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# COMPLIANCE WITH ADVANCE DIRECTIVES

## WRONGFUL LIVING AND TORT LAW INCENTIVES

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## INTRODUCTION

The recognition of personal autonomy as an essential element of liberty has historically been a hallmark of American society. It was not until the 1960s, however, that patient autonomy began to be asserted as a central principle of medical ethics.[1] Today, physician paternalism has been widely rejected,[2] and modern ethical and legal norms generally require that deference be accorded to patients' decisions regarding treatment, including decisions to refuse life-sustaining care, even when patients no longer have the capacity to

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[1] *See* David J. Rothman, *The Origins and Consequences of Patient Autonomy: A 25-Year Retrospective*, 9 HEALTH CARE ANALYSIS 255 (2001) (containing detailed discussion of the patient autonomy movement).

[2] *See generally* DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE: NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH (1979); TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (5th ed. 2001).

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communicate those decisions to their physicians.[3] Advance directives were developed as a means by which a patient's autonomy regarding medical care might survive such incapacity.[4]

Unfortunately, however, preserving patient autonomy at the end of life has been no simple task. First, it has been difficult to persuade patients to prepare for incapacity by making their wishes known.[5] Second, as this article makes clear, even when they have done so, there is a distinct possibility that those wishes will be disregarded or ignored and that a patient whose expressed choice was to refuse life-sustaining treatment will nonetheless be kept alive against his or her will.[6] This problem is only exacerbated by the fact that patients finding themselves in this situation have routinely been denied adequate legal remedies on the grounds that continued life is not a compensable harm. This article rejects that reasoning, and in so doing, takes an important step toward more fully enforcing one's legal and moral right to refuse care at the end of life.

Section I sets out the initial hopes for advance directives as instruments to reify patient choices about end-of-life care and describes how those hopes have yet to be realized. Section II examines courts' reluctance to date to recognize a cause of action for "wrongful living" in cases where the refusals of care contained in an advance directive have not been followed. Finally, Section III argues for recognition of a wrongful living variant of battery in situations where physicians have recklessly or intentionally disregarded or misinterpreted advance directives and offers guidance on some of the difficult questions relating to damages that have perplexed the courts and commentators in this area. Although allowing recovery for wrongful living will not resolve many of the outstanding issues leading to low utilization of advance directives by patients or eliminate the need for interpretation of a patient's stated wishes in many circumstances, it will offer significant protection to those who have made their wishes clear.

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[3] *See* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990) (holding that both competent and incompetent patients have the right to refuse medical care, but that states may require clear and convincing evidence of the patient's wish to so refuse when the patient is currently incompetent).

[4] A word on terminology is in order. The term "advance directive" is generally used to refer both to living wills (instruction instruments), in which an individual indicates which specific life-sustaining treatments he or she wants and does not want if unable to communicate with the physician, and to the appointment of a surrogate decision-maker (proxy). In this article, we use the term advance directive more narrowly to refer to written living wills and a patient's oral statements to a physician indicating specific wishes for the provision or withholding of life-sustaining treatments. Where a reference to the appointment of a surrogate decision-maker is intended, it is stated explicitly.

[5] *See infra* note 25 and accompanying text.

[6] *See infra* § 1.

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## I. BACKGROUND: THE UNFULFILLED PROMISE OF ADVANCE DIRECTIVES

In the 1960s and 1970s, the public began to grow progressively more concerned over the ability of medical technology to sustain ever more tenuous holds on life and the use of such technology in situations where it seemed unwanted or unwarranted. Beginning with *In re Quinlan*, decided by the New Jersey Supreme Court in 1976, a number of widely reported court cases challenging the provision or continuation of life-sustaining treatments raised public alarm at the prospect of patients and their families having to endure a heart-wrenching legal process before unwanted treatment would be withheld or withdrawn.[7] People realized that this could happen to them too, and in hopes of avoiding similar situations, increasingly called for the development of a means by which patients could control the kind and intensity of interventions they would receive if they could no longer communicate their wishes to physicians.

The first legal literature advocating the creation of living wills appeared almost four decades ago.[8] Although these documents were initially hailed as a means of exercising "prospective autonomy,"[9] advance directives have regrettably proved to be less successful in effectuating patient choice regarding end-of-life care than originally envisioned. Notwithstanding significant legislative and judicial support—including the United States Supreme Court's recognition of a constitutional liberty interest in making medical decisions for oneself that survives mental incapacity,[10] passage of the Patient Self-Determination Act (PSDA) requiring health care providers receiving federal Medicare and Medicaid funds to inform patients of their right to make a living will and/or appoint a surrogate decision-maker,[11] and the enactment of laws in every state giving legal recognition to advance directives[12]—research has shown that

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[7] *See In re* Quinlan, 355 A.2d 647 (N.J. 1976) (holding, based on the constitutional right of privacy existing at both the state and federal levels, that a patient can refuse even life-sustaining medical care herself or himself or through a guardian); *see also In re* Conroy, 486 A.2d 1209 (N.J. 1985) (holding that the competent patient's right to refuse care does not disappear when that patient becomes incompetent, and that care can be withheld or withdrawn based on either a substituted judgment analysis of what the patient would have wanted, or barring that, a best interest analysis); *Cruzan*, 497 U.S. at 271-78 (reviewing state law cases addressing the right of an incapacitated person to refuse life-sustaining treatments).

[8] Louis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969).

[9] Norman L. Cantor, *Prospective Autonomy: On the Limits of Shaping One's Postcompetence Medical Fate*, 8 J. CONTEMP. HEALTH L. & POL'Y 13 (1992); *see also* ROBERT S. OLICK, TAKING ADVANCE DIRECTIVES SERIOUSLY: PROSPECTIVE AUTONOMY AND DECISIONS NEAR THE END OF LIFE (2001); BEN A. RICH, STRANGE BEDFELLOWS: HOW MEDICAL JURISPRUDENCE HAS INFLUENCED MEDICAL ETHICS AND MEDICAL PRACTICE (2001).

[10] *Cruzan*, 497 U.S. 261.

[11] Pub. L. No. 101-508, *codified at* 42 U.S.C. § 1395cc.

[12] *See* Matthew B. Hickey, Note, *Oklahoma Advance Directive Act: Denying Choice to Those Who Cannot Choose—A Proposal for Legislative and Practical Alternatives*, 59 OKLA. L. REV. 449, 453-54, nn.37-49 (2006) (describing the Uniform Rights of the Terminally Ill Act and corresponding state statutes recognizing living wills, advance directives, and surrogate decision making).

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medical care at the end of life is often inconsistent with patient choice even when the patient has made a choice known.

In 1989, researchers undertook a national project known as SUPPORT, the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment, to obtain a better understanding of the experience of dying in American hospitals.[13] In Phase I of the study, researchers identified five aspects of care that most objectively mark the quality of patient experience in this context, including whether the patient had a written Do Not Resuscitate (DNR) order and, if so, when it was entered into the patient's chart, as well as whether the physician knew that the patient did not want cardiopulmonary resuscitation (CPR).[14] The researchers found that, even though 79% of Phase I patients who died while hospitalized had DNR orders, 46% of these orders were written within two days of death. Thirty-one percent of all Phase I patients expressed a preference to avoid CPR, but slightly fewer than half of their physicians accurately understood this preference.[15]

In response to these results, the SUPPORT investigators developed, implemented, and evaluated a multi-pronged intervention intended to improve the quality and exchange of information among physicians and patients. Physicians were given written reports describing their specific patients' probability of survival to six months, likelihood of being severely functionally impaired, and probability of surviving CPR, as well as information regarding their patients' views on CPR and the presence of advance directives. Meanwhile, specially trained nurses were assigned to promote communication among patients and the health care team concerning the use of life-extending treatments, and also documented patients' treatment wishes regarding future care.[16] When the results of this second phase of the SUPPORT study were tabulated, however, the conclusions were startling. Even after the carefully researched intervention was implemented, there was no significant change in the timing of DNR orders or in physician awareness of patient preferences. Moreover, fewer than half of physicians in the study who reported receiving written information regarding patients' preferences actually discussed this information with their patients or their surrogates.[17]

Although it failed to achieve significant changes in end-of-life care, SUPPORT provided critical information for understanding the nature and quality of care being provided to dying hospital patients. In a subsequent

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[13] The SUPPORT Principal Investigators, *A Controlled Trial to Improve Outcomes for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)*, 274 J.A.M.A. 1591 (1995).

[14] Ellen H. Moskowitz & James Lindemann Nelson, *The Best Laid Plans*, 25 HASTINGS CTR. REP. (Special Supplement) S3 (1995).

[15] *Id.* at S4.

[16] *Id.* at S4-S5.

[17] *Id.*

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study based on SUPPORT data, investigators identified 618 patients who reported having formal written advance directives. Of these, 358 had living wills, 411 had durable powers of attorney, and 151 had both.[18] However, the medical records of only 36% of these patients included any mention of the subject of advance directives, and the relevant document was actually filed in the medical records of only two patients.[19] Furthermore, even among two important subsets of the population—those who had living wills and those who preferred to forgo resuscitation—advance directives failed to have a significant effect on either physician orders concerning resuscitation or the use of hospital resources as measured by the hospital bill, average intensity of therapy, or length of stay. The investigators concluded that "[q]uite simply, as far as we could tell, advance directives were irrelevant to decision making" by medical providers.[20]

Despite many interim efforts to improve patient autonomy and compliance with patient wishes at the end of life, a 1996 study of the impact of patient preferences on life-sustaining treatment reached the same dismal conclusion that these preferences did not impact the treatments patients ultimately received.[21] Unfortunately, today—more than a decade after the SUPPORT studies were published and nearly two decades after passage of the PSDA—data show that advance directives often are still unavailable to health care providers, and even when specific instructions are present, care remains inconsistent with those instructions as much as half of the time.[22]

However, despite the fact that advance directives have not in practice fulfilled proponents' expectations, the public continues to place its hopes, though perhaps not its confidence, in them, if for no other reason than lack of a better alternative. This was made plain during the public spectacle surrounding the recent case of Theresa Schiavo.

Ms. Schiavo existed in a persistent vegetative state,[23] and her parents and husband had opposing views regarding the kinds of life support, if any,

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[18] Joan M. Teno et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resources for Seriously Ill Patients?*, 5 J. CLIN. ETHICS 23, 25 (1994).

[19] *Id*.

[20] *Id*. at 27.

[21] Marion Danis et al., *A Prospective Study of the Impact of Patient Preferences on Life-Sustaining Treatment and Hospital Cost*, 24 CRIT. CARE MED. 1811, 1815 (1996).

[22] Lauren G. Collins et al., *The State of Advance Care Planning: One Decade After SUPPORT*, 23 AM. J. HOSP. PALLIAT. CARE 378, 379 (2006); *see also* Bernard Lo & Robert Steinbrook, *Resuscitating Advance Directives*, 164 ARCH. INT. MED. 1501, 1502 (2004) ("Even when patients provide written advance directives, physicians may not be aware of them, and they frequently have little impact on clinical decisions.").

[23] There was some disagreement about her condition while she was still alive, but the autopsy left no room for doubt. *See* Jon R. Thogmartin, *Medical Examiner's Report: Autopsy of Theresa Schiavo*, June 13, 2005, *available at* http://northcountrygazette.org/documents/autopsyreport.pdf (last accessed Nov. 6, 2007); Abby Goodnough, *Schiavo Autopsy Says Brain, Withered, Was Untreatable*, N.Y. TIMES, June 16, 2005, *available at* www.nytimes.com/2005/06/16/national/16schiavo.html (last accessed Nov. 6, 2007).

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Ms. Schiavo would have chosen for herself under the circumstances. By the time the matter was resolved and Ms. Schiavo was allowed to die, her family had engaged in war with itself before a national audience, and the executive, legislative, and judicial branches of government at both the state and federal levels had become involved.[24] Although completion rates for advance directives and appointments of surrogate decision-makers have historically been low,[25] in a single day during the height of the Schiavo press coverage the National Hospice and Palliative Care Organization (NHPCO) fielded more than 900 phone calls and processed more than 2,000 e-mails from people across the country requesting copies of state-specific advance directives, likely in hopes of avoiding a similar struggle in their own families. Moreover, in the two-week period following Ms. Schiavo's death, the NHPCO received over 200,000 downloads from its Web site regarding advance directives.[26]

Thus, although many patients unfortunately still fail to draft advance directives, the need to protect patient autonomy at the end of life is clear. Numerous efforts are under way to encourage patients to make their wishes known. Remarkably, however, despite strong public support, and despite the role of courts and legislatures in creating and endorsing the legal status of advance directives, neither judges nor lawmakers have yet formulated coherent or effective remedies for physicians' failures to comply with the instructions patients have provided. The lack of such remedies has arguably contributed to what many commentators consider to be the "failure of the living will"[27]—namely, there are few, if any, effective incentives for physicians and other health care providers to be scrupulous in their adherence to advance directives and, relatedly, for patients to complete them.[28] The re-energized and expanded call for the completion of advance directives following the Schiavo case, however, invites further exploration of the as-yet-unresolved problems associated with how these statements of patient wishes ought to be enforced.

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[24] For an analysis of the many issues raised by this case, see *The Schiavo Case: A Symposium*, 22 CONST. COMMENT. 383 (2005).

[25] A poll conducted by the Pew Research Center between November 9 and November 27, 2005 found that 29% of Americans had a living will. Although showing a significant increase in the percentage of people preparing written instructions (up from 12% in 1990), still only slightly more than a quarter of the population had completed advance directives, notwithstanding the public reaction to the Schiavo case and broad discussion of the value of advance directives during the intervening 15 years. NewsMax.com Wires, *Poll: More Americans Have Living Wills, at* http://archive.newsmax.com/archives/articles/2006/1/5/125608.shtml (last accessed Nov. 6, 2007).

[26] Stephen Spotswood, *Congress Grapples with Issues Brought Out by Schiavo Case*, U.S. MED., July 2006, *at* http://www.usmedicine.com/article.cfm?articleID=1091&issueID=89 (last accessed Nov. 6, 2007).

[27] *See, e.g.*, Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 HASTINGS CTR. REP. 30 (2004); Henry S. Perkins, *Controlling Death: The False Promise of Advance Directives*, 147 ANNALS INTERN. MED. 51 (2007); Lo & Steinbrook, *supra* note 22; Joan M. Teno, *Advance Directives: Time to Move On*, 141 ANNALS INTERN. MED. 159 (2004).

[28] Daniel P. Kessler & Mark B. McClellan, *Advance Directives and Medical Treatment at the End of Life*, 23 J. HEALTH ECON. 111 (2004).

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## II. INADEQUATE REMEDIES OFFERED BY EXISTING LAW

Critically ill patients and their families are frequently shocked and dismayed when life-saving or life-sustaining treatments are imposed despite what they consider to be clear instructions to the contrary. Confused by physicians' actions and often outraged by the results, patients and families may turn to the legal system to seek recourse for such violations of their autonomous choices. Unfortunately, they usually find that, outside of injunctive relief that in many cases may come too late, the current legal framework offers little support for recovery.[29]

### A. Theories of Recovery for Violation of Advance Directives

When a medical provider fails to comply with a patient's advance directive and has already provided unwanted treatment, the patient or his or her representatives may bring a civil action for damages under a variety of theories of recovery.[30] The most common approaches are based either on the intentional tort of medical battery or the negligent tort of medical malpractice, although alternative approaches exist.

