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Nadia N. Sawicki

Loyola University Chicago, School of Law, nsawicki@luc.edu

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NADIA N. SAWICKI

A New Life for Wrongful Living

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ABOUT THE AUTHOR: Nadia N. Sawicki is an Assistant Professor of Law at the Beazley Institute for Health Law & Policy at Loyola University Chicago School of Law. The author wishes to thank Peter Strauss, the Justice Action Center, and the organizers of this symposium, *Freedom of Choice at the End of Life: Patients' Rights in a Shifting Legal and Political Landscape*, for crafting such a well-planned and inspirational event. Her thanks also go out to all the symposium participants, particularly Lisa Comeau, David Leven, Carlin Meyer, Ann Neumann, Alicia Ouellette, Thad Pope, Bonnie Steinbock, and Kathryn Tucker for their insightful commentary. The research for this article was conducted during a semester's research leave generously provided by Loyola University Chicago School of Law, supported by the American Bar Foundation's Visiting Scholar program, and facilitated by the valuable research assistance of Loyola law student Joshua Wood.

A NEW LIFE FOR WRONGFUL LIVING

I. INTRODUCTION

A patient has an indisputable right under federal and state laws to set forth her wishes for end-of-life medical care in an advance directive or other legal document, or by way of a health care proxy.¹ Such directives are legally binding in that they can be used to enjoin a medical provider from administering life-sustaining care against the patient's wishes.² However, if a medical provider wrongfully provides treatment in contravention of the patient's directive, the force of this directive essentially vanishes. For the past few decades, patients in such situations have been unable to recover in tort for the injury of suffering unwanted life-sustaining treatment, commonly referred to as the tort of "wrongful living" or "wrongful prolongation of life."³

For years, the right to set limits on the care one receives at the end of life has been described as an "illusory protection,"⁴ a "false promise,"⁵ and a "right without a remedy."⁶ Countless scholars have written critically about the failure of tort law to accommodate claims of wrongful living,⁷ described as recently as 2011 as a cause of action that "has not gained traction."⁸ Judging by the most recent legal scholarship,

1. See Omnibus Budget Reconciliation (Patient Self-Determination) Act of 1990 § 4206, 42 U.S.C. § 1395cc(f) (2012); BARRY FURROW ET AL., *HEALTH LAW* 840–49 (2d ed. 2000).
2. See, e.g., *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 220–27 (Cal. Ct. App. 1984) (finding, after patient's death, that trial court erred in denying an injunction ordering withdrawal of life-sustaining treatment for patient who had executed a living will); *Delio v. Westchester Cnty. Med. Ctr.*, 516 N.Y.S.2d 677, 679–81 (2d Dep't 1987) (authorizing discontinuance of treatment based on evidence of patient's clearly expressed wishes while competent); *Blackman v. N.Y.C. Health & Hosps. Corp.*, 660 N.Y.S.2d 643, 649 (Sup. Ct. Kings Cnty. 1997), *rev'd on other grounds*, 671 N.Y.S.2d 339 (2d Dep't 1998) (directing hospital to withhold medical treatment in light of evidence of patient's clearly expressed wishes while competent).
3. See generally A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625 (1986) (defining "wrongful living"). Note, however, that the tort of wrongful living is not an independent cause of action: the term is used to describe a tort claim of battery or negligence when the resulting injury is the unwanted extension of life. See Holly Fernandez Lynch, Michele Mathes & Nadia N. Sawicki, *Compliance with Advance Directives: Wrongful Living and Tort Law Incentives*, 29 J. LEGAL MED. 133, 141–42 (2008). As the Ohio Supreme Court explained in one of the most frequently cited wrongful living cases, "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." *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 227 (Ohio 1996).
4. Marni J. Lerner, *State Natural Death Acts: Illusory Protection of Individuals' Life-Sustaining Treatment Decisions*, 29 HARV. J. ON LEGIS. 175 (1992).
5. Henry S. Perkins, *Controlling Death: The False Promise of Advance Directives*, 147 ANNALS INTERNAL MED. 51 (2007).
6. Mark Strasser, *A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right to Bodily Integrity*, 36 SAN DIEGO L. REV. 997, 1040 (1999); see also Maggie J. Randall Robb, *Living Wills: The Right to Refuse Life Sustaining Medical Treatment—A Right Without a Remedy?*, 23 U. DAYTON L. REV. 169 (1997); S. Elizabeth Wilborn, *The Right to Refuse Medical Treatment: Where There Is a Right, There Ought to Be a Remedy*, 25 N. KY. L. REV. 649 (1998).
7. See, e.g., Lynch et al., *supra* note 3; Perkins, *supra* note 5; Strasser, *supra* note 6.
8. Nicole Marie Saitta & Samuel D. Hodge, Jr., *Wrongful Prolongation of Life—A Cause of Action That Has Not Gained Traction Even Though a Physician Has Disregarded a "Do Not Resuscitate" Order*, 30 TEMP. J.

patients seeking ex post enforcement of their wishes to refuse life-sustaining medical treatment essentially have no legal recourse.

This article is one of the first to offer an ultimately optimistic perspective about the viability of tort claims for wrongful prolongation of life.⁹ A variety of recent developments—including favorable jury verdicts, legal settlements, supportive judicial commentary, and proposed legislation—suggests that plaintiffs seeking recovery for a wrong that has traditionally been considered non-compensable may have greater success in the future.

Part II of this article explains the basis of patients' rights to refuse life-sustaining treatment and prepare legal directives to preserve the right to refuse when they lack competence. Part III traces the history of tort claims for medical providers' refusal to comply with patients' wishes to limit care at the end of life and explains the reasons why courts have been unwilling to recognize such claims. Part IV outlines a series of promising legislative, administrative, and judicial developments suggesting that there may yet be a life for the wrongful living cause of action. Finally, Part V provides concrete recommendations for patients who want to ensure that their end-of-life preferences will be respected and for advocates tasked with seeking recovery on behalf of patients who have not been so fortunate.

II. SOURCES OF PATIENTS' RIGHTS

The patient's right to refuse unwanted medical care has long been recognized as a fundamental principle of health law.¹⁰ It took decades, however, for legal consensus to form about whether this right extends to the refusal of life-sustaining treatment, such as mechanical ventilation, cardiopulmonary resuscitation (CPR), and artificial nutrition and hydration. These treatments are unique as compared to traditional medical care because they are absolutely necessary for the sustenance of life. If a patient chooses not to take an antibiotic that has been prescribed for her, for example, she may not recover from her illness as quickly, but it is unlikely that she will die. In contrast, a patient whose heart stops beating but who has signed a do-not-resuscitate order will necessarily die, as will the patient who is unable to take food or water by mouth and refuses artificial nutrition and hydration, or the patient who is unable to breathe on her own and refuses mechanical ventilation.

SCI. TECH. & ENVTL. L. 221, 221, 238 (2011) (concluding that "[t]he only viable remedy" for ensuring compliance with end-of-life wishes is by way of an injunction, and that recovery of damages is "not a realistic option at the present time.").

9. Authors of law review articles frequently claim, perhaps with an excess of confidence, that they are among the first to make an important point or address an undiscovered topic. In this instance, the claim is actually true. Of the forty-three law review articles published since 2000 that include the terms "wrongful living" or "wrongful prolongation of life," only one other article, authored by Thaddeus Mason Pope of Hamline University School of Law and published in 2013, has likewise offered a generally optimistic perspective on the viability of such claims. *See infra* note 29.
10. *See, e.g.,* *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129–30 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.").

