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Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy

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NOTES

Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy

I. Introduction

During the past decade, right to die cases rose to the forefront of both public and judicial attention. These cases primarily focused on defining an individual's right to stop maintenance medical care[1] or on the rights of a guardian to discontinue treatment of an incompetent patient.[2] Liability concerns centered on potential civil or criminal liability for hospitals and physicians that effectuated the wishes of a patient or her family.[3]

Today, with the rights of individuals relatively well established, it is important to consider those situations in which a health care provider does not comply with an individual's wish to terminate life support. Because the right to die has gained widespread acceptance only recently, the courts have yet to give adequate consideration to liability for failure to respect this right. Only a handful of cases addresses the issues of improper initiation or continuation of life support. Similarly, although many states have enacted living will or natural death statutes, few of these statutes adequately contemplate possible problems that arise when a physician or hospital willfully or negligently ignores an individual's wishes. The recently enacted Patient Self-Determination Act[4] forces hospitals and physicians to confront the many difficult issues surrounding living wills and advance directives. This heightened awareness will force the legal community to give more thoughtful and comprehensive consideration to advance directives and the issues which surround them.

The possibility of such conflicts is not solely theoretical. For example, consider the situation in which an ambulance brings the victim of an automobile accident to a hospital with a pro-life orientation. The patient's condition deteriorates, and although the patient's living will states that she does not want to he supported by artificial means, in the process of treating the patient, the attending physician connects her to a ventilator. If the physician or hospital cannot disconnect the machine in good conscience, the patient will receive treatment against her will.

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1. Maintenance medical care generally refers to treatment that merely prolongs life instead of curing the illness or disease. This type of care also can be characterized as "extraordinary life-sustaining treatment." *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1218 (1985). The distinction is hazy at best. For example, a respirator may be ordinary treatment for one patient but extraordinary for another. Id. at 1235.

2. See generally notes 10-19 and accompanying text.

3. This type of participation generally is referred to as passive, versus active, participation. Passive euthanasia constitutes acts that simply let the patient die whereas active euthanasia hastens death. *Conroy*, 486 A.2d at 1219. The *Conroy* court recognized, quite appropriately, that "[t]he distinction is particularly nebulous . . . in the context of decisions whether to withhold or withdraw life-sustaining treatment." Id. at 1234.

4. 42 U.S.C. § 1395cc(f) (Supp. 1992). See notes 21-24 and accompanying text.

A similar situation arises when a patient enters the hospital in relatively good health and later deteriorates to the point of needing artificial life support. The patient and her family may face a situation in which the hospital has no procedures for disconnecting life support, thus producing a delay in allowing the family to come to terms with the death while they search for another hospital without this type of policy.

This Note addresses these types of problems. Part II identifies problems and conflicting interests that may prevent compliance with advance directives or a patient's express wishes. Part III explores the current state of the law with regard to liability and recovery for noncompliance with advance directives by reviewing case law and providing a general survey of the relevant provisions in state living will and natural death statutes. Part IV presents possible solutions that could minimize both the occurrences of improper maintenance of life support and the conflicts between patient and provider interests to preserve the autonomy of both parties.

II. The Conflict: Balancing Patient Self-Determination with the Concerns and Autonomy of Health Care Providers

The "right to die" creates a wealth of issues and potential conflicts. The questions presented in these cases require difficult choices and decisions without offering any easy solutions. The courts often consider patient autonomy to be the fundamental issue in right to die cases, and correctly so. Although some courts may hold this interest as absolute, consideration of physician or hospital autonomy and other concerns facing health care providers should temper this belief.[5] Thus, the general categories of either the patient or the physician interests provide a framework through which to view the issues and conflicts that the right to die creates.

A. *Patient Autonomy and Self-Determination*

Since the first right to die cases, courts have given patient autonomy substantial weight in deciding that individuals have the absolute right to control the course of their own medical treatment. Physicians must respect their patients' autonomy; this duty reflects our society's basic values and our belief in individual autonomy.[6] A person's right to

5. For the remainder of this Note, "hospital or physician autonomy" will refer to the individual religious, ethical, or moral beliefs of the physician or health care provider.

6. Justice Cardozo expressed this belief in *Schloendorff v. Soc'y of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914). "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." Id. at 93 (citations omitted).

control her own body is a "basic societal concept," which has long been recognized in common law.[7] The doctrine of informed consent embodies society's recognition of this value and thus binds all physicians.[8] That the doctrine of informed consent includes the patient's choice to refuse treatment is well accepted.[9]

This background provided the foundation for courts that addressed and sought to define an individual's right to die. In *In re Quinlan*,[10] the Supreme Court of New Jersey became one of the first courts to address an individual's right to refuse medical treatment. This court held that an individual's right to privacy, found in the unwritten penumbra of the rights guaranteed by the Bill of Rights, included the right to decline medical treatment.[11] Although the state had legitimate interests both in the preservation of life and in allowing physicians to heal patients, the individual's privacy right outweighed the state's interests as the patient's prognosis worsened.[12]

The New Jersey Supreme Court addressed the right to die issue again in *In re Conroy*.[13] Although the *Quinlan* holding was restricted to patients in a persistent vegetative state, the court in *Conroy* contemplated conscious patients with short life expectancies.[14] The court concluded that withdrawal or withholding of medical treatment was permissible under certain circumstances.[15]

The United States Supreme Court addressed the rights of a patient in a persistent vegetative state in the now famous *Cruzan v. Director*,

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7. *Conroy*, 486 A.2d at 1221.

8. The doctrine of informed consent is the primary means in the law to protect this personal interest in the integrity of one's body. "Under this doctrine, no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies." Id. at 1222 (citations omitted).

9. Id. (citations omitted).

10. 70 N.J. 10, 355 A.2d 647 (1976).

11. Id. at 663 (citing *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965)).

12. 355 A.2d at 663-64. The *Quinlan* court further held that because the patient was in a persistent vegetative state and thus incompetent to assert her own rights, her guardian's and family's substituted judgment would suffice to protect those rights. Id. at 664. Thus, with a diaguosis by her attending physicians of her terminal condition and with the approval of her family and guardian, life support could be withdrawn without civil or criminal liability for any participant, health care provider, or guardian. Id. at 671-72. Furthermore, in the future, similar declaratory relief actions would not be necessary in like situations. Id. at 672.

13. *Conroy*, 486 A.2d at 1209.

14. This case considered a patient who was "awake and conscious . . . but whose mental and physical functioning [was] severely and permanently impaired and whose life expectancy, even with the treatment, [was] relatively short." Id. at 1228-29.

15. The court allowed withdrawal of life support when the patient's subjective desire is sufficiently established, when, under a limited-objective test, it is apparent that the patient would have refused treatment and that the burdens of life outweighed the benefits of life for the patient, or when, under a pure-objective test, the burdens of life outweighed its benefits and tbe severe pain of continued treatment would be cruel. Id. at 1229, 1232, 1236.

Missouri Department of Health.[16] The Court recognized a competent person's constitutionally protected liberty interest in denying unwanted medical treatment.[17] It restricted its holding, however, to competent individuals. The Court concluded that a state could require clear and convincing evidence of the incompetent patient's wishes before a surrogate could authorize the withdrawal of life support.[18] Furthermore, the Court did not require a state to accept the substituted judgment of close family members.[19] Therefore, although the Court in *Cruzan* recognized the right of a patient to refuse medical treatment, it qualified this protection by holding that a state could restrict an incompetent patient's rights by requiring heightened evidentiary standards to prove that patient's wishes.