For example, some plaintiffs have sought damages for intentional infliction of emotional distress, although few have been able to allege facts sufficient to withstand dismissal given the high burden of proof for such actions, which requires evidence of "extreme or outrageous conduct."[31] Given how unsuccessful such claims have generally been, some families have proffered breach of contract arguments in hopes of recovering the fees paid for unwanted medical treatment; surprisingly, courts have not treated these arguments any more favorably.[32] Finally, when state actors are arguably involved, plaintiffs may pursue Fourteenth Amendment civil rights claims for violation of their liberty

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[29] For a summary of cases in which petitions for injunctive relief have been successful, see Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives: Liability for Providing Unwanted Life-Sustaining Treatment*, 20 J. LEG. MED. 1, 6 n.28 (1999).

[30] For further discussion of the various theories of recovery available under such circumstances, see M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499 (1992).

[31] *See, e.g.*, Bartling v. Glendale Adventist Medical Center, 194 Cal. App. 3d 961 (1986) (affirming dismissal of an intentional infliction of emotional distress claim raised by the survivors of a deceased patient who was resuscitated against his wishes, on the grounds that plaintiffs could not demonstrate that defendants' conduct was "outrageous"). *But see* Gragg v. Calandra, 696 N.E.2d 1282 (Ill. App. 1998) (reversing trial court's dismissal of intentional infliction of emotional distress claim where plaintiff, the patient's daughter, alleged that the defendant physicians publicly accused plaintiff and her mother of trying to kill the patient when they requested removal of life support).

[32] *See, e.g.*, Grace Plaza of Great Neck, Inc. v. Elbaum, 183 A.D.2d 10 (N.Y. Sup. Ct. App. Div. 1992) (holding that a nursing home did not forfeit its right to collect fees for life-sustaining services it provided to the patient upon a physician's orders, despite the fact that the patient's family and conservator objected); *Gragg*, 696 N.E.2d at 1286 (addressing plaintiff's claim under the Family Expense Act for medical expenses incurred in connection with alleged battery of the patient).

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interest in refusing unwanted medical treatment. To date, however, no federal court addressing such a claim has found a sufficient government nexus for the action to withstand dismissal.[33]

### *1. Assault and Battery*

In the seminal case of *Schloendorff v. Society of New York Hospital*, Justice Benjamin Cardozo explained that "[a] surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[34] This oft-quoted principle serves as the foundation for application of traditional tort theories of assault and battery to the medical context.

According to the *Restatement (Second) of Torts*, a battery occurs when a person acts intending to cause harmful or offensive contact with another person and such harmful or offensive contact results, either directly or indirectly.[35] Importantly, the requirement of intent does not implicate any personal hostility or require any physical injury, but speaks instead to whether the actor intended the very act that was not consented to; thus, battery is nothing more than the intentional tort of unconsented touching.[36] Accordingly, a physician who initiates treatment against a patient's wishes will be liable for battery, even if the treatment ultimately saves the patient's life or cures his condition, because, benefit or not, no consent was granted.[37] This concept is particularly important in the medical context, for if it were otherwise, paternalism could still easily reign over patient autonomy.[38] Thus, from a doctrinal perspective, it appears that a battery action brought by a patient whose advance directive has been disregarded should be successful, even in the absence of physical harm, because consent has been explicitly withheld in these cases; in practice, however, things have not been that easy, as we will see.[39]

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[33] *See, e.g.*, Klavan v. Crozer-Chester Medical Center, 60 F. Supp. 2d 436 (E.D. Pa. 1999) (granting the motion to dismiss of defendant, a private non-profit hospital, on the grounds that state regulation, financial assistance, and hospital licensing did not result in a symbiotic relationship or close nexus between the hospital and the state); Ross v. Hilltop Rehab. Hosp., 676 F. Supp. 1528, 1535-37 (D. Colo. 1987).

[34] Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. App. 1914).

[35] RESTATEMENT (SECOND) OF TORTS §§ 13, 18 (1977).

[36] By way of example, a person suffering from Huntington's disease who strikes another person as a result of an involuntary bodily spasm lacks the requisite intent for battery; in contrast, a person who intentionally hugs another does possess the requisite intent, even if he mistakenly thinks the recipient would consent to the hug.

[37] RESTATEMENT (SECOND) OF TORTS § 905, Comment on Clause (a) (1977). See, for example, Illustrations 1 and 2 ("A is afflicted with deafness in one ear. She informs her physician, B, that she does not desire an operation upon it. Nevertheless, while A is under an anesthetic, B operates upon the ear, thereby preventing subsequent harm but causing pain for a considerable period following the operation. A is entitled to compensatory damages for the suffering, undiminished by reason of the physical benefit conferred upon her by B except as it prevents future suffering.").

[38] *See* RESTATEMENT (SECOND) OF TORTS § 13, Comment (1977); *see also* Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984).

[39] *See infra* § II(B).

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### 2. *Negligence*

Battery is the preferred cause of action when a physician provides treatment in direct violation of a patient's wishes or entirely fails to obtain informed consent for the provided treatment. However, when the physician makes an effort to obtain consent, but such consent is based on an incomplete or insufficient disclosure of the risks involved, the physician has failed to comply with the standard of care and may be subject to liability for negligence.[40]

Unlike a plaintiff alleging battery, a plaintiff in a negligence action has the burden of proving that the defendant had a legal duty to conform to a standard of care, the defendant breached that duty, such breach was the legal cause of the injury suffered by the plaintiff, and the plaintiff has suffered actual damages.[41] In this respect, a negligence action can be more difficult to prove, and therefore more difficult to recover under because, rather than simple proof of unconsented touching, negligence suits generally require expert testimony regarding the standard of care and the defendant's compliance therewith.

However, both negligence and battery plaintiffs must demonstrate causation of a legally cognizable harm to recover anything more than nominal damages. Unfortunately, these are precisely the factors that have proven most problematic in the context of case law seeking a remedy for the imposition of life-saving or life-sustaining care against the patient's will.[42]

### 3. *Use of the Term "Wrongful Living"*

Aside from these basic and well-established common-law theories of recovery, some patients have also asserted independent claims for "wrongful living" when their end-of-life instructions have been violated, and these claims have often been described as a new tort. Both in the case law and literature, there has been much confusion surrounding the nature of these suits and how they ought to be treated by the courts. Subsequent sections of this article delve more deeply into the normative questions they raise.

At this point, however, it is essential only to recognize that "wrongful living" is not an independent cause of action, but rather is simply "a claim in tort for damages resulting from a negligent or intentional interference with one's right to refuse treatment" when the treatment results in the "unwanted extension of life."[43] Thus, "wrongful living" is nothing more than a descriptive

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[40] *See, e.g.*, Baltzell v. Van Buskirk, 752 S.W.2d 902, 906 (Mo. App. 1988). It is worth noting that, although courts have recognized claims involving unwanted life-saving care may be grounded in either negligence or battery, their doctrinal analyses have generally not followed a traditional negligence format, relying on battery instead.

[41] RESTATEMENT (SECOND) OF TORTS § 328A (1965). Note that "legal cause" in this context encompasses both cause-in-fact and proximate cause.

[42] *See infra* § II(B).

[43] Mark Strasser, *A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right to Bodily Integrity*, 36 SAN DIEGO L. REV. 997, 1021 (1999).

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term encompassing traditional tort claims raised in connection with a particular set of facts. As at least one court has helpfully explained: "[A] claim of wrongful living is a *damages* concept, just as a claim for 'wrongful whiplash' or 'wrongful broken arm,' and must necessarily involve an underlying claim of negligence or battery."[44] Although courts have phrased their reluctance to allow recovery under such circumstances as a rejection of the "cause of action" of wrongful living or wrongful prolongation of life, a careful reading of each court's analysis points instead to rejection of compensation for this particular set of damages.[45]

In the wrongful living context, the patient's recognized right to refuse care has been violated, leading to an injury, which is prolonged life itself. The harm, then, is traditional, but the damages are not; accordingly, we are dealing with nothing more than a variant of an existing cause of action, most often battery. The question at the heart of this article is: Under what circumstances and how, if at all, should those non-traditional damages be compensated? The handful of courts that have already considered these matters generally fail to state explicitly that continued life is uncompensable, but that is often their message. This unfortunately leaves patients whose established rights have been violated without an adequate remedy and opens the door for physicians to violate those rights without fear of being held accountable in any significant way.

## B. Relevant Case Law

The earliest cases seeking damages for the prolongation of life involved failures to withdraw life-sustaining treatments upon the request of a patient or patient's family. Courts were initially unwilling to allow recovery in these contexts, noting that the rights in question and the related precedents were not yet sufficiently well-defined; physicians were not confident that they could abide by such requests without risking liability.[46] However, even after the right to refuse life-sustaining care became well-established, recovery for the violation of that right has remained incredibly difficult to obtain.

### *1. Contemporaneousness of Refusal Questioned*

Some courts have denied recovery for the imposition of life-sustaining treatment against a patient's wishes when the patient made refusal of care known under circumstances allegedly too far removed from the time that the

[44] Anderson v. St. Francis-St. George Hosp., Inc., 671 N.E.2d 225, 227 (Ohio 1996) (*Anderson III*).

[45] *See, e.g., id.* at 228 (*Anderson III*); Anderson v. St. Francis-St. George Hosp., 614 N.E.2d 841, 846 (Ohio App. 1992) (*Anderson I*); Allore v. Flower Hosp., 699 N.E.2d 560, 563 (Ohio App. 1997); Estate of Taylor *ex rel.* Taylor v. Muncie Medical Investors, 727 N.E.2d 466, 471 (Ind. App. 2000).

[46] *See, e.g.*, Bartling v. Glendale Adventist Medical Center, 229 Cal. Rptr. 360 (1986); Foster v. Tourtellote, 704 F.2d 1109 (9th Cir. 1983).

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care was actually initiated. For example, in *Werth v. Taylor*, the patient was a Jehovah's Witness who believed it is a sin to receive blood transfusions.[47] Accordingly, when she became pregnant with twins, she filed a written pre-registration of her desire to refuse blood products at the hospital where she would deliver. As she was admitted for delivery two months later, her husband signed another refusal form on her behalf. However, when Ms. Werth experienced life-threatening uterine bleeding while under general anesthesia following delivery, her physicians overrode her refusals, of which they were explicitly aware, and provided a transfusion.[48]

Even though the court claimed to recognize a right to refuse medical care, even in emergencies, it held that any refusal had to be fully informed and "contemporaneous" to override the implied consent arising in the face of urgent medical necessity.[49] The court was not convinced that Ms. Werth's prior refusals met that standard because they were made while she was contemplating routine procedures, not at a time when "it appeared that death might be a possibility if a transfusion were not given."[50] Therefore, the Court of Appeals of Michigan affirmed a lower court's dismissal of Ms. Werth's battery claim and accepted the physician's defense that the patient's refusal was not operable because it was made under different circumstances than those in place when the transfusion became necessary. However, as we will see in more detail subsequently, such reasoning is clearly flawed and ought to be strenuously rejected because it could "seriously undermine the patient's right to bodily autonomy in the medical treatment context."[51]

Addressing a similar situation in *Estate of Leach v. Shapiro*, the Ohio Court of Appeals acknowledged these concerns and took a somewhat more nuanced approach.[52] The family of Edna Marie Leach, a patient who fell into a chronic vegetative state following successful resuscitation from cardiopulmonary arrest, alleged that physicians later placed her on life support without obtaining consent. According to the plaintiffs, Ms. Leach had expressly advised the hospital and her physicians "that she did not wish to be kept alive by machines," although there was some dispute among the parties regarding the timing and circumstances of her refusal. The family argued that, because

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[47] Werth v. Taylor, 475 N.W.2d 426 (Mich. App. 1991).

[48] *Id*. at 427. The lives of Ms. Werth's children were in no danger as a result of her refusal, because delivery had already occurred. Thus, the issue of maternal-fetal conflict was not a feature of the physician's decision to override the patient's refusal of care. *See* Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927 (1994); George Annas, *The Impact of Medical Technology on the Pregnant Woman's Right to Privacy*, 13 AM. J.L. & MED. 213 (1987).

[49] *Werth*, 475 N.W.2d at 430.

[50] *Id*.

[51] Strasser, *supra* note 43, at 1010; *see infra* notes 130-35 and accompanying text.

[52] *Estate of Leach*, 469 N.E.2d at 1051.

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Ms. Leach's heartbeat and breathing had already been restored through successful resuscitation and the life support appeared to have been provided simply as a preventative measure, there was no emergency situation that could justify additional treatment without consent.

Although recognizing an emergency ordinarily gives rise to implied consent to medical treatment, the court noted that consent to a particular treatment cannot be implied, even in emergency situations, if the patient has expressly withheld consent to that treatment on a previous occasion.[53] In other words, if Ms. Leach had rejected the possibility of life support, no later emergency would negate that refusal to consent, or else "a physician could circumvent the express wishes of a terminal patient by waiting to act until the patient was comatose and critical."[54] However, the court stressed that the traditional requirements for informed consent to accept or refuse care, including both knowledge and understanding, must be satisfied for the patient's refusal to carry over into the emergency context.

By way of example, the court noted that, while the refusal of "a terminally ill patient fully advised of an impending crisis" would negate implied consent in an emergency, a patient who had "generally expressed the desire to die peacefully" in the context of terminal illness could still be treated on an emergency basis if injured in an automobile crash.[55] Accordingly, to evaluate the claim brought on Ms. Leach's behalf, the trial court would need to make a factual determination of the exact circumstances and content of any advance directive made by Ms. Leach, as well as her medical condition at the time the hospital placed her on life support.

Because neither the *Werth* nor *Leach* courts reached a determination that the defendants had violated the patients' right to refuse life-sustaining care, these cases did not include an analysis of the damages potentially available to plaintiffs bringing wrongful living claims.[56] As discussed below, however, the few courts that have engaged in such analysis have limited damages awards to the barest minimum.

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[53] *Id.* at 1053.

[54] *Id.*

[55] *Id.*

[56] Even some courts that have allowed wrongful living claims based on battery or negligence to proceed have failed to conduct adequate analysis of what damages might be awarded. *See, e.g., Gragg*, 696 N.E.2d at 1282, which reversed a trial court's dismissal of a Family Expense Act claim against physicians who performed open heart surgery on a patient without his consent and thereafter maintained the patient on life support without consent. The appeals court found that the plaintiff had stated a claim for medical battery, but did not address the issue of what damages might be available to the plaintiff other than recovery (under the Family Expense Act) of medical expenses incurred in connection with the treatments. Given that the greatest challenge faced by plaintiffs in wrongful living cases has been obtaining damages for a demonstrable harm, courts' reluctance to discuss the question of damages only exacerbates the problem.

