Treated with Respect: Enforcing Patient Autonomy by Defending Advance Directives

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The right of competent individuals to direct their own health care, and even to refuse treatment, has been recognized as a right arising not only from the common law doctrine of informed consent, but also from the constitutional dimension.\(^1\) Enforcement of that right becomes more complex, however, when an individual has made such direction in the form of an advance directive, such as a power of attorney for health care or a living will. In the context of an advance directive, the agent, not the patient, carries out the patient's wishes with respect to health care.

Under the Federal Patient Self Determination Act,\(^2\) enacted in 1991, all hospitals, nursing facilities, home health agencies, hospice programs, and certain health maintenance organizations participating in Medicare and Medicaid programs must comply with certain requirements concerning advance directives. The requirements these entities must comply with are the following:

1) provide patients with written information about their rights under state law, including the individual's rights to accept or refuse medical treatment and to give advance directives;
2) provide patients with written information concerning the written policies of the provider or organization with respect to advance directives;

\(^1\) Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 262 (1990).
3) document in a prominent part of the individual's current medical record whether the individual has executed an advance directive;
4) ensure compliance with state law respecting advance directives; and
5) provide education for the staff and the community on issues concerning advance directives.3

While this legislation does not mandate states to enact advance directives laws, it ensures that health care providers will make patients aware of their rights with respect to the creation and execution of such documents where state laws exist. All states currently have legislation of some sort authorizing competent adults to direct the medical care they would receive if they are later incapacitated by an illness or injury.4

Generally, an advance directive5 is a document that is executed according to certain formalities, which may be established by state law; it provides for health care decisions to be made on behalf of the individual if and when the individual is not capable of making his or her own choices or is not capable of making those choices known. Advance directives primarily fall into two categories: instruction directive or agent-driven (proxy) directive.

An instruction directive6 is a document that contains, in written form, specific directions concerning a person's desires for health care treatment. A living will7, which describes the person's preferences regarding end-of-life care, is an example of an instruction directive. An agent-driven (proxy) directive8, often called a health care power of attorney, appoints an agent,

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5. *BLACK'S LAW DICTIONARY* 57 (8th ed. 2004), *advance directive*: "a document that takes effect upon one's incompetency and designates a surrogate decision-maker for healthcare matters."
6. Id. at 813, *instruction directive*: "a document that contains specific directions concerning the declarant's wishes for healthcare decisions."
7. Id. at 953, *living will*: "an instrument, signed with the formalities statutorily required for a will, by which a person directs that his or her life not be artificially prolonged by extraordinary measures when there is no reasonable expectation of recovery from extreme physical or mental disability."
8. Id. at 57, 1263, *proxy directive*: "a document that appoints a surrogate decision-maker for the declarant's healthcare decisions."
or attorney-in-fact, to act in the place of the individual when the individual is no longer capable of making their own health care decisions. Agent-driven (proxy) directives may also include specific instructions with respect to the individual's desires. In most states, if the agent-driven directive includes instructions to the agent, the agent must follow those instructions. If the directive does not include instructions, the agent may be required to make decisions using either "substituted judgment" or "best interest" as the standard for decision making.

Elder law attorneys frequently draft advance directives as part of a comprehensive planning process for aging clients. While drafting the document may be a simple process, enforcement is not. On the premise that the execution of an advance directive is a constitutional right, this article explores impediments to that right and how those impediments may be overcome. This article focuses on advance directives that are validly drafted and have a properly motivated agent; situations where the validity of the document or the motivations of the agent are called into question are equally important, but not discussed here.

The problems with advance directives can be sorted into three categories: 1) statutory limits on what authority a principal may give to an agent; 2) statutory provisions restricting the execution of a valid directive; and 3) providers refusing or failing to act on an agent's direction. In all three situations, enforcement of the document begins with recognition of the legal principles that are implicated in the creation of an advance directive.