Following the patients' rights movements of the 1960s,¹¹ state courts took the lead in clarifying that patients can legitimately rely on theories of tort law to protect themselves from unwanted medical care, even if the consequence of their refusal is death. In *Bouvia v. Superior Court*, for example, a California appellate court held that that the penumbral constitutional privacy right identified by the U.S. Supreme Court in *Griswold v. Connecticut* extends to a competent, non-terminal patient's right to refuse life-sustaining nasogastric feeding.¹²

Judicial decisions like that of the New Jersey Supreme Court in *In re Quinlan* also led the way in establishing that a patient's right to refuse life-saving treatment may be exercised by a surrogate or legally appointed guardian on the patient's behalf.¹³ The U.S. Supreme Court addressed this issue in 1990 in *Cruzan v. Director, Missouri Department of Health*, a case challenging Missouri's requirement that proof of an incompetent patient's wishes to refuse treatment be established by clear and convincing evidence.¹⁴ The Court's decision was somewhat unusual in that it did not definitively establish a constitutional right to refuse life-sustaining care—rather, the Court merely “assume[d]” for the purposes of the case at hand “that the United States Constitution would grant a competent person a constitutionally protected right to refuse life-saving hydration and nutrition.”¹⁵ The decision in *Cruzan* capped off a long scholarly and legislative push towards increasing patients' use of advance directives to document their end-of-life wishes.¹⁶

Cruzan was decided in June 1990. In November 1990, Congress passed the Patient Self-Determination Act (PSDA), a seminal piece of legislation that made patients' rights at the end of life even more concrete.¹⁷ The PSDA requires that all health care facilities receiving Medicare and Medicaid funding provide admitted patients with written information about their legal rights to refuse medical treatment and to execute advance directives, as well as about the facility's policies and procedures

11. See Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. & MED. 147, 150–53 (1994) (describing the patients' rights movement). These developments were perhaps most clearly visible in the realm of mental health treatment. See generally PAUL APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 10–11 (1994).
12. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 301–05 (Ct. App. 1986) (citing *Griswold v. Connecticut*, 381 U.S. 479 (1965)).
13. See generally *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (holding that the father of a patient in a persistent vegetative state may be appointed as her guardian to authorize termination of mechanical ventilation).
14. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).
15. *Id.* at 279.
16. The first scholarly proposal of living wills appears to be a 1969 article by Louis Kutner in the *Indiana Law Journal*. See generally Louis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969). The first state-law living will act, the California Natural Death Act, was adopted in 1977. Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 10 EST. & TR. J. 134, 135 (1990). By 1991, more than forty states had living will statutes. George J. Annas, *The Health Care Proxy and the Living Will*, 324 NEW ENG. J. MED. 1210 (1991).
17. See Omnibus Budget Reconciliation (Patient Self-Determination) Act of 1990 § 4206, 42 U.S.C. § 1395cc(f) (2012).

for complying with advance directives.¹⁸ The facilities are required to have policies in place for documenting advance directives, complying with state law regarding advance directives, and educating community and staff about issues relating to advance directives.¹⁹ Indeed, state legislation continues to play an important role in establishing patients' rights to refuse life-saving care. Today, every state has a law relating to advance directives, and most states have laws providing for a combination of living wills and durable powers of attorney or health care proxies—the essential legal tools that allow patients to exercise their end-of-life choices even after they lose competence.²⁰

III. THE WRONGFUL LIVING CAUSE OF ACTION: WHY IT HAS MET WITH RESISTANCE

Despite the well-established right to refuse life-sustaining medical treatment, and the legal authority for executing an advance directive to govern care when the patient is incompetent or otherwise unable to express her own wishes, some medical providers are nevertheless reluctant to withdraw life-saving care. Evidence of this can be found in a host of cases in which physicians, nurses, or emergency medical technicians have, against a patient's wishes, initiated or continued unwanted CPR,²¹ blood transfusion,²² open-heart surgery,²³ life support,²⁴ or artificial nutrition and hydration.²⁵ Further evidence is found in academic research about the disconnect between patients' end-of-life wishes and providers' understanding of those wishes.²⁶

18. *See id.*

19. *See id.*

20. *See* Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34:2 HASTINGS CTR. REP. 30, 31 (2004). Some of these laws are based on the Uniform Health-Care Decisions Act, approved by the Uniform Law Commissioners in 1993. *See generally* UNIF. HEALTH-CARE DECISIONS ACT, 9 pt. IB U.L.A. 88 (1993).

21. *See, e.g.,* *Self v. Milyard*, No. 11-CV-00813-RBJ-CBS, 2012 WL 3704958 (D. Colo. July 31, 2012); *Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360 (Ct. App. 1986); *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225 (Ohio 1996).

22. *See, e.g.,* *Werth v. Taylor*, 475 N.W.2d 426 (Mich. Ct. App. 1991).

23. *See, e.g.,* *Gragg v. Calandra*, 696 N.E.2d 1282 (Ill. App. Ct. 1998).

24. *See, e.g.,* *Duarte v. Chino Cmty. Hosp.*, 85 Cal. Rptr. 2d 521 (Ct. App. 1999); *Allore v. Flower Hosp.*, 699 N.E.2d 560 (Ohio Ct. App. 1997); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047 (Ohio Ct. App. 1984). *See also* Tamar Lewin, *Ignoring "Right to Die" Directives, Medical Community Is Being Sued*, N.Y. TIMES, June 2, 1996, at A1 (discussing the case of Brenda Young).

25. *See, e.g.,* *Ross v. Hilltop Rehab. Hosp.*, 676 F. Supp. 1528 (D. Colo. 1987).

26. *See, for example,* the nationwide Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) undertaken in the late 1980s and early 1990s. The SUPPORT study found that even after intensive interventions designed to improve the exchange of information about end-of-life wishes between patients and physicians, few physicians accurately understood their patients' preferences. *A Controlled Trial to Improve Outcomes for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment*, 274 JAMA 1591 (1995); Ellen H. Moskowitz & James Lindemann Nelson, *The Best Laid Plans*, 25:6 HASTINGS CTR. REP. 3,3 (1995).

Medical professionals are trained in improving health and preserving life,²⁷ and their dedication towards achieving these goals is to be commended. However, an equally unshakeable principle of medical practice is that treatments should not be administered against a patient's wishes.²⁸ Why, then, are there so many cases of physician noncompliance with advance directives? One of the most likely reasons is the fear, however unwarranted, of liability for prematurely ending a patient's life.²⁹ The medical community operates under a shadow of potential liability for malpractice—this explains the prevalence of the practice of “defensive medicine,” whereby providers administer tests or render treatments that are not beneficial, but that could be cited in a lawsuit as evidence of thoroughness and due care.³⁰

Physicians are all too aware of the threat of wrongful death litigation if a patient dies on their watch. In contrast, the likelihood (both perceived and actual) of a successful legal challenge for continuing a patient's life is limited.³¹ In the words of one hospital administrator, her institution would “rather have a wrongful liv[ing] claim than a wrongful death claim.”³² This imbalance in the threat of tort liability leads medical providers and administrators to quite reasonably conclude that the legal risks associated with terminating treatment are greater than the risks of continuing treatment.³³

These skewed tort law incentives arise because courts have traditionally been extremely reluctant to award damages when patients or their families bring suit for wrongful continuation of life.³⁴ When patients whose physicians are reluctant to withdraw unwanted treatment seek *ex ante* relief in the form of an injunction or declaratory judgment, courts have typically expressed willingness to enforce the patients' wishes, particularly if they are documented in an advance directive.³⁵ But

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27. See WALTER GLANNON, *BIOMEDICAL ETHICS* 1–2 (2005) (citing developments in medical ethics from the Hippocratic Oath onward).
 28. See TOM BEAUCHAMP & JAMES CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 117–21 (6th ed. 2009) (discussing the ethical grounding of the informed consent doctrine).
 29. See generally Thaddeus Mason Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMED. L. 213, 238–39 (2013). There are, however, many other reasons why physicians may decline to comply with patients' end-of-life wishes, including lack of awareness of a patient's advance directive, lack of communication, and conscientious objection. See Saitta & Hodge, *supra* note 8, at 229–32 (discussing why medical providers may ignore advance directives requesting withdrawal of treatment).
 30. See generally Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353 (1996).
 31. See Lynch et al., *supra* note 3, at 148–49.
 32. Judy Greenwald, *Medical Ethics and Risk Management: Liability at Life's End; Providers Risk Suits by Reviving Patients*, BUS. INS., May 20, 1996.
 33. See generally Lynch et al., *supra* note 3; Pope, *supra* note 29.
 34. See generally Lynch et al., *supra* note 3.
 35. See Saitta & Hodge, *supra* note 8, at 238 (describing injunctive relief as “the only viable remedy” at this time). See also *Rosebush v. Oakland Cnty. Prosecutor*, 491 N.W.2d 633 (Mich. Ct. App. 1992); *In re Fiori*, 652 A.2d 1350 (Pa. Super. Ct. 1995).

patients who seek ex post recovery once a rights violation has already occurred are often left with no legal remedy. There are three main reasons why patients who are provided with life-sustaining treatment against their will typically face an uphill battle when seeking damages for the injury to their right of self-determination: (A) statutory immunity for medical providers; (B) statutory and contextual limitations on the applicability of advance directives; and (C) the common law doctrine that life does not constitute an injury. Each is discussed in turn below.