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### 2. *Damages for Prolongation of Life Rejected*

*Anderson v. St. Francis-St. George Hospital, Inc.*, perhaps the most widely discussed (and complex) case to date on the subject of wrongful living, involved the provision of unwanted care to Edward Winter, a patient who had initially been admitted to the hospital for chest pain. Before his illness, Mr. Winter had witnessed his wife's deterioration after receiving emergency resuscitation. Consequently, he discussed his desire not to receive extraordinary life-sustaining treatment with his physician following admission, a wish that was reflected in a "No Code Blue" order entered on his chart. Despite this indisputably clear instruction, a nurse defibrillated Mr. Winter when he suffered ventricular fibrillation. Within a few days, he suffered a stroke that paralyzed his right side, but he went on to live for approximately two more years. In his complaint, Mr. Winter alleged that the nurse's actions constituted battery and negligence, causing him pain, suffering, and emotional distress, as well as medical and other expenses.[57]

The trial court initially granted summary judgment in favor of the hospital, holding that "there is no cause of action in Ohio for wrongful administration of life-prolonging medical treatment, i.e., 'wrongful living.'"[58] This holding was affirmed on appeal, where the court similarly determined that—to the extent Mr. Winter sought recovery on the basis of the "harm" of continued living—such harm was not compensable under Ohio law.[59] However, because the court determined that Mr. Winter might be able to recover for other harms that were reasonably foreseeable results of the defibrillation, provided no superseding event occurred to break the chain of causation,[60] the case was remanded. It was sent back for a determination of whether the defendants had committed battery or negligence by providing treatment specifically precluded by Mr. Winter's instructions and, if so, whether such actions proximately caused any compensable harms. On remand, however, the trial court again granted summary judgment in favor of the hospital, finding Mr. Winter had suffered no actual damages resulting from the defibrillation and noting that he had withdrawn his request for nominal damages.

On the second appeal, the Ohio Court of Appeals responded to the trial court's rejection of the damages issue by pointing out the medical expenses, costs of the nursing home, and extraordinary expenses (including pain and suffering) related to Mr. Winter's stroke. According to the appeals court, Mr. Winter could recover such actual damages if he demonstrated proximate cause—specifically, that his adverse health consequences were reasonably

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[57] *Anderson I*, 614 N.E.2d at 843.
[58] *Anderson III*, 671 N.E.2d at 226.
[59] *Anderson I*, 614 N.E.2d at 845-46.
[60] *Id*. at 845.

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foreseeable, occurring in a "natural, continuous and unbroken sequence" from the unwanted resuscitative measures.[61]

Before this issue of causation could be reconsidered by the trial court, however, the Supreme Court of Ohio accepted discretionary appeal. It asked: "Where a medical provider administers a life-prolonging treatment or procedure to a patient against the patient's instructions, is the medical provider liable for all foreseeable consequential damages resulting from the treatment or procedure?" It then condensed the question to what it called "its simplest form. . . . Is 'continued living' a compensable injury?"[62]

The court held that Mr. Winter was not entitled to the requested damages, even if his injuries were reasonably foreseeable, because he presented no evidence "that the defibrillation itself caused or contributed to [his] stroke in any way other than by simply prolonging his life."[63] Mr. Winter could recover only damages directly caused by the battery—for example, broken ribs from chest compressions or burns from defibrillation, but the court determined that Mr. Winter's battery was physically harmless, entitling him only to nominal damages. "There are some mistakes," the court concluded, "indeed even breaches of duty or technical assaults, that people make in this life that affect the lives of others for which there simply should be no monetary compensation."[64]

In rejecting the appellate court's customary determination that reasonable foreseeability may be demonstrated by a "natural, continuous and unbroken sequence" of injuries, the Supreme Court of Ohio effectively imposed an additional requirement, not recognized in any other area of tort law, beyond the traditional proximate cause determination. Under the court's reasoning, a plaintiff must show not only that the defendant's action was a but-for cause of the injury he or she suffered, and that the injury was reasonably foreseeable in light of the defendant's actions, but also must demonstrate some other, more direct, causal connection between the defendant's tortious action and his or her own injury.

Application of this requirement outside of wrongful living makes its erroneous foundations clear. Imagine that a student punches his college professor in the jaw, fracturing his jawbone and preventing him from conducting planned paid speaking engagements. According to the reasoning employed by the Supreme Court of Ohio, the defendant would be liable only for the fracture, not for the plaintiff's lost income, even if the plaintiff demonstrated that (a) he would have been able to conduct his speaking engagements but for the

[61] Anderson v. St. Francis-St. George Hosp., 1995 WL 109128 (Ohio App. 1995), at *5 (*Anderson II*).

[62] *Anderson III*, 671 N.E.2d at 226-27. Many argue that the court oversimplified the essential question upon review. *See* Strasser, *supra* note 43, at 1029.

[63] *Anderson III*, 671 N.E.2d at 229.

[64] *Id*. at 228.

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fracture caused by defendant's assault and (b) it was reasonably foreseeable that the assault upon his jaw would result in such lost income. Such a result in the context of a standard tort strains credulity. It should inspire the same concerns when the plaintiff is a patient kept alive against his or her will, particularly because this approach renders it effectively impossible for plaintiffs to recover many of the damages resulting from the unwanted prolongation of life.[65]

### *3. Limited Damages Awarded*

Since *Anderson*, cases in which damages have been awarded in connection with wrongful living actions have been few and far between.[66] Moreover, those cases in which patients have been successful have been reported in the news media rather than in legal reporters, so scholars and practitioners cannot benefit from an analysis of the court's reasoning as precedent. Nonetheless, the fact that some courts have been willing to recognize these situations as nearly textbook cases of battery and have allowed recovery for the significant harms resulting from the associated violation of patient autonomy, without distraction by the fiction that life is always a benefit, offers hope that things are moving in the right direction.

For example, in 1996, a Michigan jury awarded a $16.5 million verdict to the family of Brenda Young. She was a woman who, after suffering a seizure in 1992, was maintained through a two-month coma with a ventilator and artificial nutrition and hydration at Genesys St. Joseph Hospital despite directives by her health care proxy to the contrary.[67] Notably, Ms. Young's proxy was misled as to whether the treatments she consented to were mere "comfort care" or actually artificial life support; she repeatedly told physicians that her daughter did not want life support, but was assured that her daughter's ventilation, tube feeding, dialysis, and medication were simply treatments to keep her more comfortable. The proxy also asked that her daughter's life support be removed once it became clear that no recovery was likely, but this request went unheeded.

Ms. Young awoke from the coma in a partially vegetative state and was eventually released to her mother's care, but was bedridden and spent

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[65] Of course, some commentators have argued that if "prolonged life" is recognized as an injury, all damages or harms occurring after the imposition of unwanted life-saving treatment would be causally linked to the defendant's tortious act. *See, e.g.*, John Donahue, Comment, "*Wrongful Living": Recovery for a Physician's Infringement on an Individual's Right to Die*, 14 J. CONTEMP. HEALTH L. & POL'Y 391, 399-400 (1997); *see also infra* § III(C).

[66] Notably, at least one case, *Allore*, 699 N.E.2d at 563, has relied on *Anderson III* to conclude that damages for prolongation of life are not recognized under Ohio law.

[67] Tamar Lewin, *Ignoring "Right to Die" Directives, Medical Community Is Being Sued*, N.Y. TIMES, June 2, 1996, at Al.

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hours each day rhythmically thrashing and screaming, not speaking except to occasionally say things like "water" or "bury me." On appeal, the jury's award was reduced to $1.4 million. The parties later settled for an undisclosed amount, unfortunately voiding the trial court's finding that the hospital was guilty of battery in treating Ms. Young against her will.[68]

Similarly, in 2007, a Florida jury returned a $150,000 verdict against Joseph L. Morse Geriatric Center for keeping a resident, Madeline Neumann, alive and on life support for six days of what her family described as unnecessary suffering, in violation of her living will.[69] Though ruling in favor of Ms. Neumann's physician, the jury found that the nursing home had failed to develop a plan for dealing with Ms. Neumann's decline in the face of her advance directives.[70]

## III. CREATING CONSEQUENCES AND SETTING LIMITS

These two cases suggest some future promise for wrongful living claims, but optimists should be extremely cautious at best, for these cases appear to be the outliers. By rejecting the special variant of battery and negligence known as wrongful living, either directly by maintaining that life itself cannot be an injury or indirectly through arguments about causation and implied consent, current law generally fails to provide an effective response to the unfortunate reality that technological advances are used too often to save the lives of those who do not want to be saved for fear of precisely the decline in quality of life they ultimately experience.

This is particularly significant when we consider that physician noncompliance with patients' refusals of care need not be motivated by actual malice,[71] or even by a paternalistic belief that the physician knows better than the patient what is best. Instead, physician behavior is more likely to reflect a rational evaluation of risk. On one hand, saving a patient's life, even against the patient's wishes, carries a risk of only limited sanctions or liability;[72] on the other, choosing not to treat a patient and thereby allowing him or her to die risks a malpractice suit with the potential for significant damages, increased

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[68] *Id.*; *see generally*, *Patient Who Was Kept Alive Settles Out of Court*, DESERET NEWS, May 1, 1997, at C4; Laura Parker, *In a Crisis, Do-Not-Revive Requests Don't Always Work*, USA TODAY, Dec. 20, 2006, at 1a.; Rodriguez, *supra* note 29, at 28-32.

[69] *Jury Awards $150,000 for Failure to Follow Directive*, ELDER L. ISSUES, Mar. 26, 2007, at http://www.elder-law.com/2007/Issue1439.html; Missy Diaz, *Jury: Home Violated Living Will: Nursing Facilities Must Heed Patient's Wishes, Panel Rules*, S. FLA. SUN-SENTINEL, Mar. 17, 2007, at 1A; Parker, *supra* note 68.

[70] Diaz, *supra* note 69; Parker, *supra* note 68.

[71] *See, e.g.*, Lewin, *supra* note 67; Fagerlin & Schneider, *supra* note 27 (stating that there is no evidence that caretakers unilaterally decide to ignore living wills, but instead they often have difficulty interpreting the instructions as applied to particular situations).

[72] These may include professional sanctions, employment consequences, limited damages awards for battery, or patients' refusal to pay for the costs of unwanted care.

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insurance payments, and harm to professional reputation. One hospital administrator has stated starkly that she would "rather have a wrongful li[ving] claim than a wrongful death claim," and as a matter of risk management, it is quite difficult to disagree with her assessment.[73]

The behavior of health care professionals and institutions with respect to patient advance directives is unlikely to change unless new and stronger incentives are developed to ensure that patients' treatment decisions are respected, including decisions to forgo life-saving or life-sustaining care. A policy that imposes civil liability and promises significant penalties for a physician who ignores a patient's clear wishes will help reestablish patient autonomy as a primary good at the end of life.[74]

## A. Default Rules and Patient Autonomy

Some commentators seem to fear that allowing recovery for wrongful living would impermissibly change the current default rule that stands in favor of life. Were that the case, courts' frequent rejection of wrongful living liability would be more understandable. Given the choice between not saving patients who would prefer to be saved and saving patients who would prefer not to have been, it is certainly reasonable to choose the rule that would result in the least offensive mistake. As law professor Carl Schneider has aptly noted: "No legal regime will *ever* prevent all bad results: the goal is the system that prevents the fewest."[75] The question remains, however—Which is the least bad mistake in this context?

Whether unwanted life or unwanted death is the worse error is an incredibly difficult metaphysical question not amenable to straightforward empirical analysis.[76] Of course, because we cannot compare the knowable to the unknowable, no more than a philosophical answer to this question is possible.

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[73] Judy Greenwald, *Medical Ethics and Risk Management: Liability at Life's End; Providers Risk Suits by Reviving Patients*, BUS. INS., May 20, 1996. The hospital administrator actually said that she preferred wrongful life claims, but that was based on a clear misunderstanding of the appropriate terminology; she was not referring to torts related to conception, pregnancy, or birth. *See also* Lewin, *supra* note 67 (explaining that "if you don't intervene and the patient dies, maybe you will be liable . . . . The thinking has been that if you do intervene and you shouldn't have, the worst that will happen is that the patient will live a little longer and that you'll never be held accountable if you keep the patient from dying.").

[74] *See* Henry S. Perkins et al., *Impact of Legal Liability, Family Wishes, and Other "External Factors" on Physicians' Life-Support Decisions*, 89 AM. J. MED. 185 (1990) (providing empirical data demonstrating that whether physicians assumed that liability would ensue or they would be legally immune changed their choices about whether to withdraw life-sustaining care); Vicki Lens & Daniel Pollack, *Advance Directives: Legal Remedies and Psychosocial Interventions*, 24 DEATH STUD. 377, 391 (2000) ("Because it has been shown that physicians are motivated by the threat of lawsuits, damage awards may in fact convince physicians to pay more attention to advance directives. It may also counteract the present tendency to overtreat . . . .").

[75] Carl Schneider, *Liability for Life*, 34 HASTINGS CTR. REP. 10, 11 (2004).

[76] There is a rich philosophical literature that debates whether death can be bad for those who die, whether life is always better than death (and thus should be preserved however possible), and whether there are some states of existence that render death preferable. *See, e.g.*, Corliss Lamont, *Mistaken Attitudes*

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Eliciting preferences may be helpful, such that the outcome to be avoided is the one that most Americans (or people generally) fear, and the outcome to be sought is the one that most would prefer.[77] However, we risk a status quo bias if we rely on majoritarian preferences alone; people might prefer life only because they are currently alive and can only imagine death. Further, even if most people would seek to avoid living against their will in a state they find unbearable, it is possible that an unwanted death is so bad that fewer people fearful of that outcome could prevail.[78]

In this regard, some have argued that, even if death can at times be a welcome reprieve, dying against one's will must be worse than living against one's will because of the finality of death. In fact, this finality concern seemed to be the driving force behind the Supreme Court's decision in *Cruzan*. While allowing patients to refuse unwanted medical care, the Court aimed to protect those patients desiring to live by permitting the state to demand clear and convincing evidence of a patient's wish to forgo life-saving or life-sustaining interventions.[79] When explaining why refusers should be held to such a high standard, the Court noted that an "erroneous decision not to terminate [care] results in a maintenance of the status quo . . . . [and it is possible 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."[80]

It is, however, worthwhile to explore further the idea that, because death is final, we should always err on the side of life, particularly because continued life may bring with it irreversible harms as well. Certainly it is true that "[o]ne can die when one is alive, but one cannot be brought back to life when one is dead. So the undesirable outcome of treatment—living a life which is not worth living—can be corrected. By death."[81]

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*Toward Death*, 62 J. PHIL. 29 (1965); Thomas Nagel, *Death*, 4 NOUS 73 (1970); Richard A. McCormick, *The Quality of Life, The Sanctity of Life*, 8 HASTINGS CTR. REP. 30 (1978); M. Pabst Battin, *The Least Worst Death*, 13 HASTINGS CTR. REP. 13 (1983); Jeff McMahan, *Death and the Value of Life*, 99 ETHICS PHIL. REV. 32 (1988); Fred Feldman, *Some Puzzles About the Evil of Death*, 100 PHIL. REV. 205 (1991).

[77] For example, Savulescu presents a hypothetical scenario in which we must treat two patients identically, one of whom will be happy that he was treated and one of whom would have preferred to die. In deciding whether to treat them both or allow them both to die, he notes that one patient will be harmed in either scenario, but that we should allow them both to die only if the one who wishes to die will suffer more harm from life than the one who wishes to live will suffer from death. Savulescu argues that this is an empirical question; if the patient who would prefer to die "usually, or more often than not, later finds life worth living, the subjectively right thing to do is treat." Julian Savulescu, *Treatment Limitation Decisions Under Uncertainty: The Value of Subsequent Euthanasia*, 8 BIOETHICS 49, 68 (1994).