LEGAL FOUNDATION OF THE RIGHT TO MAKE AN ADVANCE DIRECTIVE

FEDERAL CONSTITUTIONAL RIGHTS

Each individual has a fundamental right under the federal constitution to direct his or her own health care. Over a century ago, the Supreme Court recognized that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his

9. Id. at 57.
10. Id.
11. Id.
own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." 12 This right arises out of the Due Process Clause of the Fourteenth Amendment, which provides that "[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law." 13 This liberty interest guarantees that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." 14

Likewise, the Due Process Clause of the Fourteenth Amendment includes the right to refuse unwanted medical treatment. 15 The right to direct one's own health care also arises in the constitutional guarantee of personal privacy. The U.S. Constitution does not expressly mention a right of privacy. Nonetheless, "the [Supreme] Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution." 16 This right to privacy emanates from the penumbra of specific guarantees of particular amendments to the Constitution. 17 The boundaries of this right have not been clearly defined; however, "personal rights found in this guarantee of personal privacy must be limited to those which are 'fundamental' or 'implicit in the concept of ordered liberty' . . . ." 18 These fundamental rights are not lost when an individual becomes incompetent or incapacitated: "[T]he constitutional right of privacy would be an empty right if one who is incompetent were not granted the right of a competent counterpart to exercise his rights." 19

15. Cruzan, 497 U.S. at 262; see also Vacco v. Quill, 521 U.S. 793, 807 (1997) (right to refuse live-saving medical treatment is grounded on "well established, traditional rights to bodily integrity and freedom from unwanted touching"); Washington v. Glucksberg, 521 U.S. 702, 723 (1997) (right to refuse unwanted medical treatment "may be inferred from our prior decisions").
17. Id.
However, concern is raised that the assertion that an incompetent person maintains the same rights as a competent individual "begs the question: an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate."\(^{20}\) Thus, with respect to an advance directive, the argument should be framed on the premise that when a competent person exercises the right to direct his or her health care through execution of an advance directive, the action encompassed by fundamental constitutional rights is the execution of the document itself. This right is not lost by incompetence or incapacity that generally is required for the document to become effective.

Where a state seeks to regulate these "fundamental rights," the Court has held that regulation limiting these rights may be justified only by a "compelling state interest,"\(^{21}\) and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake.\(^{22}\) It is difficult to conceive of any compelling state interest that would justify the negation of the right of an individual to execute an advance directive. The court in Cruzan left open the question as to whether states are constitutionally required to implement the decisions of a named health care surrogate.\(^{23}\) As a practical matter, where an

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\(^{20}\) Cruzan, 497 U.S. at 280.


\(^{23}\) Cruzan, 497 U.S. at 287-92 (O'Connor, J., concurring):

I also write separately to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. See [Cruzan, 497 U.S. at 287] n. 12. In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment. Few individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent. States, which decline to consider any evidence other than such instructions, may frequently fail to honor a patient's intent. Such failures might be avoided if the State considered an equally probative source of evidence: the patient's appointment of a proxy to make health care decisions on her behalf. Delegating the authority to make medical decisions to a family member or friend is becoming a common method of planning for the future. See, e.g., Areen, The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment, 258 JAMA 229, 230 (1987). Several States have recognized
advance directive is clear and detailed, the principal’s exercise of his or her constitutional right should not be questioned.

It is recognized however, that where an agent is exercising an individual’s right to direct health care, “safeguards” may be effectuated by states in light of the states’ interests, such as the preservation of human life and guarding against abuse by surrogates. At the same time, the delineation between an appropriate “safeguard” and an illegal restriction of a patient's autonomy is a boundary that warrants close examination when the decisions of an agent, or the authority of the principal to delegate decisions to the agent, are restricted by state statute.

**STATE CONSTITUTIONAL RIGHTS**

In addition to federal constitutional rights to direct health care decisions, a state constitutional right may exist. A number of states have recognized that their state constitutions provide a

the practical wisdom of such a procedure by enacting durable power of attorney statutes that specifically authorize an individual to appoint a surrogate to make medical treatment decisions. Some state courts have suggested that an agent appointed pursuant to a general durable power of attorney statute would also be empowered to make health care decisions on behalf of the patient. See, e.g., In re Peter, 108 N.J. 365, 378-379, 529 A.2d 419, 426 (1987); see also 73 Op.Md. Atty. Gen. No. 88-046 (1988) (interpreting Md. Est. & Trusts Code Ann. §§ 13-601 to 13-602 (1974), as authorizing a delegate to make health care decisions). Other States allow an individual to designate a proxy to carry out the intent of a living will. These procedures for surrogate decisionmaking, which appear to be rapidly gaining in acceptance, may be a valuable additional safeguard of the patient's interest in directing his medical care. Moreover, as patients are likely to select a family member as a surrogate, see 2 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 240 (1982), giving effect to a proxy's decisions may also protect the "freedom of personal choice in matters of . . . family life." Cleveland Board of Education v. LaFleur, 414 U.S. 632, 639 (1974).

Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. As is evident from the Court's survey of state court decisions, see ante at 2847-2851 no national consensus has yet emerged on the best solution for this difficult and sensitive problem. Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting), in the first instance.

right to privacy that includes a right to direct health care decisions. 25 "Constitutions in ten states—Alaska, Arizona, California, Florida, Hawaii, Illinois, Louisiana, Montana, South Carolina, and Washington—expressly recognize a right to privacy." 26

The recognition of a state constitutional right to make a will should also support the position that an individual has the right to create a directive as to his or her health care. 27 Where an individual's right to control the distribution of his or her property after death is recognized as a fundamental right, the right to control his or her health care while alive is certainly no less significant.

COMMON LAW INFORMED CONSENT

In conjunction with the fundamental rights discussed above, the common law doctrine of informed consent also supports an individual's right to make health care decisions. 28 The notion of an individual's right to the possession and control of his own person has been embodied in the requirement that informed consent is generally required for medical treatment. This doctrine places a duty on physicians to disclose material information to a patient in order for the patient to make an informed decision regarding medical treatment and to obtain the patient's consent to treatment. 29 The doctrine of informed consent also allows an individual to forego all treatment entirely. 30 Like the rights described previously, the common law


27. See, e.g., In re Ogg's Estate 54 N.W.2d 175, 177 (Wis. 1952) ("[E]very person of mature age and sound mind has a right, conformably to statutory regulations designed to safeguard such right, to make his own will, and have it carried out according to his intent; and the constitutional right to make a will includes the right to have a valid will so given effect as to enforce the intention of the testator.").


29. Id at 269.

30. Id at 306.
right can also be delegated to and exercised by a third party.

**Statutory Barriers to the Enforcement of Advance Directives**

**Statutes Restricting the Scope of Authority to be Granted**

In conflict with the right to direct one's own health care through the execution of an advance directive are laws within the statutory authority itself that limit the extent of authority that can be granted. Limiting laws may be based on the nature of the treatment involved or the nature of the individual's disability.

Statutory limitations on the authority of an agent frequently arise in the context of mental health treatment.\(^3\) Such limitations are found in Wisconsin law, including a law that precludes an agent's authority to consent to mental health treatment, such as electroconvulsive therapy (shock treatment), and a law that prevents an agent from authorizing a nursing home admission for long-term care—a decision that can otherwise be made by the agent if authority is granted in the document—when the principal has been diagnosed with a mental illness.\(^2\)

Where the law restricts the kinds of decisions an agent may make, the constitutional analysis as to whether the restriction is based on a compelling state interest should be applied. As the *Cruzan* court implied, a specifically worded directive should prevail over any purported state interest.\(^3\) Thus, it is important to include specific direction and authority in the advance directive, even if that direction or authority is precluded by statute. An individual in Wisconsin, for example, who has benefited from shock therapy and wants to give his or her agent the authority to consent to that treatment in the future, should include language authorizing shock treatment even though state statute prohibits it.

33. *Cruzan*, 497 U.S. at 270.
STATUTES IMPAIRING THE EXECUTION OF VALID ADVANCE DIRECTIVES

Laws outside of the advance directive statutes may impede the effectiveness of, or allow for the involuntary revocation of, the documents by a person or entity other than the principal. Wisconsin's guardianship and power of attorney statutes require a court that orders a guardianship of the person to make a specific finding in order for an advance directive to remain in effect.\(^3^4\) Similarly, the Uniform Probate Code, adopted in eighteen states, includes a provision that gives a court-appointed conservator the same authority to revoke or amend a durable power of attorney, as the principal would have if competent.\(^3^5\) Based on the constitutional foundation of the right to make an advance directive, it should be argued that these statutes are unconstitutional. Additionally, as described below, the revocation provisions may violate anti-discrimination laws, because they allow third-party revocation of the document where an individual has been found incompetent, when such third-party revocation would not be permissible if the individual were competent.