Cruzan confirmed that our society values and recognizes patient autonomy. The growing acceptance of living wills and other advance directives further confirms this judicial valuation.[20] Thus, courts and legislators always should give significant deference to patient autonomy when evaluating the failure to recognize a patient's wish to discontinue medical treatment.

Given that some physicians and health care facilities comply more willingly than others with advance directives requiring the cessation of maintenance life support, one possible solution suggests that individuals choose their health care providers based on the provider's right to die stance. To this end, the Patient Self-Determination Act (PSDA)[21] provides some relief and guidance. The statute provides that hospitals

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16. 497 U.S. 261 (1990).
17. Id. at 278.
18. Id. at 281-82.
19. Id. at 286.
20. Virtually all the states have enacted living will or natural death statutes. Furthermore, professional organizations, such as the American Medical Association, have endorsed these documents in planning for terminal illness. See Linda L. Emanuel, et al., *Advance Directives for Medical Care—A Case for Greater Use,* 324 New Eng. J. Med. 889 (1991).
21. 42 U.S.C. § 1395cc(f)(1) provides in relevant part:

> [T]he 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—
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> (A) to provide written information to each such individual concerning—
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> (i) an individual's rights under State law (whether statutory or as recognized by 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;

must inform patients of their rights to refuse medical treatment under the applicable state law and further must respect those rights.[22] Additionally, hospitals must educate their patients on hospital policies regarding advance directives and the right to die.[23] Providers must furnish this information upon an individual's admission to the hospital.[24]

On its face, PSDA would appear to solve many, if not all, of the conflicts between patients and physicians or hospitals over the right to die. Upon closer analysis, however, the statute fails to contemplate those situations frequently encountered by families who face decisions regarding the termination of life support—hospitalization due to an emergency. For instance, after a serious automobile accident, an ambulance often takes the victim to the closest hospital. If that hospital connects the patient to a ventilator or similar life support and has a pro-life orientation, a conflict might ensue when the family asks the facility to disconnect the victim from the life support system.

The court in *Strachan v. John F. Kennedy Memorial Hospital*[25] contemplated this situation. After a suicide attempt, an ambulance took the plaintiffs' son to the defendant hospital. The attending physician placed Jeffery Strachan on a respirator and diagnosed him as brain dead, a result of gunshot wound to the head. Several days lapsed between the family's request that Jeffery be taken off the respirator and the hospital's compliance with that request. This delay caused serious emotional distress to the family.[26]

Even if PSDA had been in effect at the time of this case, the hospital would not necessarily have informed the plaintiffs of both state and hospital policies regarding refusal of medical treatment until after the initiation of life support. Although informing patients of their rights

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(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.

22. Id. § 1395cc(f)(1)(A) & (D).

23. Id. § 1395cc(f)(1)(A).

24. Id. § 1395cc(f)(2)(A).

25. 109 N.J. 523, 538 A.2d 346 (1988).

26. Id. at 347-49. The *Strachan* court described the plaintiffs' plight:

> The record in this case reveals particularly compelling evidence of distress. Although plaintiffs were told that their son was brain dead and nothing further could be done for him, for three days after requesting that their son be disconnected from the respirator plaintiffs continued to see him lying in bed, with tubes in his body, his eyes taped shut, and foam in his mouth. His body remained warm to the touch. Had Jeffery's body been removed from the respirator when his parents requested, a scene fraught with grief and heartache would have been avoided, and plaintiffs would have been spared additional suffering.

Id. at 351.

upon admission may help to resolve conflicts arising during inpatient procedures, individuals often need living wills in situations that are not so clean and orderly. These situations present potential problems for both the patient; as illustrated by *Strachan*, and the physician who connects an individual to life support in an emergency situation. Common sense dictates that emergency room workers and paramedics should receive some form of immunity for their acts of resuscitation or initiation of life support. If not, concerns about potential liability for initiating life support measures could disrupt the general flow of emergency medicine. To date, however, only one state has codified such an exemption.[27]

B. Physician and Hospital Autonomy

Although the individual patient's autonomy certainly should be given significant deference, any prudent analysis should balance this factor against the values, ethics, and religious beliefs of both the physician treating the patient and the hospital where the patient is receiving care. No health care provider should be forced to hasten a patient's death if it violates her set of beliefs. Although society recognizes the rights of individuals to control their own lives, it also should acknowledge that members of the health care profession have the right to be free of intrusions on their values.

Virtually all of the early cases addressing the right to die identified the maintenance of the medical profession's integrity as a policy factor competing with the individual's right to refuse medical treatment.[28] Some courts have extended this concern to encompass the desire to grant hospitals broad discretion to care for people under their control.[29] This desire to cure and heal often may conflict with the practice of comforting the dying.[30] Although still not fully accepted, it now appears

27. Enacted in January, 1992, New Jersey's Advance Directive for Health Care Act provides in part:

> The provisions of this act shall not he construed to require emergency personnel, including paid or volunteer fire fighters; paramedics; members of an ambulance team, rescue squad, or mobile intensive care unit; or emergency room personnel of a licensed health care institution, to withhold or withdraw emergency care in circumstances which do not afford reasonable opportunity for careful review and evaluation of an advance directive without endangering the life of the patient.

N.J. Stat. Ann. § 26:2h-70(b) (West Supp. 1992).

28. See, for example, *Conroy*, 486 A.2d at 1223.

29. See *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 427 (1977) (citations omitted).

30. "We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying." *Quinlan*, 355 A.2d at 667.

that more physicians regard "passive euthanasia," or the comfort of the dying, as a valid medical endeavor.[31]

The doctrine of informed consent acts as one way to safeguard the medical profession's integrity from any harmful effects associated with assisting in a patient's wish to die. A fully informed patient who chooses a certain course of treatment accepts the outcome of that treatment.[32] Even after acknowledging that many physicians now accept a patient's right to die and that informed consent may safeguard sufficiently the ethical integrity of the medical profession, the possibility for conflict still exists. Situations that might compromise the ethical integrity of a single physician or health care provider rather than that of the entire medical profession can arise easily.

Bartling v. Glendale Adventist Medical Center[33] illustrates this point. Mr. Bartling first went to the Glendale Adventist Hospital for a routine physical examination. A chest X-ray subsequently revealed a lung tumor. During a needle biopsy of this tumor, Mr. Bartling's lung collapsed, leading to his eventual placement on a ventilator in April, 1984. He often tried to disconnect himself from the ventilator, and on May 30, 1984, executed a living will asking that he no longer be supported by artificial means. The declaration accompanying his living will attested that attachment to the ventilator caused him substantial pain and discomfort.[34]

Mr. Bartling further assigned to his wife a durable power of attorney for health care and executed consent forms releasing the hospital from civil liability if it acted in accordance with his wishes. Although the hospital tried several times to wean him from the ventilator, each time his breathing or heart stopped, and the medical staff resuscitated him. Most of the physicians at Glendale shared the hospital's pro-life orientation and could not, in good conscience, effectuate Mr. Bartling's wish to be disconnected from the respirator.[35] To satisfy Mr. Bartling's and his family's wishes, Glendale tried to have him transferred to another hospital, but no other facility would accept him.[36] Even with clear statements of intent, the attending physicians refused to remove the

31. See, for example, *Conroy*, 486 A.2d at 1225. See also note 3.

32. On this point, the *Conroy* court stated:

> If the patient rejected the doctor's advice, the onus of that decision would rest on the patient, not the doctor. Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.