[78] This is analogous to the principle justifying the high burden of proof placed on the prosecution in our criminal justice system: it is better for one hundred guilty people to go free than for one innocent person to be convicted. Perhaps it is similarly best to adopt a rule that allows for many people to be saved against their will rather than for a single person to die unwillingly.

[79] *Cruzan*, 497 U.S. at 282.

[80] *Id*. at 283.

[81] Savulescu, *supra* note 77, at 65.

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However, death may not come soon enough, and serious damage may occur in the meantime. First, a patient saved against his or her will may not be "fortunate" enough to be supported by a ventilator or feeding tubes, and there may be no care that can be withdrawn to result in that patient's death.[82] Such patients will have to go on living unless they choose to commit suicide, which, despite having the same end result as a passive death, is an extraordinarily difficult choice for patients and their families, particularly when undertaken without the assistance of a physician. Those patients who wish to end their lives but are physically incapable of doing so face an even more difficult challenge, requiring currently illegal assistance from some willing supporter.[83]

Moreover, from the point of view of the patient, an erroneous decision in either direction may be effectively irrevocable. The patient saved or kept alive against his will is robbed of "the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted. Even a later decision to grant him his wish cannot undo the intervening harm."[84] For these reasons, achieving the death one desires at the desired time is a matter of significant consequence.

Thus, both errors in favor of life and errors in favor of death have elements of finality, and we are once again left with the metaphysical question as to which should be more fiercely avoided. Medical science is increasingly able to "keep the human body alive for longer than any reasonable person would want to inhabit it,"[85] and it is likely that we can each point to personal experiences when we have been thankful that our loved ones have been able to pass before their suffering became unbearable. However, because the determination of which fates fall into the category of being worse than death is so often subjective and open to reasonable debate, it is acceptable for both courts and legislatures to decline to draw such distinctions on their own. Instead, the

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[82] The plaintiffs in Vacco v. Quill, 521 U.S. 793 (1997) made a similar argument when they challenged New York's ban on physician-assisted suicide. They argued that the state law, which permits patients on life-support systems to hasten their deaths by ordering withdrawal of treatment, denies equal protection to patients who are not on life-support systems and thus require direct physician assistance to hasten their death.

[83] The Supreme Court held in Washington v. Glucksberg, 521 U.S. 702 (1997) and *Vacco* that there is no constitutionally protected right to physician-assisted suicide in this country, though states are free to legalize the practice, as Oregon has through its Death with Dignity Act. O.S.R. §§ 127.800-995. Both voluntary and involuntary euthanasia are illegal in every American state. Additionally, active killing is psychologically more difficult to accept than allowing passive death, even if the two may be morally equivalent.

[84] *Cruzan*, 497 U.S. at 320 (Brennan, J., dissenting). Justice Brennan also pointed out the importance of preserving the image of oneself as one prefers to be remembered, an image that can be destroyed by an "ignoble end, steeped in decay." *Id*. at 310.

[85] *Id*. at 292 (Scalia, J., concurring).

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government can extend its general defense of life[86] by setting a default rule that favors it—namely, one that works to prolong life absent clear evidence that the patient would prefer to die. By taking the unassailable stance that all lives are objectively worthy of respect and protection, this default rule refuses to make quality of life assessments on a patient's behalf. Moreover, in its default-only form, the rule preserves individual autonomy by allowing patients to opt out and make their own assessments.[87]

This eminently sensible approach crumbles, however, when the subjective assessments patients make for themselves—their clear and considered decisions about what sort of lives they would wish not to live and what types of suffering they would choose not to bear—are ignored without significant consequence. When courts and legislatures deny that continued existence can ever be a compensable harm by rejecting claims of wrongful living, they do more than say that it is a decision the courts and legislatures cannot make; they also say it is one the patient cannot make. Although, in theory, patients are permitted to contract around the default position that errs in favor of life through their clear instructions to physicians in advance directives, that permission becomes meaningless without a legal remedy that is capable of fully compensating patients for violations of their instructions.[88] Eliminating the

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[86] The law generally favors life, as exhibited by laws punishing murderers, the Court's allocation of the burden of proof in *Cruzan*, the assumption of implied consent for emergency medical procedures, the existence of DNR orders to avoid the general rule of resuscitation, and states' prerogatives to fund family planning services that do not include abortion. *See* Philip G. Peters, Jr., *The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy*, 45 UCLA L. REV. 673, 685 (1998) (affirming the current default position to keep patients alive); Lewin, *supra* note 67 ("In most of the cases, the doctors and hospitals defend their actions, asserting that saving a life is never against the law.").

[87] According to the philosophers advocating a constitutional right to physician-assisted suicide in *Glucksberg* and *Vacco*, this preservation of autonomy at the end of life is absolutely essential. They note:

> [D]ifferent people, of different religious and ethical beliefs, embrace very different convictions about which way of dying confirms and which contradicts the value of their lives. Some fight against death with every weapon their doctors can devise. Others will do nothing to hasten death even if they pray it will come soon. Still others . . . want to end their lives when they think that living on, in the only way they can, would disfigure rather than enhance the lives they had created . . . . None of these dramatically different attitudes about the meaning of death can be dismissed as irrational. None should be imposed, either by the pressure of doctors or relatives or by the fiat of government, on people who reject it.

Ronald Dworkin et al., *The Philosopher's Brief*, filed as Amici Curiae Supporting Respondents, *Glucksberg*, 521 U.S. at 702; *Vacco*, 521 U.S. at 793.

[88] William C. Knapp & Fred Hamilton, *"Wrongful Living": Resuscitation as Tortious Interference with a Patient's Right to Give Informed Refusal*, 19 N. KY. L. REV. 253 (1991); *see also* Norman L. Cantor, *Twenty-Five Years After* Quinlan: *A Review of the Jurisprudence of Death and Dying*, 29 J. L. MED. & ETHICS 182, 194 (2001) (noting that the rejection of wrongful living indicates courts' reasoning that "preservation of life must be an inestimable value surpassing any suffering or indignity that might ensue from an unwanted extension of life" and forces patients or surrogates to rely only on petitions for injunction or complaints seeking professional disciplinary action against the offending physician).

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possibility of establishing personal alternatives to the default rule in this manner is unacceptable, for it fails to recognize the intrinsic and instrumental values of personal autonomy.[89]

Importantly, given the threat of wrongful death liability, there is no reason to expect that acknowledgment of wrongful living damages would encourage medical professionals to not save patients who want to be saved; allowing carefully tailored recovery of wrongful living damages would not circumvent the government's chosen sanctity-of-life approach. Instead, it would simply establish an appropriate corollary to wrongful death liability for those who do not want to be saved, thus creating a more appropriate incentive structure for those charged with implementing patient directives, such that they will take patient wishes more seriously, whatever those wishes might be. Thus, the wrongful living variant of battery ought to be recognized; the remainder of this article explores the precise shape it should take.

## B. When Should Wrongful Living Liability Attach?

### *1. Problems with Advance Directives and the Undesirability of Strict Liability*

In light of the serious consequences of failure to follow a patient's end-of-life wishes, the vulnerability of patients to the health care professionals responsible for ensuring that their wishes are respected, and the importance of protecting patient autonomy and the concomitant right to refuse care, it may seem appealing to hold health care providers liable for wrongful living and all of its consequences whenever they have violated a patient's advance directive, no matter how reasonable their decision to do so may have been.[90] After all, the patient may be harmed regardless of the physician's good intentions. Further, because a system of strict liability would provide a strong incentive for physicians to follow a patient's stated directive to the letter, we might predict that such a system would have the beneficial effect of encouraging patients to make sure that their communications about their wishes accurately reflect their current thinking.[91]

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[89] *See* Eric Rakowski, *Taking and Saving Lives*, 93 COLUM. L. REV. 1063, 1113 (1993).

[90] We might also consider a no-fault regime in which patients are compensated for bad resuscitation outcomes regardless of whether their wishes were followed. Such a structure is attractive in that it would be easier for patients to cover their medical expenses, but there would be no special incentive for physicians to comply with a patient's wishes. Instead, they would resuscitate where a good outcome seemed likely and avoid intervention when a poor outcome was predicted, oblivious to a patient's autonomous choices. Further, if a physician or institution had to pay whenever resuscitation saved the patient but resulted in a poor quality of life, they might avoid resuscitation in marginal cases in which a patient nevertheless wants to be saved.

[91] *See* Steven I. Addlestone, Note, *Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy*, 46 VAND. L. REV. 1255, 1278 (1993) (suggesting one way to avoid wrongful living-type problems is to draft living wills with more foresight). This is analogous to the arguments

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There are, however, significant problems with this approach. First and potentially most worrisome, imposing strict liability for failure to adhere to the literal terms of a living will could backfire, resulting not in more perfect drafting, but instead in a reluctance on the part of patients to draft advance directives altogether. In fact, the fear of a dictatorial reading of advance directives has been shown to be a barrier to persons considering whether to draft these documents.[92] Further, while a strict textualist approach may be appropriate in the context of statutory interpretation, where the legislature will have the opportunity to reverse incorrect applications of its laws, in light of the potential finality of the consequences of physicians' decisions regarding end-of-life care described above,[93] patients are not assured of having the same opportunity to override a physician's erroneous interpretation of their instructions. Even if they did, the time that inevitably would be required for the implications of a rule of strict liability to manifest themselves—for patients to realize that their directives are being followed to the letter and to revise them accordingly—could lead to unintended and undesirable consequences, at least in the short term.

Literal application of the terms of a patient's advance directive may also be inappropriate in light of evidence that a patient's stated preferences sometimes reflect confusion over the meaning and impact of various alternatives for treatment.[94] For example, Fischer and colleagues found that patients often express strong preferences about treatments that they do not understand. "[A] patient who states that he would never accept artificial ventilation, not recognizing that it sometimes is briefly needed to provide a full recovery, is in danger of being denied a treatment he would want if he understood it better. Conversely, a patient who wants CPR, believing that she would have a 70%

made by strict textualists in the context of statutory interpretation: if the legislature wants a certain result, it must be clear and precise in its instructions. If the legislature fails in this regard, the court should not guess at what the legislature likely had in mind. Rather, it should simply do as the legislature said, which will encourage the legislature to act to override the court if the court got things wrong and will also motivate the legislature to be more careful in drafting future laws. The problems with this approach in the context of advance directives are noted in the text, *infra*.

[92] S. Sahm et al., *Would They Follow What Has Been Laid Down? Cancer Patients' and Health Controls' Views on Adherence to Advance Directives Compared to Medical Staff*, 8 MED., HEALTH CARE & PHIL. 298 (2005); *see also* Paul R. Dexter et al., *Opportunities for Advance Directives to Influence Acute Medical Care*, 14 J. MED. ETHICS 173, 179 ("[A]pproximately 20% of patients' reservations about signing an advance directive were related to worries that it might be used inappropriately.").

[93] *See supra* notes 80-85 and accompanying text.

[94] *See* Donald L. Patrick et al., *Validation of Preferences for Life-Sustaining Treatment: Implications for Advance Care Planning*, 127 ANNALS INTERN. MED. 509, 509 (1997) ("Patients may not fully understand treatments and health outcomes, or they may have difficulty formulating and expressing preferences about future situations.").

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chance of full recovery, is in danger of being subjected to an intervention she might not want if she understood the true likelihood of success."[95]

Additionally, leaving room for interpretation is essential given that the standard language of advance directives may itself present a barrier to discerning the intent and wishes of the patient. Even for physicians who are willing to accept that there are times when efforts to prolong the life of a very seriously ill patient should cease, as most do,[96] they must nevertheless determine which efforts the patient would want terminated and when.[97] Advance directives are intended to answer these questions, but lack of clarity may compromise their instructive value.[98]

The model living will proposed by the Uniform Healthcare Decisions Act, for example, includes the following language:

> I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits . . . .[99]

Clearly, a conditional statement of instructions for care such as this invites at least some degree of subjective interpretation and prognostication.

As Teno and colleagues have observed, in practice it can be difficult to determine when a patient is no longer merely very sick but rather is dying.[100] Further, what constitutes a relatively short time in the context of illness and

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[95] Gary S. Fischer et al., *Patient Knowledge and Physician Predictions of Treatment Preferences After Discussion of Advance Directives*, 13 J. GEN. INTERN. MED. 447, 452 (1998); *see also* Michel Wreen, *Hypothetical Autonomy and Actual Autonomy: Some Problem Cases Involving Advance Directives*, 15 J. CLIN. ETHICS 319 (2004).

[96] Joan M. Teno et al., *Do Advance Directives Provide Instructions that Direct Care?*, 45 J. AM. GERIAT. SOC'Y 508, 511 (1997).

[97] *Id*. at 508.

[98] Anupama Upadya et al., *Patient, Physician, and Family Member Understanding of Living Wills*, 166 AM. J. RESPIR. CRIT. CARE MED. 1430, 1432 (2002) ("Our data demonstrate convincingly that there is a lack of clarity among patients, physicians and family members about what a living will mandates and under what circumstances it is appropriately executed."); *see also* Joanne Lynn et al., *Dementia and Advance-Care Planning: Perspectives from Three Countries on Ethics and Epidemiology*, 10 J. CLIN. ETHICS 271, 273 (1999) ("[A]dvance directives are typically not entirely clear and decisive in their application to a particular choice about the patient's care.").

[99] National Conference of Commissioners on Uniform State Laws, Uniform Health Care Decisions Act (1993), *at* http://www.law.upenn.edu/bll/archives/ulc/fnact99/1990s/uhcda93.htm (last accessed Nov. 13, 2007). This Act has been adopted by every state except Nebraska. *See also* Upadya, *supra* note 98, at 1432.

[100] Teno et al., *supra* note 96; *see also* Gary S. Fischer et al., *Can Goals of Care Be Used to Predict Intervention Preferences in an Advance Directive?*, 157 ARCH. INTERN. MED. 801, 801 (1997) (noting that documents containing the standard language refusing interventions that serve to "prolong the dying process" are difficult to apply in specific clinical situations).

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death? What is a reasonable degree of medical certainty? Is the degree of certainty regarding outcomes different when the physician is involved in medical decision-making as opposed to testifying in court? Should it be? Is it meaningful to talk of certainty regarding likely risks and burdens? How can one know what the correct balance is when weighing risks against benefits for another person? Each of these questions indicates that literal application of a patient's instructions may not even be possible in many end-of-life contexts, and hence demanding it would hold physicians to an unattainable standard.

Finally, strict adherence to advance directives may not be desirable given concerns about how clear and accurate a patient's statement of end-of-life wishes can ever be.[101] Fagerlin and Schneider argue that, for living wills to work, one crucial condition is that patients must be able to "accurately and lucidly" state which treatments they would want if incompetent. However, they suggest this condition is not only unmet in the vast majority of cases, but also that it is fundamentally unmeetable.[102] Fagerlin and Schneider explain:

> [E]ven patients making contemporary decisions about contemporary illnesses are regularly daunted by the decisions' difficulty. They are human. We humans falter in gathering information, misunderstand and ignore what we gather, lack well-considered preferences to guide decisions, and rush headlong to choice. How much harder, then, is it to conjure up preferences for an unspecifiable future confronted with unidentifiable maladies with unpredictable treatments?[103]

Thus, even if patients have great reason to state their wishes as clearly as they can, it is possible that no amount of incentives will allow them to forecast perfectly.