Where the law restricts an agent's actions or otherwise restricts the execution of an advance directive based on the nature of the principal's illness, the restriction may violate laws that prohibit discrimination based upon disability. In *Hargrave v. Vermont*,\(^3^6\) the court held that "Vermont's 'Act 114' . . . discriminated against individuals with mental disabilities under Title II of the Americans with Disabilities Act . . . and Section 504 of the Rehabilitation Act. . . ."\(^3^7\) The challenged Vermont law allowed "health care professionals [to] petition in family court for authority to medicate involuntarily individuals who have been civilly committed or prisoners who have been judged mentally ill."\(^3^8\)

Again, the lesson to be learned is that specific instructions in

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35. Unif. Probate Code § 5-503(a) (revised 1998). Draft amendments to Article 5 of the UPC would allow revocation of an advance directive by a guardian only by court order. This author was unable to determine if these draft amendments have been adopted as archives of the committee. It is necessary to check your state's probate law to determine whether a guardian or conservator has this power.
36. 340 F.3d 27 (2nd Cir. 2003).
37. Id. at 30.
38. Id. at 31.
an advance directive are vital where a principal wishes to grant authority that may be prohibited by statute. In Wisconsin, for example, the document should state (if the principal so wishes) "I specifically grant my agent the authority to admit me to a nursing facility for long term care even if I have been diagnosed with a mental illness," or "I intend for this document to remain in effect in its entirety even if a court appoints a guardian other than my agent."

**Provider Refusal to Abide by the Agent’s Decisions and Provider Immunity Statutes**

The substitute decision making process can lead to the patient's decisions being ignored for various reasons, including a real or perceived lack of clarity in the decisions expressed by the patient in the document, family disputes, ignorance of the existence of the document itself, or a health care provider's substitution of its own judgment for the agent's. In the majority of states, if a health care provider refuses to honor a patient's advance directive, there is no specific remedy at law. Some states, such as Wisconsin, go so far as to grant civil immunity to health care providers who fail to follow an advance directive. This leads to the criticism that, without a legal remedy, there is no actual right to direct one's own medical care through an advance directive. Currently, Utah is the only state to have a penalty for failure to comply with a living will. In these cases, perhaps the quickest method to secure compliance with an advance directive is an action for declaratory and injunctive relief under a state's civil procedure statutes.

In cases where a provider knowingly refuses to follow an agent's direction, a variety of causes of action could be pursued.

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39. While using Wisconsin law as an example, the problems discussed herein exist, to varying degrees, nationwide.

40. WIS. STAT. § 155.50 (2004) (addresses the duties and immunities of health care providers with respect to advance directives. Wisconsin provides broad immunity to facilities and providers who fail to honor an advance directive). WIS. STAT. § 155.50(1)(b) provides that a health care facility, health care provider, or a physician cannot be held criminally or civilly liable for failure "to comply with a power of attorney for health care instrument or the decision of a health care agent. . . . [A] physician [may be charged with] unprofessional conduct [for failure to comply only if he or she also] fails to make a good faith attempt to transfer the principle to another physician who will comply."

41. UTAH CODE ANN. § 75-2-1112 (2004).
Regardless of the theory [employed,] a plaintiff [should be prepared] to prove that: 1) the patient executed . . . [a valid] advance directive concerning his or her medical care . . . ; 2) the health care provider had knowledge or notice of the advance directive; 3) the health care provider . . . withheld [or instituted] care contrary to the [plaintiff]'s instructions . . . ; and 4) some . . . compensable harm resulted. 42

In all honesty, these theories have not yet proven to be overwhelmingly successful, nor have all of them been litigated in the context of an advance directive as opposed to other surrogate decision-making situations. However, unless the issue has been squarely decided in your jurisdiction, it should be considered.