Id.

33. 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (Cal. Ct. App. 1986).

34. Id. at 361-63.

35. Id. at 362.

36. Id.

ventilator and refused to remove Mr. Bartling's restraints to allow him to disconnect the machine himself.[37]

This situation presents a legal dilemma because the hospital clearly administered treatment against Mr. Bartling's wishes. Although the hospital and physicians tried to comply with Mr. Bartling's wishes by transferring bim to another facility, they could not find another hospital willing to take him, and they could not effectuate his wishes themselves in good conscience.[38] In this situation, not only is the patient's autonomy at stake, but also the autonomy of the physician. One should not impose her values upon anyone else, including health care providers.

The potential moral hazard facing health care providers if they are not held accountable for failing to comply with patient wishes also should affect the balance between physician and patient autonomy. If not subject to liability, hospitals or other providers may prolong patient care, consciously or unconsciously, to generate increased revenues. In *Grace Plaza of Great Neck, Inc. v. Elbaum*,[39] the court identified this concern as a potential side effect of its holding that declined to absolve a patient's family from liability on the contract for hospital services for the time in which the patient received life support over their objections.[40] The court concluded that this concern did not outweigh the "potential evil" that might occur if a patient whose life could be saved died.[41]

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37. Id. at 361.

38. See also *Grace Plaza of Great Neck, Inc. v. Elbaum*, 183 A.D.2d 10, 588 N.Y.S.2d 853 (N.Y. App. Div. 1992), in which a health care facility refused to disconnect a patient from nutrition and hydration for ethical reasons. In its decision, the court remarked, "While we recognize the right of a patient to control the course of his or her treatment, we do not recognize any right to force a health-care provider to render treatment which is contrary to his or her conscience." 588 N.Y.S.2d at 859. See also notes 98-100 and 124-30 and accompanying text.

39. *Grace Plaza*, 588 N.Y.S.2d at 853.

40. Id. at 860.

41. Id. In discussing the issue, the court stated:

> It is asserted that, in light of our decision today, all health care providers in charge of competent patients will have an additional financial incentive to prolong the lives of such patients over the objections of the patients' families. This may he true, and the potential evil which we see is that some beleaguered families may, regrettably, be forced to resort to litigation, although we believe that the dissent overdramatizes the extent to which this might place a burden on the judicial system. What is not noted is that, if Mr. Elbaum's conduct in this case were condoned, health care providers would have an additional financial incentive to obey, without question, the orders of those conservators who might prematurely despair of their conservatee's recovery, or the orders of those conservators whose judgment might be tainted by motives less altruistic than Mr. Elbaum's. The potential evil we see resulting from this, i.e., the possible death of even one patient whose life might have been saved, is infinitely greater, in our view.

Id.

By contrast, the dissent in *Grace Plaza* found the patient's right to autonomy supreme.[42] This difference of opinion presents a central conflict: physicians and hospitals should not be forced to perform acts they consider unethical, but they should not profit from a failure to act.

If an individual has an advance directive, the general assumption is that she wants the directive to be followed.[43] Nevertheless, several situations come to mind in which a patient may not want her advance directive strictly followed. First, a potentially reversible episode could cause the patient to need the assistance of life support for only a short period, after which the patient could resume a normal life.[44] Even if the patient would acquiesce to treatment in such instances, however, no physician can know absolutely which episodes are reversible. At the time, a physician may believe a condition is reversible and only later discover that permanent connection to a ventilator is required. Looking at the events with perfect hindsight, a sympathetic jury might find physicians liable for acts that appearéd reasonable at their inception.

Second, but not unrelated to the first issue, the patient's advance directive may not be as comprehensive or detailed as the physician requires. For example, it may not provide guidance on how to act during a potentially reversible episode.[45] Moreover, the directive may not specify what type of treatments the patient considers life-sustaining.[46] This problem creates uncertainty not only for the hospital and physicians,

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42. Justice Rosenblatt remarked: "The advancement of professional ethics to support the preservation of life has epitomized the medical profession, to the public benefit. However powerful those interests may be, they should not serve as a platform to afford compensation for unwanted services, rendered adversely to the patient's declared right of autonomy." Id. at 868 (Rosenblatt, J., concurring in part and dissenting in part).

43. If a patient has gone to the effort to enact an advance directive, it logically follows that the patient wants that directive followed. But see Ashwini Sehgal, et al., *How Strictly Do Dialysis Patients Want Their Advance Directives Followed?*, 267 JAMA 59 (1992).

44. See Marion Danis, et al., *A Prospective Study of Advance Directives For Life-Sustaining Care*, 324 New Eng. J. Med. 882, 884-85 (1991) (describing a situation in which a patient was briefly given artificial ventilation for a reversible episode of respiratory failure despite a living will).

45. Consider the following scenario. A patient with lung cancer enacts a living will. During the course of her illness, the patient begins experiencing headaches. The attending physician elects to order a CAT scan to see if the cancer has spread to the brain. In this procedure, the physician uses contrast dye, which routinely causes allergic reactions in patients. Such reactions generally are reversible but require a brief period of artificial ventilation. If the patient experiences such a reaction, it is a result of the treatment, not the illness. In such a case, whether the patient would want to be resuscitated is unclear.

46. See William C. Knapp and Fred Hamilton, *"Wrongful Living": Resuscitation as Tortious Interference with a Patient's Right to Give Informed Refusal*, 19 N. Ky. L. Rev. 253, 264-65 (1992). Some patients might consider treatments such as chemotherapy, dialysis, or antibiotics to be life-sustaining for the purpose of an advance directive. Id. at 265.

but also for the patient's family who may not know the actual intent and scope of the document.[47]

Patient uncertainty also hinders a physician's ability to decide whether to follow an advance directive. A recent study suggests that patients may not want their advance directives strictly followed.[48] This study produced widely differing responses. Subjects' responses greatly differed when asked how much leeway their physician and surrogate should have to override their advance directive if overriding the directive were in the subjects' best interests. The subjects replied as follows: no leeway (thirty-nine percent), a little leeway (nineteen percent), a lot of leeway (eleven percent), and complete leeway (thirty-one percent).[49] These discrepancies between an individual's actual and written intent pose a problem for health care providers. An advance directive should provide an accurate version of the individual's intent; any second-guessing about a patient's intent greatly diminishes the value and effectiveness of the instrument.

Hospitals and physicians also face other concerns that may shape and motivate their courses of action. Today, a severe shortage of organs donated for transplantation exists.[50] The need for these organs has the potential to collide with right to die issues because brain dead patients comprise the primary source of such donations. Although an individual may express a wish to be disconnected from artificial support in an advance directive, the hospital and society have a substantial utilitarian interest in keeping the patient alive until the donor's organs can be removed, or until the family can be convinced to consent to the donation.

