 895, 911 (1986), mentions ten damage theories, all but one of which have been raised in the cases reviewed here ("false imprisonment"). Additionally, plaintiffs' raised unsuccessful claims under 42 U.S.C. §§ 1981 and 1985 in *McVey* and § 504 of the Rehabilitation Act of 1973 in *Ross*.

care provider owed any duty to be governed by those principles.[145]

Recognition of patients' rights and general health care provider duties in this area should expand as case law continues to clarify the relationship between the parties. This, however, may take a significant amount of time, depending on how the courts approach the issues. Even New Jersey, which has many of the most "advanced" right-to-die cases, has chosen to announce fairly fact-specific decisions, instead of enunciating general rules of sweeping scope.[146] New Jersey also has the most reported right-to-die decisions, and has been deciding these cases since 1976, with its ground-breaking decision in *Quinlan*. The majority of other states still have no reported right-to-die decisions.

As demonstrated by the California and New Jersey opinions in *Bartling II* and *McVey*, there may be a reluctance to recognize damage claims against health care providers who ignore treatment refusal decisions for some years. This reluctance may remain even after the state's initial right-to-die case precedents are established, and may remain all the more true for cases involving claims in which the alleged tortious behavior occurred closer to the date of the state's first such decision. Therefore, if other states adopt the California and New Jersey approach of viewing these right-to-die damage actions as *sui generis*, it may well be many years before such claims can be expected to survive defendants' summary judgment motions.

On the other hand, if states to adopt the Ohio approach and apply the already clearly established law of medical battery and informed consent principles, claims will quickly pass the summary judgment hurdle and reach the juries. Under this model, health care providers will still be able to argue the difficult facts of the case in their affirmative defenses. Viewing the cases this way, the Ohio model acknowledges the general health care provider duty not to treat without consent and leaves it to the trial process to determine whether the duty was breached. The California and New Jersey model allows the judge to determine, under the specific facts of the case, whether any duty even existed.

The Ohio model obviously exposes the health care provider to more potential risk. The California and New Jersey model is oriented to, and protects the rights of, the health care provider. The Ohio model is oriented to, and protects the rights of, patient autonomy. A legitimate policy question exists regarding who, the judge or the jury, should decide whether the duty not to treat without consent should be applied under the circumstances of a given right-to-die damage action.

The question of whether a duty exists in a given situation is a matter of law to be decided by the court.[147] However, much depends on how

145. *See supra* notes 26 & 27 and accompanying text.

146. *See, e.g., In re* Conroy, 98 N.J. 321, 342, 486 A.2d 1209, 1231-32 (1985) (only applies to elderly nursing home patients who are expected to die within a year). Even the narrow holding in *Conroy* was later refined. *See In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987).

147. *See* Strachan v. John F. Kennedy Memorial Hospital, 209 N.J. Super. 300, 507 A.2d 718 (App. Div. 1986) (holding that there was no legal duty for the hospital to have a proce-

the issue is framed. The Ohio court accepted the premise that health care providers generally have a duty not to treat without consent, and that duty is absolute, until competing interests are weighed in court.[148] This approach, by the way it defines the duty involved, will allow such claims to go to trial, and require the health care provider to assert affirmative defenses based on the facts.[149]

The California and New Jersey approach, by taking a much more narrow view of the duty issue, allows the court to reject the existence of a duty as a matter of law. For example, in *McVey* the court posed the duty question as whether the failure to comply with the undocumented request of a family member to immediately stop an incompetent's life-sustaining treatment "constitutes an actionable breach of duty owed to the patient and family."[150] The court, having substantially narrowed the duty issue by phrasing the question in such a way, found that no duty legally existed.[151]

If states adopt the Ohio approach then right-to-die damage law will more quickly develop. If states adopt the California and New Jersey approach then the law will develop more slowly.

C. *Additional Problems Facing Plaintiffs*

Even if the Ohio approach is generally adopted, serious problems still exist for plaintiffs. The first problem centers around the question of the constitutional basis for the right to refuse treatment. The second problem concerns the issue of the survivability of certain tort claims.