Some commentators have responded to these difficulties by moving for a rejection of advance directives altogether, advocating a return to the best interests of the patient approach rather than continuing to grapple with accommodating patient autonomy at the end of life. They claim that "[n]o court should want to enforce a document whose authors are so ambivalent and so likely to not want the document to be binding,"[104] and argue that physicians ought to treat those whose lives will be worth living and not treat those whose lives will not.[105] In fact, many physicians seem to do just that. Evidence suggests that, despite being several decades into the patient autonomy movement, many physicians not only consider it their responsibility to make treatment

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[101] Sahm et al., *supra* note 92.
[102] Fagerlin & Schneider, *supra* note 27, at 31.
[103] *Id*. at 33.
[104] Schneider, *supra* note 75, at 11 (citing the fact that as many as 54% of patients are willing to have even "perfect" living wills overridden).
[105] Savulescu, *supra* note 77, at 60.

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decisions in the best interest of the patient, but also believe that patient preferences should be ignored when they are inconsistent with the physician's assessment.[106]

However, it seems clear that the propriety of a patient's refusal of care cannot be judged based on medical expertise alone, but instead is an area dependent on a patient's values and a patient's value-based decisions;[107] "[w]hen and whether to fight death or succumb to it is ultimately a question that extends far beyond medical judgments, encompassing values and spirituality, family dynamics, and personal predilections."[108] Thus, despite the flaws with the current system of advance directives—and even in light of the fact that some patients prefer their physicians to have significant leeway when deciding whether overriding the directive would be in their best interest[109]—absolute rejection of autonomous patient preferences at the end of life goes too far. Given that physicians, patients, attorneys, legislatures, and courts uniformly agree that advance directives are valuable tools in end-of-life care, abandoning them entirely in favor of a paternalistic best interests standard would be a major step backward.

This conclusion is bolstered by numerous studies finding that patients' previously expressed instructions regarding the provision of life-sustaining

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[106] Tricia Jonas Hackleman, Note, *Violation of an Individual's Right to Die: The Need for a Wrongful Living Cause of Action*, 64 U. CIN. L. REV. 1355, 1357-58 (1996); *see also* David Orentlicher, *Trends in Health Care Decisionmaking: The Limits of Legislation*, 53 MD. L. REV. 1255, 1283 (1994):

> Physicians often overrode patient choice when they believed that respecting patient preferences would not be in the patient's best interests. If physicians continue to believe that they are obligated to make end-of-life medical decisions based on their sense of the patient's best interests rather than on their understanding of the patient's wishes, living wills will have little effect on medical decision-making. They will be respected only when they are consistent with the physician's views of the patient's best interests.

[107] *See, e.g.*, Ashwini Sehgal et al., *How Strictly Do Dialysis Patients Want Their Advance Directives Followed?*, 267 J.A.M.A. 59, 62 (1992) (pointing out that there is no consensus on how to determine a patient's best interests, and that such an inquiry will generally involve the projection of other people's values onto the patient); Hackleman, *supra* note 106, at 1357-58.

[108] Lens & Pollack, *supra* note 74, at 392.

[109] Although admittedly out of date, a 1992 study found that 39% of dialysis patients surveyed would give their physicians and surrogates no leeway to override their advance directive, but 31% would give "complete" leeway, 11% would give "a lot" of leeway, and 19% would give at least "a little." These respondents also varied in the extent to which they wanted considerations such as pain or suffering, quality of life, the possibility of a new treatment, the financial impact of treatment on family members, and their religious beliefs to be taken into account in decisions to deviate from their prior instructions. The majority of subjects wanted these factors to be taken into account, particularly pain and suffering and the indignity caused by continued treatment, but a significant minority did not want them to play a role. *See* Sehgal et al., *supra* note 107, at 59-61. These results do not necessarily suggest that patient wishes should be overridden, but rather only that patients should be encouraged to state in their advance directives whether they are willing to have their physicians act contrary to their stated instructions and, if so, under what circumstances.

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care remain reliable expressions of the patient's will over time. These studies have analyzed the stability of patient preferences either by presenting research subjects with hypothetical scenarios of illness and treatment possibilities[110] or by documenting how closely patients' preferences stated in advance correlated with the decisions the patients made when actually facing life-threatening illness.[111] Importantly, the results of these analyses have shown that the preferences expressed to govern care during hypothetical episodes of illness were stable 70% to 80% of the time for up to two years,[112] with higher stability among patients who had initially declined rather than accepted treatment and among those who had a living will.[113] These findings are particularly important for the purposes of wrongful living liability because they suggest that patients bringing such suits have been harmed when their stated preferences are disregarded.

Given that patients are in the best position to make choices for themselves, or at least a position that is superior to that held by any other party,[114]

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[110] *See, e.g.*, Linda L. Emanuel et al., *Advance Directives: Stability of Patients' Treatment Choices*, 154 ARCH. INTERN. MED. 209 (1994); Fisher et al., *supra* note 95; Marion Danis et al., *Stability of Choices About Life-Sustaining Treatments*, 120 ANNALS INTERN. MED. 567 (1994).

[111] Melinda A. Lee et al., *Do Patients' Treatment Decisions Match Advance Statements of Their Preferences?,* 9 J. CLIN. ETHICS 258 (1998); *see also* Emanuel et al., *supra* note 110 (finding most study subjects made moderately stable treatment choices that were not impacted by recent hospitalization).

[112] Some commentators have suggested that advance directives should have expiration dates. *See, e.g.*, Trevor Thompson et al., *Health Professionals' Views on Advance Directives: A Qualitative Interdisciplinary Study*, 17 PALLIATIVE MED. 403, 408 (2003).

[113] *See* Lee et al., *supra* note 111, at 260 (noting that 75% of the subjects in this study comparing hypothetical preferences with actual treatment decisions chose to receive either the same or less treatment than had been indicated in response to the hypothetical); Emanuel et al., *supra* note 110, at 213 ("In the illness scenarios we studied, there was higher stability among declines of treatment than the other three response options"); Danis et al., *supra* note 110 (finding a choice to forgo treatment was twice as stable as a choice to receive treatment); R. Mitchell Gready et al., *Actual and Perceived Stability of Preferences for Life-Sustaining Treatment*, 11 J. CLIN. ETHICS 334, 339 (2002) ("In 24 of 35 judgments, participants' preferences to refuse treatment were more stable than their preferences to accept treatment."); Patrick et al., *supra* note 94, at 516 ("Concordance was remarkably stable across the observational periods for health states [rated by the subject to be] worse than death. This result is consistent with earlier reports that the choice to forego treatment is more stable than the choice to receive treatment."). *But see* Kenneth E. Rosenfeld et al., *Factors Associated with Change in Resuscitation Preference of Seriously Ill Patients*, 156 ARCH. INTERN. MED. 1558 (1996) (finding that, although there was an 80% two-month stability of preferences for resuscitation among all 1590 patient subjects, preference stability for patients initially preferring CPR was 85%, but only 69% for patients initially choosing DNR).

[114] *See* Steven Luttrell & Ann Sommerville, *Limiting Risks by Curtailing Rights: A Response to Dr. Ryan*, 22 J. MED. ETHICS 100, 102 (1996). Some commentators claim, though, that present competent selves should not be able to bind future incompetent selves because they are completely different people with different interests. *See, e.g.*, John A. Robertson, *Second Thoughts on Living Wills*, 21 HASTINGS CTR. REP. 6, 7 (1991) ("Because [living wills] either confuse the present interests of an incompetent patient with interests she had when competent, or forthrightly privilege the competent person's interest in control and certainty over the incompetent patient's current interests, they pose a threat to incompetent patients. If this threat arises in many cases, it is a serious problem for an ethical-legal position that purports to be patient-centered."); Thompson et al., *supra* note 112, at 406 ("preferences of the well might not equate with those of the unwell"). This position, however, completely rejects the theoretical foundation upon which advance directives are built.

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there is no need to sacrifice the autonomy of those whose wishes are abundantly clear for the benefit of others whose wishes are more opaque. Therefore, patient directives must be enforced, though not through the mechanism of strict liability. Alternatively, we propose a wrongful living concept that is tailored to protect those patients who have gone far enough to clearly contract around the default rule. It also recognizes a degree of appropriate physician discretion in cases when a patient's wishes are ambiguous.

### *2. Permissible Deviation from Stated Instructions*

By now it should be clear that mechanical adherence to patient directives cannot be the proper goal of wrongful living liability. But, without protection of their reasonable decisions to deviate from directives, it is quite likely that physicians made overly fearful of liability would behave ministerially rather than thoughtfully, resulting in the sort of defensive medicine we have seen in response to the current medical malpractice system.[115] Dogmatic adherence to the text of advance directives merely trades one problem for another and would promote neither patient autonomy nor the best interests of patients, and therefore must be avoided.

Physicians faced with directives regarding how to treat a patient at the end of life ought to be encouraged to act as an extension of the patient, not incentivized to do what the patient said but clearly not what the patient would want. Discretion—and the willingness to exercise it—are both essential. We must be careful, though, not to afford too much leeway lest we hold patients to an impossible standard of clarity and specificity that must be met before their refusals of care will be acknowledged as valid and actually implemented. With these considerations in mind, we now assess the type of circumstances that might indicate a permissible disregard of a patient's directive.[116]

At a most basic level, it is likely inappropriate to hold a physician responsible for failing to implement treatment refusals of which he or she was reasonably unaware.[117] This conclusion is particularly important given that any other rule might demand from physicians a standard of conduct that evidence suggests they simply cannot meet in many cases. For example, in a study of the effectiveness of advance directives for seriously ill hospitalized patients, researchers found that only one in three directives was documented

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[115] *See, e.g.*, David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J.A.M.A. 2609 (2005); Daniel P. Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353 (1996).

[116] *See generally* L. Willmot et al., *Overriding Advance Refusals of Life-Sustaining Medical Treatment*, 25 MED. L. 647 (2006) (discussing changed circumstances, intention to revoke a directive, uncertainty, incorrect information or assumptions, and no decision made).

[117] The paradigmatic case here is when the physician is presented with an incompetent patient in an emergency situation and taking the time to uncover the patient's wishes would eliminate the window in which the patient's life could be saved.

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in the patient's permanent medical record.[118] In modern-day medical practice, a hospital patient will probably be seen by multiple attending physicians and house staff, few or none of whom have seen the patient previously. In the absence of a directive in the chart, these physicians have no basis upon which to presuppose its existence. Dexter and colleagues have also noted that inter-institutional barriers impede advance directives' accompanying patients across care settings.[119] Under these circumstances, imposing liability for ignorance that is essentially ascribable to systemic failures is not appropriate.

Even though this approach avoids overstated concerns that wrongful living liability could inhibit emergency responses,[120] it does not necessarily absolve the physician or hospital if the patient's wishes reasonably could have been made known. If a hospital failed to have an existing advance directive included in the patient's chart or failed to implement an effective system for quickly identifying patients with directives refusing life-sustaining treatment (for example, signage at the patient's bedside, indicative bracelets, necklaces, and so on),[121] that institution should be held responsible.[122] Similarly, wrongful living liability should attach to a care provider who purposefully concealed a patient's preferences from others or a physician who is unreasonably ignorant of a patient's desire to refuse treatment. This might be the case if the physician had time to investigate the patient's wishes prior to the point where intervention became urgent, perhaps by verbally discussing the issue with a patient while

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[118] Joan M. Teno et al., *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention*, 45 J. AM. GERIATR. SOC'Y 500, 507 (1997); *see also* Teno et al., *supra* note 96, at 311 ("Despite the PSDA [Patient Self-Determination Act], most documents that the patients and surrogates report to exist are not placed in the medical record."); J. Virmani et al., *Relationship of Advance Directives to Physician-Patient Communication*, 154 ARCH. INTERN. MED. 909, 912 (1994) (finding that 27 of 38 physicians did not know their seriously ill cancer patients had written advance directives).

[119] Paul R. Dexter et al., *Opportunities for Advance Directives to Influence Acute Medical Care*, 14 J. CLIN. ETHICS 173, 178 (2003) ("[E]vidence supports the belief that significant inter-institutional barriers exist."); *see also* R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, 274 J.A.M.A. 478 (1995); Steven Miles, *Advanced Directives to Limit Treatment: The Need for Portability*, 35 J. AM. GERIATR. SOC'Y 74 (1987). In fact, failure to inform health providers, to document a patient's decision to forgo resuscitation, and to communicate that decision upon the patient's transfer to another setting (for example, nursing home to hospital emergency department) falls within the Institute of Medicine's definition of medical error. Joanne Lynn & Nathan E. Goldstein, *Advance Care Planning for Fatal Chronic Illness: Avoiding Commonplace Error and Unwarranted Suffering*, 138 ANNALS INTERN. MED. 812, 813 (2003).

[120] Rodriguez, *supra* note 29, at 21 ("Having to consider all the ramifications of employing a life-sustaining procedure is bound to inhibit emergency response.").

[121] *See, e.g.*, Fagerlin & Schneider, *supra* note 27, at 35 (finding that only 26% of the patient's charts accurately recorded information about the patient's directives and only 16% of the charts contained the form).

[122] Daniel P. Kesseler, *The Effects of the U.S. Malpractice System: A Review of the Empirical Literature*, Working Paper 16 (2006) (explaining that "to the extent that medical errors are caused by systematic errors rather than the carelessness of individual physicians, assigning liability to institutions would lead to system-wide quality improvement as well").

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competent or familiarizing himself or herself with a patient's preferences as memorialized in the patient's chart.[123]

In other words, when the patient's stated wishes are reasonably attainable by the treating physician or other health care professional, straightforward application of the default rule is no longer appropriate and new standards will come into play. However, even then, a physician's failure to follow a patient's refusal of life-sustaining treatment may be justified if the physician has reason to believe that the refusal was not fully informed or was based on a mistake or misunderstanding of the sort described above about the nature of a particular intervention or its likely outcome.[124] In such contexts, the physician cannot be sure the refusal represents a true exercise of the patient's autonomy, and actually has reason to believe it does not.[125] Similarly, physicians should not be expected to implement refusals proffered by patients who lacked the capacity to make such decisions for themselves at the time the advance directive was made, or refusals that appear to have been coerced, particularly when it seems clear the patient would have made a different choice if left to his or her own devices.[126]

Mistake and coercion aside, physicians may also appropriately avoid liability if they provide treatment based on a reasonable interpretation of the language of a patient's instructions or on a logical determination that the patient's refusal was inapplicable to the current circumstances, such that the patient really has not given any directive that could be understood to override the default rule. As previously discussed, many directives are less than comprehensive; the particular set of facts surrounding a decision about the patient's end-of-life treatment may not have been contemplated by the patient or been addressed in the document, leaving the physician to extrapolate from the preferences expressed to what the patient would have wanted.[127] For example, it may be the case that the patient's refusal was never intended to apply to the present situation, as when a patient has a directive rejecting ventilation but consents to a surgery that requires general anesthesia, during

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[123] This indicates the main problem with the physician's behavior in the *Werth* case, as explained below.

[124] *See supra* notes 90-103 and accompanying text.

