

COMMENT

ADVANCE DIRECTIVES: PEACE OF MIND OR FALSE SECURITY?

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This Comment is dedicated in loving memory of my father, John B. Joiner, Jr., 1926–1990.

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I. INTRODUCTION — THE LANDMARK QUINLAN DECISION

*"[T]hank God I've got this taken care of. I can go in peace when my time comes."*¹

*Tempora mutantur et nos mutamur in illis.*²

March 31, 1996, marked the anniversary of the genesis of two decades of legal and societal change. Exactly twenty years earlier, a landmark decision of the New Jersey Supreme Court decided the nation's first major right-to-die case.³

The gradual metamorphosis began quite unexpectedly almost a full year earlier when twenty-one-year-old Karen Ann Quinlan slipped into a coma at a party on April 15, 1975.⁴ When doctors diag-

1. *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4, 8-9 (Fla. 1990). Estelle Browning, referring to her living will executed more than five years before she was placed on life-sustaining nutrition. *See id.*

2. Times change and we change with them.

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

4. *See id.* at 653-54. On April 15, 1975, for reasons unknown, Karen Quinlan stopped breathing for at least two 15-minute intervals and resuscitation attempts by friends were unsuccessful. *See id.* When Karen arrived at the hospital, she had a fever,

nosed her as being in a “chronic persistent vegetative state,”⁵ her parents began a process of agonizing soul-searching, seeking guidance from their faith and from medical professionals about how to handle their crisis.⁶ Doctors predicted that Karen would probably not survive more than a year regardless of any treatment she received, and that removal from her respirator would very likely cause death.⁷ Attempts to wean Karen from the respirator were unsuccessful and eventually abandoned.⁸ With no hope that Karen would ever recover, the Quinlans reached the difficult decision to remove her life-sustaining respirator even with the “known” consequences.⁹

Yet, the Quinlan's dilemma was only beginning because Karen's doctor refused to honor their request based on his conception of medical standards, practice, and ethics.¹⁰ Turning to the judicial system for relief, the Quinlan family unknowingly, and quite unintentionally, launched the nation's first major right-to-die case. The case received substantial publicity prior to the New Jersey Supreme Court's March 31, 1976 decision.¹¹ In a recent interview recalling the

unreactive pupils, and she did not respond even to deep pain. *See id.* at 654. Three days later, she was comatose and required a respirator to breathe. *See id.*

5. *Quinlan*, 355 A.2d at 654. A person who is in a “chronic persistent vegetative state” is one who “remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function.” *Id.* (quoting Dr. Fred Plum, an expert witness who testified at the trial).

6. *See id.* at 657–58.

7. *See id.* at 655.

8. *See id.*

9. *See Quinlan*, 355 A.2d at 656. Competent medical testimony established Karen Quinlan had “no reasonable hope of recovery from her comatose state by the use of any available medical procedures.” *Id.* at 659 (quoting Bishop Lawrence B. Casey who is cited in an amicus curiae brief filed by the New Jersey Catholic Conference). Joseph Quinlan endured months of “tortured indecision” preceding his conclusion, and sought solace in private prayer, his parish priest, and the Catholic chaplain at St. Clare's Hospital before reaching his decision. *See id.* at 657–58.

10. *See id.* at 657. Medical obligations relate to standards and practice “prevailing in the profession.” *Id.* at 666. “[A] doctor is required to exercise in the treatment of his patient the degree of care, knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in his field.” *Id.* (citing *Schueler v. Strelinger*, 204 A.2d 577, 584 (N.J. 1964)). Thus, the trial court appropriately denied authorization to withdraw the respirator, consistent with the then-existing standards. *See id.* However, the court re-evaluated the applicability of the medical standards and found the decision should have been based upon the reasonable probability that Karen would return to a cognitive and sentient life, rather than the forced continuance of Karen's biological vegetative state. *See id.* at 669. The court could not justify declaratory relief based solely on the pertinent medical standards and practices. *See id.*

11. *See Quinlan*, 355 A.2d at 671–72.

case, Karen's mother, Julia Quinlan, stated, "our privacy was totally erased after that."¹² Indeed, the Quinlan name became renowned by the widely published photograph and story.¹³

As plaintiff, Joseph Quinlan represented two interests: he derivatively raised the constitutional and legal rights of his daughter, and individually raised his own parental rights.¹⁴ The Quinlans' case ultimately reached the New Jersey Supreme Court.¹⁵ That court weighed the State's interests in preserving and sanctifying human life and defending the physician's right to administer medical treatment according to his best judgment,¹⁶ against Karen's personal right to privacy.¹⁷ The court reasoned that the State's interest weakens and the individual's right to privacy strengthens as the "degree of bodily invasion increases and the prognosis dims [eventually reaching a point where] the individual's rights overcome the State's interest."¹⁸ In Karen's situation, the bodily invasion was great — requiring around-the-clock care, antibiotics, a respirator, a catheter, and a feeding tube.¹⁹ The court and the Quinlan family were confident that if she were able to communicate her choice, Karen would have exercised her right to refuse treatment.²⁰

Because of Karen's incompetent physical condition,²¹ the New Jersey Supreme Court held that her right of privacy, and thus her right to refuse treatment, could be asserted by her guardian, her father Joseph Quinlan.²² The guardian and family were permitted to

12. Ravi Nessman, *Quinlans Mark Date of Right-to-Die Ruling*, FLA. TIMES-UNION (Jacksonville), Mar. 31, 1996, at A1, A9.

13. *See id.* at A1.

14. *See Quinlan*, 355 A.2d at 660.

15. *See id.* at 651.

16. *See id.* at 663.

17. *See id.* at 663–64. An "unwritten constitutional right of [personal] privacy . . . exist[s] . . . [in] the Bill of Rights." *Id.* at 663 (citing *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965)). This right includes "a patient's decision to decline medical treatment under certain circumstances, [just as it encompasses] a woman's [right] to terminate pregnancy under certain conditions." *Id.* (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

18. *Quinlan*, 355 A.2d at 664.

19. *See id.*

20. *See id.*

21. "Incompetency" is a relative term and can be used to show lack of physical or intellectual fitness. *See* BLACK'S LAW DICTIONARY 765 (6th ed. 1990); *see also* FLA. STAT. § 765.101(7) (1995) (defining "incapacity" or "incompetent" to mean a patient who is "physically or mentally unable to communicate a willful and knowing health care decision").

22. *See Quinlan*, 355 A.2d at 664. The court stated:

render their best judgment as to how Karen would have exercised her choice,²³ but only after they first satisfied three criteria: (1) agreement between Karen's guardian and her family, (2) conclusion of the attending physicians that there was no reasonable possibility Karen would ever emerge from her coma, and that artificial life-support should be discontinued, and (3) concurrence of the hospital Ethics Committee.²⁴ Since all three criteria had been met, the New Jersey Supreme Court unanimously allowed withdrawal of Karen Ann Quinlan's life-support system.²⁵ That court also specifically provided immunity from any civil or criminal liability for any and all participants.²⁶

A. Why Was *Quinlan* First?

An obvious question occurs: why was *Quinlan*, decided in 1976, the nation's first major right to die case? As early as 1891, the Supreme Court recognized the common law right of every individual to "possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."²⁷ From this notion stemmed the requirement of informed consent for medical treatment.²⁸ The right of sound-minded adults to determine what shall be done with their own bodies had been recog-

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice.

Id.

23. *See id.*

24. *See id.* at 671.

25. *See id.* at 672. The judge considered the character and motivation of Joseph Quinlan as prospective guardian of his daughter. *See id.* at 658. Ironically, Karen Quinlan was removed from the respirator in May 1976, but she did not die as expected. *See* Nessman, *supra* note 12, at A9. She died June 11, 1985. *See id.*

26. *See Quinlan*, 355 A.2d at 672. Participants included the guardian, any physician, hospital, or others who were involved in withdrawing Karen's life support system. *See id.* *See infra* note 114 for examples of current statutes which absolve participants from liability.

27. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (quoting *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891)).

28. *See id.* at 269. Justice Cardozo stated, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id.* (quoting *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

nized for more than six decades prior to the *Quinlan* decision.²⁹ At common law, the legally unjustified, nonconsensual touching of one person by another is a battery.³⁰ The logical corollary to the doctrine of informed consent is the right to withhold consent and refuse treatment.³¹ This right stems from the common law personal liberties of self-determination and informed consent, protected by the Fourteenth Amendment.³² Yet, even though enforcement is often difficult, there were relatively few right-to-refuse treatment decisions prior to *Quinlan*.³³

B. Technology Forces Evolution

Perhaps one reason the issue seldom arose previously is that terminally ill and permanently vegetative patients of earlier eras often died at home, quickly and quietly, surrounded by family.³⁴ Yesteryear's diseases and epidemics frequently killed swiftly, without warning, and available treatments were often ineffective.³⁵ Today, the potential for indeterminate prolongation of life, whether accompanied by pain and suffering or suspended in a vegetative existence, is no longer science fiction. Even unconquered diseases often are controlled for extended periods of time.³⁶ The result is that

29. *See id.* at 269–70 (citing Schloendorff, 105 N.E. at 93).

30. *See id.* at 269 (citing W. PAGE KEETON ET AL., PROSSER AND KEETON ON LAW OF TORTS § 9, at 39–42 (5th ed. 1984)).

31. *See id.* at 270.

32. *See Lenz v. L.E. Phillips Career Dev. Ctr. (In re Guardianship of L.W.)*, 482 N.W.2d 60, 68 (Wis. 1992) (citing Schloendorff, 105 N.Y. at 93). The Fourteenth Amendment to the United States Constitution provides that “[n]o state shall . . . deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV, § 1.

33. *See Cruzan*, 497 U.S. at 270.

34. *See Compassion in Dying v. Washington*, 79 F.3d 790, 812 n.61 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 116 S. Ct. 2494, *and cert. granted*, 117 S. Ct. 37 (1996). In 1939, 37% of Americans died in care facilities. *See id.* (citing Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-To-Die Jurisprudence*, 25 U. MICH. J.L. REFORM 133, 154 (1991)). Today, 80–85% of Americans die in care facilities. *See id.* (citing *President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment* 17–18 (1983)).

35. *See Compassion in Dying*, 79 F.3d at 811–12. Scarlet fever, cholera, measles, diarrhea, influenza, pneumonia, and gastritis are but a few illnesses that previously killed quickly, but today are almost never fatal in America. *See id.* at 812.

36. *See Compassion in Dying*, 79 F.3d at 812. Several diseases such as diabetes, muscular dystrophy, Parkinson's disease, cardiovascular disease, cancer, and AIDS can

fifty percent of Americans die of a disease diagnosed more than two years in advance.³⁷ In 1978, chronic conditions caused more than eighty-seven percent of deaths.³⁸ The nation abruptly awakened to the potentially negative implications of revolutionary life-sustaining technology developed in the 1950s and 1960s.³⁹ New technology brought the potential for machine and artificially-induced sustenance which could last weeks, months, or even years. Medical science's new-found capabilities altered nature's course and forever changed death's profile. Consequently, physicians, families, and patients began facing unprecedented decisions about when life should end.⁴⁰ *Quinlan*, as the first major case addressing the ethical dilemma of an individual's right to die to emerge from this new medical era, became the basis for numerous subsequent court rulings.

Initially, this Comment will discuss judicial analysis and statutory development following *Quinlan* by discussing the critical struggle to determine when a life should be allowed to end. This Comment will show that, even with judicial and statutory bolstering, end-of-life decisional resolutions are often poor at best, many times offering too little, too late. This Comment will then show that, although the judicial system, as well as federal and state governments, have attempted to provide solid ground for honoring suspension of treatment decisions via provisions for advance directives, living wills, and recognition of health care surrogates and guardians for proxy decisionmaking,⁴¹ the results remain unpredictable. The

be controlled for long periods of time. *See id.* The result is that Americans live longer and often succumb to death either in tremendous pain or in a heavily sedated or semi-comatose state. *See id.* As a result, death typically comes with less dignity. *See id.*

37. *See Compassion in Dying*, 79 F.3d at 812 n.60 (citing G. Steven Neeley, *Chaos in the "Laboratory" of the States: The Mounting Urgency in the Call for Judicial Recognition of a Constitutional Right to Self-Directed Death*, 26 U. TOL. L. REV. 81, 86 (1994)).

38. *See id.*

39. *See* Nessman, *supra* note 12, at A9.

40. *See* *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 270-72 (1990). Most earlier cases concerned patients who exercised First Amendment rights as well as common-law rights of self-determination, and refused medical treatment due to religious beliefs. *See id.* at 270. Advanced medical technology capable of sustaining life beyond the natural point of death produced cases involving the right to refuse life-sustaining treatment. *See id.* Between 1976 and 1988, 54 decisions were reported. *See id.*; *see also* *Cruzan v. Harmon*, 760 S.W.2d at 412 n.4 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

41. Florida defines an "advance directive" as:

A witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concern-

highly individualized nature of each circumstance and the impossibility of accurately foreseeing the future often results in a resolution that comes too late to accomplish the intended purpose. As stated in *Martin v. Martin (In re Martin)*,⁴² “neither law, medicine nor philosophy can provide a wholly satisfactory answer [to a question with such] incalculable ramifications.”⁴³

This Comment will conclude with the recommendation that an aggressive and comprehensive public education program, coupled with a trustworthy health care surrogate for every individual, is the optimum solution. While potential for abuse must be carefully considered, a national system is necessary to alert individuals to the importance of making advance, informed choices about their end-of-life decisions, and health care providers must be allowed to honor valid decisions without incurring liability. Courts and health care providers frequently disregard the woefully inadequate boilerplate advance directive forms. To the extent possible, consistent national guidelines for preparing effective advance directives should be established to consider the myriad of potential end-of-life situations.

ing any aspect of the principal's health care, and includes, but is not limited to, the designation of a health care surrogate, a living will, or orders not to resuscitate

FLA. STAT. § 765.101(1) (1995).

A “living will” is defined as: “[a] witnessed document in writing, voluntarily executed by the principal . . . [or a] witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.” FLA. STAT. § 765.101(10)(a)–(b) (1995).