1. Is there really a constitutional right to refuse treatment?

Virtually every case that has discussed the right to refuse treatment has found that such a right exists by virtue of the United States Constitution. The *Quinlan* case started it all. There, the court analyzed the father's claim that Ms. Quinlan had a constitutional right to refuse treatment.[152] After considering and rejecting the first and the eighth

dure in place to turn off life-support) (citing W. PROSSER & P. KEETON, THE LAW OF TORTS § 356 (5th ed. 1984); F. HARPER & F. JAMES, THE LAW OF TORTS 1015 (1956); RESTATEMENT (SECOND) OF TORTS § 4 (1965)).

148. Estate of Leach v. Shapiro, 13 Ohio App.3d 393, 396, 469 N.E.2d 1047, 1051-52. The court framed the legal interests in terms of the patient's absolute right to refuse treatment. Where such a right exists, it creates a correlative duty on the part of the health-care provider not to infringe that right. *See* Oddi, *supra* note 16, at 636.

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

150. 216 N.J. Super. at 218, 524 A.2d at 452.

151. *Id.*

152. *Quinlan*, 70 N.J. at 355, A.2d at 660. Karen Ann Quinlan was 21 years old when she lost oxygen flow to her brain for two fifteen-minute periods on April 15, 1975. She was hospitalized in a persistent vegetative state with no cognitive function. She was placed on a respirator and fed through a nasogastric tube. The parties stipulated that she was incompetent. Her father sought both to be appointed her guardian and to be given an order allowing him to discontinue life-sustaining treatment. These requests were opposed

amendments as grounds for such a right, the court considered whether the right of privacy protected the choice to refuse treatment. The court traced the development of the constitutional right of privacy from *Griswold v. Connecticut*[153] through *Roe v. Wade*,[154] and concluded that it was broad enough to encompass a decision to refuse treatment.[155] After ruling that no criminal liability would result to anyone if life-sustaining treatment were discontinued, the court granted the father's petition.[156]

In right-to-die cases following *Quinlan*, the courts relied on this constitutional right to privacy as the basis for the power to refuse treatment. The next several cases decided in the area all picked up on *Quinlan's* constitutional privacy right language. In *Superintendent of Belchertown State School v. Saikewicz*[157] and *In re Dinnerstein*,[158] the Massachusetts appellate courts decided the next two right-to-die cases. Both opinions upholding the right to refuse treatment were based on the same right to privacy.[159] While *Saikewicz* involved the petition of a state facility, the court in *Dinnerstein* failed to mention whether any governmental entities were involved.

The year 1980 saw three right-to-die opinions issued in three different states. Massachusetts decided *In re Spring*,[160] Florida decided *Satz v. Perlmutter*,[161] and Delaware decided *In re Severns*.[162] *In re Spring* involved an incompetent 79 year-old hemodialysis patient whose wife and son petitioned for an order appointing a guardian and approving termination of life-support treatment.[163] The court granted the order, holding that the constitutional right of privacy "to prevent unwanted infringement of bodily integrity," outweighed the state's interest in preserving life.[164] Likewise, in *Satz*, the Florida court of appeals held that a competent 73 year-old totally disabled ALS patient had the constitutional (privacy) right to refuse respirator treatment. The decision relied heavily on the *Saikewicz* opinion.[165] Finally, in *Severns*, the Delaware Chancery

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by Ms. Quinlan's doctors, the hospital, the County Prosecutor, the State of New Jersey and the guardian *ad litem*.

153. 381 U.S. 479 (1965).

154. 410 U.S. 113 (1973).

155. *Quinlan*, 70 N.J. at 10, 355 A.2d at 663. The court also found that such a privacy right existed under the state constitution. *Id.*

156. *Id.* at 52-53, 355 A.2d at 670-71.

157. 373 Mass. 728, 370 N.E.2d 417 (1977).

158. 6 Mass. App. 466, 380 N.E.2d 134 (1978).

159. *Saikewicz*, 373 Mass. at 738, 370 N.E. 2d at 424 (also relying on the common law interest in preserving the inviolability of the person). *Dinnerstein* did not explicitly discuss the constitutional issue but upheld the right to refuse treatment based on *Saikewicz*. 6 Mass. App. at 468-70, 380 A.2d at 136-38 (concluding that judicial proceedings not normally required).