[125] Christopher J. Ryan, *Betting Your Life: An Argument Against Certain Advance Directives*, 22 J. MED. ETHICS 95, 97 (1996); *see also* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 242 (1983), *available at* http://www.bioethics.gov/reports/past_commissions/deciding_to_forego_tx.pdf (suggesting not that physicians should override patient preferences about resuscitation, but that informational discrepancies should be brought to the patient's attention).

[126] *See, e.g., In re* Dorone, 502 A.2d 1271, 1278 (Pa. Super. Ct. 1985) (stating that the context of a patient's refusal is essential information, and noting that if the only evidence of a patient's refusal of blood transfusions was a medical alert card, it could be relevant whether that card was signed by the patient independently or as a symbolic affirmation of faith in the context of a religious congregation).

[127] Linda L. Emanuel et al., *Advance Directives: Can Patients' Stated Treatment Choices Be Used to Infer Unstated Choices?*, 32 MED. CARE 895 (1994).

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which temporary ventilation will be required.[128] Or, it may be that the refusal was intended to apply to the present situation at one point, but things have since changed to render its applicability questionable, such as refusal of blood products made by a patient who was a practicing Jehovah's Witness but who has now converted to Islam.[129]

The interpretation involved in these scenarios is essential, since no one wants an agent who is unable to adjust and is rigid to a fault, but determining how much room for interpretation ought to be allowed can be extremely challenging in practice. The *Werth* case offers an excellent example of why this is so,[130] demonstrating the unfortunate result when physician discretion in the context of changed circumstances is taken too far.

Recall that Ms. Werth, a Jehovah's Witness, had repeatedly refused blood products when she was well, but the court was not convinced that her refusal carried over to a situation in which she faced imminent death. This was a dubious conclusion, however, given the several different recollections of the conversation occurring among Ms. Werth, her husband, and her physician immediately prior to the procedure that necessitated the transfusion at issue in the litigation. In Ms. Werth's account, the physician was aware of her prior refusal of blood products and asked specifically whether she would want blood if she were actually dying. This question sparked fear in both Mr. and Ms. Werth because they felt the question indicated that the procedure was more serious than they had previously believed. Ms. Werth testified that her husband responded, in her presence, that he did not want her to die, but that he did not want her to have blood. Instead, he wanted the alternative treatment that he was aware other Jehovah's Witnesses had received in emergency situations.[131] Mr. Werth's testimony was entirely consistent with this account.[132]

The physician testified that when she asked whether the Werths would consent to a transfusion, Ms. Werth said no, but her husband expressed concern about the risk. She testified that when Mr. Werth asked her whether she thought things really looked that bad, she simply responded: "'Not right now.' And I didn't get any further answer from him in terms of whether he felt that if it became that bad he might change his mind. And I left it at that."[133]

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[128] *See, e.g.*, Cleveland Clinic Department of Bioethics, *When You Need to Have Surgery; A Letter to Our Patients with Advance Directives*, *at* http://www.clevelandclinic.org/bioethics/patients/dnr_surgery.html (offering three options to patients who have chosen only comfort care but who nonetheless need surgery to make them as comfortable as possible before death: suspending their advance directive during surgery, modifying their advance directive during surgery, or retaining it entirely without change).

[129] Strasser, *supra* note 43, at 1009 (suggesting a physician might be able to ignore a patient's requests if those requests are unlikely to hold under new circumstances about which the patient was not informed or did not foresee); Willmot et al., *supra* note 116, at 651.

[130] *See supra* notes 47-50 and accompanying text.

[131] *Werth*, 475 N.W.2d at 426.

[132] *Id.* at 429-30. However, Mr. Werth testified that he did not think death was really a risk, based on reassurance from the physician.

[133] *Id.* at 430.

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That the physician made no attempt to elicit a more specific and concrete answer when one could have been obtained from a patient who was both competent and conscious was irresponsible and unreasonable, particularly in light of the fact that the physician herself described Mr. Werth's response as "wishy-washy." This failure alone suggests the physician should have been held liable for getting things wrong. Nonetheless, the court was seemingly moved by Mr. Werth's expression of concern over the risk of the procedure and accepted the physician's testimony, concluding that all of the prior refusals of blood, which had begun several months earlier and continued right up to the procedure itself, were inapplicable to the transfusion in question.

It was absolutely appropriate for the court to inquire into whether the patient really intended her refusal to apply to the current situation. However, it was not sound for the physician to draw a conclusion that care was desired and refusal had been withdrawn based on a simple question about the risks of a procedure. This does not appear to be a situation where the physician behaved reasonably in applying the default rule because no decision about treatment had been made.[134] Instead, it seems that a concrete decision had been made in the context of precisely the situation at hand (though perhaps not using the language the court was expecting) but the physician nevertheless acted according to her own preferences. Thus, the *Werth* case presents a good example of the inapplicability argument being taken too far, because it veers dangerously toward the "kind of doctrine that would allow a physician to simply wait until after the patient had lost consciousness, and then transfuse without fear that he would be subject to liability for damages, clarity of the patient's expressed wishes notwithstanding."[135]

Even so, there certainly are other situations in which a physician might reasonably conclude that a patient would not want his or her refusal of care to extend to the present context. If it is intention that matters, then room for physicians to make these determinations must be preserved.[136] At the very

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[134] Willmot et al. categorize the *Werth* case as one in which no decision about treatment had been made. *See supra* note 116, at 657.

[135] Strasser, *supra* note 43, at 1009.

[136] The case of Dr. Michael DeBakey may provide such an example. Dr. DeBakey suffered a dissecting aortic aneurysm, but he initially refused admission to the hospital for fear that undergoing the required surgery would leave a man of his age severely disabled. Eventually he yielded, and was admitted to the hospital more than three weeks after the initial event. His physicians suggested surgery, but Dr. DeBakey refused, though he told them that he wanted to reevaluate the situation in a few days. However, nearly two weeks passed without that reevaluation. By that time, Dr. DeBakey was unresponsive and near death. His wishes appear to have been ambiguous. He clearly did not want the surgery previously, but because he left room for reevaluation, it was not clear that his refusal should have applied to an imminently life-or-death situation. Although his physicians should have attempted to elucidate a clearer statement of preferences while it was still possible, it appears that their behavior in providing the surgery (applying the default rule) was appropriate. For a discussion of this case, see Lawrence K. Altman, *The Man on the Table Devised the Surgery*, N.Y. TIMES, Dec. 25, 2006, at A1.

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minimum, however, a physician should not be permitted to ignore a patient's directive with impunity solely because it was expressed when the patient was healthy or the need for the care that was refused was hypothetical rather than real.[137] These changed circumstances would be present in so many cases that to allow them to invalidate a patient's directive would allow the exceptions to swallow the rule.

So long as we recognize patient autonomy as preferable to a best interests standard of medical paternalism, we must accept patients' imperfect ability to predict their future desires, while encouraging them to be as clear as they possibly can. In fact, it will likely be most protective of patient autonomy to educate patients about the possibility of changed circumstances resulting in changed preferences, alert them to potential ambiguities in the language they might use, and encourage them to express their treatment refusal preferences accordingly, rather than hoping that physicians will make good guesses about what their patients would want. Taking these steps will help those charged with implementing patient wishes, whether physicians or surrogates, and minimize the need for interpretation to the extent possible.

### *3. Standards for Interpreting Patient Directives: Reasonableness and Recklessness*

Nevertheless, in all but the clearest cases, some interpretation of patient directives will always remain necessary. This is a basic problem associated with nearly every instance of agency, when one party is asked to carry out the instructions of another. Just as legislatures struggle to impossibly "(1) work out exactly what rule they want, (2) imagine all the circumstances in which it might apply, and (3) find language to specify all those but only those circumstances," and thus often choose to bestow the enforcers of statutes with

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[137] But at least one commentator would encourage exactly that. Ryan, *supra* note 125, at 95-98, suggests that the very change from healthy to sick is an essential change in circumstances sufficient to void a prior refusal of care. In light of the fact that many patients change their minds about treatment decisions made when they were well once they become sick, but mistakenly believe their treatment preferences will remain stable over time and circumstance, Ryan argues that we ought to abolish advance directives written by the healthy, accepting only those written once a patient is ill and able to properly assess his or her treatment preferences. Thus, he claims that healthy-then-sick drafters should be resuscitated as a rule so their treatment preferences might be solicited again now that the imagined scenario has actually occurred. Ryan recognizes that "[f]or some no doubt this will lead to considerable hardship, as they must again state their preference that they would rather be allowed to die, but for others, perhaps the majority, it will provide a safety net and a chance to reconsider their decision with all available information."

Unfortunately, however, Ryan's argument would limit end-of-life freedom only to a very narrow class, essentially to those who had actually experienced the state and the care they now express a repeated desire to avoid. His rarely attainable threshold for the expression of valid treatment refusals would place a patient's ability to plan for the future in grave peril. For a critique of his position, see Luttrell & Sommerville, *supra* note 114; *see also supra* notes 110-13 and accompanying text (discussion of the stability of patient refusal preferences).

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some discretion,[138] we have seen that it is in the best interest of patients to bestow their physicians with similar flexibility.[139]

However, there may sometimes be arguments as to what sort of interpretive behavior is appropriate. Was a particular mistake of fact significant enough to change the patient's wishes? Was the change in circumstances sufficient to render a prior refusal void? Did the patient really mean for his or her refusal to apply here? Was the patient's directive truly ambiguous? Arguments on both sides of these questions are often passable, and simply allowing room for "reasonable interpretation," which is itself an ambiguous phrase, will not give physicians the security they need to feel confident in exercising discretion. This could result in precisely the sort of mechanical reading of patient directives that we are hoping to avoid.

Thus, it may be best to allow room for physician discretion beyond a simple negligence standard and to implement a more nuanced and layered approach to wrongful living liability. First, the court should ask whether the health care providers have behaved recklessly in providing life-saving or life-sustaining care or have intentionally disregarded a patient's clear refusal.[140] If they were not reckless and did not exhibit knowing or intentional disregard for the patient's wishes, then the patient's consent to care ought to be implied, as it is in emergency contexts in which actual consent cannot be obtained[141] even if the patient meant to withhold consent, and the health care providers should not be held liable for wrongful living damages. On the other hand, when the decision to treat is made as a result of reckless or intentional behavior, there is no implied consent, rendering the imposition of care an unconsented violation to which wrongful living liability should attach.[142] In other words, physicians ought to apply the default rule in favor of preserving life unless the patient has given clear instructions that another rule is to be followed. We should

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[138] Fagerlin & Schneider, *supra* note 27, at 34-35.

[139] Technically, this room for discretion should be able to go either way, allowing physicians to save their patients who likely would want to be saved and allowing patients to die who would likely prefer that outcome, regardless of the exact content of the patient's directive and instead based on its underlying reasons. However, given the potential for abuse of discretion, conflicts of interest, financial pressures to give minimal care, and historical mistreatment of certain minority groups, concerns about a physician being allowed to choose death for some patients without their explicit consent or that of a surrogate are likely too great to allow that sort of leeway. This is not because continued life is always better than death, which is an enormously subjective and difficult judgment, but rather because of the need to avoid feeding into and worsening any mistrust of the medical profession.

[140] *See* Rodriguez, *supra* note 29, at 11 ("[P]hysicians should not be held liable for providing life-sustaining treatment in cases where the refusal is unclear. But they should be held liable when a patient or a relative clearly refused care either by written document or oral statement.").

[141] Laura Hunter Dietz et al., *Emergency Operation or Treatment*, 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 167 (2006).

[142] Importantly, this approach retains the battery framework.

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respect a physician's good faith determination that the patient's instructions to withhold care were not clear enough.

It may seem as though such a standard offers too much leeway to physicians and other health care providers charged with implementing a patient's directives, or that it may be ineffective to protect patients who have rejected the assumption that life is always preferable to death. To the contrary, however, a recklessness standard aims to preserve the physician's ability to do what the physician believes that patient would choose without imposing unnecessary uncertainty and fear of liability, which could lead to over-deterrence. If physicians are free to deviate from stated instructions when such deviation advances the patient's true end-of-life wishes, patients can depend on their physicians for expertise, caring input, and the desire to get things right.

This will eliminate much of the fear that one's directive is set in stone, as well as the need to think of every possible contingency, ultimately resulting in a far more efficient model of the physician-patient relationship than that of a master and unthinking agent.[143] Patients who have stated their wishes clearly, as well as patients whose directives are more flexibly drafted, will each be protected to the greatest extent compatible with similar protection of the other. At the very least, this approach is preferable to either strict liability or a rejection of wrongful living liability altogether.

To demonstrate that this standard will not effectively destroy the possibility of recovery for wrongful living, consider its application to the very unfortunate experience of Dr. Marshall Klavan. After witnessing his father suffer a stroke, Dr. Klavan was concerned about being completely debilitated himself, and executed an advance directive that refused extraordinary medical measures. Four years later, Dr. Klavan attempted suicide and left a note stating that he did not wish to be resuscitated. Upon being discovered, Dr. Klavan was taken to the emergency room, where extreme measures were taken to successfully resuscitate him. Three days later, by which point he had deteriorated to a persistent vegetative state, Dr. Klavan's family notified the hospital of his note and his earlier medical directive. The hospital agreed to provide care in accordance with the directive and reduced his care levels.

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[143] Of course, this may require a significant investment of time on the part of the physician, who is likely to already be extremely time pressured as a result of the demands of modern medical practice. This perhaps explains why so many physicians fail to discuss end-of-life wishes with their patients. However, this is simply another reason to reform the American health care system; it is not a reason to accept poor patient care. Further, lack of time may be less of a problem than lack of the important communication skills physicians need to introduce and adequately discuss these sensitive issues. *See, e.g.*, Joseph S. Weiner & Steven A. Cole, *Three Principles to Improve Clinician Communication for Advance Care Planning: Overcoming Emotional, Cognitive, and Skill Barriers*, 7 J. PALLIATIVE MED. 817, 818 (2004) (explaining that physicians routinely fail to initiate meaningful advance care planning discussions with their patients, but suggesting that introducing mechanisms to address and diminish physicians' emotional, cognitive, and skill barriers, combined with larger health system changes, will improve health care delivery near the end of life).

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When his condition worsened, however, the hospital again used extraordinary resuscitative measures, and Dr. Klavan then suffered a stroke.[144]

It is unclear whether those who originally found Dr. Klavan were aware of his suicide note when they tried initially to resuscitate him, but even if they were, the emergency room's refusal to abide by the note's rejection of care would likely have been appropriate. Dr. Klavan's mental state and competency to refuse at the time the note was written were certainly questionable; despite his wishes as stated while he was in a state of extreme despair, his autonomous wishes could very well have been different.[145] Thus, the initial resuscitation was not reckless, nor did it reflect an intentional disregard of Dr. Klavan's clear wishes, and his physicians should be free from liability for their behavior.