A health care “surrogate” is “any competent adult expressly designed by a principal to make health care decisions on behalf of the principal upon the principal's incapacity.” FLA. STAT. § 765.101(14) (1995).

In Florida, a health care surrogate's decision must be the decision the surrogate believes the patient would have made under the circumstances. *See* FLA. STAT. § 765.205(1)(b).

A “proxy” is defined as “a competent adult who has not been expressly designated to make health care decisions for a particular incapacitated individual, but who, nevertheless, is authorized . . . to make health care decisions for such individual.” FLA. STAT. § 765.101(13) (1995).

In Florida, a proxy's decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence that the decision is the one the patient would make if competent. *See* FLA. STAT. § 765.401(3) (1995). *See infra* note 219 for the statutory hierarchy of proxies designated by the court. *See supra* note 21 and accompanying text for a discussion of incompetency and incapacitation. Hereinafter the terms “advance directive” or “directive” shall include “living will” as well as decisions of surrogates or proxies made at the direction of the principal.

42. 538 N.W.2d 399, 401 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1996).

43. *Id.* at 401.

Consistency and education will aid both individuals and health care providers to ensure advance directives are properly honored.

C. Judiciary vs. Medical Ethics

Although courts make every effort not to cross the line between the legal and medical professions, technology has forced the end-of-life decision issue to the forefront of the judicial arena. The judicial system is charged with, *inter alia*, (1) protecting the states' interests in preservation of life, (2) protecting the interests of innocent third parties, (3) preventing suicide, and (4) maintaining the medical profession's ethical integrity.⁴⁴ Courts have recognized that while preservation of life is the most important interest, that interest is most significant with a curable affliction, as opposed to an affliction for which treatment can only briefly extend life.⁴⁵ The issue is no longer whether to sustain life, but when to sustain life, how long to sustain life, and at what cost to the individual.⁴⁶ The state's interest in life preservation, separate from the individual's interest, cannot legitimately outweigh the individual's own personal choice to refuse medical treatment.⁴⁷ Yet, the right to autonomy is not absolute when it is weighed against other state interests, particularly the protection of innocent third parties.⁴⁸

II. INCOMPETENT PATIENTS AND THE SUBSTITUTED

44. See *Cruzan*, 497 U.S. at 271. The last and least significant of the state interests is the maintenance of the medical profession's integrity. See *Browning*, 568 So. 2d at 14; see also *Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360, 362 (Ct. App. 1986) (stating a competent adult's right to discontinue life support systems is stronger than the medical profession's ethical integrity). In appropriate circumstances, the right to refuse necessary treatment threatens neither the medical profession's integrity, nor the hospital's proper role, nor the state's interest in protecting the same. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426–27 (Mass. 1977).

45. See *Cruzan*, 497 U.S. at 271.

46. See *id.* (citing *Saikewicz*, 370 N.E.2d at 426).

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

48. Perhaps the most compelling cases for third party protection include those where life-saving blood transfusions are refused by parents of minor children. See *infra* notes 177–81 and accompanying text for examples of cases forcing unwanted treatment on pregnant women and mothers to protect their minor children.

JUDGMENT DOCTRINE

As indicated in *Quinlan*, questions of patient competency further muddled the issue of when end-of-life decisions to refuse or remove life-sustaining treatment should be honored. Following *Quinlan*, in 1977, Massachusetts Supreme Court extended the right to refuse medical treatment to include incompetent patients by applying the substituted judgment doctrine⁴⁹ to determine whether a profoundly retarded, elderly man should receive chemotherapy.⁵⁰ The same year, that court allowed withholding treatment where the evidence supported a determination that the incompetent patient, if competent, would have elected to refuse treatment.⁵¹

In 1981, the New York Court of Appeals heard two cases simultaneously which also set precedent.⁵² That court upheld the right of an eighty-three-year-old brain-damaged man in a vegetative state to remove his respirator based on clear and convincing evidence of statements, made by the patient when he was competent, that he did not want to be maintained in a vegetative state by a respirator.⁵³ In the companion case, the court rejected the substituted judgment rule and ordered that painless blood transfusions not be withheld from a lifelong profoundly retarded man because there was no way to determine what he would want if he were competent.⁵⁴

A. *Cruzan*: The United States Supreme Court Speaks

49. The "substituted judgment doctrine" allows the court to determine what an incompetent individual's decision would have been under the circumstances. *See Saikewicz*, 370 N.E.2d at 431, 434. This standard allows an incompetent person to retain the same rights as a competent individual because the value of human dignity extends to both competent and incompetent individuals. *See id.* at 427. A surrogate decisionmaker can also exercise "substituted judgment" but must decide what the patient would personally choose. *See, e.g., In re Guardianship of Barry*, 445 So. 2d 365, 370-71 (Fla. 2d Dist. Ct. App. 1984). *See also* FLA. STAT. § 765.205(1)(b) (1995), which requires the surrogate to make the decision the patient would make if the patient were capable of making such a decision.

50. *See Saikewicz*, 370 N.E.2d at 427, 431, 434 (holding that the evidence supported a determination that the incompetent patient, if competent, would have elected to refuse chemotherapy and, thus, allowed refusal under the substituted judgment doctrine).

51. *See id.*; *see also* *John F. Kennedy Mem'l Hosp., Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984) (holding that an incompetent person has the same right to refuse medical treatment as a competent person).

52. *See Soper v. Storar (In re Storar)*, 420 N.E.2d 64 (N.Y. 1981).

53. *See id.* at 72.

54. *See id.* at 72-73.

Subsequent cases continued to build upon the principles of *Quinlan*, *Saikewicz*, *Storar* and *Eichner*.⁵⁵

Not until 1990 did the United States Supreme Court address the right-to-die issue.⁵⁶ In that case, thirty-three-year-old Nancy Beth Cruzan sustained severe injuries resulting from an automobile accident in which she was oxygen-deprived for twelve to fourteen minutes.⁵⁷ Paramedics resuscitated Nancy at the scene, but Nancy subsequently required artificial feeding and hydration to sustain her life.⁵⁸ She had no chance of recovering her cognitive faculties.⁵⁹ After emotionally draining deliberation, Nancy's parents requested that hospital employees terminate the artificial nutrition and hydration procedures.⁶⁰ When the hospital refused, the Cruzans petitioned the court to allow them to exercise their substituted judgment⁶¹ and remove Nancy's nutrition.⁶² The trial court found for the Cruzans, but the Missouri Supreme Court reversed the trial court's decision and denied the petition, after finding no clear and convincing evidence of Nancy's desire to have the life-sustaining treatment with-

55. *See In re Conroy*, 486 A.2d 1209 (1985) (holding the right of self-determination is not lost because an individual is unable to sense violation of the right and, thus, incompetent patients retain a right to refuse treatment). The right to refuse treatment can be subjectively exercised by a surrogate decisionmaker in the presence of clear evidence that the incompetent person would have exercised it if capable. *See id.* at 1233. Absent clear evidence, an objective "best interest" standard can be applied if some trustworthy evidence existed that the patient would have terminated treatment, and that the burden of a prolonged life of pain and suffering outweighs the continuation of such a life. *See id.* A "pure objective" standard would apply if no trustworthy evidence of the patient's decision existed, and if administration of life-sustaining treatment would be inhumane. *See id.* at 1231-33. In the absence of any of these conditions, the court held any error should be in favor of preserving life. *See id.* at 1233. *But cf. In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 613-15 (N.Y. 1988) (holding that less than the clearly expressed wishes of the patient should be exercised by a surrogate decisionmaker, and requiring every effort to follow the patient's expressed intent to minimize opportunity for error).

56. *See Cruzan*, 497 U.S. at 261.

57. *See id.* at 266. Permanent brain damage generally results after six minutes of oxygen deprivation. *See id.*

58. *See id.*

59. *See id.* at 267. Nancy was neither dead nor terminally ill. *See Cruzan*, 760 S.W.2d at 411. On the contrary, medical experts testified she could live another 30 years in her then-present state. *See id.*

60. *See Cruzan*, 497 U.S. at 267.

61. *See id.* at 261. *See supra* note 49 and accompanying text for a discussion of the substituted judgment standard.

62. *See Cruzan*, 497 U.S. at 261.

drawn under such circumstances.⁶³ On appeal, the United States Supreme Court cited *Quinlan*, recognizing that the state's interest in sustaining life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."⁶⁴ However, the *Cruzan* Court affirmed the Missouri Supreme Court's holding that clear and convincing evidence of the incompetent's wishes for withdrawal of life-sustaining treatment is required, and concluded that the state is not forced to accept substituted judgment of close family members absent substantial proof their views reflect the patient's views.⁶⁵ Because Nancy Beth Cruzan's family members did not present clear and convincing evidence of Nancy's wishes, the court did not allow removal of her nutrition at that time.⁶⁶

III. THE PATIENT SELF-DETERMINATION ACT

Following *Cruzan*, this area of medico-legal ethics continued to evolve. In a world quickly advancing medically and technologically, an individual's right to die and to control medical treatment either personally or through a surrogate or guardian was gaining attention and strength.

In the same year as the *Cruzan* decision, Congress enacted the Patient Self-Determination Act ("PSDA")⁶⁷ acknowledging patients'

63. *See id.*

64. *Id.* at 270 (citing *Quinlan*, 355 A.2d at 662-64).

65. *See id.* at 269-85. The court rejected the idea that the Cruzans were entitled to order termination of their daughter's medical treatment absent clear and convincing reliable evidence of Nancy's wishes or the formalities required under Missouri's Living Will statutes. *See id.* at 268.

66. *See id.* at 285-86. After hearing more evidence, however, the lower court held that the Cruzan family met the clear and convincing standard and issued a court order that her feeding tube be removed. *See id.* at 261. Nancy Cruzan died December 26, 1990, 12 days after the tube was removed. *See* RONALD D. ROTUNDA, MODERN CONSTITUTIONAL LAW CASES AND NOTES 700 (4th ed. 1983).

67. 42 U.S.C. § 1395cc (1994). This statute provides in pertinent part:

(f) Maintenance of written policies and procedures

(1) For purposes of subsection (a)(1)(Q) of this section and sections 1395i-3(c)(2)(E), 1395l(s), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by

general rights to refuse medical treatment, even if such refusal results in death.⁶⁸ The PSDA, which established a “Miranda⁶⁹ law for patients,”⁷⁰ does not create new rights. Instead, through information distribution requirements, it encourages patients to exercise their existing rights and to make their wishes clear while they remain competent.⁷¹ The PSDA applies to all health care facilities receiving Medicare or Medicaid funds and requires provider organizations to

the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1395mm(b) of this title) or an organization provided payments under section 1395l(a)(1)(A) of this title, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term “advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

Id. § 1395cc(f).

68. *See id.* § 1395cc(f)(1).

69. *See Miranda v. Arizona* 384 U.S. 436 (1966) (holding the police must advise suspects of their rights, including the right to remain silent).

70. Alfred F. Conard, *Elder Choice*, 19 AM. J.L. & MED. 233, 248 (1993) (citing Terese Hudson, *Hospitals Work to Provide Advance Directives Information*, HOSPITALS, Feb. 1991, at 26).

71. *See* 42 U.S.C. § 1395cc(f)(1) (1994).

meet four requirements. First, facilities must document in the patient's medical records whether or not an advance directive⁷² has been executed.⁷³ Second, they must provide education for the community and staff on issues concerning advance directives.⁷⁴ Third, they must maintain written policies and procedures to implement the patients' rights to accept or refuse life-sustaining treatment and execute advance directives.⁷⁵ Finally, they must provide patients with written information about such policies.⁷⁶ Although the PSDA defers to the states' individually-sanctioned directives,⁷⁷ most of those directives echo the PSDA procedures and goals. The goal of the PSDA is not to force execution of directives, but to encourage and motivate patients to draft them.

IV. THE LAW EVOLVES

As a direct result of *Quinlan*, *Cruzan*, and the PSDA, nearly all states now have laws governing living wills and advance directives, as well as durable powers of attorney for health care decisions, which allow a designated person to make life and death decisions in the event of the patient's incompetence.⁷⁸ In addition, the Ameri

72. *See id.* See *supra* note 41 for definitions of advance directive, living will, health care surrogate, and proxy.

73. *See* 42 U.S.C. § 1395cc(f)(1)(B) (1994).

74. *See id.* § 1395cc(f)(1)(E).

75. *See id.* § 1395cc(f)(1).

76. *See id.* § 1395cc(f)(1)(A)(ii).

77. *See id.* § 1395cc(f)(1)(A)(i).

78. *See* *Compassion in Dying v. Washington*, 79 F.3d 790, 819 n.77 (9th Cir. 1996) (citing ALAN MEISEL, *THE RIGHT TO DIE* § 11.12, at 392-93 (1994 Supp. No. 2):

Ala. Code § 22-8A-3(6) (1984); Alaska Stat. § 18.12.100(7) (1986); Ark. Stat. Ann. § 20-17-201(9) (Supp. 1987); Cal. Health & Safety Code § 7186(j) (West Supp. 1992); Colo. Rev. Stat. § 15-18-103(10) (1987 & Supp. 1992); Conn. Gen. Stat. Ann. § 19a-570(3) (West Supp. 1993); Del. Code Ann. tit. 16, § 2501(e) (1983); D.C. Code Ann. § 6-2421(6) (Supp.1987); Fla. Stat. Ann. § 765.101(17) (West Supp. 1993); Ga. Code Ann. § 31-32-2(13) (1991 & Supp. 1992); Haw. Rev. Stat. Ann. § 327D-2 (1991); Ill. Ann. Stat. ch. 110½, para. 702(h) (Smith-Hurd Supp. 1988); Ind. Code Ann. § 16-8-11-9 (Burns Supp. 1988); Iowa Code Ann. § 144A.2(8) (West 1989 & Supp.); La. Rev. Stat. Ann. § 40:1299.58.2(9) (West 1992); Me.Rev.Stat.Ann. tit. 18-A, § 5-701(b)(9) (West Supp. 1991); Md. Health-Gen. Code Ann. § 5-601(g) (1990); Minn. Stat. Ann. § 145B.02(8) (West Supp. 1993); Miss. Code Ann. § 41-41-113 (Supp. 1987); Mo. Ann. Stat. § 459.010(6) (Vernon Supp. 1993); Mont. Stat. Ann. § 50-9-102(14) (1991); Neb. Rev. Stat. § 20-403(11) (Supp. 1992); Nev. Rev. Stat. Ann. § 449.590 (Michie Supp. 1991); N.H. Rev. Stat. Ann. § 137-H:2(VI) (Supp. 1992); N.J. Stat [sic] Ann. § 26:2H-55 (West Supp. 1992) ("A determination of a specific life expect-

can Hospital Association estimated that in 1990, over sixty percent of United States Hospitals had formed bioethics committees to help establish hospital policies on medical-ethical issues and to advise health professionals, patients, and families of their rights and alternatives.⁷⁹ However, statistics indicate additional affirmative steps are necessary to achieve the goal of ensuring every individual's right to make his or her own end-of-life decision is honored.