160. 380 Mass. 629, 405 N.E.2d 115 (1980).

161. 362 So.2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980).

162. 425 A.2d 156 (Del. Ch. 1980).

163. *See supra* notes 29-35 and accompanying text.

164. 380 Mass. at 634, 405 N.E.2d at 119-20. The opinion includes no discussion of whether any governmental entities or parties were involved. The court also relied on the common law right to be "free from nonconsensual invasion of his bodily integrity." *Id.*

165. Satz v. Perlmutter, 362 S.2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 S.2d 359 (Fla. 1980) (adopting appellate court decision).

Court adopted a previous appellate court decision in the same case,[166] and held that the husband of a 55 year-old comatose private nursing home patient could exercise his wife's constitutional right to privacy and refuse life-sustaining treatment.[167]

While most of the early cases relied on the common law right of bodily integrity, they primarily rested on the constitutional right to privacy as the basis for refusing life-sustaining treatment. Then, in 1981, the New York Court of Appeals decided *In re Storar*.[168] This case involved facts surrounding two individuals, Brother Joseph Fox, an 83 year-old respirator patient maintained in a vegetative state, and John Storar, a 52 year-old profoundly retarded incompetent with terminal cancer who needed regular blood transfusions to extend his life. In upholding the guardians' right to refuse life-sustaining treatment for both patients, the court specifically discussed whether the right was guaranteed by the constitution. However, the court ultimately refused to decide the issue, holding that the right was "adequately supported by common law (sic) principles."[169] Since the *Storar* decision, New York courts have continued to rely solely on the common law as a basis for the right to refuse treatment.[170]

Since the New York decision in *Storar*, somewhat of a split has developed in the cases. New York and Maine[171] have become the two jurisdictions which base the right to refuse treatment solely on common law principles. All other jurisdictions recognize a federal constitutional privacy right to support such treatment refusal decisions.[172] Even New York and Maine have not rejected the existence of such a constitutional right. They merely have not reached the issue.[173]

Yet, for the most part, the courts that have found a constitutional

166. Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. 1980).

167. *Id.* at 159.

168. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 *cert. denied sub nom.*, Storar v. Storar, 454 U.S. 858 (1981).

169. 52 N.Y.2d at 376, 420 N.E.2d at 70, 438 N.Y.S.2d at 273.

170. *See, e.g.*, Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987); Saunders v. State, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985); *In re* Lydia E. Hall Hospital, 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982).

171. *See In re* Gardner, 534 A.2d 947, 951-52 (Me. 1987).

172. Most cases which acknowledge the federal constitutional basis for the right to refuse treatment also discuss the state constitutional and common law rights as well. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (1984) (basing right to refuse treatment on federal constitution and common law but not discussing the state constitution); Corbett v. D'Alessandro, 487 So.2d 368 (Fla. Dist. Ct. App.), *reh'g denied*, 492 So.2d 1331 (Fla. 1986) (basing right to refuse treatment on federal and state constitutions but not discussing the common law right); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986) (recognizing federal constitutional and common law right to refuse treatment, but not mentioning the state constitution); *In re* Torres, 357 N.W.2d 332 (Minn. 1984) (agreeing with states which have found a federal and common law right to forego life-sustaining treatment); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

173. It may be argued that such an approach is preferred under the rule that if a court can avoid reaching a constitutional issue, it should do so. *See* Gulf Oil Co. v. Bernard, 452 U.S. 89, 99 (1981); Dillard v. Industrial Comm'n, 416 U.S. 783, 785 (1974).

basis for treatment rejection have failed to supply the necessary analysis justifying application of the right. If the constitutional right of privacy exists as part of the freedoms implicit in the Bill of Rights, it exists as a protection against government interference with a fundamental privacy interest.[174] If the government has not invaded the privacy interest, no constitutional issue exists. For example, in an analogous area, the fourth amendment of the United States Constitution protects "[tlhe right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures . . . ." However, when a private party, acting on his own, seizes and inspects mail without the sender's or recipient's permission, neither the fourth amendment nor any other part of the Constitution is implicated.[175] The lesson is that while a constitutional right protecting privacy may exist, without governmental intrusion into that protected interest, no constitutional violation or issue is raised. As in the mail search example, a private, unauthorized search and seizure may violate the common law right to privacy, but it does not implicate the constitution.[176]