Strachan v. John F. Kennedy Memorial Hospital[51] hinted at this possibility. Glendale Hospital actively participated in organ transplants and affiliated itself with the Delaware Valley Transplant Program. One of the patient's attending physicians recorded in the medical chart that

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47. A conflict between the patient's wishes in the form of an advance directive and the desires of the patient's family might jeopardize the individual's autonomy. Suppose, for instance, that the patient expressed a wish to be maintained on life support, but the family wants the individual disconnected either to get the inheritance or simply to prevent a drain on the estate's finances. In these situations, it is clear that the patient's wishes should control. David Randolph Smith, *Legal Recognition of Neocortical Death*, 71 Cornell L. Rev. 850, 887 (1986). To preserve patient autonomy and to prevent courts from having to discern proper from improper family motives, the individual's expressed wishes should dictate the course of treatment. Similarly, a living will should take precedence over a durable power of attorney for health care.

48. Sehgal, 267 JAMA at 61 (cited in note 43).

49. Id.

50. See generally Mike Woods, *Organ Donations Vital*, Chi. Trib. 7 (Oct. 15, 1992) (stating that although almost 24,000 people are on waiting lists for organ transplants, there are only about 4,000 donations each year).

51. 109 N.J. 523, 538 A.2d 346, 346 (1988).

his organs could be harvested if parental consent was obtained.[52] The plaintiffs subsequently informed the hospital that they did not wish to donate their son's organs and wished to have him disconnected from the respirator.[53] Another physician advised them to consider their decision further.[54] Receiving no change in reply after several days, the hospital finally disconnected the patient from the ventilator.[55]

This case suggests that the facility maintained the patient's life support while attempting to persuade the family to donate his organs. These situations bring to light a potential conflict between the duties of a patient's attending physician, who has a duty to follow and respect her patient's wishes, and the interests of a physician or hospital that participates in an organ transplantation program and seeks organs for harvesting.[56] Although this conflict potentially could jeopardize an individual's autonomy, only one state's natural death statute contemplates this conflict by forbidding individuals involved in organ transplantation from participating in decisions to withdraw life support.[57]

Two additional factors may account for noncompliance with an advance directive: simple negligence and fear of potential liability. Physicians and hospitals may not follow living wills for the simple reason that the instruments are unknown to the hospital or its staff.[58] In these instances, easy remedies exist. PSDA certainly will increase hospital staff awareness of these documents, thereby helping to decrease noncompliance due to simple negligence.[59]

52. Id. at 347.

53. Id.

54. Id.

55. Id. at 348.

56. See *Kirker v. Orange County*, 519 S.2d 682 (Fla. Dist. Ct. App. 1988) (allowing the plaintiff to recover damages for intentional infliction of emotional distress against the county medical examiner who removed her dead daughter's eyes and corneas for transplantation without authorization). But compare *Mandatory Organ Donation Sought*, N.Y. Times C7 (Dec. 23, 1992) (discussing a proposal that would make organ donation mandatory unless the individual or a relative objects in advance).

57. Mississippi is the only state to address this potential conflict of interest. Its living will statute provides in part: "No physician participating in a decision to withdraw life-sustaining mechanisms from a declarant may participate in transplanting the vital organs of the declarant to another person." Miss. Code § 41-41-115(3) (Supp. 1992).

58. A study in the New England Journal of Medicine confirms this theory. In a study of patients with advance directives at nursing homes, a survey determined that although advance directives were placed into the medical charts of the nursing home 74% of the time, the directives were incorporated into hospital medical charts in only 25 of 71 occasions. Danis, 324 New Eng. J. Med. at 884 (cited in note 44). Members of the nursing staff at hospitals receiving the patients from nursing homes commented that staff turnover often caused the unfamiliarity with and infrequent transfer of the documents. Id.

59. PSDA provides that hospitals must ensure compliance with state law, record in the patient's medical chart whether she has an advance directive, and educate their staffs about advance directives. 42 U.S.C. § 1395cc(f)(1)(B), (D), & (E).

Fear of liability proved to be one of the reasons why hospitals and physicians hesitated to comply with patients' wishes to die in early cases. Most statutes, however, provide immunity for physicians, hospitals, and health care providers for acting reasonably in respect of a patient's wishes.[60] In those states that do not have natural death statutes and have not established immunity by case law, however, fear of potential liability still may influence many health care providers. In *Grace Plaza*,[61] the plaintiff needed to obtain a court order before his wife could be disconnected from life support. The court noted that Grace Plaza could not be expected to disconnect a patient before obtaining a court order because this act might implicate liability.[62] Thus, the fear of liability remains a very real factor affecting the way health care providers approach the withdrawal of life support.

III. The Current State of the Law Regarding Improper Maintenance of Life Support

This Part provides an overview and analysis of the current state of the law with regard to finding physicians, hospitals, or other health care providers liable for noncompliance with a patient's wish to be disconnected from life support.[63] The first subpart will review the types of actions brought in the courts and which types have succeeded. The second subpart examines the status of state living will and natural death statutes, focusing on how they address the issues of noncompliance and physician and hospital autonomy.

A. *Causes of Action for Improper Maintenance of Life Support*

As a matter of common sense, noncompliance with a patient's wishes should give rise to some type of liability. To date, however, the courts have not granted significant monetary recovery to a patient or her family.[64] This Part analyzes situations under which cases have been

60. See notes 120-21 and accompanying text.

61. *Grace Plaza*, 588 N.Y.S.2d 853.

62. "New York provides for civil, administrative, and . . . even criminal penalties for any health-care professional who violates these obligations without court approval." Id. at 857.

63. Hospital ethics committees that serve in advisory roles to physicians, hospitals, family members, and patients also could face liability. Andrew L. Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. Cal. L. Rev. 1239 (1987). In general, these committees help to shape hospital procedures, educate both the hospital staff and the general public, and consult physicians when difficult decisions must be made regarding individual patients. Id. at 1243. Given their advisory and policy shaping roles, these committees may become exposed to lawsuits by patients or their family members. Id. at 1241.

64. M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 S.L.U. Pub. L. Rev. 499 (1992). "Despite the accelerated momentum of legal and public opinion supporting patient choice at the end of life, there is a large disjunction between what the law requires and the actual practice in the health care setting." Id. at 502.

brought, what types of actions have been brought, and which cases have been successful.

1. Battery

Breach of informed consent may give rise to an action in negligence or an action in the intentional tort of battery.[65] Thus, a patient conceivably could bring an action in battery for the improper maintenance of life support. In *Estate of Leach v. Shapiro*,[66] the plaintiffs brought an action for damages for the time that the hospital maintained Edna Marie Leach on life support against her and her family's wishes. The medical team at Akron General Hospital restored Mrs. Leach's heartbeat after she suffered a cardiac arrest, but she remained in a persistent vegetative state. On October 21, 1980, Mrs. Leach's husband and guardian petitioned the probate court for an order to terminate life support.[67] The ventilator was disconnected finally on January 6, 1981.[68]

The plaintiffs filed an action for damages, contending that the hospital placed Mrs. Leach on life support and wrongfully maintained her contrary to her and her family's wishes.[69] The court agreed that the doctrine of informed consent included the right to refuse treatment and that the breach of such a duty could support an action for battery.[70] The plaintiffs did not allege, however, that the resuscitation efforts amounted to a battery, but that the hospital's improper placement of Mrs. Leach's on life support without her or her family's consent constituted battery.[71] Therefore, whether the plaintiffs stated a valid claim depended upon when and under what pretext the hospital connected Mrs. Leach to the life support systems.[72] If she was connected to life support as part of the resuscitation efforts, this situation would insulate the defendants from liability.[73] The plaintiffs viewed the timing of the connection of life support differently, alleging that the defendants connected Mrs. Leach after she was already in a chronic vegetative state.[74] They contended that absent an emergency, the defendants needed to secure the family's consent, which they would have denied because Mrs. Leach previously had expressed to the defendants her desire not to be

65. Restatement (Second) of Torts § 892B cmt. i (1979).
66. 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984).
67. Id. at 1051.
68. Id.
69. Id.
70. Id. at 1052.
71. Id.
72. Id. at 1053-54.
73. Id. at 1052.
74. Id. at 1053.

kept alive by machines.[75] Therefore, the maintenance of a cause of action for battery in this case depended upon the timing and context in which Mrs. Leach was connected to life support. Nevertheless, this case does stand for the proposition that the potential for a cause of action in battery does exist.