A. Public Inaction

A 1990 Gallup Poll indicated 84% of respondents would not want life support if they had no chance of recovery.⁸⁰ Yet 75% of Americans still die in institutions, many after a decision to withhold life-sustaining assistance.⁸¹ The Poll also indicated 75% of Americans favor the advance directive⁸² concept, yet only 20% have executed one.⁸³ One unfounded reason cited is fear the directive will take effect even if the patient is able to express his or her own

tancy is not required as a precondition for a diagnosis of a 'terminal condition,' but a prognosis of a life expectancy of six months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical certainty, shall be deemed to constitute a terminal condition."); N.M. Stat. Ann. § 24-7-2(f) (1986); N.D. Cent. Code § 23-06.4-02.7 (Supp. 1989); Ohio Rev. Code Ann. § 2133.01(AA) (Anderson 1991); Okla. Stat. Ann. tit. 63, § 3101.3(12) (West Supp. 1993); Or. Rev. Stat. Ann. § 127.605(6) (1990); 20 Pa. Cons. Stat. Ann. § 5403 (Supp.); R.I. Gen. Laws § 23-4.11-2(h) (Supp. 1992); S.C. Code Ann. § 44-77-20(4) (Law. Co-op. Supp. 1988); Tenn. Code Ann. § 32-11-103(9) (Supp. 1991); Tex. Health & Safety Code Ann. § 672.003(9) (West 1992); Utah Code Ann. § 75-2(10) (Michie Supp. 1993); Vt. Stat. Ann. tit. 18, § 5252(5) (1987); Va. Code Ann. § 54.1-2982 (Michie Supp. 1992); Wash. Rev. Code Ann. § 70.122.020(9) (West Supp.); W. Va. Code § 16-30-2(6) (1985); Wis. Stat. Ann. § 154.01(8) (West 1989 & Supp. 1992); Wyo. Stat. § 35-22-101(a)(ix) (1988 & Supp. 1992). . . . [sic]

Id.; see also Uniform Rights of the Terminally Ill Act, § 1(9), 9B U.L.A. 96, 98 (Supp. 1992).

79. See *Lenz v. L.E. Phillips Career Dev. Ctr. (In re Guardianship of L.W.)*, 482 N.W.2d 60, 74 n.19 (Wis. 1992) (citing Robertson, *Ethics Committees in Hospitals: Alternative Structures and Responsibilities*, 7 ISSUES IN LAW & MED. 83 (1991)).

80. See Lynn Simms-Taylor, *Reasoned Compassion in a More Humane Forum: A Proposal to Use ADR to Resolve Medical Treatment Decisions*, 9 OHIO ST. J. ON DISP. RESOL. 333 n.1 (citing *Mirror of America: Fear of Dying*, Gallup Poll (GALLUP POLL NEWS SERVICE, Jan. 6, 1990)).

81. See Nessman, *supra* note 12, at A9 (quoting John Fletcher, Director, Center for Biomedical Ethics, University of Virginia).

82. See *supra* note 41 for definition of advance directive.

83. See Attorney Barbara Kate Repa, *Living Wills and Health Care Directives*, Nolo Press On-line Seminar, Jan. 16, 1996.

wishes.⁸⁴ However, not only does an advance directive activate only in the event of the patient's incompetency,⁸⁵ but a competent patient's contemporaneous instructions supersede any written directive.⁸⁶ Furthermore, most statutes include provisions for revoking directives without regard to the patient's mental state.⁸⁷ Therefore, a patient who is able to communicate, but lacks decisionmaking capacity, can invalidate an advance directive even though the decision does not accurately reflect his or her current wishes. It is a felony to willfully conceal, cancel, deface, or withhold a known living will of a principal, or conceal personal knowledge of a revocation.⁸⁸ However, statutes may provide immunity from civil or criminal liability for failure to act upon a revocation unless that person has actual knowledge of such revocation.⁸⁹

Another reason for not finalizing this paramount decision is the reluctance to face one's own mortality. Most people only give their end-of-life decision serious consideration when they hear about or personally witness someone else's tragedy or terminal illness. Even then, they often only make casual remarks such as "I would never want to live like that," and take no further action. Such casual remarks, without more, may be insufficient to meet the required standard of proof regarding the individual's wishes.⁹⁰ Young, healthy

84. *See id.*

85. *See* Conard, *supra* note 70, at 252 n.117 (citing COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, ABA PUBLIC SERVICES DIVISION, POWER OF ATTORNEY FOR HEALTH CARE, HEALTH CARE POWERS OF ATTORNEY ¶ 7 (1990)). "[T]he power is declared to be effective upon, and only during, any period of incapacity . . ." *Id.* *See also* FLA. STAT. § 765.204 (1995) (stating the surrogate's authority commences only upon a determination that the principal lacks capacity and ceases in the event the attending physician determines that the principal has regained capacity).

86. *See, e.g.,* FLA. STAT. § 765.104(1)(c) (1995) (stating an advance directive or designation of surrogate may be revoked at any time by the principal with an oral expression of intent to revoke); *see also In re Dubreuil*, 603 So. 2d 538 (Fla. 4th Dist. Ct. App. 1992) (holding a husband of a competent patient can neither make decisions for the patient while she is competent, nor overrule any decisions she made while competent).

87. *See* ALAN MEISEL, THE RIGHT TO DIE 371 (1989).

88. *See, e.g.,* FLA. STAT. § 765.310 (1995) (stating that willfully concealing, canceling, defacing, obliterating or damaging a living will without permission of the principal, resulting in utilization of life-prolonging procedures, is a third degree felony. Willfully concealing or withholding personal knowledge of a revocation resulting in action contrary to the principal's wishes is a second degree felony).

89. *See, e.g.,* FLA. STAT. § 765.104(3) (1995) (stating actual knowledge of a revocation is required before incurring civil or criminal liability).

90. *See* *Martin v. Martin (In re Martin)*, 538 N.W.2d 399, 410 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1995) (stating "[t]he amount of weight accorded prior oral state-

individuals may believe they have plenty of time to think about what they would or would not want done under catastrophic circumstances. *Quinlan*, *Cruzan*, and *Martin* all prove them wrong.⁹¹ The reality is young people probably have more at stake than the elderly. A healthy twenty-one-year-old person who sustains head injuries resulting in a vegetative state would probably survive in that condition with treatment much longer than a similarly-injured sixty-five-year-old.⁹²

Patients should make every effort to provide a copy of their advance directive to all health care providers and/or designated family member, while the patient is still competent.⁹³ Some states specifically place the burden on the patient to advise his or her physician of the advance directive's existence.⁹⁴ It is equally, if not more important to keep health care providers and family members advised of any revocations or changes in their choice of surrogate. It is imperative to take affirmative action and, in order to avoid mistakes, to communicate intent effectively.

B. False Security

The twenty percent of Americans who have executed advance directives are most likely living with a false security that their end-of-life decision is settled. Studies indicate at least twenty-five per-

ments depends on the remoteness, consistency, specificity, and solemnity of the prior statement"); see also *infra* note 116 and accompanying text (discussing *In re Westchester County Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988)); see also, e.g. *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990); *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

91. See *Cruzan*, 497 U.S. at 261; see also *In re Quinlan*, 355 A.2d 647 (N.J. 1976); *Martin v. Martin (In re Martin)*, 538 N.W.2d 399 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1996).

92. See, e.g., *Quinlan*, 355 A.2d at 647 (describing 21-year-old Karen Ann Quinlan who, for unknown reasons, stopped breathing and slipped into a coma at a party); see *Cruzan*, 497 U.S. at 261 (describing then 30-year old Nancy Cruzan's medical condition following an automobile accident; experts testified she was neither dead nor terminally ill, and she could live another 30 years).

93. See 42 U.S.C. § 1395cc(f)(1)(A)(1) (1994). Medicare-Medicaid program providers are required to inform all competent adult patients about state laws on advance directives and record in the patient's medical records any advance directive the patient has, regardless of the condition for which the patient is admitted. See *id.*

94. See, e.g., FLA. STAT. § 765.302(2) (1995) (stating the principal is responsible for notifying his attending or treating physician that the living will exists).

cent of the executed advance directives are not honored.⁹⁵ This statistic is especially disturbing considering the state and federal statutes currently enacted which provide for advance directives or other forms of advance health care decisions,⁹⁶ some of which require certain health care providers to actively provide information and document patient files.⁹⁷

A growing conflict exists between technology's ability to sustain life, the health care provider's endeavor to heal and relieve pain, and the individual's desire for and right to self-determination. No easy answers exist to such emotionally-charged issues. Attorneys ponder the legality, and the religious community argues afterlife implications.⁹⁸ Aside from the patient, the family probably suffers the most in the decisionmaking process. Health care providers, written directives, surrogates, and proxies are challenged on a myriad of bases. Did the patient change his or her mind after making the decision? Are these the precise circumstances under which the patient intended implementation? Was the directive ambiguous? Is there any medical probability the patient will regain competency or recover?⁹⁹

95. See Lynda M. Tarantino, *Withdrawal of Life Support: Conflict Among Patient Wishes, Family, Physicians, Courts and Statutes, and the Law*, 42 BUFF. L. REV. 623, 630 n.32 (1994) (citing Brian McCormick, *Flaws Surfacing in Use of Advance Directives*, 35 AM. MED. NEWS, Aug. 24, 1992, at 32) (stating that a two-year study of nursing home patients with living wills found physicians overrode them in about 25% of cases)); see also Richard E. Shugrue, *The Patient Self-Determination Act*, 26 CREIGHTON L. REV. 751, 779 n.235 (citing Moran Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 884 (1991) (reporting one study where only 75% of patients' advance directives were followed)).

96. See *supra* notes 67 and 78 and accompanying text for a list of federal and state statutes. For an example of a recommended advance directive statute, see FLA. STAT. § 765.303 (1995). For an example of a statutorily recommended designation of health care surrogate statute, see FLA. STAT. § 765.203 (1995).

97. See 42 U.S.C. § 1395cc(f)(1) (1994). The Patient Self-Determination Act (PSDA) is part of the Medicare-Medicaid program and applies only to providers who participate in those coverages. See *id.*

98. See Simms-Taylor, *supra* note 80, at 334 (citing Michele Yuen, Note, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581, 582 (1992)).

99. See FLA. STAT. § 765.306. (1995) which states:

In determining whether the patient has a terminal condition or may recover capacity, or whether a medical condition or limitation referred to in an advance directive exists, the patient's attending or treating physician and at least one other consulting physician must separately examine the patient. The findings of each such examination must be documented in the patient's medical record and signed by each examining physician before life-prolonging procedures may be withheld or withdrawn.

Is the condition really terminal?¹⁰⁰ Does the condition have to be terminal for the directive to take effect? Is the surrogate making the same decision the patient would make or allowing personal feelings to color judgment? Does the surrogate have any personal motive for

Id. See also FLA. STAT. § 765.204(5) (1995) which states: "In the event the surrogate is required to consent to withholding or withdrawing life-prolonging procedures, the provisions [relating to life-prolonging procedures] shall apply."