2. The state action issue

If courts are going to base the right to refuse life-sustaining treatment on the constitutional right of privacy, such decisions should properly include an analysis of what governmental action invaded the right. To date, few courts have even addressed the issue. The first decision to raise the question was the 1980 New York case of *Eichner v. Dillon*.[177] In deciding whether the federal constitutional right to privacy justified an order to withdraw a respirator from an 83 year-old incompetent in a permanent vegetative coma, the court analyzed the state action issue for the first time. The court held that the existence of three factors was sufficient to support a finding of state action. First, the state had implied a threat to seek civil and criminal penalties were the respirator withdrawn. Second, the health care providers were licensed by the state, and their right to practice medicine might be threatened were they to discontinue treatment. Finally, the court held that the state's *parens patriae* responsibility over incompetents was sufficient to establish the existence of state action. Having considered these factors, the court concluded that there was "a sufficiently close nexus between the State and the *challenged action* of the regulated entity so that the action of the latter may be fairly treated as that of the State itself."[178] This decision, however, was

174. *See* Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965) ("zone of privacy created by several fundamental constitutional guarantees"); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("right of the individual . . . to be free from unwarranted governmental intrusion into matters . . . fundamentally affecting a person"); Roe v. Wade, 410 U.S. 113, 153 (1973) ("right of privacy . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state actions").

175. *See, e.g.*, United States v. Jacobsen, 466 U.S. 109, 113 (1984).

176. *See, e.g.*, Vernars v. Young, 539 F.2d 966, 969 (3d Cir. 1976).

177. 73 A.D.2d at 431, 426 N.Y.S.2d 517 (1980).

178. *Id.* at 461, 426 N.Y.S.2d at 540 (quoting Jackson v. Metropolitan Edison Co., 419 U.S. 345, 351 (1974)).

overturned in *In re Storar* where the higher court affirmed the order to remove the respirator but deleted all other findings in the *Eichner* decision below.[179]

The next case to explicitly consider the state action question was Washington's first right-to-die case, *In re Colyer*.[180] This decision involved a 69 year-old comatose patient being kept alive by a respirator, whose husband sought an order discontinuing life-sustaining treatment. The court noted that the federal constitutional right to privacy only extended to situations involving state action.[181] Adopting the test and the factors considered in the overruled *Eichner* case, the court held that state action was present and the constitutional right of privacy applied.[182] Exactly the same analysis and result was reached in Arizona's first right-to-die case, *Rasmussen v. Fleming*, where the court cited both *Eichner* and *Colyer*.[183]

The above cases create a string of well over a dozen right-to-die decisions based on the constitutional privacy right to refuse treatment where either an explicit or an implicit finding of state action was made. The three cases that directly confront the issue, *Eichner*, *Colyer* and *Rasmussen*, specifically found state action. However, two recent decisions cast doubt on this line of cases and analysis. Both arose where plaintiffs were seeking to impose civil liability on defendant health care providers for providing unwanted life-sustaining treatment.

Prior to its most recent decision in the *Bouvia* cases, California had consistently held that patients had a federal constitutional right to refuse life-sustaining treatment.[184] One of these earlier cases was set in the context of Ms. Bouvia's attempts to have health care providers refrain from providing unwanted treatment. However, in a more recent opinion in which Ms. Bouvia sought attorney's fees for successfully obtaining injunctive relief orders against her health care providers, an intermediate California appellate court retreated from earlier constitutional analysis. In *Bouvia II* the court held:

> [w]hile it is true that in both *Bartling I* and *Bouvia II* the author of the majority opinion alluded to a constitutional basis for the right vindicated, it seems clear that the right primarily is a development of common law and for that reason applies to patients in private as well as governmental facilities and to patients being treated by private as well as publicly-employed medical practitioners.[185]

179. *Storar*, 52 N.Y.2d at 382, 420 N.E.2d at 74, 438 N.Y.S.2d at 276 (holding that the common law right to bodily integrity was sufficient to support the treatment withdrawal decision). *See supra* text accompanying notes 172-74.