However, when the physicians engaged in a second resuscitation, they were no longer saving Dr. Klavan from a suicide attempt. At that point, it was clear that he would not regain his prior quality of life or anything close to it. He was in precisely the condition that he had hoped to avoid when he previously expressed his desire to refuse extraordinary care, regardless of how he got there. Thus, his physicians were faced with clear instructions applicable to the present circumstances, verified by the patient's family, that they nonetheless intentionally disregarded. The drastic nature of suicide and the questionable competence of those who attempt it make this a difficult case worthy of debate, but it nevertheless appears that the second resuscitation was so outrageous that wrongful living liability would likely be appropriate.[146] The same could be said of the life-saving and life-sustaining care provided to Cindy Werth, Brenda Young, and Edward Winter.[147]

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[144] The facts of this case are derived from the opinion rendered in *Klavan v. Crozer-Chester Med. Ctr.*, 60 F. Supp. 2d 436, 439-40 (E.D. Pa, 1999). However, there is significant confusion about whether Dr. Klavan's wishes truly were clear, because the court record variously describes him as existing in a persistent vegetative state and as carrying on conversations with medical staff, descriptions that are absolutely incompatible. Therefore, we use the case essentially as a hypothetical based on the version of events offered by the court.

[145] Savulescu argues that "if there are reasons to believe that [a patient's advance] directive was not an expression of the patient's autonomy, then it is appropriate to disregard such a directive and assess the situation afresh." Savulescu, *supra* note 77, at 211.

[146] Unfortunately, the court never reached this issue, as the case was moved to state court on jurisdictional grounds.

[147] Also consider the case of Maria Duran, a Jehovah's Witness patient in need of a liver transplant who chose her transplant center for its willingness to perform the procedure without the transfusion of blood. She executed a durable power of attorney specifically in anticipation of the transplant. It stated in relevant part:

> I absolutely, unequivocally, and resolutely refuse . . . blood under any and all circumstances, no matter what my medical condition. . . . Even if health-care providers . . . believe that only blood transfusion therapy will preserve my life or health, I do not want it. Family, relatives or friends may disagree with my religious beliefs and with my wishes expressed herein . . . . Any such disagreement should in no way be construed as creating ambiguity or doubt about the strength or substance of my wishes.

Because there was no question about coercion, the circumstances under which Ms. Duran executed this statement, or her intentions, this was the epitome of a clear patient directive. Nonetheless, when

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### C. The Remedy: Damages for Wrongful Living

Recognizing the sorts of situations in which wrongful living liability ought to attach is an important step. However, once a physician's failure to abide by a patient's clear directive has been deemed reckless or intentional such that wrongful living liability is warranted, the more difficult question of damages enters the picture. The task of crafting an appropriate remedy for the harm in this context has perplexed the courts. Consequently, patients who have experienced serious harms are left uncompensated and physicians are left without any real incentive to balance the countervailing incentive to save the patient in every case, thus subjecting future patients to the same plight.

Damages are essential to the resolution of both problems. Typically, when a defendant has committed a tort, he or she is held liable for all of the reasonably foreseeable consequences of the tortious action. However, while prolonged life was certainly foreseeable, and in fact was the desired result of the decision to disregard the patient's refusal of care, many critics argue there is no reasonable way to determine an appropriate level of compensation.

As a compromise, they may be willing to allow nominal damages, which are trivial sums awarded to recognize the violation of some legal right when there has been no proven injury. Because nominal damages would be woefully inadequate to resolve and prevent the problems associated with the wrongful prolongation of life, however, allowing them would not prove to be much of a compromise at all. Just as lawsuits have created the current cost-benefit ratio that has resulted in the widespread incentive to save patients rather than let them die, regardless of their stated preferences, only lawsuits resulting in significant penalties for violations of advance directives will be capable of re-crafting those incentives and bringing them to a more balanced state.[148] Critics may be right that there is no perfect measurement of wrongful living damages, but given the countervailing considerations, perfection is not required; creating a reasonable metric is both necessary and possible.

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Mr. Duran petitioned the Orphans' Court to be appointed Ms. Duran's emergency limited guardian for the sole purpose of consenting to a blood transfusion that became necessary after the transplant, the court granted his request. Mr. Duran then authorized the transfusion, which the hospital provided. The hospital behaved appropriately, since it was simply following the court's order, but the court behaved improperly in allowing Ms. Duran's directive to be overridden. Had a health care professional overridden it on his or her own, it would represent a paradigmatic case to which wrongful living liability should attach. *See In re* Duran, 769 A.2d 497 (Pa. Super. Ct. 2001). Also, Ms. Duran's directive was likely the sort that the *Werth* court was looking for, but it is not clear that this level of specificity is what ought to be required of all patients.

[148] Rodriguez, *supra* note 29, at 63 ("Lawsuits against physicians and providers who administer unwanted life-sustaining treatment represent the 'incentive' mechanisms for change. Lawsuits may provide the effective pressure needed to change a medical culture that too often insists on prolonging life without regard for the patient's condition or desires. History establishes that the fear of liability works, and works quickly.").

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### *1. Economic Damages*

When a patient is saved against his or her will, he or she is faced with a variety of expenses that would not have otherwise accrued, including general costs of living and extraordinary medical expenses. Cause-in-fact analysis is quite straightforward here; if the patient had been allowed to die, he or she would not have incurred any of these pecuniary expenses. Proximate causation is what seems to have frustrated the courts and many commentators, but those who would deny recovery for living expenses and all but the most direct medical expenses seem to be ignoring or misapplying some basic principles of tort law.

Recall the case of Edward Winter, discussed previously,[149] in which the court denied recovery for medical expenses beyond those stemming immediately and directly from the patient's unwanted resuscitation, and was willing to allow recovery only for things such as ribs broken during CPR or burns sustained during defibrillation. The court held that Mr. Winter's stroke, which occurred a few days after the unwanted resuscitation, was not caused by the defendant's act of resuscitation, and that the stroke actually cut the causal chain that would otherwise link the resuscitation to later medical expenses.[150] However, to the extent the defendant's acts caused Mr. Winter's life and pre-existing medical condition to continue and this condition led to his stroke, the reasoning by which courts hold tortfeasors liable for harms to "eggshell" plaintiffs in more traditional contexts should apply to Mr. Winter's case as well.[151]

The tortious act of resuscitation set in motion a chain of events for which the defendant ought to be liable even if the harm that actually occurred was greater than the defendant may have foreseen, for it is a well-established exception to the foreseeability requirement of proximate cause that the tortfeasor must take his victim as he finds him.[152] Because Mr. Winter suffered from pre-existing medical problems that could have contributed to his stroke, it is not outrageous to claim that the defendants who ignored his refusals of

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[149] *Supra* notes 57-65 and accompanying text.

[150] *Anderson* III, 671 N.E.2d at 225.

[151] Under the "eggshell plaintiff" rule, a plaintiff with a pre-existing physical or mental condition (or other relevant characteristic) may recover for physical harms resulting from a defendant's tortious conduct, even when the harms are "of a greater magnitude or different type than might reasonably be expected." *See generally* RESTATEMENT (THIRD) OF TORTS § 31 (2005); RESTATEMENT (SECOND) OF TORTS § 461 (1965). Thus, if a defendant pushes a plaintiff in a way that would not have caused any serious injury to a typical person, but that plaintiff just so happens to have extremely thin bones many of which are broken by the push, the defendant will be held liable for those more extensive injuries.

[152] This mirrors the results some courts have reached in cases of negligent sterilization, allowing parents to recover for the extraordinary expenses (those going beyond normal child rearing costs) associated with raising a mentally or physically handicapped child born—but not disabled—as a result of the physician's mistake. *See, e.g.*, Emerson v. Magendantz, 689 A.2d 409 (R.I. 1997); Fassoulas v. Ramey, 450 So. 2d 822 (Fla. 1984).

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care should be held liable for all future medical expenses he incurs, unless a superseding cause breaks the causal chain. It may seem a harsh outcome, but as between the parties it would be even more severe to impose the costs on the patient who actively sought to avoid the harm, particularly given that significant leeway is provided for reasonable (and even unreasonable, up to the point of recklessness) physician mistakes. Patients like Mr. Winter should not have to deplete their life savings or those of their families to pay for care made necessary against their will.[153]

With regard to claims for general expenses associated with continued living, however, the analysis becomes somewhat more difficult. Some may find it problematic for a patient, particularly one who is living a relatively good life, to be freed from all living expenses from the point of the wrongful resuscitation onward, since that appears to offer an extraordinary windfall. However, no matter how good the patient's current life is following unwanted care, these intangible benefits do not relate to the economic interests that were harmed, and thus cannot appropriately be used to offset the purely economic harms resulting from continued life which are our focus at the moment.

If the patient obtains royalties for writing a book about the ordeal, for example, or can continue to earn some income, it may indeed be a windfall not to take those sums into account when assessing economic damages.[154] However, the simple joys of existence do not represent a double benefit in this context, because they will not pay the bills. This is precisely the rationale behind the benefits rule provided by the *Restatement (Second) of Torts,* which explains: "[W]hen the defendant's tortious conduct has caused harm to theplaintiff. . . and in so doing has conferred a special benefit *to the interest of the plaintiff that was harmed*, the value of the benefit conferred is considered in mitigation of damages."[155] When the benefit is conferred to an interest other than the one at issue, however, the mitigation principle does not apply.

Applying this rule, some courts facing wrongful pregnancy and conception suits,[156] although in the minority, have rightly set aside the potential emotional benefits associated with becoming a parent when analyzing claims for economic damages. These courts have been willing to allow recovery of the entire cost of raising an unplanned child born as a result of the defendant's

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[153] *See, e.g.*, David Margolick, *Patient's Lawsuit Says Saving Life Ruined It*, N.Y. TIMES, Mar. 18, 1990, at A1 (discussing the fact that Winter depleted his $100,000 life savings, which he intended to leave to his family upon his death, paying for post-resuscitation medical bills).

[154] RESTATEMENT (SECOND) OF TORTS, BENEFIT TO PLAINTIFF RESULTING FROM DEFENDANT'S TORT § 920 illustrations 5 & 6 (1979).

[155] *Id.* (emphasis added); *see also* Comment b ("Damages resulting from an invasion of one interest are not diminished by showing that another interest has been benefited.").

[156] In these suits, parents seek recovery for violation of their rights to reproductive freedom, including the rights to receive non-negligent sterilization and abortion services or to make informed decisions for themselves about whether to terminate a pregnancy.

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negligence, not just limited to medical and other extraordinary expenses.[157] The courts' reasoning in awarding these extensive damages is simple: the parents were owed a duty of care that was breached by a faulty procedure, and the tortfeasor should be held responsible for the entire loss that the tortfeasor caused.[158]

Similarly, in wrongful living actions, the patient actively sought to avoid life-sustaining treatment that he or she had a right to refuse by drafting an advance directive, and the accrual of living expenses that would not otherwise exist is just one of many foreseeable consequences of the physician's failure to respect that right. Thus, applying standard tort principles, when a health care provider recklessly or intentionally violates a patient's refusal of care, that patient should be permitted to recover for all of the pecuniary expenses resulting from the violation of the right to refuse. Courts have extensive experience in drawing lines based on proximate causation and should not be blinded by the fact that these cases involve recovery for continued life. The rules that apply elsewhere ought to apply here as well.

Allowing recovery of living expenses in addition to medical expenses will create a situation in which physicians are appropriately discouraged from violating refusals of care made even by those who are likely to have an objectively excellent physical quality of life if saved. If physicians were held liable only for medical expenses, they would have every incentive to avoid erring on

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[157] For example, in dicta, the *Emerson* court stated that when a physician is placed on actual or constructive notice that the patient seeking sterilization has a reasonable expectation of giving birth to a disabled child, the entire cost of raising such a child should be recoverable. *Emerson*, 689 A.2d at 414; *see also* Lovelace Medical Center v. Mendez, 805 P.2d 603 (N.M. 1991); Marciniak v. Lundborg, 450 N.W.2d 243 (Wis. 1990) (both applying traditional tort principles to allow recovery of all reasonably foreseeable damages resulting from negligent sterilization, without offsetting either the economic or emotional benefits of having a healthy child). The New Mexico Supreme Court specifically concluded that applying emotional benefits to economic loss fails to apply similar benefits to similar losses, as the *Restatement* requires. *Lovelace*, 805 P.2d at 613. Similarly, the Wisconsin Supreme Court refused to offset emotional benefits against economic losses, and also refused to mitigate economic losses, on the grounds that the economic benefits of having an unwanted child were insignificant. *Marciniak*, 450 N.W.2d at 248-49. However, such results are relatively uncommon; most courts addressing pregnancy-related torts are unwilling to permit recovery of foreseeable child rearing costs. *See generally* Russell G. Donaldson, Annotation, *Recoverability of Cost of Raising Normal, Healthy Child Born as a Result of Physician's Negligence or Breach of Contract or Warranty*, 89 A.L.R., 4TH 632, § 3 (1991) (analyzing the many wrongful pregnancy, conception, and birth cases in which courts have determined that parents may not recover for the typical costs of rearing and educating an unwanted child).

[158] *Emerson*, 689 A.2d at 418 (Bourcier, J., dissenting) (citing Ochs v. Borrelli, 445 A.2d 883, 885 (Conn. 1982)):

> [T]he better rule is to allow parents to recover for the expenses of rearing an unplanned child to majority when the child's birth results from negligent medical care. The defendants ask us to carve out an exception, grounded in public policy, to the normal duty of a tortfeasor to assume liability for all the damages that he has proximately caused. . . . But public policy cannot support an exception to tort liability when the impact of such an exception would impair the exercise of a constitutionally protected right.

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the side of life for those patients who would likely have a bad outcome. However, physicians would also have every incentive to save those likely to have a good outcome, regardless of whether the patient had refused care or not, because there would be no extraordinary medical expenses for these patients to recover.

Although it may seem as though this incentive structure gets things right, because the discretion to save a patient who is likely to have a good outcome appears desirable, Cindy Werth's case proves precisely why that cannot be so. Individuals subjectively value their lives differently, and physical health is not relevant to the question of whether a patient's interests were harmed; rather, it is relevant only to the question of magnitude, and even there it is only one of many factors. Patients refuse care on many grounds beyond the fear of bad outcomes; we have given competent patients the right to do so regardless of their reasons. Physicians cannot decide which sorts of lives will be worth living for their patients. This is the point of recognizing advance directives, but allowing patients who seem to have good health outcomes no economic recovery for wrongful living risks encouraging physicians to do just that.[159]

Moreover, allowing expansive pecuniary damages for wrongful living irrespective of the quality of life that ensues from the medical intervention has the additional advantage of avoiding the need for courts to engage in controversial quality-of-life analyses. Instead, the court must only find as a factual matter that the patient is facing concrete expenses that would have been avoided had his or her wishes been followed. The damages may be steep, but that will simply encourage those charged with implementing a patient's end-of-life wishes to behave appropriately.

### *2. Non-economic Damages*

Unfortunately, difficult quality of life issues cannot be avoided when dealing with damages for pain and suffering. Perhaps this explains why many wrongful living commentators have been willing to surrender on this point.[160] Nonetheless, nonpecuniary damages are generally recoverable in tort actions and are certainly part of the harm associated with having one's refusal of

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[159] This discussion also explains why it is so important to avoid having the outcome of the physician's interventions cloud our judgment as to whether the physician's behavior was appropriate.

[160] For example, Milani makes an argument against wrongful living, but suggests that patients should be able to recover in battery for the cost of their unwanted medical care. Thus, his argument against wrongful living is not against the claim *per se*, but rather against the recovery of pain and suffering damages, which he rejects because it would require the courts "to decide whether life with a disability is worth living." Adam A. Milani, *Better Off Dead Than Disabled?: Should Courts Recognize a "Wrongful Living" Cause of Action When Doctors Fail to Honor Patients' Advance Directives?*, 54 WASH. & LEE L. REV. 149, 228 (1997); *see also* Donahue, *supra* note 65, at 413 ("A possible solution to mitigate the courts' reluctance or inability to award general damages for the violation of the right to refuse medical treatment would be to allow only special damages for the medical expenses and extraordinary costs incident to the plaintiff's continued living.").