100. See *Compassion in Dying v. Washington*, 79 F.3d 790, 819 n.78 (9th Cir. 1996) which cites:

CONN. GEN. STAT. ANN. § 19a-570(3) (West Supp. 1993); FLA. STAT. ANN. § 765.101(17)(b) (West Supp. 1993); IOWA CODE ANN. § 144A/2(8) (West 1989 & Supp.) (state of permanent unconsciousness); LA. REV. STAT. ANN. § 40:1299.58.2(7) (West 1992); NEB. REV. STAT. § 20-403(11) (Supp. 1992); NEV. REV. STAT. ANN. § 449.590 (Michie 1991); OHIO REV. CODE ANN. § 2133.01(U) (Anderson Supp. 1991); R.I. GEN. LAWS § 23.411-2(h) (Supp. 1992); TENN. CODE ANN. § 32-11-103(9) (Supp. 1991); VA. CODE ANN. § 54.1-2982 (Michie Supp. 1992). Other statutes reach the same result by defining qualified patient as one who is in a terminal condition or a persistent vegetative state. See, e.g., CAL. HEALTH & SAFETY CODE § 7186(h) (West Supp. 1992); COLO. REV. STAT. § 15-18-103(9) (1987 & Supp. 1992); IOWA CODE ANN. § 144A.2(7) (West 1989 & Supp.); ME. REV. STAT. ANN. tit. 18A, § 5 701(b)(7) (West Supp. 1991); NEB. REV. STAT. § 20-403(9) (Supp. 1992); NEV. REV. STAT. ANN. § 449.585 (Michie Supp. 1991); N.H. REV. STAT. ANN. § 137-H:2(V) (Supp. 1992); OHIO REV. CODE ANN. § 2133.01(Z) (Anderson Supp. 1991); OKLA. STAT. ANN. tit. 63, § 3101.3(10) (West Supp. 1993); OR. REV. STAT. ANN. § 127.605(5) (1990); 20 PA. CONS. STAT. ANN. § 5403 (Supp. 1995); TEX. HEALTH & SAFETY CODE ANN. § 672.002(8) (West 1992); WASH. REV. CODE ANN. § 70.122.020(8) (West Supp. 1995); WIS. STAT. ANN. § 154.01(6) (West 1989 & 1992 Supp.). The amended Hawaii statute, however, achieves this result by deleting the definition of "qualified patient" and adding a definition of "permanent loss of the ability to communicate concerning medical treatment decisions" which includes being in a persistent vegetative state or a deep coma or having a permanent loss of the capacity to participate in medical treatment decisions. See HAW. REV. STAT. ANN. § 327D-2 (1991). Other statutes reach the same result by including a separate definition of persistent vegetative state or permanent unconsciousness. See, e.g., CONN. GEN. STAT. ANN. § 19a-570(4) (West Supp. 1993); GA. CODE ANN. § 31-32-2(9) (1991 & Supp. 1992); ME. REV. STAT. ANN. tit. 18A, § 5-701(b)(10) (West Supp. 1991); MD. CODE ANN., HEALTH-GEN. § 5-601(0); NEB. REV. STAT. § 20-403(6) (Supp. 1992); N.H. REV. STAT. ANN. § 137-H:2(VII) (Supp. 1992); N.J. STAT. ANN. § 26:2H-55 (West Supp. 1992); OKLA. STAT. ANN. tit. 63, § 3101.3(7) (West Supp. 1993) (defining persistently unconscious); 20 PA. CONS. STAT. ANN. § 5403 (Supp. 1995); S.C. CODE ANN. § 44-77-20(7) (Law. Co-op Supp. 1991); UTAH CODE ANN. § 75-2-1103(8) (Supp. 1993); VA. CODE ANN. § 54.1-2982 (Michie Supp. 1992); WASH. REV. CODE ANN. § 70.122.020(6) (West Supp. 1995) (permanent unconscious condition); WIS. STAT. ANN. § 154.01(5m) (West 1989 & Supp. 1992); WYO. STAT. § 35-22-101(a)(v) (1988 & Supp. 1992) ("irreversible coma" [sic]).

Id. (quoting MEISEL, *supra* note 87, at § 11.12 (1989 & Supp. No. 2 1994).

terminating treatment, perhaps as heir to an estate? Are the conditions of the directive properly satisfied? The potential list is endless, and no single unanswered question is less important than another. When families, surrogates, and physicians do not agree with each other, the courts must become involved. Once the courts are involved, and until a definitive answer is reached, the only "safe" solution is to err on the side of life.¹⁰¹ The ultimate result becomes a moot point to the patient who dies before the requisite determination is made and after enduring unwanted life-sustaining procedures.¹⁰²

Physicians and hospitals ponder the medical ethics and liability of withholding life-prolonging treatment, even at a patient's request or at the request of a surrogate decisionmaker. Courts endeavor to balance the patient's rights and the rights of the health care provider, and at the same time avoid forced action which may be contrary to the provider's or facility's moral or ethical beliefs concerning life-prolonging procedures.¹⁰³ Many state statutes provide relief in the form of transfer to a willing facility¹⁰⁴ in the event the health care provider cannot honor the directive for an ethical, moral, religious, or other reason. In such an event, statutes typically qualify the health care provider's immunity based upon notification of the agent,¹⁰⁵ transfer of the patient to a health care provider willing to follow the directive,¹⁰⁶ or both.¹⁰⁷

C. Early Cases of General Civil and Criminal Liability

101. See, e.g., *Martin*, 538 N.W.2d at 399, 401-02.

102. For examples of patients who died prior to resolution of their treatment plan, see, e.g., *Florida v. Herbert* (*In re Guardianship of Browning*), 568 So. 2d 4 (Fla. 1990); *Lenz v. L.E. Phillips Career Dev. Ctr.* (*In re Guardianship of L.W.*), 482 N.W.2d 60 (Wis. 1992).

103. See, e.g., FLA. STAT. § 765.308 (1995).

104. See *id.* (defining a willing facility as "another health care provider or facility that will comply with the declaration or treatment decision").

105. See, e.g., OR. REV. STAT. ANN. § 127.555(5) (1993).

106. See, e.g., FLA. STAT. § 765.308(2) (1995) (stating one must transfer to another health care provider within seven days or carry out wishes of patient or patient's surrogate); OHIO REV. CODE ANN. § 1337.16(B)(2)(a) (Baldwin 1995) (stating a health care provider must not prevent transfer of patient).

107. See, e.g., GA. CODE ANN. § 31-36-8(2) (1995) (holding a provider responsible for advising the agent of its refusal to comply with the directive; agent is then responsible for the transfer of the patient to another facility).

In early cases, fear of liability was one of the reasons health care providers cited for not honoring advance directives. However, courts have held that neither health care providers nor surrogate decisionmakers are subject to criminal liability for honoring advance directive instructions in good faith. In a 1983 case, *Barber v. People*,¹⁰⁸ the State of California charged Doctors Neil Leonard Barber and Robert Joseph Nejdil with murder and conspiracy to commit murder based on their honoring of requests by the patients' families to discontinue life support.¹⁰⁹ The California Court of Appeal held their failure to continue treatment, "though intentional and with knowledge that [the] patient would die, was not [an] unlawful failure to perform [a] legal duty."¹¹⁰ However, health care providers remained cautious, even after *Barber*.¹¹¹

As recently as 1992, a Michigan Court of Appeals held that termination of life support treatment of a vegetative minor subjected neither the parents nor the physicians to criminal liability for homicide.¹¹² Every state with a living will statute provides immunity to any physician, licensed health care professional, medical care facility, or employee who "in good faith and pursuant to reasonable medical standards causes or participates in withholding or withdrawing of life-sustaining procedures."¹¹³ In addition, statutes immunize agents from liability so long as they act in good faith.¹¹⁴

108. 195 Cal. Rptr. 484 (Ct. App. 1983).

109. *See id.*

110. *Id.*

111. *See Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360 (Ct. App. 1986). Bartling's attorney explained that many institutions would not accept Mr. Bartling as a patient because they feared potential criminal and civil liability. *See id.* at 362. Many institutions cited the recent, but unsuccessful, prosecutions of Drs. Nejdil and Barber as reasons for avoiding this situation. *See id.* at n.3. Consequently, the providers would neither accept Mr. Bartling as a patient nor accept a civil liability release. *See id.* Guidelines for the medical profession regarding a competent adult patient's right to die were still developing, and there were no comprehensive legal standards in effect when Mr. Bartling requested removal of his ventilator. *See id.* at 363.

112. *See Rosebush v. Oakland County Prosecutor (In re Rosebush)*, 491 N.W.2d 633, 641 (Mich. Ct. App. 1992).

113. Susan J. Steinle, *Living Wills in the United States and Canada: A Comparative Analysis*, 24 CASE W. RES. J. INT'L L. 435, 452 (1992) (quoting ALA. CODE § 22-8A-7 (1990)).

114. *See, e.g.*, FLA. STAT. § 765.109(1) (1995) stating:

A health care facility, provider, or other person who acts under the direction of a health care facility or provider is not subject to criminal prosecution or civil liability, and will not be deemed to have engaged in unprofessional conduct, as a result of carrying out a health care decision made in accordance with the

Yet, health care providers or doctors may be unable to make a “good faith” decision that requires withholding or removing treatment. That stumbling block is exemplified in *In re Westchester County Medical Center*.¹¹⁵ In that case, the New York Court of Appeals refused to order removal of seventy-seven-year-old Mary O'Connor's feeding tube because the doctor would not certify that she would never recover her gag reflex.¹¹⁶ Mrs. O'Connor's daughters could not provide the required clear and convincing evidence that she would want the feeding tube removed under those circumstances.¹¹⁷ Therefore, the court would not overrule the doctor's deci-

provisions of this chapter.

Id. See also GA. CODE ANN. § 31-36-8(4) (1995) (stating “[n]o agent who, in good faith, acts with due care for the benefit of the patient and in accordance with the terms of a health care agency, or who fails to act, shall be subject to any type of civil or criminal liability for such action or inaction”). See *supra* notes 3–26 and accompanying text for a discussion of *Quinlan*, which specifically absolved participants from liability for removing life-sustaining equipment.

115. 531 N.E.2d 607 (N.Y. 1988).

116. See *id.* at 610. Mrs. O'Connor's physician testified that her condition was otherwise fairly stable and the gastric tube would preserve her life for several months or even several years. See *id.* The physician stated that, because Mrs. O'Connor was conscious, if the tube were removed, she would suffer a painful death of thirst and starvation within seven to ten days. See *id.* The respondent's expert witness admitted he could not be “medically certain” she would not suffer, even if given pain medications. See *id.* He confirmed the patient's extensive brain damage, but admitted she did exhibit improvement in her condition, and was able to state her name and respond to questions 50% or 60% of the time. See *id.* He also observed her gag reflex and acknowledged the possibility she would again be able to eat. See *id.*

Mrs. O'Connor did not have a written directive and her daughters sought to have the gastric tube removed based on her orally expressed wish that “no artificial life support be started or maintained in order to continue to sustain her life.” *In re Westchester*, 531 N.E.2d at 609. The daughters urged the court to consider her statements in light of the number of relatives she had comforted during prolonged final illnesses. See *id.* at 611. However, the court stated only speculation existed to prove that her statements were more than “immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death.” *Id.* at 614. Her comments were normal for one witnessing agonizing death and typical for older people. See *id.* Determining that such routine statements are clear and convincing proof of a refusal to accept treatment at the onset of incompetency would result in few nursing home patients ever receiving life-sustaining treatment. See *id.*

The fundamental question is whether the infirmities the patient considered are qualitatively different from the present situation. See *In re Westchester*, 531 N.E.2d at 614. The daughters candidly admitted they did not know what her wishes were under the specific circumstances. See *id.* at 615. Thus, absent clear and convincing evidence of Mrs. O'Connor's wishes, the court refused to order the tube removed. See *id.* at 616–17.

117. See *id.* at 615.

sion.¹¹⁸

The recent Michigan cases of Dr. Jack Kevorkian, well-known for assisting terminally-ill patients with his "suicide machine," illustrate the potential for penalties.¹¹⁹ Although suicide is not illegal in Michigan,¹²⁰ the State tried Dr. Kevorkian for first-degree murder for assisting in suicide.¹²¹ Michigan authorized a commission on death and dying to study "voluntary self-termination of human life, with or without assistance."¹²² Sometimes a state may charge suicide assisters with involuntary manslaughter, as well as murder.¹²³ It is difficult to define the line between a directive refusing treatment and a directive requesting treatment, either of which most probably will result in hastened death.

D. The Emergency Dilemma

118. See *supra* note 116 and accompanying text for the court's reasoning.

119. See Steinle, *supra* note 113, at 453.

120. See *id.* at n.109. Effective February 25, 1993, assisted suicide was a felony in Michigan. See MICH. COMP. LAWS ANN. § 752.1027 (West 1996). The statute was declared constitutional. See *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).

121. See, e.g., *Kevorkian*, 527 N.W.2d 714; *People v. Kevorkian*, 517 N.W.2d. 293 (Mich. Ct. App. 1994). In May, 1996, Dr. Kevorkian was acquitted for the third time. See *What's News*, WALL ST. J., May 15, 1996, at A1. Prosecutors would not say whether further charges would be instituted. See *id.* The United States Supreme Court granted certiorari in two cases to determine whether a state can constitutionally prohibit terminally ill adult patients from committing physician-assisted suicide. See *Quill v. Vacco*, 80 F.3d 716 (2d Cir. N.Y.), *cert. granted*, 117 S. Ct. 37 (1996), and *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 116 S. Ct. 2494, *cert. granted*, 117 S. Ct. 37 (1996). The Supreme Court heard oral arguments on January 8, 1997, but at the time of this writing had not handed down its decision. See *Supreme Court Calendar*, WASH. POST, Jan. 8, 1997, at A6.

122. MICH. STAT. ANN. § 752.1021 (Law Co-op. 1995).

123. See *Compassion in Dying*, 79 F.3d at 790. A 77-year-old man who helped his cancer-ridden wife of 42 years commit suicide by preparing an overdose of sedatives; sitting with her as she took them; and helping her place a plastic bag over her head, was sentenced under *Florida Statutes* to a 15-year maximum penalty. See *id.* at n.135. For cases which involve prosecution of a third party when the decedent actually caused his or her own death, see *People v. Creaves*, 229 Cal. App. 3d 367 (Ct. App. 1991) (Beezer, J., dissenting); *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995) (holding Dr. Kevorkian may be prosecuted either under a Michigan statute previously held to be constitutional, or under the common-law felony of assisting suicide); *State v. Bauer*, 471 N.W.2d 363 (Minn. Ct. App. 1991); *People v. Duffy*, 586 N.Y.2d 150 (App. Div. 1992); *Akron v. Head*, 73 Ohio Misc. 2d 67 (Akron Mun. Ct. 1995).

Emergency situations frequently place the health care provider in a no-win situation. Often emergency technicians transporting patients to hospitals from homes or nursing homes are unaware of the directive and may institute resuscitation procedures against the patient's wishes. Even with a directive presented, common sense indicates time constraints will not allow the technician to evaluate the directive for authenticity and obtain requisite determinations while endeavoring to timely treat the patient. In addition, there may be situations, particularly in an emergency, when the patient might not want the directive strictly construed.

Consider the following hypothetical situation. Mr. Doe has severe emphysema with a survival prognosis of less than one year, as well as an inoperable heart condition that could threaten his life at any time without warning. Mr. Doe has executed an advance directive indicating he is to receive neither CPR nor life-sustaining treatment if either he goes into cardiac arrest, or if his condition deteriorates due to the emphysema. One day while eating lunch at a restaurant, Mr. Doe suddenly chokes on a chicken bone. An alert waitress initiates the Heimlich maneuver and someone else calls for help. By the time emergency personnel arrive, the chicken bone has been expelled, but Mr. Doe is going into cardiac arrest. Absent knowledge of contradicting instructions, the law requires health care personnel, including physicians and emergency technicians, to use their best professional judgment to provide treatment in a life-threatening emergency to a patient lacking decision-making capacity.¹²⁴ The technician performs CPR on Mr. Doe and rushes him to the nearby hospital where he is sustained on a ventilator for twenty-four hours. Three days later Mr. Doe is back at home with his wife. He still has terminal emphysema, and he still has an inoperable heart condition which threatens his life. But, thankfully, he also now has more time to enjoy his wife and grandchildren. What if, in accordance with his instructions, the paramedics had not performed CPR? What if, in accordance with his instructions, the hospital had not put him on a ventilator temporarily? Obviously, the outcome could have been much different.