180. 99 Wash. 2d 114, 660 P.2d 738 (1983).

181. *Id.* at 121, 660 P.2d at 742.

182. *Id.*

183. Rasmussen v. Fleming, 741 P.2d 674, 682 n.9 (Ariz. 1987).

184. *See* Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 301; Bartling v. Superior Court, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225.

185. Bouvia v. County of Los Angeles, 195 Cal. App. 3d 1075, 1080, 241 Cal. Rptr. 239, 247 (1987) (citations omitted). The court also found that the way in which Ms. Bouvia was treated did not reflect a governmental policy or custom, so the governmental entity

The denial of fees under Ms. Bouvia's federal civil rights act claim, based on a finding of no state action, spells trouble for her pending damage actions claiming violations of 42 U.S.C. § 1983.

The California court's finding of no state action in *Bouvia II* was cited in the recent Colorado case of *Ross v. Hilltop Rehabilitation Hospital.*[186] In support of a § 1983 claim, the plaintiff in *Ross* advanced the factors and arguments which had led to a finding of state action in *Eichner*, *Colyer* and *Rasmussen*. The patient in *Ross* was being cared for in a private medical facility, by private doctors, presumably, as in all three previous cases.[187] The federal district court in *Ross*, however, came to the opposite conclusion. Relying on several recent cases which had found that private health care facilities and doctors were not state actors, even though they had received federal funds, the district court granted summary judgment against the plaintiff.[188] In analyzing the state action claim the federal district court ignored the issue of the *parens patriae* relationship between the patient and the state—a factor heavily relied on by the other courts.[189]

Trying to harmonize these different rulings is difficult. The early right-to-die opinions were based on the constitutional right to privacy, but failed to even address the state action issue. The New York and Maine approach side-stepped the issue by relying on the common law right to bodily integrity. Later right-to-die cases continued relying on the constitutional privacy right, and a few even performed some analysis, finding the requisite state action. However, as soon as plaintiffs started to use the constitutional rights theory in order to support civil claims against providers of unwanted treatment, the courts retreated and found no state action. To reach such a result, the California court actually had to ignore two prior rulings in much heralded cases.

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could not be found liable. *Id.* at 1087-88, 241 Cal. Rptr. at 246-47 (citing Monell v. New York City Dept. of Social Services, 436 U.S. 658, 690-91 (1978)). However, the court then went on to add that there had not as yet been any showing that the individual defendant doctors had violated any of plaintiff's constitutional rights and so no attorney's fees would be assessed against them under 42 U.S.C. § 1988. *Id.* This finding is questionable in light of the court's decision in that there was a constitutional right to refuse treatment. *See Bouvia v. Superior Court*, 179 Cal. App. 3d at 1137, 225 Cal. Rptr. at 301. Ms. Bouvia's attorneys, however, were awarded fees under the California private attorneys general statute for her success in *Bouvia I* and the lower court decision in *Bouvia II*. *Bouvia v. County of Los Angeles*, 195 Cal. App. 3d at 1086, 241 Cal. Rptr. at 245-46.

186. 676 F. Supp. 1528 (D. Colo. 1987). *See supra* text accompanying notes 82-92.

187. In *Rasmussen*, the patient was in a private Tucson, Arizona nursing home. In *Colyer* the patient was in a religiously affiliated hospital. In *Eichner* the patient was in "Nassau Hospital." In none of the decisions did the courts discuss the public or private status of the hospitals or doctors.

188. 676 F. Supp. at 1535-37. *See* Annotation; *Action of Private Hospital as State Action Under 42 U.S.C. § 1983 or Fourteenth Amendment*, 42 A.L.R. Fed. 463 (1979).

189. *See Rasmussen*, 741 P.2d at 682 n.9; *Eichner*, 73 A.D.2d at 460, 426 N.Y.S. 2d at 540. *Colyer*, 99 Wash. 2d at 120, 660 P.2d at 742; In *Ross*, however, the plaintiff alleged that the patient was competent. This was contested by the defendants. Ironically, if the plaintiff in *Ross* was correct, that fact theoretically might have weakened plaintiff's state action argument, since the state has no *parens patriae* duties with respect to competent patients. However, since the *Ross* patient was being treated as if he were incompetent, the net effect should have been the same.