A. Statutory Immunity for Medical Providers

Some state laws relating to advance directives and end-of-life care explicitly provide legal immunity for medical providers who are not willing to comply with a patient's advance directive.³⁶ State legislatures that have granted statutory immunity in these situations have weighed the interests at stake and concluded that patients should not be able to seek legal recovery if their end-of-life wishes are disregarded.³⁷ Notably, many such statutes do not distinguish between situations in which the patient has requested ongoing life support and those in which the patient has expressed a wish to stop treatment.³⁸

Typically, these statutes are drafted in a way that protects a physician from liability, provided she has used her best medical judgment.³⁹ Oklahoma's advance directive statute, for example, states that a health care provider "whose actions under the Oklahoma Advance Directive Act are in accord with reasonable medical standards" will not be subject to criminal liability, civil liability, or professional discipline with respect to those actions.⁴⁰ Nevada law provides that the physician "must give weight" to a patient's declaration of wishes, but "may also consider other factors in determining

36. See Saitta & Hodge, *supra* note 8, at 226–27 (discussing statutory immunity); Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 768–78 (1987) (noting that many immunity statutes treat advance directives as merely advisory or permissive).

37. The existence of immunity statutes such as these is somewhat odd in light of the fact that courts have typically been unwilling to recognize a common law cause of action for wrongful living. Presumably, a statutory grant of immunity would be necessary only if there were a possibility of civil or criminal liability in the absence of such a statute.

38. See *infra* text citing statutes at notes 40–42. But cf. CONN. GEN. STAT. ANN. § 19a-571 (2013) (providing immunity when a physician "withholds, removes or causes the removal of a life support system of an incapacitated patient," provided he has first "considered the patient's wishes"). There also exist "treat-til-transfer" requirements, which, as a practical matter, apply only when a patient requests ongoing treatment but the medical provider is unwilling to provide it. See ROBERT POWELL CTR. FOR MED. ETHICS, WILL YOUR ADVANCE DIRECTIVE BE FOLLOWED? (rev. ed. Dec. 2012), available at <http://www.nrlc.org/euthanasia/AdvancedDirectives/WillYourAdvanceDirectiveBeFollowed.pdf>.

39. Saitta & Hodge, *supra* note 8, at 227.

40. OKLA. STAT. tit. 63, § 3101.10(B) (2013). See also CAL. PROB. CODE § 4740 (West 2013) (providing civil and criminal immunity for providers and institutions "acting in good faith and in accordance with generally accepted health care standards . . . for any actions in compliance with [the Uniform Health care Decisions Act] . . ."); GA. CODE ANN. § 31-32-10(a)(3) (2013) (providing that failure to comply with "any direction or decision by the health care agent" will not be subject to liability provided that the decision is "substantially in accord with reasonable medical standards" and the provider cooperates in the transfer of the patient).

whether the circumstances warrant following the directions” and will not be liable if she chooses not to follow the patient’s directive.⁴¹ Minnesota law expressly provides that a health care provider who administers life-sustaining treatment against the wishes of a patient or her agent will not be subject to criminal, civil, or administrative liability, provided that the decision is made known and is documented, and the patient has an opportunity to transfer.⁴²

Ostensibly, exemptions based on best medical judgment are often included in these immunity statutes because of how the medical standard of care is defined as a matter of common law. Under state common law, a physician will be liable for malpractice only if her actions deviate from what her peers (either a majority of peers or a respectable minority) would normally do.⁴³ In other words, as long as a medical provider can demonstrate that her best exercise of medical judgment conforms to that of her peers, she would be free from liability for common law malpractice, just as she would be free from liability under the immunity statutes.

Some courts, however, have interpreted even narrowly tailored immunity statutes as completely foreclosing the possibility of liability when a physician administers or continues life-sustaining treatment against a patient’s wishes. In *Stolle v. Baylor College of Medicine*, for example, a Texas appellate court considered the claims of parents against pediatricians who used “heroic efforts” to save their brain-damaged child in contravention of a medical directive.⁴⁴ The Texas Natural Death Act explicitly provided that medical professionals would not be held “civilly or criminally liable for failing to effectuate a qualified patient’s directive.”⁴⁵ The court denied the parents’ claims, holding that the statutory immunity provided by the Natural Death Act precluded the possibility of tort liability under common law.⁴⁶ In a similar case, a California appellate court rejected a wrongful living claim on the ground that state law immunized providers from liability for failing to comply with a request to discontinue life-sustaining treatment by a patient’s attorney-in-fact or surrogate.⁴⁷

State laws that provide statutory immunity for medical providers who fail (under some circumstances, at least) to comply with patients’ advance directives make it far more difficult for such patients to recover damages when their wishes are disregarded. Accordingly, patients and their advocates must be aware of state law limitations on provider liability when considering whether litigation is even feasible in the event that a patient’s life is prolonged against her will.

41. NEV. REV. STAT. § 449.640 (2013).

42. See MINN. STAT. § 145C.11(c) (2012).

43. See generally FURROW ET AL., *supra* note 1, at 264–66 (discussing the standard of care).

44. 981 S.W.2d 709, 710 (Tex. App. 1998).

45. *Id.* at 712 (quoting TEX. HEALTH & SAFETY CODE ANN. § 672.016(b) (West 2013)).

46. *Id.* at 714.

47. See *Duarte v. Chino Cmty. Hosp.*, 85 Cal. Rptr. 2d 521, 523–24 (Ct. App. 1999).

B. Statutory and Contextual Limitations

Many patients are surprised to learn that their advance directives will not automatically go into effect when they lose competence to make medical judgments. State laws impose a variety of conditions that must be satisfied before a medical directive takes effect. The most significant of these is the requirement, codified in about half of all states, that a patient be “terminally ill” or satisfy some other physical condition—be in a permanent vegetative state, for example—before an advance directive can be used to direct her treatment.⁴⁸ Many states require that this diagnosis be confirmed by two physicians;⁴⁹ some also require a formal medical determination of lack of capacity.⁵⁰

A number of suits brought by patients to recover for unwanted continuation of life-sustaining treatment have failed when courts have determined that the conditions set forth by the state’s living will act, or by the advance directive itself, were not satisfied.⁵¹ In *Wright v. Johns Hopkins Health Systems*, for example, the Maryland Court of Appeals, that state’s highest court, noted that the state’s law provided that an advance directive becomes effective under the conditions specified by the declarant or, if no such conditions are specified, when two physicians certify in writing that the patient is not competent to make medical decisions.⁵² According to the Court of Appeals, the living will of the declarant in that case never became operative because “there [was] no evidence that any physicians certified that [he] was in a terminal condition and that his death was imminent,” as was required by the terms of his living will.⁵³

Wrongful living suits may also fail when state law narrowly defines the types of life-sustaining treatments that can be rejected or withdrawn. In *Ross v. Hilltop Rehabilitation Hospital*, for example, a Colorado district court rejected the plaintiff’s wrongful living claim because the Colorado Medical Treatment Decision Act specifically excluded artificial nutrition and hydration from its definition of “life-

48. See Lerner, *supra* note 4, at 188–97; Gelfand, *supra* note 36, at 740–47.

49. See Gelfand, *supra* note 36, at 763–66. See also *Wright v. Johns Hopkins Health Sys. Corp.*, 728 A.2d 166, 170 (Md. 1999), *superseded by statute*, Health Care Decisions Act, 2000 Md. Laws 152, MD. CODE ANN., HEALTH-GEN. § 5-608 (LexisNexis 2013), *as recognized in* *Plein v. Dep’t of Labor*, 800 A.2d 757, 765 n.5 (Md. 2002).

50. See, e.g., *Ficke v. Evangelical Health Sys.*, 674 N.E.2d 888, 888 (Ill. App. Ct. 1996) (citing Illinois statute regarding physician determination of lack of capacity). Additional requirements may apply in some states—for example, some statutes provide that an advance directive will not be deemed effective if the patient is pregnant. See generally Timothy J. Burch, *Incubator or Individual? The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Directive Statutes*, 54 MD. L. REV. 528 (1995).

51. See, e.g., *Stolle*, 981 S.W.2d at 713 (stressing that none of the treating physicians had categorized the patient’s condition as terminal); *Ficke*, 674 N.E.2d at 892 (finding that no physician had made a formal determination of lack of patient capacity).

52. 728 A.2d at 169–70.