Consider the dilemma of Mr. Doe's personal physician if he is at the emergency room when Mr. Doe arrives. The physician is fully

124. See *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984). See *infra* notes 132-38 and accompanying text for a discussion of *Shapiro*.

aware of Mr. Doe's wishes and his physical condition. However, the physician evaluates Mr. Doe and determines that temporary ventilation could produce a desired result. Now consider what would happen if, three weeks later, Mr. Doe still cannot breathe without assistance. Although no doctor can absolutely know whether Mr. Doe's condition is reversible, suppose his doctor believes Mr. Doe is making progress and will eventually return home to spend at least a few months enjoying his family. Based on this belief, the doctor refuses to honor Mrs. Doe's request that the ventilator be removed in accordance with the advance directive because he cannot in "good faith" adhere to it. If the doctor is correct in his prognosis, Mr. Doe might well thank him later.¹²⁵ If the doctor is incorrect, he and the hospital could face liability for battery.¹²⁶

V. CURRENT CIVIL LIABILITY AND CAUSES OF ACTION

Most statutes rely on common law theories of liability, such as abandonment, negligence, and lack of informed consent, as remedies for a health care professional's failure to follow an agent's directions.¹²⁷ Even with statutory protection, physicians and other health care providers may fear the civil liability and consequential damage to their practices if they withhold or remove treatment, even at the patient's request.¹²⁸ For treatment to be withheld, the health care provider must determine that the patient is unlikely to recover competency, that the principal is terminally ill, and that any conditions expressed in an oral or written directive are satisfied.¹²⁹ Yet, the greater liability may lie in refusing to withhold or remove treatment because some courts have held health care providers liable for failure to honor written or surrogate decisions.¹³⁰ The determining

125. See, e.g., Ashwini Sehgal et al., *How Strictly Do Dialysis Patients Want Their Advance Directives Followed?* 267 J. AM. MED. ASS'N 59 (1992) (stating patients in outpatient hemodialysis clinics were willing to allow their surrogates leeway from strict adherence to their living wills should they become incompetent).

126. See *infra* Part V. (discussing cases imposing civil and criminal liability for administering unwanted medical treatment).

127. See MEISEL, *supra* note 87, at 370 (Cum. Supp. No. 2 1994) (citing ALASKA STAT. § 13.26.353(b) (1988) as the sole exception providing civil penalties and damages for a health care provider's failure to comply with an agent's good faith decisions).

128. See Steinle, *supra* note 113, at 453.

129. See, e.g., FLA. STAT. § 765.304(2) (1995).

130. See Tamar Lewin, *Ignoring End-of-Life Directives Begins to Cost/Lawsuits Increase Against Doctors, Hospitals for Unwanted Lifesaving Acts*, NEWS TRIB. (Tacoma,

factors of liability are frequently fact-specific jury questions. A sympathetic jury can be unpredictable, and a lawsuit alone can be damaging, regardless of the outcome.¹³¹

A. Battery

A physician who treats a patient without the patient's consent commits a battery regardless of whether the treatment results are neutral or favorable.¹³² In 1984, an Ohio Court of Appeals, in *Estate of Leach v. Shapiro*,¹³³ stated, absent contrary legislation, a patient's right to refuse treatment is absolute until the competing interests are weighed in a court proceeding.¹³⁴ Although the *Shapiro* complaint did not allege that the resuscitation efforts were a battery, it did allege nonconsensual implementation of life-support systems.¹³⁵ The appellate court refused to uphold the trial court's dismissal of the complaint and held that a cause of action did exist for wrongfully placing and maintaining a patient on life-support systems.¹³⁶ The appellate court also directed the trial court to determine factual questions as to the existence and nature of any consent to place the patient on the life-support systems.¹³⁷ If the trial court did not find proof of consent to implement the life-support system, punitive damages would have been available.¹³⁸

In 1991, a Michigan patient and her husband brought an action against a doctor alleging battery when the patient received a blood transfusion despite her refusals.¹³⁹ A Michigan Court of Appeals

Wash.), June 9, 1996, at G2, available in 1996 WL 2990498 (discussing cases involving health care provider liability for failing to honor end-of-life directives); see also *Anderson v. St. Francis-St. George Hosp.*, No. C-930819, 1995 WL 109128 (Ohio Ct. App. Mar. 15, 1995); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047 (Ohio Ct. App. 1984).

131. See *supra* Part V. (discussing cases where physicians attempted relief beyond honoring the advance directive).

132. See *Shapiro*, 469 N.E.2d at 1051 (citing *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956)).

133. *Id.* at 1047.

134. See *id.* at 1051-52.

135. See *id.* at 1052.

136. See *Shapiro*, 469 N.E.2d at 1050.

137. See *id.* at 1055.

138. See *id.* After the case was remanded, the defendant hospital settled the case for \$50,000. David H. Miller, *Right-to-Die Damage Actions: Developments in the Law*, 65 DENV. U. L. REV. 181, 189 (1988). The case against the physician was dismissed due to insufficient evidence. See *id.*

139. See *Werth v. Taylor*, 475 N.W.2d 426, 427 (Mich. Ct. App. 1991).

affirmed the trial court's decision finding no assault and battery, despite the patient's prior refusals to permit transfusions, because the patient was under anesthesia and the doctor determined the transfusion was necessary to save her life.¹⁴⁰

In 1995, a procedural technicality accounted for a Tennessee Court of Appeals' dismissal of a medical malpractice complaint alleging battery, breach of contract, and outrageous conduct.¹⁴¹ Even though the decedent had executed a living will denying life support systems, the document did not bear the signatures of two unrelated witnesses as required by Tennessee statute.¹⁴² The doctor did not honor the living will because the medical center's general counsel advised him the living will was not valid.¹⁴³ Again, a court denied the requested relief, but a validly executed living will may have allowed for a different outcome.

B. Intentional Infliction of Emotional Distress

Cases also indicate a cause of action exists for both negligent and intentional infliction of emotional distress arising out of prolonging a patient's life against his or her wishes. In *Bartling v. Glendale Adventist Medical Center*,¹⁴⁴ the California Second District Court of Appeal denied a claim for negligent infliction of emotional distress, but only because the plaintiffs failed to establish a prima facie case.¹⁴⁵ The California court found the hospital acted in conformity with its perceived professional and religious obligations.¹⁴⁶ Therefore, its actions were not so extreme or outrageous as to war-

140. *See id.* at 430.

141. *See* *McCroskey v. University of Tenn.*, No. 03A01-9409-CV-00356, 1995 WL 329133, at *3 (Tenn. Ct. App. May 31, 1995).

142. *See id.* at *1, *3.

143. *See id.* at *1.

144. 229 Cal. Rptr. 360 (Ct. App. 1986).

145. *See id.* at 366. The complaint alleged battery, violation of constitutional and federal civil rights, breach of fiduciary duty, intentional infliction of emotional distress, and conspiracy arising out of the hospital's efforts to preserve Mr. Bartling's life. *See id.* at 361. All counts were dismissed. *See id.* at 366. Mr. Bartling, who was on a ventilator but still competent, had executed a living will while refusing artificial or heroic measures. *See id.* at 361. While hospitalized, Mr. Bartling attempted to remove his ventilator tubes on several occasions. *See id.* To prevent him from doing so, the hospital restrained him by placing cloth cuffs on his wrists. *See id.* Mr. Bartling died almost seven months after being placed on the ventilator. *See id.*

146. *See id.* at 364.

rant general or punitive damages for intentional infliction of emotional distress.¹⁴⁷ In addition, the defendant hospital acted in reliance on the prevailing community medical and legal standards and had no intent to harass or intimidate the Bartlings.¹⁴⁸

The California Second District Court of Appeal affirmed the trial court's judgment of dismissal and held that the Bartlings failed to meet their burden of proof.¹⁴⁹ The appellants proved neither that the hospital's use of soft restraints and close supervision of patients was so extreme as to shock the community, nor that hospital employees could reasonably foresee their effort to preserve a patient's life was a conscious disregard of the patient's rights.¹⁵⁰ No proof existed for a prima facie case of negligent or intentional infliction of emotional distress and, therefore, the court denied liability.¹⁵¹ However, had appellants met their burden of proof, the hospital could have incurred liability.

In a 1989 California case, widow Barbro Westhart sued her husband's doctors for intentional infliction of emotional distress because they inserted a feeding tube into her husband, despite the widow's explicit instructions not to perform life-prolonging heroic measures.¹⁵² As with previous cases, this action failed based on a crucial factual deficiency. Mrs. Westhart failed to state a cause of action because she did not allege she specifically sought removal of the feeding tube.¹⁵³ Thus, her complaint lacked the extreme and outrageous elements required to justify relief.¹⁵⁴

C. Negligence

147. *See id.*

148. *See id.* at 365.

149. *See Bartling*, 229 Cal. Rptr. at 366. While the court recognized Mr. Bartling's right to die, it also stressed the sincerity of Glendale Adventist Medical Center. *See id.* at 362. Most of the doctors at the pro-life oriented hospital considered disconnection of life support in cases like Mr. Bartling's as incompatible with a physician's healing obligations. *See id.* The hospital tried to compromise by locating another hospital which would admit and honor Mr. Bartling's request, but could find none. *See id.*

150. *See id.* at 364.

151. *See id.* at 366.

152. *See Westhart v. Mule*, 261 Cal. Rptr. 640, 641 (Ct. App. 1989).

153. *See id.*

154. *See id.*

A potentially significant case occurred in 1995 when an Ohio Court of Appeals, on a second appeal, held that a patient is entitled to compensation for foreseeable injuries proximately caused by life-prolonging treatment administered in spite of the patient's refusal.¹⁵⁵ Eighty-two-year-old Edward Winter, admitted to the hospital in 1988 suffering from cardiac insufficiency, had a "no code blue" order on his chart.¹⁵⁶ When Winter experienced an episode of potentially fatal irregular heart rhythm, a hospital nurse, apparently unaware of the order, resuscitated Winter by defibrillation.¹⁵⁷ Keith Anderson, the Winter estate administrator, alleged battery and negligence, and sought damages for pain, suffering, and disability, as well as for medical bills and expenses.¹⁵⁸ The court denied Winter's claim of damages for "finding himself . . . alive after unwanted resuscitative measures."¹⁵⁹ The claim raised the important public policy of the right to refuse treatment.¹⁶⁰ The court remanded the case and ordered the jury to examine the facts and determine whether battery or negligence did indeed occur.¹⁶¹ If so, the estate could legally recover damages caused by the unwanted resuscitation and violation of Mr. Winter's directive.¹⁶²

155. *See* Anderson v. St. Francis-St. George Hosp., No. C-930819, 1995 WL 109128, at *1 (Ohio Ct. App. Mar. 15, 1995).

156. *See id.* A "no code blue" order prohibits anything that would initiate or accomplish resuscitation. *See id.*

157. *See id.* Defibrillation is an effort to restore a normal heart rhythm by electrically shocking the heart with paddles applied to the patient's chest. *See id.* at *1 & n.2.

158. *See id.* at *2.

159. *Id.* at *3.

160. *See* Anderson, 1995 WL 109128, at *3.

161. *See id.* at *5.

162. *See id.* Even though the Ohio Supreme Court allowed a discretionary appeal and reversed the decision, health care providers still have reason to take notice and evaluate their practices and procedures. *See* Anderson v. St. Francis-St. George Hosp., Inc., 671 N.E.2d 225 (Ohio 1996) (4-3 decision) (Pfeifer, Jr., dissenting). The majority held Winter did not have a cause of action for wrongful administration of life-prolonging treatment, and could not recover for "wrongful life" unless damages resulted under the theories of negligence or battery. *See id.* at 227. However, the court did not find proof that Winter suffered damages as a result of the defibrillation. *See id.* The dissent argued that a factual issue as to causation existed, and that Winter's estate had the right to prove that the hospital was negligent and that Winter was harmed because his constitutional rights were violated. *See id.* at 230. The court's reasoning seems to contravene the common law and the statutory progression since *Cruzan*, but re-emphasizes the continuing struggle between medical ethics, technology, and individual rights. *See id.* at 227, 229 (Douglas, J., concurring).

D. Reimbursement for Costs Incurred

In 1992, a New York court held a family liable for nursing home charges incurred subsequent to the family's demand for withdrawal of life support up until the time of the actual court-ordered withdrawal.¹⁶³ In that case, the nursing home entered into a contract with the patient's husband to provide life support services to the patient.¹⁶⁴ The husband refused to pay for those services rendered subsequent to his demand to discontinue his wife's treatment.¹⁶⁵ The nursing home refused to discontinue treatment on the basis that the patient's wishes were unknown until they were judicially determined.¹⁶⁶ Waiting to act until it received a judicial decree neither breached the nursing home's contract of care nor waived its right to payment for services rendered.¹⁶⁷ New York's Public Health Law § 2803-c "imposes on every nursing home a duty to honor a patient's decision to refuse treatment."¹⁶⁸ As a result, patients who communicate their lack of consent are not held liable for expenses of unwanted treatment.¹⁶⁹ It is important to note, however, at the time of the events relative to this action, there were no statutes in effect authorizing proxies, living wills, advance directives, or surrogate decisions.¹⁷⁰ Following *Westchester*, *Eichner*, and *Storar*, New York law did not recognize surrogate decisions absent clear and convincing evidence that the patient, when competent, expressed clear wishes against continued care under specified circumstances.¹⁷¹ One could speculate that a different outcome would result today if the clear and convincing evidence standard is met and it indicates the patient would refuse the treatment.