Certainly, the early cases glossed over the important state action question without the necessary analysis. Even the cases which later addressed the issue provided little in the way of reasoning. The recent findings of no state action, however, seem equally flawed. California's latest decision in *Bouvia II* contradicts the holdings in its two earlier right-to-die cases without sufficiently considering the status of the doctors who violated Ms. Bouvia's rights. The Colorado federal district court, on the other hand, failed to appreciate, or even consider, the unique and important *parens patriae* relationship between a patient attempting to exercise his right to refuse treatment and his health care providers. This issue had been the crucial factor in the earlier decisions finding state action. To date, therefore, an adequate analysis of the issue has not been performed by the courts. The future of plaintiffs' § 1983 damage claims and § 1988 attorney's fees claims is thus uncertain.

3. State tort claims — the survivorship problem

Much of the future of right-to-die damage actions rests on the how the duties of health care providers are defined and whether courts adopt the Ohio approach or the California and New Jersey approach to the duty issue. However, another, analytically more difficult, issue exists: the survivability of a decedent's personal damage claim against his health care providers.

Of the damage claims that have been brought, two cases have been directly affected by this issue. In *Leach* and *Bartling II*, the courts dismissed the plaintiffs' claims for emotional and physical pain and suffering because state law precluded survival of such damage claims for the decedent.[190] In *Ross*, after the death of the patient, the federal court damage action was amended to exclude all state claims. Colorado's survival statute prohibits damages for pain and suffering.[191] In none of the other damage actions was the issue relevant, since claims were not made by the estate for decedent's pain and suffering. However, this was perhaps because those claims were precluded by the applicable state survival statutes.[192]

190. Bartling v. Glendale Adventist Medical, Center 184 Cal. App. 3d 961, 969, 229 Cal. Rptr. 360, 364 (1986) ("decedent's cause of action for pain and suffering dies with him"). Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 395, 397, 469 N.E.2d 1047, 1052, 1054 (1983) (patient's estate may recover for battery but not for invasion of privacy claim since privacy is a personal right which lapses with decedent's death).

191. COLO. REV. STAT. § 13-20-101(1) (1987). An issue not addressed in *Ross* is whether the § 1983 claims would have been limited by the Colorado survival statute. See Annotation, *Survivability of Civil Rights Course of Action Based on 42 U.S.C. § 1983*, 42 A.L.R. Fed. 163 (1979).

192. The pending *Bouvia* damage claims are not affected by the California survival statute which precluded recovery for pain and suffering in *Bartling II* because Ms. Bouvia is still alive. *Westheart*, currently pending, includes no claims for decedent's pain and suffering. *See supra* note 104 and accompanying text. *Galvin* includes a battery claim on decedent's behalf. *See supra* note 108 and accompanying text. This claim is not barred by Ohio law, as reflected in *Leach*. *See supra* note 50 and accompanying text. The *Strachan* case asserted no such claims, and while the *McVey* complaint did, the case was dismissed on the

The law of the survival of actions is a patchwork of confusing and probably outmoded rules.[193] At common law if a tort victim died (from whatever cause) before judgment was entered on his behalf, his claim died with him.[194] This rule has been modified by statute in almost every state, but the statutory provisions themselves greatly vary, and several do not permit recovery for decedent's pain and suffering.[195] While it has been argued that permitting such recovery would bestow a windfall to decedent's heirs,[196] in right-to-die damage actions a countervailing factor exists.