53. *Id.* at 175.

sustaining procedures.”⁵⁴ Because the plaintiff’s claim was based on the unwanted administration of nutrition and hydration, it was unsuccessful.⁵⁵

Finally, the context in which the plaintiff’s claim is made may reduce her likelihood of success. Specifically, some courts have rejected claims that medical providers wrongfully disregarded advance directives in cases in which the patient’s directive was considered to be not contemporaneous enough with the condition that triggered a medical decision. In *Werth v. Taylor*, in which a Michigan appellate court engaged in a particularly extreme form of this kind of reasoning, the patient was a Jehovah’s Witness who believed that receiving blood transfusions was a sin.⁵⁶ When she became pregnant, she filed a written confirmation of her desire to refuse blood products at the hospital where she planned to deliver; when she was admitted for delivery, her husband signed another refusal form on her behalf.⁵⁷ However, when she experienced life-threatening uterine bleeding during delivery, her physicians provided a blood transfusion.⁵⁸ The court found that the patient’s clearly stated refusals of blood products were not applicable in a life-or-death context because they were made while she was contemplating a routine delivery, and not when “it appeared death might be a possibility if a transfusion were not given.”⁵⁹ Such reasoning strains credulity, as it would support a physician’s decision to let a patient’s condition deteriorate before providing unwanted treatment, and then to claim that the patient’s directive was inoperative because it did not contemplate a deteriorated condition.⁶⁰

Just as with the statutory immunity provisions described above, state law limitations on the contexts in which advance directives are considered valid can limit patients’ ability to recover when treatment is provided against their wishes. A patient who is not competent to express her wishes regarding life-sustaining care at the time it is needed may reasonably expect her previously stated wishes to be respected. But if, for example, state law dictates that advance directives are only effective when a patient is in a terminal condition, and the patient in question has more than six months to live, her physician may be legally justified in disregarding her earlier written directive.

C. Common Law Doctrine: Life Is Not an Injury

The final, and most important, reason why courts traditionally have rejected recovery for wrongful living is that most consider such recovery incompatible with

54. 676 F. Supp. 1528, 1534 (D. Colo. 1987) (citing COLO. REV. STAT. § 15-18-103(7) (2012)).

55. *Id.*

56. *See Werth v. Taylor*, 475 N.W.2d 426, 427–30 (Mich. Ct. App. 1991).

57. *Id.*

58. *Id.*

59. *Id.* at 430.

60. *See Lynch et al.*, *supra* note 3, at 163–64; Strasser, *supra* note 6, at 1009–10. *See also* Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984) (holding that consent to a particular treatment cannot be implied in emergency situations if the patient has clearly withheld consent to that treatment on previous occasions).

traditional principles of tort law. A tort law cause of action for negligence requires that the plaintiff demonstrate that the defendant had a duty of care, that she breached this duty, and that the breach caused a compensable injury. Many courts have held that life or human existence cannot constitute a legally compensable injury. Others have determined that, in wrongful living cases, there is an insufficient causal connection between the medical provider's actions and the harms suffered by the plaintiff. In either case, the plaintiff will have failed to satisfy the elements of the cause of action and will not be permitted to recover.

The most common roadblock in wrongful living cases is the judicial conclusion that continued life does not constitute an injury for the purposes of tort recovery. This principle arose first in the reproductive arena in the context of wrongful conception, wrongful birth, and wrongful life claims.⁶¹ Each of these claims is based on a medical provider's negligence in providing reproductive care or counseling that, according to the plaintiffs, resulted in the birth of an unwanted child.⁶² The simplest case—that of wrongful conception—might arise if a pharmacist negligently dispenses another drug instead of an oral contraceptive, and the parents claim that this negligence caused the conception and birth of an unwanted child. A more difficult case would be a wrongful life suit, in which a disabled child brings suit against her parents' physician—for example, if the parents chose to conceive and give birth to a child as a result of the physician's negligent prenatal counseling. Nearly every state prohibits wrongful life suits on the basis that a child cannot claim to be injured by having been born.⁶³ Most also prohibit wrongful birth suits, which are similar claims brought by the parents of the disabled child. As the Georgia Supreme Court noted in *Fulton-DeKalb Hospital Authority v. Graves*, “We instinctively recoil from the notion that parents may suffer a compensable injury on the birth of a child.”⁶⁴

Courts that have rejected wrongful living claims rely on similar reasoning, noting that a plaintiff cannot claim to have been injured by having his life extended. In *Anderson v. St. Francis-St. George Hospital*, an Ohio Supreme Court case that is perhaps the most widely cited in the literature on wrongful living claims, the court found that mere prolongation of life did not constitute a compensable injury.⁶⁵ “There are some mistakes,” the court wrote, “indeed even breaches of duty or technical assaults, that people make in life that affect the lives of others for which there simply should be no monetary compensation.”⁶⁶ It also held that while the plaintiff could recover for damages directly caused by unwanted resuscitation—such as burns from

61. See, e.g., *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 227 (Ohio 1996) (discussing reproductive torts in the context of a wrongful living claim).

62. See Nadia N. Sawicki, *Wrongful Pregnancy: Wrongful Life and Wrongful Birth*, 51:3 MED. TRIAL TECH. Q. 283, 283 (2005).

63. See *id.* at 286.

64. 314 S.E.2d 653, 654 (Ga. 1984).

65. See generally 671 N.E.2d at 299.

66. *Id.* at 228.

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defibrillation or broken ribs from manual resuscitation⁶⁷—other foreseeable consequences, such as the pain and suffering and medical complications that normally arise at the end of life, bore an insufficient causal connection to the unwanted resuscitation to merit recovery.⁶⁸ Numerous other courts have reached the same conclusion,⁶⁹ and many commentators have criticized this seemingly unjust result.⁷⁰ Other courts, moreover, have found that because patients and families can seek ex ante injunctive relief for noncompliance with a patient's end-of-life wishes, there is no need to permit ex post tort recovery of monetary damages.⁷¹

Judicial precedent in both the wrongful living and wrongful birth/life contexts has repeatedly emphasized the notion that life is not a legally compensable injury. Because of this narrow definition of "injury" in the context of tort litigation, patients whose lawsuits are premised on the idea that they were harmed when physicians provided them with treatment to extend their lives often have difficulty recovering in court.

IV. PROMISING DEVELOPMENTS

While tort claims seeking recovery for wrongful prolongation of life have traditionally not met with great success, a change may be on the horizon. A variety of legislative, administrative, and judicial developments suggests increased support for the idea that medical providers who disregard a patient's wish to refuse life-sustaining treatment have committed a harm for which some form of penalty is appropriate.

A. Legislative Developments

While some states provide statutory immunity for failure to comply with advance directives,⁷² others have established that medical providers may be civilly or criminally

67. See generally *Allore v. Flower Hosp.*, 699 N.E.2d 560, 563 (Ohio Ct. App. 1997) (holding that damages for injuries allegedly sustained by a resuscitated patient are limited to those connected to the battery claim).

68. See *Anderson*, 671 N.E.2d at 228–29.

69. See, e.g., *Cronin v. Jamaica Hosp. Med. Ctr.*, 875 N.Y.S.2d 222 (2d Dep't 2009) ("[T]he status of being alive does not constitute an injury in New York."); *Scheible v. Joseph L. Morse Geriatric Ctr.*, 988 So. 2d 1130, 1133–34 (Fla. Dist. Ct. App. 2008) (quoting *Kush v. Lloyd*, 616 So. 2d 415, 423 (Fla. 1992)) (holding that the Florida Supreme Court's refusal to "weigh the value of impaired life against the value of nonexistence" in a wrongful life case precluded such a determination in the wrongful living case).

70. See, e.g., *Lynch et al.*, *supra* note 3, at 134; *Strasser*, *supra* note 6, at 1038–41; 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, 275 (1992); Tricia Jonas Hackleman, *Violation of an Individual's Right to Die: The Need for a Wrongful Living Cause of Action*, 64 U. CIN. L. REV. 1355, 1381 (1996). But see 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, 227 (1997) (arguing that the wrongful living cause of action is not the best way to address these problems).

71. See, e.g., *Estate of Taylor v. Muncie Med. Investors, L.P.*, 727 N.E.2d 466, 471–72 (Ind. Ct. App. 2000).

72. See *supra* Part III.A.

liable for failure to comply with a patient's advance directive.⁷³ Statutes like these are based on the text of the Uniform Health-Care Decisions Act, which provides that "[a] health-care provider or institution that intentionally violates this [act] is subject to liability to the aggrieved individual for damages of \$[500] or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees."⁷⁴

A review of the case law, however, suggests that these laws have not been enforced when noncompliance with patient wishes results in continued life, rather than premature death.⁷⁵ Clearly, if a state wishes to provide concrete guidance about the obligation to withdraw care at a patient's request, it must enact legislation explicitly targeted at preventing such harms.

Patient advocates in New York State are currently working on a bill that would accomplish this goal.⁷⁶ Their draft proposal provides that medical providers who undertake unwanted medical treatment will not be able to receive payment or reimbursement for such care.⁷⁷ Moreover, it provides a civil cause of action for damages when unwanted medical treatment is provided.⁷⁸ This bill is an important step in recognizing the rights of patients to refuse care at the end of life and, if passed, would set a good example for other states wishing to pursue legislative solutions.