Bartling[76] also affirms the potential of bringing a cause of action in battery for improper maintenance of life support. After Mr. Bartling died in November, 1986, his family brought an action for battery.[77] The court dismissed the family's action primarily because the establishment of the rights of patients in California in such a situation had not evolved yet.[78] The court found that a common or comprehensive legal standard was not present at the time of the patient's hospitalization to guide the medical community.[79] Because his rights were not defined during the time of his hospitalization, the court could not find that the defendant consciously acted to disregard Mr. Bartling's constitutional rights.[80] Furthermore, because Mr. Bartling died, any cause of action he had for pain and suffering died with him.[81] Therefore, the court determined that the action in battery was dismissed properly.[82]

Bartling, therefore, does not stand for the proposition that a plaintiff cannot succeed in an action for battery. Rather, the patient's rights were not defined sufficiently to support an action arising from the improper maintenance of life support. Furthermore, Mr. Bartling's potential causes of action died with him. A court would face a different situation, however, if the patient is living or her rights are defined more adequately.[83]

2. Duty to Provide Procedures for the Removal of Life Support

Given the increased awareness and execution of living wills, health care providers could face a duty to have procedures in place to remove

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75. Id. The case was remanded for further fact finding on why and when Mrs. Leach was connected to life support. Id. at 1055.

76. *Bartling v. Glendale Adventist Medical Ctr.*, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (Cal. Ct. App. 1986).

77. Id. at 361. The plaintiffs also alleged breach of fiduciary duty, intentional infliction of emotional distress, violation of federal civil rights, and conspiracy. Id.

78. Id. at 363.

79. Id.

80. Id. at 364.

81. Id. The court noted that the applicable survival statute only provided for limited damages and did not include an award for pain and suffering. Id. at 364 n.6.

82. Id. at 364.

83. Under either a battery or a negligence framework, an individual or her family could attempt to argue a "wrongful living" cause of action as tortious interference with the right to die because of improper resuscitation. Knapp and Hamilton, 19 N. Ky. L. Rev. at 254-55, 261-63 (cited in note 46).

patients from life support systems.[84] With such a duty acknowledged, any delay in taking a patient off of life support because of a failure to have procedures established could give rise to an action in negligence. To date, only one case has addressed this issue.

In *Strachan*,[85] the plaintiffs argued that the hospital had a duty to have procedures in place for the removal of life support upon the request of the patient's family.[86] The plaintiffs sought damages from the hospital and hospital administrator for negligent infliction of emotional distress for the hospital's failure to have termination of life support procedures in place.[87] In addition, the plaintiffs sought damages for the mental distress caused by the willful holding of their son by the hospital, preventing a proper burial.[88] The jury found for the plaintiffs on both counts and awarded damages in the amount of $140,000.[89]

The intermediate appellate court reversed and found that the plaintiffs did not establish a cause of action under either theory.[90] The Supreme Court of New Jersey disagreed, but hesitated to force upon all hospitals the duty to have such procedures in place.[91] The court concluded that public policy prevented them from announcing an absolute duty binding all hospitals to have established procedures for the removal of life support mechanisms upon the request of a patient's family.[92] The court found that the imposition of such a duty was not proper for the court, but should be addressed by the hospitals and physicians themselves.[93] If the medical community considered this obligation essential, then to be more than a mere "paperwork duty," it must be responsible for defining the appropriate standard of care.[94]

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84. It should be noted that this argument gains significant strength given the extensive requirements imposed on health care providers by PSDA.

85. *Strachan*, 538 A.2d 346.

86. Id. at 349.

87. Id. at 348. The plaintiffs initially filed suit against the hospital, the hospital administrator, the physicians involved, and the Delaware Valley Transplant Program, but the case was dismissed voluntarily against all but the hospital and administrator. Id.

88. Id. at 348-49.

89. Id. at 349.

90. *Strachan v. John F. Kennedy Memorial Hosp.*, 209 N.J. Super. 300, 507 A.2d 718, 719 (Super. Ct. App. Div. 1986).

91. *Strachan*, 538 A.2d at 349.

92. Id.

93. Id.

94. Id. The court explained its position:

> The imposition of a paperwork duty does little to advance either the mission of health-care providers or the needs of society. If "procedures" are to be viewed as more than mere "paperwork" and considered indispensable in this area—in the nature of a standard that governs the medical community—then those procedures should be designed and imposed by those most directly involved, the physicians and hospitals themselves. That is the business of the medical community itself, not of this Court.

Id.

Thus, given the delicate nature of such matters, the *Strachan* court found that the establishment of an absolute duty in this area would impose too much of a burden on the medical community. For a standard to have any real significance, it must be more than a declaration by the court. It must encompass the views of the health care community as a whole.

3. General Duty to Act Reasonably

Although the *Strachan* court chose not to define an absolute duty to establish procedures for the termination of life support, it did find liability under another duty of care: to act reasonably in respecting the family's legitimate request to relinquish their son's body.[95] The absence of procedures to disconnect a patient from life support systems was but one factor considered by the court in determining whether the hospital satisfied its duty of reasonableness owed to the Strachans.[96]

Given the foreseeability of a patient's wish to be disconnected from life support, if a hospital insists on consent forms or procedures for taking a body off of life support, then the hospital has a duty either to have the forms or procedures in place, or to make some sort of arrangement immediately upon the family's request.[97] By refusing to impose an absolute duty to have procedures in place, the *Strachan* court acknowledged the difficulty inherent in right to die cases. Yet, by recognizing a general duty to act reasonably, the court struck an appropriate balance between the needs of the medical community and the wishes of the patient and his family. If a hospital will not disconnect life support without such procedures, given the foreseeability of a living will or right to die incident, having procedures in place is both necessary and reasonable.