In 1995, the North Carolina Court of Appeals heard a similar

163. See *Grace Plaza, Inc. v. Elbaum*, 588 N.Y.S.2d 853, 854-55 (App. Div. 1992) (holding that the nursing home acted in good faith and did not forfeit its right to payment for treatment provided to patient after the nursing home refused to follow spouse's instruction to remove a patient's feeding tube), *aff'd*, 623 N.E.2d 513 (N.Y. 1993).

164. See *id.* at 855.

165. See *id.*

166. See *id.*; see also *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988) (holding that if a provider is uncertain as to whether or not to discontinue treatment, it should refuse to discontinue treatment until the issue is legally determined).

167. See *Elbaum*, 623 N.E.2d at 515, 516.

168. *Id.* at 515.

169. See *id.* (citing *Shapira v. United Med. Serv.*, 205 N.E.2d 293 (N.Y. 1965)).

170. See *Elbaum*, 623 N.E.2d at 515.

171. See *id.*

case. First Healthcare Corporation, d/b/a Hillhaven South, Inc. sued Mrs. Rettinger individually and as personal representative of her husband's estate for services rendered during the approximately four months between the time Mrs. Rettinger requested removal of her husband's nasogastric tube, and the time the convalescent center removed it pursuant to court order.¹⁷² The court found a material issue of fact as to whether the doctor's order to remove the tube conformed to North Carolina statutory requirements and whether the doctor communicated the order to Hillhaven.¹⁷³ The court remanded to the trial court for a jury determination on that factual issue.¹⁷⁴ Assuming satisfaction of the statutory requirements, Mrs. Rettinger need only pay costs incurred from the date of compliance with the statutory requirements through Mr. Rettinger's probable date of death, assuming the tube would have been removed immediately upon compliance.¹⁷⁵ This case represents another victory for honoring advance directives, and another reason for health care providers to be concerned about their actions.

E. Liability and Enforcement in Special Circumstances

1. Blood Transfusions

Honoring directives refusing blood transfusions often presents unique problems for healthcare providers. Although typical directives address life-sustaining treatment for terminally ill or comatose individuals, directives refusing blood transfusions may address life-saving measures for an otherwise healthy individual. Just a few decades ago, doctors and courts agreed patients were better off with forced transfusions rather than risking death without them.¹⁷⁶ Although courts now recognize patients' rights, the potential still ex-

172. See *First Healthcare Corp. v. Rettinger*, 456 S.E.2d 347, 348-49 (N.C. Ct. App. 1995).

173. See *id.* at 350. N.C. GEN. STAT. § 90-321(b) required specific language by the attending physician determining the declarant is terminal and incurable, and such language and diagnosis must be confirmed by a second physician. See *Rettinger*, 456 S.E.2d at 350. If the statutory requirements had been met, then the tube should have been removed four months earlier. See *id.*

174. See *id.* at 351.

175. See *id.*

176. See Conard, *supra* note 70, at 255 (citing *Winthrop Univ. Hosp. v. Hess*, 490 N.Y.S.2d 996 (App. Div. 1985)); see also Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 *FORDHAM L. REV.* 1, 2-3 (1975).

ists that pregnant women and mothers with young children will have their directives ignored.

In 1987, a Caesarean section was forced on a dying, twenty-seven-week pregnant woman, based on the state's interest in protecting children.¹⁷⁷ Other courts, however, give the patient's rights tremendous weight irrespective of the ramifications. As recently as 1990, a New York court recognized the right of a Jehovah's Witness mother to refuse a transfusion during a Caesarean section.¹⁷⁸ Florida and Massachusetts followed New York's lead.¹⁷⁹ In those cases, the courts allowed the mothers to refuse transfusions, provided there was evidence that the mothers' relatives were willing and able to care for the potentially motherless children.¹⁸⁰ Following this specific requirement, in 1992, the Florida Fourth District Court of Appeal held that a pregnant mother must be transfused unless there is evidence someone will care for her other children if she were to die.¹⁸¹ Thus, without proof that her children will be adequately cared for if she dies, a pregnant woman or mother of minor children is likely to receive an unwanted transfusion.

Courts treat refusals of blood transfusions by male parents responsible for minor children the same as refusals by female parents. In 1985, the Florida Fourth District Court of Appeal upheld a male patient's right to refuse a life-saving blood transfusion even though

177. See *In re A.C.*, 533 A.2d 611, 612-13 (1987), *vacated*, 573 A.2d 1235 (D.C. 1990). However, the child died within a few hours, and the mother within a few days. See *In re A.C.*, 573 A.2d at 1238.

178. See *Fosmire v. Nicoleau*, 551 N.E.2d 77, 80 (N.Y. 1990). Although a transfusion was made under the trial court's order, the appellate court vacated the order. See *id.* at 78.

179. See *Public Health Trust v. Wons*, 541 So. 2d 96 (Fla. 1989); see also *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017, 1025 (Mass. 1991) (holding that a competent adult patient has the right to refuse lifesaving medical treatment, and no interest of the state overrode the patient's rights). The leading case in Florida regarding blood transfusions in the face of religious objection held that a mother can refuse a blood transfusion when she can show that by refusing the transfusion, she is not abandoning her minor children because they would be cared for by their father. See *id.* at 97-98. However, the *Wons* court determined that each case of this nature requires individual attention. See *id.*

180. See *Wons*, 541 So. 2d at 98; *Munoz*, 564 N.E.2d at 1025.

181. See *In re Dubreuil*, 603 So. 2d 538, 541-42 (Fla. 4th Dist. Ct. App. 1992), *quashed*, 629 So. 2d 819 (Fla. 1993). The court held that the state's interests in the preservation of innocent third parties (Mrs. Dubreuil's four minor children) outweighed the wishes of Mrs. Dubreuil, because she and her husband were separated and no testimony was presented showing the availability of care for her four minor children. See *id.* at 541.

the patient was obligated to pay fifty dollars per week in child support.¹⁸² In honoring the patient's request, that court cited evidence in the record that the mother and both families would help support the child if the father died.¹⁸³

However, courts may be reluctant to enforce withholding of transfusions in the absence of proof the declarant fully understood the potential ramifications. New Jersey Superior Court held a trial court did not err in allowing a transfusion to a Jehovah's Witness patient who, for religious reasons, had given written instructions prior to surgery that she was not to receive blood.¹⁸⁴ The court expressed doubt as to whether the patient's refusal was a fully informed and knowing decision because there was no indication anyone had adequately explained to her the risk and severity of complications which were possible during her particular surgery.¹⁸⁵ The court emphasized this was not an emergency situation where there was no time to fully discuss the potential risks.¹⁸⁶ The court placed the burden on the patient to make her medical preferences and directive unequivocally known to the treating physician, should life-threatening complications arise.¹⁸⁷ "This protect[ed] both the patient's right to freedom of religion and self-determination, as well as the hospital's obligation to preserve life whenever possible."¹⁸⁸

Although refusal of transfusions has primarily involved religious beliefs, fear of infection is a bona fide concern in today's world. As recently as the 1980s, the HIV virus infected some transfused

182. *See* St. Mary's Hosp. v. Ramsey, 465 So. 2d 666, 667 (Fla. 4th Dist. Ct. App. 1985).

183. *See id.* at 668. The court held that the patient could refuse the transfusion based on "fear of adverse reaction, religious belief, recalcitrance, or cost [even though the patient did not want to die but wanted to live only] under his own power." *Id.*

184. *See In re Hughes*, 611 A.2d 1148 (N.J. Super. Ct. App. Div. 1992). Although Mrs. Hughes signed forms prior to surgery refusing any blood or blood products due to her religious beliefs, unanticipated problems arose during surgery which required blood transfusions to save her life. *See id.* at 1149. Even though family members testified that Mrs. Hughes would not want a blood transfusion, the judge found the evidence was unclear as to whether she would refuse the blood if she knew her life was at risk without the transfusion, because the consequences of refusal were not explained in the context of her particular surgery. *See id.* at 1152-53.

185. *See id.*

186. *See id.* at 1153.

187. *See id.* The Jehovah's Witnesses refuse to receive blood or blood products into their body because it "precludes resurrection and everlasting life after death." *Id.* at 1149.

188. *Id.* at 1153.

patients.¹⁸⁹ Because viruses mutate, new strains may infect future patients prior to detection.¹⁹⁰ Patients may choose to refuse transfusions to protect their spouses, children, and themselves.¹⁹¹ Whether or not the choice is honored may be fact-specific, as indicated by the transfusions forced on both pregnant women and mothers of minor children.

2. Rights of Minors

In 1990, the Illinois Supreme Court recognized the right of minors to refuse medical treatment.¹⁹² In *In re E.G.*,¹⁹³ the State filed a neglect petition against a mother who acquiesced in her seventeen-year-old daughter's religious-based decision to refuse a blood transfusion necessary to prevent her death from leukemia.¹⁹⁴ Reversing the trial court, the appellate court held that a minor whom the court has determined to possess a requisite degree of maturity has a limited right to refuse life-sustaining treatment.¹⁹⁵ In addition, a parent who acquiesces in the mature minor's decision is not guilty of neglect.¹⁹⁶ In that same year, the Maine Supreme Judicial Court held that where sufficient evidence existed to determine that a minor patient had made a pre-accident decision that he did not want life-sustaining procedures should he fall into a vegetative state, the decision should be honored.¹⁹⁷ The court deemed the minor's parents appropriate to carry out the decision and ensure palliative care¹⁹⁸ would be provided upon termination of hydration and nutrition.¹⁹⁹

The following year, a Michigan Court of Appeals also upheld a

189. See Conard, *supra* note 70, at 255 (citing Ronald Bayer, *Gays and the Stigma of Bad Blood*, HASTINGS CTR. REP., Apr. 1983, at 5; *Transition*, NEWSWEEK, Feb. 15, 1993, at 70) (reporting Arthur Ashe's death from AIDS, apparently contracted in 1983 from a blood transfusion during heart bypass surgery).

190. See Conard, *supra* note 70, at 255.

191. See *id.*

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

193. *Id.*

194. See *id.* at 323.

195. See *id.* at 327-28. The case was remanded to the trial court to determine whether the minor possessed the requisite degree of maturity by clear and convincing evidence. See *id.*

196. See *id.* at 323, 328.

197. See *In re Swan*, 569 A.2d 1202 (Me. 1990).

198. "Palliative care" is defined as the care required to maintain humane treatment. See *id.* at 1206.

199. See *id.*

minor's right to decline life-sustaining treatment. The court held that surrogate decisionmakers should act in the best approximation of the patient's preference based on available evidence, or in the best interests of the patient.²⁰⁰ In *Rosebush v. Oakland County Prosecutor (In re Rosebush)*,²⁰¹ the court dissolved a county prosecutor's preliminary injunction prohibiting transfer of a minor for the purpose of removing life-support systems.²⁰² Thus, it appears that courts tend to enforce directives of mature minors if properly evidenced.

3. Rights of Prisoners

Even prisoners have a constitutional right to refuse medical treatment. Although a 1982 New York decision held that the obligation of the state to protect the health and welfare of persons in its custody and its interest in preservation of life outweighed the claimed rights of a fasting prisoner,²⁰³ it is questionable whether the court would reach the same decision today. That case is distinguished from today's typical right-to-die case because the prisoner was purportedly exercising his First Amendment rights of expression by refusing to eat in protest.²⁰⁴ The state's legitimate interests could not be overshadowed by a prisoner's suicide attempt disguised as First Amendment expression.²⁰⁵ In a more typical case, the California Supreme Court in 1993 upheld a quadriplegic prisoner's right to refuse a surgical tube required for nutrition and medication, stating the physician had no duty to provide further life-sustaining procedures.²⁰⁶

F. Current Pending Cases

200. See *Rosebush v. Oakland County Prosecutor (In re Rosebush)*, 491 N.W.2d 633 (Mich. Ct. App. 1992).

201. See *id.*

202. See *id.* at 635. The minor was in a persistent vegetative state following a traffic accident. See *id.* See *supra* note 5 and accompanying text for an explanation of "vegetative state."

203. See *Von Holden v. Chapman*, 450 N.Y.S.2d 623 (App. Div. 1982) (holding the director of a state psychiatric center was authorized to force-feed a prisoner in order to sustain his life).

204. See *id.* at 627.

205. See *id.*

206. See *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993).

Other cases continue to appear in trial courts nationwide. In early 1996, in one of the first cases in which a jury awarded substantial damages for failure to follow a proxy's decision, a Michigan mother and daughter were awarded \$16.5 million.²⁰⁷ In that case, Brenda Young had executed a document naming her mother as her health care proxy after she suffered a brain hemorrhage which doctors warned would eventually cause seizures so severe that she would emerge profoundly disabled if she even lived.²⁰⁸ On February 3, 1992, Brenda had a seizure and her mother rushed her to Genesys St. Joseph Hospital. She took the power of attorney with her.²⁰⁹ Brenda was in critical condition when she arrived at the hospital, and doctors repeatedly came to her mother seeking permission for various procedures.²¹⁰ However, there was no evidence that anyone fully explained Brenda's condition to her mother, and she never understood enough to give genuine consent.²¹¹ The doctors assured Brenda's mother all measures taken were for comfort, not life support.²¹² Brenda, now thirty-eight, never recovered and needs around-the-clock total care.²¹³ Because she screams constantly, no convalescent home is willing to take her.²¹⁴ The \$16.5 million will help pay for the around-the-clock nursing care, but it may be years before Brenda's mother receives it as the verdict makes its way through appeals.²¹⁵ The *Young* case is a prime example of how advance directives and surrogate decisionmakers can fail to accomplish the goal of avoiding unwanted treatment.