Beyond legislative proposals addressing unwanted provision of life-sustaining treatment, however, there also have been a number of promising developments in the administrative and judicial arenas. Recent decisions by administrative agencies and courts, as well as verdicts from juries, suggest an increased willingness by some

73. See *infra* note 74; Memorandum from Kathryn Tucker, (Nov. 17, 2011) (on file with author) ("Currently, fifteen states classify disregard of advance directives as a form of unprofessional conduct, seven provide for a civil cause of action, and four allow for criminal charges.").

74. UNIF. HEALTH-CARE DECISIONS ACT § 10, 9 pt. IB U.L.A. 122 (1993). For examples of state laws reflecting the uniform provision, see CAL. PROB. CODE § 4742(a) (West 2013) (\$2,500 or actual damages); HAW. REV. STAT. § 327E-10(a) (West 2013) (\$500 or actual damages); ME. REV. STAT. tit. 18-A, § 5-810(a) (2013) (\$500 or actual damages); MISS. CODE ANN. § 41-41-221(1) (West 2013) (\$500 or actual damages); N.M. STAT. ANN. § 24-7A-10(A) (West 2013) (\$5,000 or actual damages); TENN. CODE ANN. § 68-11-1811(a) (West 2013) (\$2,500 or actual damages); WYO. STAT. ANN. § 35-22-411(a) (West 2013) (\$500 or actual damages). For an example of a similar statute providing for non-monetary penalties, see TEX. HEALTH & SAFETY CODE ANN. § 166.045(b) (West 2013) ("A physician, or a health professional acting under the direction of a physician, is subject to review and disciplinary action by the appropriate licensing board for failing to effectuate a qualified patient's directive in violation of this subchapter or other laws of this state.").

75. This conclusion is based on a review of the relevant cases citing to state laws regarding liability for violation of advance directives. See also Memorandum from Kathryn Tucker (Nov. 17, 2011) (on file with author) ("To date, there appears to be no successful uses of . . . [criminal,] professional or civil sanctions Such a lack of action on those fronts can probably be attributed to a general skepticism in the courts and medical profession to claims of damages resulting from prolonged life.").

76. E-mails from David Leven, Exec. Dir., Compassion & Choices of N.Y., to author (Dec. 5 & 7, 2012) (on file with author) (noting that the Chair of the New York State Assembly Standing Committee on Health was reviewing this proposal as of December 2012).

77. Draft, New York Health Care Consumer Protection Act (on file with author).

78. *Id.*

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decisionmakers to recognize the wrongs associated with deviation from patients' express end-of-life wishes.

B. Growth in Administrative Penalties

In the past decade, administrative enforcement actions relating to the unwanted provision of end-of-life care have proliferated at both the federal and state levels. While these actions provide no tangible relief to the patients who were harmed, they signal increased attention to the importance of this issue.

At the federal level, institutional compliance with the Patient Self-Determination Act is a condition of participation in the federal Medicare and Medicaid programs.⁷⁹ A health care facility that fails to comply with the PSDA's requirements regarding patient rights with respect to end-of-life care can be penalized or even excluded from Medicare and Medicaid. In the past decade, the Departmental Appeals Board of the U.S. Department of Health and Human Services (HHS) has twice affirmed decisions by the Centers for Medicare & Medicaid Services (CMS) against two health care facilities for failing to satisfy these requirements.

In 2003, a state agency surveyed the Brookridge Life Care & Rehabilitation Center in Arkansas and found violations in the nursing home's compliance with federal certification requirements. In particular, the survey found that the facility had no documentation regarding at least two patients' do-not-resuscitate (DNR) statuses, and that facility staff were unable to find any such documents when end-of-life decisions were being made for at least one of these patients.⁸⁰ HHS's Departmental Appeals Board fined Brookridge \$3,050 for a single day of noncompliance with CMS requirements; the agency found, however, that the facility's conduct fell short of "substantial noncompliance," which would have triggered a greater penalty.⁸¹

In 2009, a similar situation occurred at Evergreen Commons, a long-term care facility in New York.⁸² A survey of patient records revealed that the facility was not in compliance with Medicare requirements regarding documentation of and compliance with patients' advance directives and that Evergreen "lacked a coherent and consistent policy for identifying, and thus honoring, its residents'" directives; the survey also found that some facility staff were "sufficiently confused [about the facility's procedures] to present the potential for more than minimal harm."⁸³ Consequently, the administrative law judge upheld a penalty of \$10,000 for substantial noncompliance with program requirements.⁸⁴

79. See generally *supra* Part II.

80. See Brookridge Life Care & Rehab. Ctr., Decision No. CR1538 (Dep't of Health & Human Servs. Departmental Appeals Bd. Dec. 8, 2006), *available at* <http://www.hhs.gov/dab/decisions/CR1538.htm>.

81. *Id.*

82. See Evergreen Commons, Decision No. CR2372 (Dep't of Health & Human Servs. Departmental Appeals Bd. May 20, 2011), *available at* <http://www.hhs.gov/dab/decisions/civildecisions/cr2372.pdf>.

83. *Id.*

84. *Id.*

Some state agencies have taken similar actions when faced with allegations of physician noncompliance with advance directives. The Office of Inspector General of the Kentucky Cabinet for Health and Family Services, for example, has issued at least one citation to a long-term care facility for resuscitating a patient in violation of a DNR order.⁸⁵

Finally, administrative law judges have upheld state disciplinary boards' sanctions of medical providers for failure to comply with patients' end-of-life wishes. In a New York case, the state medical board disciplined a gynecologic oncologist, Mahmood Yoonessi, for, among other things, resuscitating multiple patients who had signed DNR orders and whose families opposed continued treatment.⁸⁶ The disciplinary board chose to revoke Yoonessi's license to practice medicine in New York.⁸⁷

These administrative decisions provide no relief for patients who have already suffered harm as a result of a facility's failure to document and comply with advance directives, and are unlikely to provide precedential support for wrongful living claims. However, CMS is actively monitoring health care facilities' compliance with the PSDA and fining them for noncompliance, and state administrative agencies are attuned to physicians' deviations from end-of-life care instructions. All of this suggests an increased focus on the consequences of noncompliance. Any increased attention to the plight of patients whose advance directives are not followed is a promising development in the path towards recognition of tort recovery for wrongful living.

C. *Recovery for Direct Harms and Medical Expenses*

While courts typically have been reluctant to award damages for the wrongful continuation of life, plaintiffs in wrongful living suits have been able to recover limited damages for pecuniary harms directly caused by unwanted resuscitation or medical treatment.

As recognized by the Ohio Supreme Court in *Anderson*, a patient who is provided with life-saving treatment against her wishes may be able to recover damages associated with physical injuries directly resulting from the unwanted treatment; these could include injuries such as burns resulting from defibrillation,⁸⁸ broken bones resulting from resuscitative efforts,⁸⁹ or physical injuries associated with intubation.⁹⁰ There seems to be relatively little controversy about a patient's ability to recover from direct physical harms such as these, and plaintiffs bringing wrongful living suits would do well to demand such damages in their complaints.

85. See Valarie Honeycutt Spears, *System Suggested for DNR Tracking*, LEXINGTON HERALD-LEADER (May 4, 2009), <http://www.kentucky.com/2009/05/04/783805/system-suggested-for-dnr-tracking.html>.

86. Mahmood Yoonessi, M.D., BPMC 02-188, 2002 WL 33840948 (N.Y. Dep't of Health Bd. for Prof'l Med. Conduct June 5, 2002).

87. See *id.* For further discussion of this case, see Pope, *supra* note 29, at 287–89.

88. See *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 229 (Ohio 1996).

89. See *id.*

90. See *Allore v. Flower Hosp.*, 699 N.E.2d 560, 565 (Ohio Ct. App. 1997).

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Moreover, at least one court has held that patients who are provided with life-saving care against their will may be entitled to recover medical expenses for the unwanted treatment.⁹¹ In the 1998 decision *Gragg v. Calandra*, an Illinois appellate court found that the Illinois Family Expense Act provided a mechanism for recovering “wrongfully caused medical expenses”—in this case, expenses stemming from unwanted open-heart surgery and life support.⁹² In a similar New York case, a court denied recovery of medical expenses due to uncertainty about the patient’s end-of-life wishes, but seemed to suggest that recovering medical costs would have been a possibility had the patient’s wishes been clearer.⁹³ Accordingly, patient advocates should review itemized hospital bills and specifically seek recovery of the costs of unconsented-to care.