4. Breach of Contract

If an individual, or more likely her family, feels that life support was continued inappropriately by a health care provider, the family might make a conscious decision to withhold payment for services, breaching their contract with that health care provider. Under these circumstances, wrongful maintenance of life support would not comprise an action, but a defense to a breach of contract suit. In *Grace Plaza*, the health care facility filed a breach of contract action to recover fees for care rendered to the defendant's wife before a court order

95. Id.
96. Id.
97. Id. at 349-50.

was obtained allowing termination of nutrition and hydration.[98] The court reasoned that because New York does not accept any form of surrogate decisionmaking, Grace Plaza did not act wrongfully in maintaining life support until the court declared that the patient's desire was not to be maintained by artificial means.[99] Because Grace Plaza committed no legal wrong by continuing medical treatment until it obtained judicial approval, the court held that the facility was entitled to payment of medical fees.[100]

Under a different set of facts, improper maintenance of medical treatment clearly would constitute a defense to a breach of contract for medical services suit. As a practical matter, where to place the burden of the cost of uncertainty about the patient's desire in such case is problematic. If the burden is placed upon the health care provider, cases will proceed to court only if there is a serious question about the sufficiency of the evidence.[101] By contrast, if the burden is placed on the family, plaintiffs will be able to bring fewer cases because of the emotional and financial costs.[102]

5. Actions Under 42 U.S.C. Section 1983

Given that the Supreme Court has recognized a constitutional right to die,[103] a patient or her family could bring a 42 U.S.C. Section 1983 action for violation of this constitutional right. Recovery under such a theory has two requirements. First, the plaintiff must establish that the physician or hospital is a state actor. In *Ross v. Hilltop Rehabilitation*

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98. *Grace Plaza*, 588 N.Y.S.2d at 853.

99. Id. at 856-57. The court explained New York law:

> New York at present expressly rejects any form of surrogate decision making in "right to die" cases because such an approach would be "inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another."

Id. at 857 (citations omitted). The court also clarified its previous order granting Mrs. Elbaum the right to be taken off of life support. "What we obviously did *not* hold . . . is that the plaintiff acted wrongfully in keeping Mrs. Elbaum alive until the actual nature of her desires bad in fact been proved." Id. at 856 (emphasis in original).

100. Id. at 860. The dissent in *Grace Plaza* characterized the facts differently and gave patient autonomy more weight. "Grace Plaza is on record as having discounted utterly tbe patient's wishes to die naturally, proclaiming itself to be the transcendent arbiter of the patient's artificial life support." Id. at 860-61 (quoting Judge Rosenblatt). According to the dissent, the court's holding "allows a nursing home to profit financially, while ignoring a patient's wishes, as it imposes its own ethical standards upon her." Id. at 861. The gist of the dissent's reasoning is that in maintaining medical treatment, Grace Plaza was not acting out of a fear of liability because the patient's wishes were not clearly established; rather, it was imposing its own ethical beliefs on the patient. Id. at 861-64.

101. Gasner, 11 S.L.U. Pub. L. Rev. at 513 (cited in note 64).

102. Id. at 514 (notes omitted).

103. See notes 16-19 and accompanying text.

Hospital,[104] the plaintiff unsuccessfully brought a Section 1983 action for failure to cease medical treatment and deprivation of his privacy rights.[105] His estate's action failed because of its inability to establish that the hospital and physician were state actors.[106]

Even if the plaintiff successfully establishes state action, she must overcome another difficult obstacle. To recover, the plaintiff must prove that the defendant state actor intended to violate her constitutional rights.[107] In *Bartling*, the plaintiffs could not recover for deprivation of constitutional rights because the court concluded that the defendant did not act with conscious disregard for Mr. Bartling's rights.[108] The requirements of proving state action and intent stand as serious hindrances to recovery under Section 1983.

A successful Section 1983 action does bring with it, however, the possibility of recovery of attorney's fees under 42 U.S.C. Section 1988(b).[109] In *Gray v. Romeo*,[110] the plaintiff previously had recovered damages under a Section 1983 action for the defendant's refusal to withdraw a feeding tube.[111] In this action, the plaintiff recovered just over $38,000 in attorney's fees accrued during her previous action.[112] Such a recovery provides the plaintiff with additional incentive to recover for a constitutional rights violation.

B. *State Living Will and Natural Death Legislation*

In response to the growing recognition of patients' rights, many states have enacted "natural death" or "living will" legislation enabling patients to dictate for themselves the withdrawal of medical assistance upon diagnosis of a terminal condition.[113] In general, two principal types of statutes exist: durable power of attorney for health care stat-

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104. 676 F. Supp. 1528 (D. Colo. 1987).

105. Id. at 1530.

106. Id. at 1535. "In the case at bar, plaintiff has failed to show *specific conduct* of the defendants that can be considered state action causally connected to plaintiff's injury." Id. at 1536 (emphasis added).

107. Gasner, 11 S.L.U. Pub. L. Rev. at 507-08 (cited in note 64).

108. See notes 76-80 and accompanying text.

109. This section provides: "In any action or proceeding to enforce a provision of Sections 1981, 1981A, 1982, 1983, 1985, and 1986 of this title, title IX of Public Law 92-318 [20 U.S.C. 1681 et seq.], or title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs." 42 U.S.C. § 1988(b) (Supp. 1991).

110. 709 F. Supp. 325 (D.R.I. 1989).

111. Id. at 326.

112. Id. at 328.

113. Jeffery J. Delaney, Note, *Specific Intent, Substituted Judgment and Best Interests: A Nationwide Analysis of an Individual's Right to Die*, 11 Pace L. Rev. 565, 630 (1991).

utes and living will or natural death acts.[114] Durable power of attorney for health care statutes allow an individual to designate surrogate decisionmakers for medical treatment in the event that the individual becomes incapacitated.[115] Living will acts allow individuals to specify what type of medical care they want to receive should they become incompetent.[116]

The requirements of living will and natural death statutes vary from state to state, but distilling a few general requirements is possible. Usually, the actual document must be witnessed by two competent adults who are not related to the declarant by blood or marriage.[117] The statutory forms also allow individuals to specify what their medical condition must be before the living will takes effect.[118] The declarant also may specify which forms of treatment she wishes to receive, such as whether a feeding tube is to be allowed.[119]

More importantly, in the area of physician and medical liability, these statutes generally serve to insulate those health care providers who help effectuate the living will from both civil and criminal liability.[120] For example, a statute may exempt from liability any health facility, physician, or health care provider acting under direction of a physician if the requirements of the statute are met.[121] Many statutes also impose the additional requirement that all health care providers who participate in fulfilling the living will must act in accordance with reasonable medical standards to avoid liability or a citation for unprofessional conduct.[122] This additional requirement is common in many living will statutes, and courts might view it as an extension of the physician's or health care provider's general duty of care.

Although virtually all of these statutes contemplate liability that might arise from compliance with the provisions of a living will, liability for failure to comply with the patient's wishes receives varying treat-

114. Id.

115. Id. (citations omitted).

116. Id. at 630-31 (citations omitted). This Note primarily considers living will and natural death statutes.

117. See, for example, Ga. Code Ann. § 31-32-3 (Michie Supp. 1992), Ind. Code Ann. § 16-8-11-11 (Burns 1990), Tenn. Code Ann. § 32-11-104 (Supp. 1992), and W. Va. Code § 16-30-3 (Supp. 1992).

118. See, for example, Ga. Code Ann. § 31-32-3(b) (Michie Supp. 1992) (allowing the declarant to specify if she wants the will to take effect upon any of the following: "a terminal condition, . . . a coma with no reasonable expectation of regaining consciousness, or . . . a persistent vegetative state with no reasonable expectation of regaining significant cognitive function").