Pending lawsuits cover a variety of other situations involving advance directives. An Arkansas woman sued a hospital and charged battery of both herself and her husband, as well as intentional infliction of emotional distress, after the hospital forcibly re-

207. See Lewin, *supra* note 130, at G2. This case has not been reported.

208. See *id.*

209. See *id.*

210. See *id.*

211. See *id.* Brenda's mother had a fifth-grade education and did not understand the ramifications of her consent. See *id.*

212. See Lewin, *supra* note 130, at G2.

213. See *id.* The total care Brenda requires includes feeding, bathing, and diapering at night. See *id.* Because she screams and thrashes constantly, Brenda must be tied into bed so that she cannot push herself over the padded bedrails. See *id.*

214. See *id.*

215. See *id.* At the time of this writing, a judgment had not yet been formally entered, but the hospital intended to appeal to modify or overturn it. See *id.*

moved her from her husband's hospital room when she protested treatment based on her authority as surrogate.²¹⁶ In another case, an Indiana family is suing a nursing home for fraud and negligence for inserting a feeding tube into a woman whose son placed her in the home to allow her to die naturally.²¹⁷

VI. THE SURROGATE SOLUTION

Surrogate decisionmakers offer a viable alternative to a standard written advance directive attempting to control an unknown future. In the absence of specific instructions through a living will, advance directive, or durable power of attorney which designates a health care surrogate decisionmaker,²¹⁸ the court may be required to appoint a guardian or surrogate.²¹⁹ Some state statutes may provide a hierarchy of surrogates.²²⁰ Surrogate decisions, like other advance directives, are effective only during the period of time, whether temporary or permanent, when the individual cannot speak for himself or herself.²²¹ Thus, if the individual regains the ability to communicate, the surrogate's power terminates as long as the individual maintains the ability to communicate. An informed surrogate can mitigate the problems of written instructions that are too specific, and may therefore be questionable under the circumstances, thus eliminating the need for health care providers to hesitate in honoring the decision. Individuals fortunate enough to have a trusted family member or friend willing to take such a responsibility probably have the best chance of having their wishes carried out, if they

216. See Lewin, *supra* note 130, at G2.

217. See *id.* The son held power of attorney and had instructions to allow only administration of intravenous fluids. See *id.* However, additional nutrition from the feeding tube kept the mother alive five more months. See *id.*

218. See *supra* note 41 and accompanying text for definition and discussion of advance directive, living will, health care surrogate, and health care proxy.

219. See FLA. STAT. § 765.401(1) (1995). Florida has the following statutory proxy hierarchy: "[t]he judicially appointed guardian of the patient, . . .," "[t]he patient's spouse," "[a]n adult child . . . or . . . a majority of the adult children . . . reasonably available for consultation," "[a] parent . . .," "[an] adult sibling . . . or . . . majority of adult siblings . . . reasonably available for consultation," "an adult relative . . . who has exhibited special care and concern . . . and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs," or "[a] close friend . . ." FLA. STAT. § 765.401(1)(a)-(g) (1995).

220. See *supra* note 219 for the hierarchy of surrogates in Florida.

221. See *supra* note 85 and accompanying text.

take the time to ensure the surrogate fully understands their intentions. A surrogate or guardian who fully knows and understands the patient's wishes and value systems, and is willing to implement them regardless of his or her own personal feelings, is invaluable.

The key ingredients to ensure enforcement of the patient's wishes through the surrogate are: (i) specificity to the surrogate so there is no doubt in the surrogate's mind as to the patient's wishes, and (ii) the ability of the surrogate to prove the patient's wishes. Otherwise, faced with a doctor recommending prolonged care, an unsure proxyholder may be reluctant to bear the weight of a final, fatal decision. Furthermore, interested parties can challenge the surrogate's decision.²²² Some courts, particularly in New York, Missouri, and Michigan, are likely to refuse to accept less than the clearly expressed wishes of a patient in allowing the surrogate to exercise the right to refuse treatment.²²³

In 1990, the Florida Supreme Court established four issues which require proof with up-to-date medical evidence before the surrogate or guardian's decision will be honored:²²⁴ first, whether the patient suffers from a medical condition which would permit the patient, if competent, to forego the life-sustaining medical treatment;²²⁵ second, whether any reasonable probability exists that the patient will regain competency and could exercise his or her own rights;²²⁶ third, whether the patient's personal decision on the subject is sufficiently clear and is made knowingly, willingly, and without undue influence so the guardian can make substituted judgment;²²⁷ fourth, whether the patient's right to forego treatment is outweighed by the state's interests in preserving life.²²⁸

Ironically, in the case prompting these issues, a competent

222. See, e.g., FLA. STAT. § 765.105 (1995) (allowing a proxyholder or interested person to seek expedited judicial review).

223. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 268 (1990); *State v. Herbert*, (*In re Guardianship of Browning*), 568 So. 2d 4, 13 (Fla. 1990); *Martin v. Martin* (*In re Martin*), 538 N.W.2d 399, 413 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1996); *In re Conroy*, 486 A.2d 1209, 1229-30 (N.J. 1985); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988).

224. See *State v. Herbert* (*In re Guardianship of Browning*), 568 So. 2d 4 (Fla. 1990) [hereinafter *Browning*].

225. See *id.* at 17.

226. See *id.* at 15.

227. See *id.*

228. See *id.* at 13-14.

eighty-one-year-old Estelle Browning executed a directive stating that in the event she developed a terminal condition with no hope of recovery and death was imminent, no life-prolonging procedures were to be utilized.²²⁹ Mrs. Browning specifically stipulated a desire not to have nutrition and hydration administered by tube or intravenously.²³⁰ When she suffered a stroke five years later, the hospital inserted a feeding tube in her stomach because she was unable to swallow, and transferred Mrs. Browning to a nursing home.²³¹ Nearly two years later, when the medical evidence indicated the brain damage was permanent and there was no chance of recovery, Mrs. Browning's guardian petitioned the court to terminate the feeding based upon Mrs. Browning's directive.²³² Acknowledging an individual's constitutional right of self-determination, the Florida Supreme Court granted the petition, stating its hope that the decision would "encourage those who want their wishes to be followed to express their wishes clearly and completely."²³³ The court further held that judicial approval is not required for surrogates or proxies to exercise

229. See *Browning*, 568 So. 2d at 8. Mrs. Browning executed the directive after visiting nursing home patients and stating, "[o]h, Lord, I hope this never happens to me . . . thank God I've got this taken care of. I can go in peace when my time comes." *Id.* at 8-9. In spite of her precaution, Mrs. Browning died July 16, 1989, in a nursing home with a nasogastric tube implanted and a court case still pending to allow her guardian to force its removal. See *id.* at 8 n.1. Because the matter was of such great public importance and likely to recur, the court continued its review of the case. See *id.*

230. See *id.* at 8. At the time, FLA. STAT. § 765.03(3) (1987) "specifically exclude[d] the provision of sustenance from the term 'life-prolonging procedure'" which could be ordered withheld by competent adults. *Browning*, 568 So. 2d at 9 n.5. However, "[n]early every state's final court to consider the issue has concluded that artificial feeding" as a life-prolonging procedure can be refused. *Lenz v. L.E. Phillips Career Dev. Ctr. (In re Guardianship of L.W.)*, 482 N.W.2d 60, 66 (Wis. 1992) (citing *In re Conroy*, 486 A.2d at 1235-36).

231. See *Browning*, 568 So. 2d at 8. Initially a gastrostomy tube was inserted directly into her stomach, but approximately eighteen months later, due to continuing physical difficulties including the feeding tube becoming dislodged, "[t]he gastrostomy tube was replaced by a nasogastric tube . . ." *Id.*

232. See *Browning*, 568 So. 2d at 8. Mrs. Browning's neurologist described her as being "in a persistent vegetative state . . . defined as the absence of cognitive behavior and inability to communicate or interact purposefully with the environment." *Id.* at 9. The trial court denied the petition, concluding death was not imminent because "Mrs. Browning could continue to live for an indeterminate time with artificial sustenance but . . . death would result within four to nine days without it." *Id.* However, the Florida Supreme Court found that, because her life was being sustained only by artificial, intrusive medical measures, death was imminent within the construction of her express written intent. See *id.* at 17.

233. *Id.*

the constitutional right to privacy and right to refuse treatment for an incompetent individual who expressed his or her wishes orally or in writing while competent.²³⁴

Similarly, in 1977 the case of *Lenz v. L.E. Phillips Career Development Center (In re Guardianship of L.W.)*,²³⁵ the Wisconsin Supreme Court held that court approval of the guardian's decision is not required unless an interested party objects to the decision.²³⁶ If an interested party objects, the guardian or surrogate bears the burden of proof to show that the persistent vegetative state exists to a high degree of certainty, that the decision to withhold treatment is in the ward's best interest, and that the decision was made in good faith.²³⁷

Lenz echoes *Delio v. Westchester County Medical Center*,²³⁸ a 1987 New York case where the court allowed the wife of a thirty-three-year-old patient in a chronic vegetative state to discontinue feeding and hydration tubes in accordance with the prior, clearly-expressed wishes of the patient.²³⁹ However, the *Browning* court cautioned that where an advance directive appoints a proxy, but gives no instructions, there may be reason to question the degree of knowledge the proxyholder has of the patient's wishes.²⁴⁰ In such cases, as well as in the absence of a directive, judicial review may be appropriate to ensure the *patient's* wishes are honored.²⁴¹ Some state statutes provide specific procedures for such cases.²⁴²

234. *See id.* See also *supra* note 17 and accompanying text for an explanation of the constitutional right to privacy regarding medical treatment.

235. 482 N.W.2d 60 (Wis. 1992).

236. *See id.* at 75.

237. *See id.*

238. 516 N.Y.S.2d 677 (App. Div. 1987).

239. *See id.* at 679.

240. *See Browning*, 568 So. 2d at 18.

241. *See id.*; see also *Soper v. Storar (In re Storar)*, 420 N.E.2d 64, 73 (N.Y. 1981) (holding decisions should be limited to a case-by-case approach, requiring court approval if the patient's wishes are unknown); *In re Eichner v. Dillon*, 420 N.E.2d 64, 72 (N.Y. 1981) (holding the facts in each case will determine the outcome, and the patient's wishes must be unequivocally evidenced).

242. *See, e.g.*, FLA. STAT. § 765.304(1) (1995) which states:

In the event of a dispute or disagreement concerning the attending physician's decision to withhold or withdraw life-prolonging procedures, the attending physician shall not withhold or withdraw life-prolonging procedures pending review under s. 765.105. If a review of a disputed decision is not sought within 7 days following the attending physician's decision to withhold or withdraw life-prolonging procedures, the attending physician may proceed in

A. The Supreme Court Denies Certiorari to 1996 Case

In February 1996, the United States Supreme Court denied certiorari to the Michigan Supreme Court case of *Martin v. Martin (In re Martin)*,²⁴³ a case of first impression in Michigan, addressing the burden of proof required of a surrogate.²⁴⁴ Michael Martin did not have a written directive, but he and his wife Mary had discussed the issue on numerous occasions and had mutually agreed that they would not allow the other to live in a vegetative state.²⁴⁵

In 1987, Michael sustained a severe head injury in a car accident which left him with significantly impaired physical and cognitive abilities, unable to walk or talk, and dependent on a colostomy and gastrostomy tube.²⁴⁶ Michael, however, was conscious, and all medical experts agreed he was neither terminally ill nor in a vegetative state.²⁴⁷ In January 1992, the Butterworth Hospital bioethics committee issued a report indicating "withdrawal of Michael's nutritive support was both medically and ethically appropriate," but the committee required court authorization prior to the hospital removing the equipment.²⁴⁸ Mary petitioned the probate court re-

accordance with the principal's instructions.

Id. See also N.J. STAT. ANN. § 26:2H-66(a) (West 1996) which states:

In the event of disagreement among the patient, health care representative and attending physician concerning the patient's decisionmaking capacity or the appropriate interpretation and application of the terms of an advance directive to the patient's course of treatment, the parties may seek to resolve the disagreement by means of procedures and practices established by the health care institution, including but not limited to, consultation with an institutional ethics committee, or with a person designated by the health care institution for this purpose or may seek resolution by a court of competent jurisdiction.

Id.

243. 538 N.W.2d 399 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1996).

244. See *id.* at 406.

245. See *Martin*, 538 N.W.2d at 411. Michigan's patient advocate act, MICH. COMP. LAWS ANN. § 700.496 (West 1995), allows a third party to execute decisions of incompetent patients, even those resulting in death, provided the patient properly executed a patient advocate designation while competent, and provided the patient is in the condition delineated in the designation. See *Martin*, 538 N.W.2d at 406. However, Michael's accident occurred nearly four years before the legislation was enacted. See *id.* at 406 n.11.

246. See *id.* at 402.

247. See *id.* at 403.

248. *Id.* at 402. The committee consulted with Mary Martin, a family friend, a social worker, Michael's treating physician, and nurses at Butterworth Hospital, but consulted neither personnel at the New Medico Neurological Center where Michael resided nor any

questing authorization to withdraw Michael's nutritive support, and Michael's mother and sister opposed the petition.²⁴⁹ The court concluded Michael's right to refuse life-sustaining medical treatment survived his incompetency and could be exercised by his surrogate.²⁵⁰ However, the issue became the standard of proof required.²⁵¹

After analyzing each alternative, the court held that the clear and convincing evidence standard, required in both *Quinlan* and *Cruzan*, was the most appropriate standard under these circumstances.²⁵² The court followed *Conroy* and *Westchester* respectively, by remarking that the amount of weight accorded prior oral statements depends on "remoteness, consistency, specificity, and solemnity of the prior statement"²⁵³ and on whether it was "a well thought out, deliberate pronouncement or a casual remark made in reaction to the plight of another."²⁵⁴ Mary Martin was unable to meet the standard and her petition was denied.²⁵⁵ If Michael Martin had executed a written directive the outcome might have been different. Alternatively, if Mary could have proven she and her husband had more than "casual" conversations regarding their mutual end-of-life decisions, she would have been a more credible surrogate and the outcome likely would have been different. Absent those elements, Michael Martin remains in his helpless state and will receive relief neither from his health care providers nor the courts.²⁵⁶

Ironically, forty-two-year-old Gary Dockery personified the ramifications of an erroneous decision the same week the United States Supreme Court denied certiorari to *Martin*. News reports shocked the nation when they reported that Dockery, who was in a near-vegetative state, partially paralyzed, and mute since being shot in the head in 1988, suddenly awoke and spoke.²⁵⁷ For eigh

other family members. *See id.*

249. *See id.*

250. *See Martin*, 538 N.W.2d at 406.