D. Some Claims Survive Motions to Dismiss

While no court has gone so far as to say it recognizes a cause of action for “wrongful living,” some courts have permitted well-crafted claims seeking similar recovery to proceed against a defendant’s motion to dismiss. For example, the Illinois appellate court in *Gragg* was open to the possibility of recovery for unwanted continuation of life, though it did not refer to the plaintiff’s claim as one for “wrongful living.”⁹⁴ In *Gragg*, the hospital allegedly performed open-heart surgery without a patient’s consent and subsequently provided unwanted life support after the patient suffered irreversible brain damage.⁹⁵ The patient’s family raised a variety of claims against the physicians and the hospital where the underlying treatment occurred, including a battery claim for the administration of unwanted treatment. Although the trial court initially dismissed the battery claim, the appellate court reversed, allowing the case to proceed as a traditional battery action.⁹⁶ Indeed, even courts that have rejected recovery for wrongful living in particular instances have included supportive judicial language in their opinions. In *Anderson*, for example, the Ohio Supreme Court rejected a cause of action for wrongful living when a patient was resuscitated despite a “No Code Blue” order on his chart, but a concurring judge suggested that recovery might be available when a medical professional blatantly “ignor[es] a living will or a durable power of attorney for health care”⁹⁷

91. Even in wrongful birth and wrongful life cases—the reproductive precursors to wrongful living suits—courts have generally allowed parents to recover medical expenses directly caused by the provider’s negligence, such as the expenses related to delivery and hospitalization of an unwanted child. Sawicki, *supra* note 62, at 287.

92. 696 N.E.2d 1282, 1286 (Ill. App. Ct. 1998).

93. *See Grace Plaza of Great Neck, Inc. v. Elbaum*, 82 N.Y.2d 10, 17–18 (1993).

94. *See generally Gragg*, 696 N.E.2d at 1286–87.

95. *See id.* at 1285.

96. *See id.* at 1284–87. The court did not, however, explicitly address the type of damages that might be available beyond recovery of expenses for unwanted medical treatment. *See id.* at 1286.

97. *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 229 (Ohio 1996) (Douglas, J., concurring) (citations omitted) (“Short of ignoring a living will or a durable power of attorney for health

Two recent decisions have shown that there is continuing judicial support, at both the state and federal levels, for the viability of a wrongful living cause of action.

In 2011, a state trial court in Oklahoma heard *Callison v. Hillcrest Healthcare System*, a case in which a hospital allegedly continued intubation of a patient in violation of his advance directive and the wishes of his family.⁹⁸ The patient's family claimed that despite his DNR order and advance directive, the hospital continued ventilation for eight days, with "the end result of ventilating" the patient being that he was subjected "to a painful, agonizing death by the very caregivers . . . who were supposed to have helped ease [his] pain and give him a better quality of life as he and his family prepared themselves for his death."⁹⁹ The court denied the hospital's motion to dismiss with respect to the claim of battery, which was based on allegations of wrongful intubation and medical negligence.¹⁰⁰ Court filings indicate that the case against the hospital ultimately settled.¹⁰¹

In 2012, the U.S. District Court for the District of Colorado reviewed *Self v. Milyard*, a case brought by a prisoner serving a life sentence in the Colorado Department of Corrections (CDOC).¹⁰² The prisoner alleged violations of the Eighth and Fourteenth Amendments in connection with the prison's failure to honor his DNR directive, which both parties agreed was "validly executed . . . and . . . binding upon the CDOC."¹⁰³ The district court ultimately found that the prisoner had not made out a valid Eighth Amendment claim because he offered no evidence that the DNR had actually been triggered—the prisoner had not suffered a cardiac or respiratory arrest, and his condition was the result of an unsuccessful suicide attempt.¹⁰⁴ However, the court in no uncertain language emphasized that the prison's procedures for documenting and responding to advance directives was deeply flawed: "[I]t is constitutionally mandatory that a prison have in place a reasonable and effective method of assuring that an inmate's DNR directive will be honored There is simply no excuse not to

care medical professionals should not be subjected to liability for carrying out the very mission for which they have been trained and for which they have taken an oath.").

98. See *Callison v. Hillcrest Healthcare Sys.*, No. CJ-2010-3197, 2011 WL 7990001 (Okla. Dist. Ct. Tulsa Cnty. Apr. 14, 2011). See also Plaintiff's Motion for Partial Summary Judgment and Brief in Support, *Callison v. Hillcrest Healthcare Sys.*, No. 201003197 (Okla. Dist. Ct. Tulsa Cnty. Sept. 28, 2011), 2011 WL 8058079 [hereinafter *Callison* Brief in Support].

99. *Callison* Brief in Support, *supra* note 98, at 4.

100. *Callison*, 2011 WL 7990001, at 8.

101. See Dismissal with Prejudice as to Defendant AHS Medical Center, LLC, *Callison v. ACS Hillcrest Med. Ctr., LLC*, No. CJ-2010-3197 (Okla. Dist. Ct. Tulsa Cnty. May 14, 2012). See also Summary of *Callison v. AHS Hillcrest Med. Ctr., LLC*, MORELAW LEXAPEDIA, <http://www.morelaw.com/verdicts/case.asp?n=CJ-2010-3197&cs=OK&d=55782> (last visited Jan. 2, 2014) (reporting a settlement with Hillcrest Medical Center in the amount of \$650,000).

102. *Self v. Milyard*, No. 11-CV-00813-RBJ-CBS, 2012 WL 3704958, at *1 (D. Colo. July 31, 2012).

103. *Id.* at *1, *5.

104. See *id.* at *2–3, *9.

do so.”¹⁰⁵ The court found that the prison “did not . . . establish or maintain a reliable method of assuring” that the plaintiff’s wishes would be followed because it did not flag his file with a sticker or include a DNR notation anywhere in his medical records.¹⁰⁶ Had the plaintiff been in a condition that would have triggered his DNR order, the court’s language suggests, he would have had a valid constitutional claim.¹⁰⁷

The fact that two courts in the past two years have either allowed a wrongful living claim to proceed, or left open the possibility that such a claim might succeed under the right circumstances, is a very positive sign. Even if these cases are not precedential for a particular plaintiff in state or federal court, future litigants raising similar claims would be well advised to cite to *Callison* and *Self* for their persuasive value.

E. Cases Ripe for Appellate Review

In addition to the supportive judicial language cited above, procedural decisions by some courts suggest a willingness to revisit the issue of wrongful living recovery. In a recent New York case, a suit was brought against Jamaica Hospital Medical Center by the widow of a patient who was resuscitated twice against hospital orders and the family’s explicit wishes.¹⁰⁸ Two lower courts¹⁰⁹ rejected the plaintiff’s claims, citing precedent from wrongful life cases establishing that “the status of being alive does not constitute an injury in New York.”¹¹⁰

The plaintiff’s attorneys sought discretionary appeal from the New York Court of Appeals, the state’s highest court, arguing in part that the lower courts’ reliance on wrongful life cases was misplaced—specifically, that each of the cases the lower courts relied on for support dealt with wrongful life claims by disabled children asserting damages for having been born.¹¹¹ The Court of Appeals granted leave to appeal,¹¹² a move that suggested that the court was willing to reconsider the lower courts’ decisions, possibly in light of the plaintiff’s shocking allegation that the hospital

105. *Id.* at *8.

106. *Id.* at *7.

107. *Self* is somewhat unusual in that it involves a constitutional claim, rather than a pure tort claim—most patients who receive life-sustaining care against their wishes are not being treated by medical providers who are state actors, and therefore have no basis on which to bring a constitutional claim. *See generally* Klavan v. Crozer-Chester Med. Ctr., 60 F. Supp. 2d 436 (E.D. Pa. 1999) (holding that state regulation, licensing, and financial assistance is not sufficient to classify a private, not-for-profit hospital as a state actor for the purposes of liability in a federal civil rights action); Ross v. Hilltop Rehab. Hosp., 676 F. Supp. 1528 (D. Colo. 1987) (reaching an analogous legal conclusion in similar federal civil rights action).

108. Cronin v. Jamaica Hosp. Med. Ctr., 875 N.Y.S.2d 222, 223 (2d Dep’t 2009).

109. *See* Cronin v. Jamaica Hosp. Med. Ctr., No. 25029/2004, 2007 WL 6860641 (Sup. Ct. Queens Cnty. May 11, 2007); *Cronin*, 875 N.Y.S.2d at 223.