119. See, for example, id.; Ind. Code Ann. § 16-8-11-12 (Burns 1990); and Tenn. Code Ann. § 32-11-105 (Supp. 1992).

120. See, for example, Tenn. Code Ann. § 32-11-110 (Supp. 1992).

121. Id. § 32-11-110(h).

122. Id. § 32-11-110(i).

ment.[123] Transfer provisions are the primary means by which state statutes address conflicts between patient and physician autonomy. In essence, these statutes provide that an attending physician who does not wish to participate either in the withdrawal or withholding of medical care either can or must take steps to transfer the patient to another qualified physician.[124]

State statutes employ four general types of transfer provisions. The most prevalent version imposes a duty on the physician to transfer the patient. An attending physician may discharge this duty by making either a successful transfer or a reasonable, good faith effort to transfer.[125] The slightly different Alabama version of this provision creates no duty but simply permits transfer to another physician.[126] The third variation of the transfer provision imposes no duty on the physician to transfer; instead, these statutes place the burden on the patient, the surrogate decisionmaker, or the family to arrange for transfer.[127]

Finally, Minnesota employs a unique version of the transfer provision. If the physician or other health care provider notifies a competent patient of her unwillingness to comply with the patient's wishes, that provider has no duty to transfer.[128] If the physician fails to notify the patient before the patient becomes incompetent, the statute places a

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123. See, for example, D.C. Code § 6-2427 (1981) (stating that failure to transfer the patient or comply with a living will constitutes unprofessional conduct); Ga. Code Ann. § 31-32-8(b) (Michie Supp. 1992) (granting no civil liability for good faith refusal to comply with a living will, but the physician must either transfer the patient or allow the family to obtain a new physician); Ind. Code Ann. § 16-8-11-14(e) (Burns 1990) (stating that failure to transfer the patient or comply with a living will results in disciplinary sanctions); N.M. Stat. Ann. § 24-7-5(B) (Michie 1978) (giving a physician immmity from civil and criminal liability if she takes appropriate steps to transfer the patient); Tenn. Code Ann. § 32-11-108(a) (Supp. 1992) (stating that failure to comply with a living will or transfer the patient may result in civil liability and professional disciplinary action, including revocation or suspension of license); and W. Va. Code § 16-30-7(b) (Supp. 1992) (requiring a physician to make a reasonable effort to transfer the patient).

124. See, for example, D.C. Code § 6-2427(b) (1981); Ga. Code Ann. § 31-32-8(b) (Michie Supp. 1992); Ind. Code Ann. § 16-8-11-14(e) (Burns 1990); N.M. Stat. Ann. § 24-7-5(B) (Michie 1978); Tenn. Code Ann. § 32-11-108(a) (Supp. 1992); and W. Va. Code § 16-30-7(b). Compare *Bartling*, 229 Cal. Rptr. at 360 (discussing a hospital's unsuccessful attempts to transfer a patient to another hospital). See notes 33-37 and accompanying text.

Some states include similar provisions for a physician who does not wish to follow the directives of a surrogate appointed by a durable power of attorney for health care statute. See, for example, Ga. Code Ann. § 31-36-7(2) (Michie 1991).

125. See, for example, Ga. Code Ann. § 31-32-8(b) (Michie Supp. 1992); N.J. Stat. Ann. § 26.2h-62 (West Supp. 1992); S.D. Cod. Laws § 34-12D-11 (Supp. 1992); and Tenn. Code Ann. § 32-11-108(a) (Supp. 1992).

126. Ala. Code § 22-8A-8(a) (1990).

127. See Ill. Ann. Stat. ch. 110.5, § 703(d) (Smith-Hurd Supp. 1992) and Ky. Rev. Ann. Stat. § 311.634 (Supp. 1992).

128. Minn. Stat. Ann. § 145B.06(a) (West Supp. 1992).

duty on the physician to transfer.[129] Several states, however, have no transfer provisions in their natural death statutes.[130]

Some living will statutes also mandate specified penalties for failure to transfer. Of the states that do specify penalties, the vast majority hold a physician guilty of unprofessional conduct for a willful failure to transfer.[131] A number of states provide that willful failure to transfer by an attending physician or other health care provider constitutes a criminal misdemeanor.[132] Alaska takes a unique approach in penalizing a failure to effect a transfer by providing that the exclusive penalty shall be a maximum fine of one thousand dollars plus the actual costs accrued by the patient because of noncompliance.[133]

Clearly, the state statutes differ in approach and comprehensiveness, but the more recent statutes generally contemplate the problems and conflicts arising from advance directives more completely. PSDA should have an enormous effect on the way legislatures treat these issues in the future. State natural death legislation enacted after PSDA reflects these changes. For example, New Jersey's Advance Directives for Health Care Statute,[134] enacted in the beginning of 1992, is very comprehensive and incorporates much of PSDA.

IV. Preserving Autonomy and Preventing the Conflict

No simple panacea can cure the inherent conflicts between patient and physician autonomy. Both parties have interests supported by immense conviction and emotion. With such strong interests at stake, any possible solution will be imperfect at best. Although this realization is indeed unattractive and hard to swallow, the medical and legal communities can take steps to minimize conflicts in order to protect each party's autonomy as much as possible. This Part suggests several steps that can improve the present situation. The first two suggestions are precautionary in nature and seek to prevent any conflict or improper maintenance of care from the outset. The final two remedies contemplate situations in which some course of treatment has led to a conflict.

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129. Id. at § 145B.06(b).

130. See, for example, Conn. Gen. Stat. Ann. § 19a-570 et seq. (West Supp. 1992); 16 Del. Code Ann. § 2501 et seq. (1983); and N.C. Gen. Stat. § 90-320 et seq. (1990).

131. See, for example, Cal. Health and Safety Code § 7191 (West Supp. 1992); S.C. Code Ann. § 44-77-100 (Law Co-op Supp. 1991); and Utah Code Ann. § 75-2-1112 (Supp. 1992).

132. See, for example, Ark. Stat. Ann. § 20-17-209 (1992); 18-A Me. Rev. Stat. Ann. § 5-708 (Supp. 1991); and Mont. Code Ann. § 50-9-206 (1991). Many of these states also classify willful failure to record a terminal condition as a crime. See id.

133. Alaska Stat. § 18.12.070(a) (1991).

134. N.J. Stat. Ann. § 26:2H-53 et seq. (West Supp. 1992).

A. Market Participant Requirements

One potential solution simply consists of advising individuals to take an active role in choosing a physician and health care facilities. Patients would select health care providers based upon their stance on right to die issues. Thus, selection of health care providers would resemble the selection of any other commodity in the marketplace.[135] Those individuals who value individual autonomy could choose physicians or other providers who share their views. Those persons either with no strong view or who are ethically opposed to the withdrawal or withholding of life support similarly could elect to use like-minded physicians.

This idea works well in an ideal world, but in reality, several factors prevent its widespread use. First, such a scenario assumes that the patient or consumer has perfect knowledge. A patient with means may be able to determine her physician's ethical stance, but the everyday person generally will not have access or foresight to inquire about such information. Kentucky's Living Will Act[136] takes a novel approach that may help to remedy this concern. This statute provides that no physician, nurse, or health care employee will be held liable for failure to comply with an advance directive if that objection is stated in writing to the hospital or health care facility and if the individual follows the other provisions of the statute pertaining to patient notification and transfer.[137] This novel solution could provide both the hospital and patient with information about which health care providers are best suited to care for like-minded patients.

The second concern is that the physician, hospital, or clinic used by an individual may represent the only choice available. Financial considerations limit many patients' choices of health care providers. Geographic location, such as a rural area, also may limit the choice to none at all. A national health care system currently under consideration also could limit patient choices. Finally, emergency situations often prevent selection of a health care facility or physician. In fact, these situations may account for conflicts encountered most often in this area.