251. *See id.* at 409.

252. *See id.* at 410. The conclusion to require a clear and convincing standard was in accord with the state's patient advocate act which also required clear and convincing evidence that the patient would allow treatment withheld if death would result. *See id.* at 410 n.22; *see also* MICH. COMP. LAWS ANN. § 700.496(7)(d) (West 1995).

253. *Martin*, 538 N.W.2d at 411 (citing *In re Conroy*, 486 A.2d 1209 (N.J. 1985)).

254. *Id.* (citing *In re Westchester County Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988)).

255. *See id.* at 412.

256. *See Martin*, 538 N.W.2d at 419 (Levin, J., dissenting).

257. *See* Shirley E. Perlman, *He Hopes to Hear "Hey, Buddy" Again — Brother Re-*

teen hours prior to undergoing surgery for pneumonia he communicated with his family, recalling friends and camping trips.²⁵⁸ Dockery's awakening mystified his doctors, elated his family, and gave similarly-situated families renewed hope. Research shows patients in a true persistent vegetative state for more than six months have a less than one-half of one percent chance of regaining consciousness.²⁵⁹ Sadly, within a few weeks Gary Dockery was back in his near-vegetative state.²⁶⁰ But no one can predict with complete accuracy what the future holds for Gary Dockery and similarly-situated individuals, and an erroneous decision to withhold treatment is irrevocable.

VII. CREATING EFFECTIVE ADVANCE DIRECTIVES

Presently, courts honor directives that clearly state the patient's intention, so long as the doctor can determine the condition is terminal or irreversible, and no one disagrees with the decision. Accomplishing all of the required elements appears deceptively simple. Whether written or oral, specificity and comprehensiveness within the advance directive are of utmost importance. Boilerplate forms are often inadequate and open to challenge.²⁶¹ However, more can often mean less when it comes to enforcement, because too much detail can be as fatal as too little. Typical directives apply to conditions of terminal illness, permanent coma, or vegetative states. Although directives in these areas may be appropriate for young and middle-aged patients who could enjoy productive years should they survive an emergency, they may be inappropriate for older patients

calls Dockery's Rally, NEWS & OBSERVER (Raleigh, N.C.), July 14, 1996, at A22, available in 1996 WL 2888130.

258. See Associated Press, *Something to Say: Injured Policeman Speaks on Occasion*, KNOXVILLE NEWS-SENTINEL, Apr. 11, 1996, at A4, available in 1996 WL 8744161.

259. See William J. Winslade, *What to do with our Real-life Rip Van Winkles?*, HOUSTON CHRON., Apr. 11, 1996, at 25, available in 1996 WL 5592148.

260. See Perlman, *supra* note 257. Dockery's speech slowly diminished, soon becoming intermittent responses of "yes" and "no." Then he slipped back to his previous state. See *id.* The reason for his brief awakening remains a medical mystery. See *id.*

261. See FLA. STAT. § 765.203 (1995) for an example of a recommended form for the designation of a health care surrogate, and FLA. STAT. § 765.303 (1995) for a recommended form for a written advance directive. See also FLA. STAT. § 765.105 (1995) for an example of a statute permitting the patient's family, health care facility, attending physician, or any other interested party to challenge written directives or surrogate decisions which they believe to be ambiguous or not in accord with the patient's present wishes.

trapped in severe dementia and immobility, with some degree of consciousness but with no prospect of early death.²⁶² Even a terminally ill or irreversibly comatose patient could endure weeks, months, or years of unwanted treatment before a doctor will label the prognosis terminal.²⁶³ Additionally, a coma is not labeled irreversible until every available treatment is exhausted.²⁶⁴ The requirement of “imminent” death can be problematic when an individual, although vegetative or comatose, can live for an undetermined period of time with treatment.²⁶⁵ Meanwhile, both patient and family suffer physically, emotionally, and financially. Directives that activate only under such extreme conditions encourage, and perhaps force, doctors to utilize exhaustive measures granting little hope before giving up. Often those exhaustive measures may be exactly what the patient sought to avoid, but the cost of making a mistake is far too high, and the doctor most likely will not, indeed should not, chance error.

Terms like “extraordinary” or “artificial” are vague and ambiguous. While a health care provider may not deem feeding and hydration to be extraordinary or artificial even with a nasogastric tube, that may be precisely the treatment the patient sought to avoid.²⁶⁶ Effective directives must be clear as to the conditions under which treatment is unwanted, as well as the specifics of treatment requested or refused — such as feeding and hydration, artificial respiration, or resuscitation. Even such treatments as chemotherapy, radiation, dialysis, antibiotics, or emergency surgeries to correct related or unrelated physical conditions can be considered life-sustaining in certain situations. In other words, “ordinary” to one patient in one situation may be “extraordinary” to another patient in another situation. Ambiguity breeds doubt, and doubt causes directives to be ignored. A double-edged sword is inevitable when too much specificity causes patients to receive unwanted treatments not considered at the time they executed the directive or, perhaps worse, forego treatment which would have been welcomed under the spe-

262. See Conard, *supra* note 70, at 246 (citing Steven J. Wallach & Jeff P. Crabtree, *Living Wills and the Right to Die*, 49 HAWAII MED. J. 461 (1990)).

263. See *id.*

264. See *id.* at 246–47.

265. See generally *In re Quinlan*, 355 A.2d 647, 655 (N.J. 1976) (recognizing treatment will prolong patient's slow deterioration, but will not improve or cure condition).

266. See Conard, *supra* note 70, at 247.

cific circumstances.

A. Timing

Of paramount concern is the possibility that medical practice will change between the time of making the directive and implementation. Diseases or conditions considered hopeless at the time of executing the directive may not be fatal when the patient is later treated.²⁶⁷ Personal changes may also cause a patient's desires to be altered over time. A decision made at age thirty may be different from a decision one would make at age eighty. It is extremely difficult, if not impossible, to compose a document to cover hypothetical situations such as future health requirements, especially in an ever-changing world of technology.²⁶⁸ Unlike most legal documents which gain credence over time, directives tend to lose credibility. The greater the time span or change in circumstances between the directive's creation and its implementation, the greater the uncertainty that the previous and present desires are identical.²⁶⁹

Although courts have had little occasion to specifically address that issue, a few have indicated in dictum that "temporal remoteness of a document should affect its probative value."²⁷⁰ The Florida Fourth District Court of Appeal, in *John F. Kennedy Memorial Hospital v. Blutworth*,²⁷¹ addressed the issue, stating the weight accorded a living will should take into account, among other things, the "timeliness of its execution."²⁷² The *Martin* court noted that the patient's remarks were supposedly made when he was young and healthy and thus were too remote in time and place from his current

267. See MEISEL, *supra* note 87, at 350.

268. See *Cruzan v. Harmon*, 760 S.W.2d 408, 417 (Mo. 1988), *aff'd sub nom.*, *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). "[I]t is definitionally impossible for a person to make an informed decision — either to consent or to refuse — under hypothetical circumstances; under such circumstances, neither the benefits nor the risks of treatment can be properly weighed or fully appreciated." *Id.*; see also *supra* notes 124–26 and accompanying text.

269. See MEISEL, *supra* note 87, at 351.

270. *Id.* The *Browning* court acknowledged an interested party may challenge a directive by alleging the patient changed his or her mind after executing the directive. See *Browning*, 568 So. 2d at 16.

271. 432 So. 2d 611 (Fla. 4th Dist. Ct. App. 1983), *quashed*, 452 So. 2d 921 (Fla. 1984).

272. *Id.* at 620.

circumstances.²⁷³ Casual remarks, even though repeatedly made, may be considered too remote in time.²⁷⁴ Earlier courts have held that oral statements made five years previously, in addition to being vague, were too remote and, therefore, unenforceable.²⁷⁵

A few state statutes specify expiration of enforcement after a fixed period of time, usually five to seven years.²⁷⁶ The obvious intent of such legislation is to force individuals to review their wills to ensure they reflect their current wishes. To be safe, declarants should reaffirm directives at least every five years, or when a life-altering event occurs such as illness or retirement. For example, at one extreme "Jehovah's Witnesses are instructed to execute and date new declarations annually."²⁷⁷

VIII. CONCLUSION

The right to refuse medical treatment is no longer the issue. The issue is enforcement of that right in a timely manner to avoid unwanted medical intervention and treatment. Times continue to change in the arena of medical technology and public awareness, and the law must continue to change with them. As medical technology advances and informed patients continue to assert their rights, health care providers and courts are finding it more difficult to dance around the liability fire and avoid significant punitive or compensatory awards for failure to honor advance directives, living wills, and health care surrogate decisions. Increasing public awareness fans the liability flames higher, and the trend is moving toward greater liability. However, even though courts and juries are begin-

273. See *Martin*, 538 N.W.2d at 411.

274. See *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 614 (N.Y. 1988). See *supra* notes 270-73 and accompanying text for a discussion of remoteness of statements.

275. See *In re Clark*, 510 A.2d 136, 143 (N.J. Super. Ct. Ch. Div. 1986) (finding patient's statement was too remote because it was made five years previously, and his medical condition had since changed).

276. See CAL. PROBATE CODE § 4654 (West Supp. 1996) (limiting durable power of attorney for health care, executed between January 1, 1984 and before January 1, 1992, to seven years, unless the principal lacks capacity to make health care decisions for himself or herself); see also GA. CODE ANN. § 31-32-6(b) (1996) (rendering living will executed prior to March 28, 1986, ineffective after seven years unless declarant specifically crosses through and initials or signs the limiting paragraph).

277. Conard, *supra* note 70, at 277 (citing Interview with Danny C. DeMatteis, representative of Greater Detroit Hospital Liaison Committee for Jehovah's Witnesses (Dec. 21, 1992)).

ning to recognize and compensate victims and families when a declarant's wishes are not honored, appeals of those decisions slow down and may even negate or substantially reduce awards. The issue is moot for patients who die while the courts cautiously consider their destiny.

One cannot find the answer to every situation in statutes or legal precedent. Today's public is better educated about its right to refuse treatment, but often even the best efforts fail to make provisions adequate enough to withstand the *Cruzan* standard. Boilerplate advance directive forms are woefully inadequate for many situations, but carefully drafted advance directives are often too specific. Both inaction and insufficient action, whether intentional or unavoidable due to an unobtainable standard, effectively become action, making a choice for the patient. Yet opponents of lesser burdens of proof argue that a lower threshold would increase the potential for erroneous, irreversible decisions.²⁷⁸ Gary Dockery's awakening, albeit temporary, reinforces the doubt about when to concede that an individual's condition is irreversible, thus making it appropriate to withhold life-prolonging procedures. Perhaps Mr. Dockery will awaken again when medical technology is able to cure him. No one can know for sure. Meanwhile, health care providers face tort

278. See *Cruzan*, 497 U.S. at 283, stating:

We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.

Id. In *Martin*, 538 N.W.2d at 401-02, the court offered an excellent summary of the problem:

[W]e are mindful that the paramount goal of our decision is to honor, respect, and fulfill the decisions of the patient, regardless of whether the patient is currently competent. The decision to accept or reject life-sustaining treatment has no equal. We enter this arena humbly acknowledging that neither law, medicine nor philosophy can provide a wholly satisfactory answer to this question. To err either way has incalculable ramifications. To end the life of a patient who still derives meaning and enjoyment from life or to condemn persons to lives from which they cry out for release is nothing short of barbaric. If we are to err, however, we must err in preserving life.

Id.

liability for administering unwanted treatment, leaving them confused about which way to proceed in emergency and questionable treatment situations. Protective statutes lull patients into a false sense of security — believing that their wishes will be honored. They do not realize the many factors that can cause their wishes to be ignored.

The optimum solution lies with an aggressive and comprehensive public awareness program which includes notice of the potential loopholes in standard directives. Individuals must be alerted to the importance of making advance, informed choices about their end-of-life decisions, as well as to the importance of keeping those choices current. Health care providers must be free to honor valid decisions without incurring liability. To the extent possible, consistent national guidelines for preparing and updating effective advance directives should be established to consider the myriad of foreseeable potential end-of-life situations.

In addition, a trustworthy health care surrogate for every individual is desirable. The individual should keep the surrogate fully informed at all times of the individual's preferences. But with the surrogate comes more unanswered questions, and any doubt will likely result in treatment at any cost. Even well-informed surrogates will frequently have doubts when they must make the final decision.

The United States Supreme Court's refusal to hear the *Martin* case reinforces its reluctance to address the issue, and at the same time the Court effectively makes a tacit statement that its 1990 *Cruzan* decision is still valid. Although *Cruzan*'s stringent "clear and convincing evidence" standard may guard against potential abuse or error by surrogates,²⁷⁹ it is sometimes an impossible burden to meet and may serve only to thwart the patient's wishes. The Supreme Court left it to the states' discretion to develop procedures to protect the interest of the patient.²⁸⁰ Thus, the surrogate's burden of proof can vary from state to state, making enforcement requirements even more difficult to predict. Nationwide standards are a better solution.

279. See *Cruzan*, 497 U.S. at 283. "Close family members may have a strong feeling . . . [b]ut there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." *Id.* at 286.

280. See *id.* at 281–82.

The liability fire may never be completely extinguished, and as technology continues to advance, patients will continue to endure unwanted treatment. However, nationwide consistency and education will aid both individuals and health care providers to ensure advance directives are properly honored without jeopardizing ethics or incurring liability. Until then, the day of unequivocal peace of mind that one can easily plan and go in peace when the time comes,²⁸¹ but not before or after that time has passed, remains a statutory and common law mirage of security.

281. See *Browning*, 568 So. 2d at 8 (quoting testimony regarding Browning's statements made when her living will was executed, more than five years before she was placed on life-sustaining nutrition. Eighty-nine year old Mrs. Browning died July 16, 1989, while her case was still pending).