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care ignored. Thus, the difficulty of calculating non-economic damages in this context should not be treated as an adequate justification for withholding such damages entirely.

Some commentators have suggested that when the injury to be compensated is life itself, the determination of non-economic damages is metaphysically impossible. Compensatory damages are generally calculated by comparing the victim's pre-tort condition to the post-tort condition and making up the difference. In this context, however, we would have to compare the benefits and harms of the patient's post-tort state (life) with those of the position the patient would have occupied if not for the commission of the tort (death, or perhaps more generally speaking, nonexistence). Because life is knowable and death is not, many have argued that the necessary comparison between the two states simply cannot be achieved.[161]

However, courts have acknowledged that the right to refuse even life-sustaining treatment implicates patients' constitutional liberty interests and, often, statutory rights. We have already recognized as a policy matter, therefore, that in some situations and for some people some conditions may be at least subjectively worse than death and the preservation of life may constitute an actual injury.[162] Therefore, even if we do not know the exact values of the comparisons we are making, we do know their relative values and we should not allow our ignorance to create the legal fiction that there was no

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[161] *See, e.g.*, Milani, *supra* note 160, at 222:

> There are no damages available that can put the patient in the position in which he would have been if not for the health care provider's failure to honor the advance directive: if the defendant had not acted, the plaintiff would be dead. A computation of damages "would require the trier of fact to measure the difference in value between life in an impaired condition and the 'utter void of nonexistence." Such an endeavor, however, is literally impossible. . . . [M]an "who knows nothing of death or nothingness' simply cannot affix a price tag to non-life."

Similar arguments have been made in the context of wrongful life suits. In these cases, disabled children whose conception or birth allegedly resulted from a medical provider's negligence in not providing accurate information to the child's parents—for example, misdiagnosing a hereditary condition, misrepresenting the risks associated with conception or delivery, or misinterpreting a diagnostic test—essentially argue that they should have never been conceived or should have been aborted. Thus, the harm for which they seek compensation is essentially their very existence, rather than a violation of their right to medical self-determination. Most jurisdictions reject these claims on the grounds that a child cannot be harmed by life. *See, e.g.*, Robak v. United States, 658 F.2d 471, 474 (7th Cir. 1981). However, California, Washington, and New Jersey permit wrongful life claims, though limiting available damages to extraordinary expenses associated with the disability or impairment. *See* Turpin v. Sortini, 182 Cal. Rptr. 337 (Cal. 1982); Harbeson v. Parke-Davis, Inc., 656 P.2d 483 (Wash. 1983); Procanik v. Cillo, 478 A.2d 755 (N.J. 1984).

[162] *See* Strasser, *supra* note 43, at 70; Peters, *supra* note 86, at 691 ("At the end of life, state courts and legislatures have already made the crucial policy decision that the prolongation of life is not always a blessing."); Alan J. Belsky, Comment, *Injury as a Matter of Law: Is This the Answer to the Wrongful Life Dilemma?*, 22 U. BALT. L. REV. 185, 223 (1993) ("Right-to-die cases evidence some concession by courts that life may not always be preferable to nonexistence").

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non-economic injury at all. Instead, we can recognize the injury resulting from violation of a patient's wishes by using a proxy measure of damages comprised of entirely knowable elements: a comparison of the relative benefits and burdens of continued life.

Here, the "same interests" principle of the *Restatement*'s benefit rule is unproblematic, because nonpecuniary benefits would be offsetting only nonpecuniary harms. If the hedonic benefits of continued life truly outweigh the pain and suffering experienced by the patient kept alive against his or her will, the patient is better off alive and there could be no recovery of this particular type of damages. However, it cannot be the case that, as a matter of law, the benefits of life always outweigh the burdens; again, continued life can be an injury. Therefore, we must not import the "blessings" doctrine created in the context of pregnancy-related jurisprudence to wrongful living.[163] If the burdens of continued life are so bad as to outweigh the joys (perhaps as in the experience of Brenda Young), the patient truly may have been better off dead and should be compensated for having been harmed in this way.[164]

There is nothing inherently wrong about the patient making this determination, because we can assume this balancing was precisely why he or she refused care in the first place. The more difficult issue, however, is that to recover, the patient must prove to the court that he or she is objectively worse off, for courts are not satisfied to award damages based on a patient's subjective view of harm.

Unsurprisingly, having courts involved in this sort of quality of life assessment worries disability rights advocates. They fear it would inevitably amount to a governmental endorsement of the idea that certain types of lives ought not be lived, which could lead to dangerous results for vulnerable groups of people enjoying precisely those sorts of lives.[165] However, aside from the fact that autonomous individuals should not be used as pawns in the disability rights debate,[166] this fear is unfounded.

The courts would not be announcing a public policy that certain types of patients are better off dead. Instead, they would simply be signaling agreement

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[163] Many courts faced with wrongful birth claims have rejected or limited the parents' recovery for emotional damages on the ground that the birth of a child is always a blessing. Michael T. Murtaugh, *Wrongful Birth: The Courts' Dilemma in Determining a Remedy for a "Blessed Event,"* 27 PACE L. REV. 241, 258 (2007).

[164] *See* Peters, *supra* note 86, at 696 (noting that many commentators argue that, to win a wrongful living claim, patients must show that they would be better off dead because otherwise there is no injury); Daniel Pollack et al., Anderson v. St. Francis-St. George Hospital: *Wrongful Living from an American and Jewish Legal Perspective*, 45 CLEV. ST. L. REV. 621, 635 (1997) (arguing that "damages for 'wrongful living' can only exist if the life one is left with is worse than not living at all").

[165] *See generally* Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141 (2005); Milani, *supra* note 160, at 154 (arguing that recognition of wrongful living causes of action would be inappropriately detrimental to disabled populations).

[166] Alicia Ouellette, *Disability and the End of Life*, 85 OR. L. REV. 123, 176 (2006).

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with the patient's own assessment that a certain quality of life is essential, an assessment that patients have the right to make for themselves.[167] Enforcement of that assessment would "send a message that patient rights must be respected, not a message that other patients with a similar prognosis must decline care."[168] In fact, courts would have an opportunity to make this evaluation only if the patient had already made it personally; if a patient wished to receive life-sustaining care but was denied, no court could withhold recovery for wrongful death based on the conclusion that the patient's wish was not appropriate, except perhaps if the care was deemed to be futile. Because wrongful living would not require a court or any other person to independently decide for someone else that a particular sort of life is injurious, recognition of the cause of action does not pose a threat to anyone.

Thus, the pain and suffering damages experienced by wrongful living plaintiffs are in some way calculable and recognizing them would not burden those who would prefer not to refuse care. Additionally, because pain and suffering damages are always somewhat subjective, they will be no more difficult to prove in the context of wrongful living than they are for any other tort.

However, patients like Cindy Werth pose a unique problem in this context. Given their favorable medical outcome, they will have a difficult time establishing that they would have been better off dead. Nonetheless, compensation for economic damages alone seems insufficient in light of the fact that such patients have certainly suffered real emotional damages from having some of their fundamental religious beliefs ignored and autonomy trampled.

In fact, the *Restatement*'s benefit rule has an "equitable considerations" clause that accounts for precisely this sort of problem. While we saw previously that the rule is intended to prevent a windfall and ensure the victim's recovery is limited to the harm actually incurred, it is explicitly not intended to permit the tortfeasor to force a benefit on another against his or her will. Thus, no mitigation of damages is required when application of the rule would create such a result.[169] Because wrongful living plaintiffs specifically sought

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[167] Peters, *supra* note 86, at 700 ("In an action for unconsented treatment, the jury's task is aided by their knowledge that the patient or her proxy felt certain enough about the harmfulness of the unwanted treatment to forego the chance of a longer life."); *see also* Ouellette, *supra* note 166, at 182 ("One person's preference to terminate treatment is not a judgment about the value of another person's life. It is a statement about that individual only: that for this person, with this history, this experience, and this existence, the treatment is not wanted.").

[168] Peters, *supra* note 86, at 695.

[169] RESTATEMENT (SECOND) OF TORTS § 902, cmt. f (1979). This comment provides the following example: "When a person has land or chattels that he has devoted to a particular purpose, he is entitled to continue to use them for that purpose, and the person who interferes with the use is not entitled to have damages mitigated by the fact that he has added to their market value." Similarly, a patient ought to be entitled to devote his or her body to a particular purpose, for example, serving God, and should not have damages mitigated by someone else's version of value.

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to avoid the "benefit" conferred upon them, they ought to be permitted to recover for the serious dignitary harms associated with having one's refusal of care violated regardless of how well their lives proceed thereafter.

Finally, there is one additional hurdle to overcome before we can conclude that damages for pain and suffering should be recoverable in the wrongful living context: namely, the argument that monetary damages will not actually compensate for the harm suffered. Compensatory damages are intended to restore the plaintiff as closely as possible to a pre-tort state, once again making the plaintiff "whole." This goal is easily accomplished when it comes to economic harms because money lost can be restored. But, when it comes to pain and suffering, money is impotent.

Some commentators have relied on this mismatch to argue that pain and suffering damages are inappropriate in the context of wrongful life,[170] and these arguments are equally applicable to wrongful living. For example, Steinbock asserts a paradox at the heart of the argument for general damages: "The more serious the impairment, the stronger the claim for large damages, but the less the award is capable of compensating the [plaintiff] for the injury. Once such a [plaintiff] has recovered for his or her medical expenses, how can further financial awards be *compensation*?"[171] On similar grounds, some tort reform proposals suggest the elimination of noneconomic damages altogether.[172]

However, the fact remains that pain and suffering damages are part of the package to which tort victims are generally entitled, assuming they can be proven. Until that policy changes in all contexts, there is no reason to treat wrongful living plaintiffs differently. Money may be an inadequate form of compensation, but it is often the best we can offer.

At this point, it would be helpful to summarize the sort of wrongful living variant we have crafted. Physicians could rest assured that, if they avoid recklessness or intentional disregard of a patient's wishes, they will not be held liable. Some patients may thereby be saved when they would have preferred to die, but such errors are an unavoidable casualty of allowing room for the sort of interpretive discretion that physicians as agents must be granted. However, when a physician has behaved inappropriately in saving a patient, he or she could be held liable for wrongful living and would be responsible for all of the pecuniary and nonpecuniary losses flowing from the tortious behavior.[173]

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[170] *See supra* note 161 (discussion of these claims).

[171] Bonnie Steinbock, *The Logical Case for "Wrongful Life,"* HASTINGS CTR. RPT., Apr. 1986, at 15, 20.

[172] Joseph H. King, *Pain and Suffering, Noneconomic Damages and the Goals of Tort Law*, 57 SMU L. REV. 163 (2004).

[173] If the physician behaved particularly badly, punitive damages may be appropriate as well. *See* Milani, *supra* note 160, at 225 n.355:

> The physician who continues to treat the patient and who disregards the patient's instructions forbidding use of life-sustaining procedures is chargeable with a conscious, knowing disregard

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This combination of payments would compensate the patient to the fullest extent that tort law is capable. It also would provide an excellent counterweight to the liability physicians currently face for wrongful death, the fear of which has entrenched the rule in favor of life as more than just a default.[174] With the possibility of significant damages for saving people against their will rather than allowing them to die, hospital counsel will no longer be able to assert that they prefer a wrongful living suit to a wrongful death suit.[175]

## CONCLUSION

There may be some rights that, for reasons of public policy, must remain without a remedy, but the right to refuse medical care through the use of advance directives is not one of them. A patient's refusal of care can be enforced without having a detrimental impact on any other party who might have made a different choice for himself or herself, and without weakening the traditional default rule in favor of life. When a patient has made no statement of wishes or only an unclear statement, the rule that assumes the patient desires life-saving or life-sustaining care is unproblematic, or at the very least supportable. However, there is no reason that this rule should be permitted to crowd out those who have made clear statements to the contrary. The goal should always be to preserve patient autonomy to the fullest extent possible. In some cases, we can only guess what the patient would want, but in others the patient has already told us.

Unfortunately, evidence suggests that, even in these latter cases, patient wishes are often not fulfilled and the patients are being saved against their will with some frequency. The current legal structure has proven impotent to resolve this problem. By failing to recognize that wrongful living is merely a particular instantiation of more traditional torts presenting somewhat unique (though resolvable) damage issues, the courts have unnecessarily complicated matters. They have created a situation in which it is always safer to save

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of the patient's legal right. Such knowing disregard for the patient's legal right, whether for good motives or ill, cannot be tolerated. Punitive damages are appropriate in these cases, regardless of the caregiver's motives in disregarding the patient's instructions.

[174] Hackleman, *supra* note 106, at 1370 (suggesting a similar ensemble of damages for wrongful living, including consequential damages for pain and suffering resulting from prolongation of life, dignitary damages based on mental distress, medical costs caused by survival, and punitive damages in appropriate cases).

[175] *See supra* notes 72-73 and accompanying text. If public policy concerns surrounding a court's declaration that a patient's life is an injury are too great (even if illogical), allowing recovery of pecuniary damages alone will likely serve a sufficient deterrent function, though it will be less than fully compensatory. Incremental changes in this arena are better than none. We may hope for progressive realization of, and appropriate compensation for, the full injury associated with having one's end-of-life wishes ignored, but allowing weaker recovery is better than allowing no recovery at all.

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patients rather than risk a wrongful death suit. This leaves patients to bear the externalities of that "play-it-safe" mentality—namely, the costs of medical care and other harms they had specifically sought to avoid.

However, because behavior is influenced by the threat of liability, allowing patients to recover for all of the harms flowing from the violation of their right to refuse care could go a long way toward changing the intolerable status quo. It could accomplish this while still leaving room for the fact that perfect clarity can rarely be achieved in the expression of end-of-life wishes. If we allow liability for both wrongful death and wrongful living, then fear of liability itself may cease to be a driver of physician behavior. Instead, facing potential liability on both fronts, the "only legally prudent thing to do would be to act in good faith, consistent with the patient's wishes as expressed by that patient or the patient's family, and in accordance with good medical practice."[176] We cannot ask for more.

However, recognition of wrongful living is not a panacea.[177] Huge strides must still be made in improving advance directives, helping people reflect upon their end-of-life wishes and how they might change or adapt, and finding new ways to ensure that those responsible for decision-making once a patient can no longer speak for himself or herself are guided as closely as possible by the patient's desires. There is little, though, to drive those important changes if no real consequences exist for failure to adhere to even the clearest refusals of care. Permitting recovery for wrongful living against health care professionals and medical institutions would provide a helpful shift in the right direction.

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[176] Gasner, *supra* note 30, at 504.

[177] For example, although recognition of wrongful living claims will help improve autonomy at the end of life, without the possibility of physician-assisted suicide or even voluntary euthanasia, there is no direct remedy for the inherent difficulties associated with predicting, from an *ex ante* perspective, which treatments we will find worthwhile and which will do no more than preserve us in a state of misery. *See* Savulescu, *supra* note 77.