B. Drafting Advance Directives

The second protective step is to draft a more comprehensive and detailed living will that reduces uncertainty about action in a given situation. This suggestion stems from the premise that individuals do not

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135. See generally Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 L. & Contemp. Probs. 143 (1986).

136. Ky. Rev. Ann. Stat. § 311.634(2) (Supp. 1992).

137. Id.

contemplate fully the entire range of situations in which they want their advance directives followed. A general directive may not answer all of a physician's questions about what to do under a given set of circumstances. The potentially reversible situation encountered by a physician exemplifies this concern. The easiest way to minimize this problem is to improve the methods used to draft advance directives.

This solution does have limitations because no document can contemplate all possible situations and a too detailed and lengthy document might become cumbersome. A well-developed instrument is, however, clearly within reason. Drafting should involve consultation with a physician in order to satisfy a dual purpose. The physician may provide insight into possible trouble areas in which an instrument could provide direction. At the same time, this consultation serves to inform the individual of possible life threatening situations so she can decide what course of action should be followed under a given set of circumstances. Because this type of forethought may force the individual to contemplate difficult decisions and situations, the presence of the family physician may help alleviate the discomfort and provide valuable advice.

C. Actions Under PSDA

Although the above two suggestions are preventive in nature, the next two consider how to address problems after a conflict has arisen. First, with the advent of PSDA, it has become necessary to reconsider what sort of common-law actions should be allowed. In *Strachan*, the court refused to find an absolute duty for providers to have procedures in place for the removal of life support systems.[138] With PSDA now in place, a strong argument exists that this duty should bind all hospitals. As evidenced by the number of living will statutes that have been enacted, the states clearly see that self-determination of patients is a right to be given substantial protection. Furthermore, PSDA requires hospitals to be aware of these state requirements and to inform the patient and hospital staff of them. Instances of individuals wishing to exercise the right to terminate life support are no longer rare. Thus, hospitals should anticipate this trend and have procedures in place for the removal of life support. Although an absolute duty to establish procedures might have seemed overreaching and burdensome at one time, it now appears appropriate.

An individual also might argue convincingly that a breach of the duties established in PSDA itself gives rise to an action in negligence. The statute arguably creates several duties that could support tort ac-

138. See notes 91-94 and accompanying text.

tions. A viable cause of action might arise when a hospital fails to inform the patient of her rights under state law or fails to inform the patient of its policies with regard to the withdrawal of life support. This duty places a large burden on the hospital to educate its patients and is problematic in emergency cases, but certainly protects patient autonomy. Furthermore, because PSDA directs the hospital to respect the patient's rights as established by statute or common law, failure to respect those rights could constitute a breach of duty.

D. Clearly Defined Transfer Provisions

The final suggestion contemplates the situation in which interests of the patient and physician collide and create a stalemate. As discussed earlier, an individual may take steps to reduce the risk of conflicts when medical treatment has been anticipated, but emergencies and other situations remain problematic. In their proper role, the transfer provisions in state natural death statutes seek to protect both patient and physician autonomy. A transfer ensures compliance with the individual's wishes while preserving the physician's or hospital's choice not to participate in an activity that might be viewed as inappropriate or unethical.

Upon reflection, transfer provisions are the only method of achieving this end, but at best they are only an imperfect solution. Even with a provision in place, a transfer does not remedy all possible problems. At least three scenarios exist in which a transfer provision would not resolve a possible conflict in autonomy. First, no other physician or hospital may accept a patient who wishes to be disconnected from life support. Even assuming that another health care provider has no problem with assisting a patient in a natural death, a difference exists between facing the problem with an existing patient and accepting a patient with the express intent of withdrawing life support. Although a physician may agree to respect a patient's wishes when a right to die situation arises unexpectedly, accepting a patient only to aid in her death seems a quantitatively different situation. Many health care providers may not wish to act in such a purposeful situation.

Hospitals and physicians in rural and remote areas present additional problems for transfer provisions. In many areas, the doctor or health care facility may be the only option; no other convenient or reasonable provider may exist. Finally, in a rural area or not, a time lag certainly will exist between when the patient wants her directive carried out and the directive's actual effectuation in the event of a transfer.

These problems are inherent in any type of system that seeks to balance the competing autonomy interests of patients and health care providers. Giving meaning to the term "transfer," however, might lessen the possibility for infringement on both parties' autonomy when such a conflict exists. Most states only recently have enacted natural death statutes. Given that the statutes and the dilemma involving transfers in such situations are new, both the patient and physician may be unaware of their rights and duties arising from these provisions. By defining how far the duty to transfer extends, all parties may take steps to preserve their autonomy.

When Congress enacted the Anti-Dumping Act[139] under COBRA in order to curb incidents of patient dumping, it specifically defined transfer in the context of the Act.[140] Although the definition of transfer under the Anti-Dumping Act has little relevance to a natural death statute, a detailed definition particularly suited to natural death acts would provide a way to lessen the uncertainty surrounding transfers. At present, the physician has no idea exactly what steps she must take to comply with the meaning of the natural death statute. Although the desired definition of transfer might vary under differing circumstances, both physician and patient would benefit from a well-defined rule.

Ideally, the statute should place the burden of transfer on the physician or hospital, because they have the best access to information about options and alternatives. Indeed, most states follow this course.[141] The definition of transfer also should give the provider an idea of how much effort should be expended in finding a replacement. Most statutes allow for a reasonable, good faith effort. Given the sensitivity of the issue, this duty should be recast as exploring every reasonable option within the community. If the individual inhabits a remotely populated area, the physician seeking the transfer should consider other major care providers in the state.

Finally, the definition of transfer should take account of possible delay in effectuating the transfer. Tennessee's statute makes an appropriate statement disclaiming liability for the transferring provider until the transfer is completed.[142] A provider should not be held liable for the maintenance of life support while seeking to find a suitable alternative. Although this immunity impinges on the patient's autonomy, it preserves that of the health care provider and reflects a reasonable compromise between the two positions. Even with this clarification of the

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139. 42 U.S.C. § 1395dd (1988 & Supp. 1992).

140. 42 U.S.C. § 1395dd(e)(4) defines transfer:

The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

141. See notes 125-27 and accompanying text.

142. Tenn. Code Ann. § 32-11-108(a) (Supp. 1992).

term transfer under a natural death statute, patients and physicians invariably will confront situations in which a transfer cannot be made easily or at all. In such a situation, the imperfections of the transfer provision provide little relief, but hopefully reasonable parties can find some solution.

V. Conclusion

With our society facing an increased number of senior citizens requiring medical care and a health care system that seems to be increasing in cost to the consumer, more individuals will face difficult decisions about whether to maintain or withdraw life support systems in situations when a terminal condition has been diagnosed. A more liberal outlook on an individual choosing to die naturally has emerged in recent years as evidenced by the increased number of living will and natural death statutes. The removal of much of the stigma surrounding the right to die brings with it the opinion that, in some cases, the termination of life support is the most humane choice for both the patient and the family.

To ensure that these choices are respected, the medical and legal communities need to find an approach that will safeguard the autonomy of both the individual patient and the health care provider. Because physicians and patients most frequently will face the possibility of a transfer when there are conflicts between the parties' autonomy, legislatures should draft transfer provisions that clearly define the rights and obligations of both parties. With such direction, fewer instances that threaten the patient's and the physician's autonomy will arise.

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