In cases where defendant health care providers administer unwanted life-sustaining treatment, the nature of the intrusion can be significant. For example, in *Bartling II*, a competent and extremely ill patient was placed on a ventilator against his will, with a tube inserted in his throat by way of a tracheostomy. His hands were literally tied down to prevent him from pulling out the tube, and (presumably) he was being supplied artificial nutrition through a nasogastric or gastrostomy tube inserted into his stomach.[197] For a competent unwilling patient such as Mr. Bartling, that kind of treatment can only be described as torture. He was kept in this state from May 30, 1984, when he signed a declaration demanding to be freed from what he complained was a battery, until his death, 160 days later, on November 6, 1984, when he died with the machines still attached.[198] During that entire time he was in constant pain. Yet, because of the application of the California survival statute, no claim could be made to recover for Mr. Bartling's suffering.[199]

The injustice of such a rule of law is perhaps less apparent in the *Bartling II* case because it was an early right-to-die damage action where the court held that the health care provider's duty was not clear. However, the applicability of the survival statute does not depend on the existence of the underlying tort or the duty owed by defendants. Therefore, if and when California law develops to the point where right-to-die damage actions are recognized, plaintiffs will nevertheless be precluded from claiming damages for the decedent's pain and suffering. Application of such a statutory bar creates a terribly anomalous situation. Defendants may provide highly intrusive life-sustaining treatment to

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duty issue without reaching the survival question. *See supra* notes 78-80 and accompanying text.

193. 2 S. SPEISER, RECOVERY FOR WRONGFUL DEATH § 14:4 (2d ed. 1975 and Supp. 1987).

194. *See, e.g.*, Higgins v. Butcher, 80 Eng. Rep. 61 (K.B. 1607).

195. 2 S. SPEISER, *supra* note 194, App. A at 648-787 (setting out all state survival statutes). Examples of jurisdictions with survival statutes which preclude all recovery for decedents' pain and suffering include: ARIZ. STAT. ANN. § 14-3110 (West 1975); CAL. PROB. CODE § 573 (West 1956 & Supp. 1988); COLO. REV. STAT. § 13-20-101(1) (1987); D.C. CODE ANN. § 12-101 (1981). *But see* R.I. GEN. LAWS § 10-7-7 (1985).

196. W. PROSSER & P. KEATON, THE LAW OF TORTS § 126 (5th ed. 1984).

197. *Bartling v. Glendale Adventist Medical Center*, 184 Cal. App. 3d at 966, 229 Cal. Rptr. at 361.

198. *Id.* at 966-67, 229 Cal. Rptr. at 361-62.

199. *See supra* notes 193 & 196.

unwilling patients and then automatically extinguish any potential liability for the pain and suffering that has been caused by merely honoring the right to refuse treatment and letting the patient die.

This macabre result is not ameliorated by allowing surviving family members to sue on their own, since they may not have been present to suffer the harm necessary under emotional distress theories.[200] Application of survival statutes barring actions for decedent's pain and suffering thus allows the defendants to absolutely limit liability by ceasing the tortious behavior. Such a result is highly unusual if not unique, and certainly against public policy. However, the only solution which can be offered at this time is for surviving family members to make pain and suffering claims in the face of such statutes and be prepared to argue their inapplicability or unconstitutionality as applied.[201]

VI. CONCLUSION

Right-to-die jurisprudence has developed quickly over the last dozen years. However, substantial uncertainties exist in the legal and medical communities about when particular behavior is required of health care providers. A deep reluctance exists on the part of the courts to assess civil liability against health care providers when they are seen as having acted in good faith to preserve life. The courts themselves have failed to come to grips with many of the fundamental issues involved and have been careless in analyzing important constitutional and state action questions.

At some point the courts will be forced to give broader recognition to the right-to-die damage action. If health care providers are never held liable when they do violate the patient's right to refuse treatment, there will never be any material incentive for them to acknowledge those rights. Under such circumstances, health care providers would be encouraged to act in their own best interests and not that of their patients. While the courts are understandably reluctant to interfere with the details of the doctor-patient relationship when basic bioethical principles are in a state of flux, the fundamental rights of patients must be recognized. Legislative action in such an area is, of course, preferred. However, living will statutes and other legislative forays into the field will never address all of the issues. The courts, as well as the legislatures, have a legitimate role in protecting patient rights.

200. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 46(2)(a) (1965).

201. *Cf.* Rodgers v. Ferguson, 89 N.M. 688, 556 P.2d 844 (1976) (neither common law nor survival statute applicable to bar personal injury claim of decedent brought by surviving spouse). *See also* Moyer v. Phillips, 462 Pa. 395, 341 A.2d 441 (1975) (application of survival statute held unconstitutional as violation of equal protection).