110. *Cronin*, 875 N.Y.S.2d at 223 (citing *Alquijay v. St. Luke’s-Roosevelt Hosp. Ctr.*, 63 N.Y.2d 978, 979 (1984); *Becker v. Schwartz*, 46 N.Y.2d 401, 412 (1978)).

111. Brief for Plaintiff-Appellant, Cronin v. Jamaica Hosp. Med. Ctr., No. 2007-05447 (2d Dep’t Dec. 31, 2007), 2007 WL 6861253 at *14–18 [hereinafter Cronin Brief for Plaintiff].

112. Cronin v. Jamaica Hosp. Med. Ctr., 12 N.Y.3d 715 (2009).

disregarded a documented DNR order on two separate occasions.¹¹³ Before the Court of Appeals heard the case, however, the plaintiff's appeal was withdrawn, roughly four-and-a-half months after leave to appeal had been granted.¹¹⁴ While one cannot read too deeply into an appellate court's willingness to review a lower court decision, at the very least, one can conclude that the Court of Appeals considered the issue of recovery for wrongful living to be ripe for review.

F. Settlements Between Parties

Settlement is the process by which litigants mutually agree to resolve their dispute for a set dollar amount, rather than go to trial. Private settlement of a legal dispute does not resolve questions of liability and thus has no precedential value. However, in the context of a suit by a private individual against a health care provider or medical institution, a settlement may indicate that the defendant considered the plaintiff's claims as likely to succeed¹¹⁵—or, at the very least, as requiring substantial resources to defend.¹¹⁶ Some recent settlements relating to the enforcement of patients' end-of-life wishes are worth noting.

In 2005, the American Civil Liberties Union (ACLU) brought suit against the New Mexico Orthopaedic Surgery Center, which required patients to sign a document acknowledging that the facility does “not honor [requests] for ‘Do Not Resuscitate’ status and/or Advance Directives or Living Wills.”¹¹⁷ The facility claimed that it had reasons of conscience for having such a policy, as permitted under state law.¹¹⁸ The plaintiffs, however, noted that there was nothing in the facility's bylaws or mission statement that indicated a conscientious commitment to religious doctrine requiring a policy of noncompliance with DNR orders.¹¹⁹ The parties ultimately settled, and the Center agreed to clarify the language on its intake forms,

113. See Cronin Brief for Plaintiff, *supra* note 111, at *6–9.

114. See Cronin v. Jamaica Hosp. Med. Ctr., 13 N.Y.3d 857 (2009). The attorney who served as plaintiff's appellate counsel in *Cronin* has publicly stated that the litigation concluded with a settlement. See Lisa Comeau, Remarks at New York Law School Law Review Symposium: Freedom of Choice at the End of Life (Nov. 16, 2012) (video available at <http://youtu.be/8lgCi5VWx3g>).

115. See David Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1119–20 (2006).

116. Recent empirical research, however, suggests that settlements in medical malpractice cases are relatively rare. See *id.* at 1123. This appears to occur, at least in part, because defendants know that if they proceed to trial, they have a higher chance than plaintiffs of winning their cases. See *id.* at 1117–19. Indeed, a recent study has shown that, in most medical malpractice cases that proceeded to trial, the defendants failed to make any settlement offer at all. *Id.* at 1123.

117. Press Release, ACLU of N.M., ACLU of New Mexico Defends Patient's End-of-Life Wishes (June 9, 2005), <http://www.aclu.org/technology-and-liberty/aclu-new-mexico-defends-patients-end-of-life-wishes>.

118. See *id.*

119. See *id.*

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pay the ACLU's legal fees, and donate \$5,000 to the United Way of Central New Mexico.¹²⁰

The *Cronin v. Jamaica Hospital Center* case, referenced above in Part IV.E, also reportedly ended in a settlement after being litigated in New York courts between 2004 and 2009.¹²¹ Although two lower courts rejected the plaintiff's wrongful living claim, the state's highest court granted the plaintiff leave to appeal, shortly after which the case apparently settled for an undisclosed amount.¹²² That a case would settle only after the granting of a discretionary appeal in favor of a plaintiff suggests that the defendant was less than confident about its chances of success before the appellate court that granted the plaintiff leave to appeal. A settlement was likewise reached in the *Callison* case, referenced above in Part IV.D.¹²³

G. Substantial Jury Verdicts

Finally, despite the fact that judicial analyses of tort law doctrine have traditionally been resistant to wrongful living as a cause of action, some juries considering these cases have been willing to award recovery. A widely publicized 1996 Michigan case, for example, resulted in a \$16.5 million jury verdict for the family of Brenda Young, a comatose woman who was provided with life-sustaining treatment against the explicit wishes of her health care proxy.¹²⁴ When Young awoke from her coma, she was in a partially vegetative state, but appeared to be suffering immensely.¹²⁵ She spent hours each day screaming and repeatedly made statements such as "bury me."¹²⁶ On appeal, the jury's award to Young's family was reduced to \$1.4 million.¹²⁷

More recently, in 2007, a Florida jury awarded a nursing home resident's representatives \$150,000 in connection with a wrongful living suit.¹²⁸ The suit claimed that Madeline Neumann's advance directive rejected the use of "life-prolonging

120. Press Release, ACLU of N.M., Following ACLU of New Mexico Lawsuit, Surgical Center Agrees to Honor Patients' End-of-Life Wishes (Feb. 2, 2006), <http://www.aclu.org/technology-and-liberty/following-aclu-new-mexico-lawsuit-surgical-center-agrees-honor-patients%E2%80%99-end->.

121. See Lisa Comeau, *supra* note 114.

122. See *supra* notes 108–14 and accompanying text.

123. See Summary of *Callison v. AHS Hillcrest Med. Ctr., LLC*, *supra* note 101.

124. See Pope, *supra* note 29, at 265; Lewin, *supra* note 24; Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives*, 20 J. LEGAL MED. 1, 28–32 (1999).

125. See Lewin, *supra* note 24.

126. *Id.*

127. See Pope, *supra* note 29, at 265; Laura Parker, *In a Crisis, Do-Not-Revive Requests Don't Always Work*, USA TODAY (Dec. 19, 2006, 11:16 PM), http://usatoday30.usatoday.com/news/health/2006-12-19-do-not-revive-cover_x.htm.

128. *Jury Awards \$150,000 for Failure to Follow Directive*, 14 ELDER L. ISSUES 39 (Fleming & Curti, P.L.C., Tucson, Ariz.), Mar. 26, 2007, available at <http://www.elder-law.com/2007/Issue1439.html>; Missy Diaz, *Jury: Home Violated Living Will*, SUN SENTINEL (Fort Lauderdale, Fla.) (Mar. 17, 2007), http://articles.sun-sentinel.com/2007-03-17/news/0703170091_1_nursing-home-morse-verdict; Parker, *supra* note 127.

treatments or resuscitative measures” at the end of life, but that when nursing home staff found her unresponsive, they called emergency services and she was intubated and taken to the hospital.¹²⁹ Neumann’s representatives brought suit, alleging “willful disregard of advance health care directive under [state law], willful disregard of the federal [PSDA], common law intentional battery, and violation of the Nursing Home Resident’s Rights Act.”¹³⁰ The court dismissed these claims, noting, among other things, that the PSDA offered no private right of action; however, the court allowed a breach of contract claim to proceed on the theory that Neumann’s advance directive was incorporated into her contract with the nursing home.¹³¹ It was on this breach of contract claim that the jury found the nursing home liable and awarded damages, which were upheld on judicial review.¹³²

Other successful suits challenging the administration of life-sustaining treatment against a patient’s will have included claims for damages for emotional distress. In one such case, the emotional distress claim stemmed from a blood reinfusion that was performed on a patient who was a Jehovah’s Witness.¹³³

V. RECOMMENDATIONS FOR PATIENTS AND ADVOCATES

While the legal developments described above do not guarantee success for future plaintiffs whose lives have been prolonged against their wishes, they offer reason to hope that there may indeed be life for the wrongful living cause of action. Until that happens, there are a number of steps that patients and their advocates can take to protect their interests at the end of life.

First, patients should make their wishes with respect to life-sustaining treatment abundantly clear to their families, close friends, medical providers, and others responsible for their care. While documents such as advance directives provide a legal foundation for requests about end-of-life treatment, these documents are far less effective if family members and medical providers are not there to reinforce the patient’s wishes. This ongoing personal support is impossible if the patient has not previously had a conversation with the key parties to explain her end-of-life goals. Accordingly, patients should be encouraged to verbally communicate their wishes to those who will be acting as their representatives if they become unable to make their own decisions. Making certain that family and friends know one’s wishes is the best way to ensure that those wishes are honored.

Second, when drafting an advance directive or living will, patients and their advocates must familiarize themselves with relevant state laws to understand what limitations, if any, they impose. For example: Does an advance directive only become effective if the patient has a terminal illness or another statutorily specified condition?

129. *Scheible v. Joseph L. Morse Geriatric Ctr., Inc.*, 988 So. 2d 1130, 1131 (Fla. Dist. Ct. App. 2008).

130. *Id.* at 1132.

131. *See id.*

132. *See id.* at 1132–33.

133. *See Pope*, *supra* note 29, at 271 (citing *Campbell v. Delbridge*, 670 N.W.2d 108, 113 (Iowa 2003)).

Will requests regarding refusal of nutrition and hydration be respected under state law? Understanding the nuances of the statutory limitations described in Part III.B can prevent surprise and disappointment when the time comes to enforce an advance directive against a third party's objections. Similarly, patients should be sure that an advance directive is as clear as possible in describing the situations it contemplates in order to avoid contextual problems (such as those relating to emergencies and changed medical conditions)¹³⁴ that might make its enforcement more difficult.

Despite these precautions, patients or their advocates might nevertheless find themselves in situations in which health care providers are resisting a request for withdrawal of life-sustaining care. If no accommodation can be reached through consultation with the hospital's ethics committee, or through mediation or other non-legal means, the most effective approach might be to seek injunctive relief in court. Courts generally have been quite willing to enforce advance directives from an *ex ante* perspective,¹³⁵ and petitioning for injunctive relief can be a successful way to prevent further injury to the patient. Moreover, if a medical provider violates a court-ordered injunction, penalties may be available.

Finally, there is hope for those in the unfortunate circumstance of dealing, after the fact, with the violation of a patient's end-of-life wishes. When life-sustaining care has been provided or continued against a patient's will, and the resulting dignity-related or pecuniary harms are sufficiently serious, pursuing tort recovery is an option. Awareness of the recent developments described in this article will give patient advocates a roadmap for bringing a more successful wrongful living claim.

Patient advocates should continually track state legislative proposals relating to enforcement of advance directives and liability for noncompliance. While no state has yet adopted a law ensuring recovery for patients who have received unwanted life-sustaining treatment, proposals such as the one being put forward in New York¹³⁶ would be extremely helpful to patients if ultimately passed. Moreover, the passage of such a law in one state might inspire patient advocates and legislators in other states to adopt similar mechanisms for recovery.

Likewise, attorneys drafting complaints and briefs on behalf of plaintiffs in wrongful living actions ought to take advantage of the legal developments described in Part IV. Some developments, such as the increased frequency of administrative penalties imposed for noncompliance with Medicare and Medicaid requirements relating to advance-directive documentation,¹³⁷ can be used to support policy arguments about the importance of compliance with advance directives. The fact that federal and state agencies have become increasingly active in pursuing medical facilities for violating the PSDA suggests a nationwide recognition of issues related to patient wishes at the end of life. Clear judicial language suggesting that state institutions have a constitutional obligation to assure compliance with prisoner-patients' advance

134. *See generally supra* Part III.B.

135. *See supra* text accompanying note 35.

136. *See supra* Part IV.A.

137. *See supra* Part IV.B.

directives also supports this line of reasoning.¹³⁸ Furthermore, beyond the realm of policy arguments, these cases could be used more concretely in a wrongful living case to support a claim of institutional negligence for failure to have appropriate policies in place with respect to the documentation and enforcement of advance directives.

Attorneys can also rely on recent judicial developments for their precedential or persuasive value. On the issue of damages, complaints should be drafted to include clear documentation of any direct physical injuries resulting from the administration of CPR, artificial ventilation, artificial nutrition and hydration, or other life-sustaining treatments; briefs should include citations to cases such as *Anderson*¹³⁹ and *Allore*,¹⁴⁰ which recognize that such harms result in compensable damages. Complaints should also include documentation of the medical expenses associated with unwanted care, and a demand for recovery should be made either under state battery law or statutory authority for recovery of medical expenses, as in *Gragg*.¹⁴¹

In their filings, attorneys should cite to cases in which courts have allowed wrongful living claims to proceed under traditional common law principles, including battery,¹⁴² negligence,¹⁴³ intentional infliction of emotional distress,¹⁴⁴ and breach of contract.¹⁴⁵ References such as these will not only help support the plaintiff's claims against a motion to dismiss, but might also inspire defendants to settle rather than run the risk of proceeding with litigation whose outcome is by no means certain.

Finally, patient advocates can take some solace in the fact that sympathetic juries might be persuaded to award recovery even in light of uncertain common law doctrine, as in the Michigan case from the mid-1990s and the Florida case from the late 2000s.¹⁴⁶ Attorneys should include requests for a jury trial in their complaints and develop trial strategies that call upon jurors' conceptions of fairness.

VI. CONCLUSION

Theories of patient autonomy and bodily integrity have developed over the past century to the extent that a patient's right to refuse life-sustaining treatment—whether on her own, through a proxy decisionmaker, or via a previously executed advance directive—is now an unshakeable part of American jurisprudence. In practice, however, medical providers and institutions may be unable or reluctant to provide care in accordance with the patient's wishes. Reasons for such departures

138. See *Self v. Milyard*, No. 11-CV-00813-RBJ-CBS, 2012 WL 3704958 (D. Colo. July 31, 2012).

139. See *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225, 229 (Ohio 1996).

140. See *Allore v. Flower Hosp.*, 699 N.E.2d 560 (Ohio Ct. App. 1997).

141. See generally *Gragg v. Calandra*, 696 N.E.2d 1282 (Ill. App. Ct. 1998).

142. See *id.* at 1286; *Callison v. Hillcrest Healthcare Sys.*, No. CJ-2010-3197, 2011 WL 7990001 (Okla. Dist. Ct. Tulsa Cnty. Apr. 14, 2011).

143. See *Callison*, 2011 WL 7990001.

144. See *Gragg*, 696 N.E.2d at 1285.

145. See *Scheible v. Joseph L. Morse Geriatric Ctr., Inc.*, 988 So. 2d 1130, 1132 (Fla. Dist. Ct. App. 2008).

146. See *supra* Part IV.G.

from standard practice include, but are not limited to: a lack of communication between providers and patients, inadequate institutional documentation of patient wishes, objections by family members to the patient's preferred course of treatment, providers' fear of liability, and individual or institutional conscientious refusal.

In such situations, patients and families have found some success enforcing patient requests by asking a court to intervene and enjoin medical providers from providing continuing treatments. But for those patients who have received ongoing life-prolonging medical treatment against their objections, policymakers have historically been reluctant to provide additional legal remedies, such as damages for the pain and suffering associated with continued life. In particular, courts have resisted recognition of the wrongful living cause of action, which they find would improperly compensate patients for an injury that the law does not recognize—the harm of continued life. It is for this reason that commentators have continually referred to the right to refuse life-sustaining care as a “right without a remedy”¹⁴⁷ and seem to consider the wrongful living cause of action a lost cause.

This article, having more carefully analyzed recent developments in the law pertaining to wrongful living claims, reaches the conclusion that the future of this cause of action may not be as bleak as often predicted. Recent legislative and judicial developments signal increased awareness by policymakers of the issue of provider noncompliance with advance directives, which provides a strong foundation for future legal changes. Some judges have permitted wrongful living-type claims to proceed beyond the motion-to-dismiss stage in the form of claims alleging battery, negligence, intentional infliction of emotional distress, and breach of contract.¹⁴⁸ Even jurisdictions that reject the wrongful living cause of action recognize a right to damages associated with direct physical injuries and recovery of medical expenses for unwanted treatment.¹⁴⁹ Finally, recent settlements and jury verdicts involving substantial amounts of money suggest that patients who have been wronged by the continuation of life-sustaining care might, in some cases, be able to recover for the harms they have suffered, even if a common law right to recovery has not been firmly established.

On the basis of these promising developments, this article offers a cautiously optimistic perspective on the future of wrongful living claims. Using the recommendations set forth in Part V, patients can take concrete steps to protect their interests at the end of life, and advocates for patients who have been wronged can use the best arguments available for crafting successful tort claims. The hope, as reflected in this article, is that the trend towards recognizing some right to recovery by patients who have suffered unwanted treatment will continue. A decade from now, perhaps the wrongful living cause of action will no longer be considered an unattainable promise, but rather an active doctrine with a long life ahead of it.

147. *See supra* note 6.

148. *See supra* Part IV and notes 142–45.

149. *See supra* Part IV.C.