**POTENTIAL CAUSES OF ACTION**

**NEGLIGENT INFILCTION OF EMOTIONAL DISTRESS**

A cause of action for the negligent infliction of emotional distress requires that the plaintiff show the following:

1) the death or serious physical injury of another was caused by the defendant's negligence;
2) there was a marital or intimate familial relationship between the plaintiff and the injured person;
3) the plaintiff observed the death or injury at the scene of the accident; and
4) the plaintiff suffered severe emotional distress as a result. 43

In *Strachan v. John F. Kennedy Memorial Hospital*, 44 Jeffrey Strachan, twenty-years-old, arrived at the defendant hospital on a Friday evening after shooting himself in the head. 45 He was intubated and placed on a respirator in the emergency room (ER). 46 The ER physician declared Strachan brain dead. 47 That same day, a neurosurgeon also found Strachan to be clinically

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42. KATHLEEN E. WHERTHEY, CAUSES OF ACTION (SECOND) Vol. 16, at 83: CAUSE OF ACTION OF RECOVER DAMAGES FOR HEALTH CARE PROVIDER'S FAILURE TO COMPLY WITH ADVANCE DIRECTIVE (2004).
45. Id. at 720.
46. Id.
47. Id.
brain dead.\textsuperscript{48} That evening, the neurosurgeon explained to Strachan’s parents that nothing could be done to restore brain function and asked if they would consider donating Strachan’s organs.\textsuperscript{49} The parents were undecided, and the neurosurgeon suggested they give it some thought overnight.\textsuperscript{50}

The following morning Strachan’s parents refused organ donation and stated they wanted the respirator turned off.\textsuperscript{51} As the day progressed, they asked a nurse and were told that no, “nobody had ever asked to have a machine shut off.”\textsuperscript{52} Again, in the evening, they asked a doctor who assured them, and noted in Strachan’s chart, that the respirator could be withdrawn as soon as the hospital administrator determined the procedure.\textsuperscript{53} The hospital contacted the administrator, who in turn contacted the hospital’s legal adviser, and the parents were told around 2:00 a.m. on Sunday that withdrawal of the respirator would require a court order.\textsuperscript{54}

In fact, however, the hospital’s legal counsel had called for a court order only if Strachan’s parents requested withdrawal of the respirator before EEGs (electroencephalograms) could be done with an interval of 24 hours between them, as required to confirm irreversible brain death.\textsuperscript{55} Two such EEGs were performed on Sunday and Monday, after which the legal adviser told the administrator that the respirator could be turned off with a proper release by the parents.\textsuperscript{56} On Monday, official brain death was recorded and the parents were summoned to the hospital.\textsuperscript{57} After they signed a release, the respirator was disconnected.\textsuperscript{58}

Strachan’s parents sued for negligent infliction of emotional distress citing the absence of consent forms and a procedure for turning off life supports.\textsuperscript{59} In addition, plaintiffs asserted a claim for wrongfully withholding the body of their dead son for

\textsuperscript{48} Id.
\textsuperscript{49} Id.
\textsuperscript{50} Strachan, 507 A2d at 720.
\textsuperscript{51} Id.
\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{54} Id.
\textsuperscript{55} Id. at 721.
\textsuperscript{56} Strachan, 507 A2d at 721.
\textsuperscript{57} Id. at 722.
\textsuperscript{58} Id.
\textsuperscript{59} Id. at 719.
Each claim resulted in a jury award of $70,000. However, the court of appeals reversed, holding that the plaintiffs did not establish any actionable wrongdoing. The court found that the "principles distilled from existing law persuade us to conclude that the hospital had no duty to provide consent forms or to have a procedure for turning off the respirator."  

**INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS**

The elements of a prima facie case of intentional infliction of emotional distress are generally:

1) outrageous conduct by the defendant,
2) intent to cause or reckless disregard of the probability of causing emotional distress,
3) severe emotional suffering, and
4) actual and proximate causation of emotional distress.  

"Outrageous conduct" denotes conduct which is so extreme as to exceed all bounds of decency and which is to be regarded as atrocious and utterly intolerable in a civilized community.

In *Gragg v. Calandra*, Florian Guintola, father of plaintiff Geraldine Gragg, had a living will that expressed his wishes that family withhold extraordinary measures to sustain his life if he lost the ability to direct them. Mr. Guintola was taken to the ER by his wife and daughter who consented to a cardiac catheterization during which the patient experienced cardiac arrest. Unconscious and unresponsive, there was no reasonable likelihood that Mr. Guintola would survive; however, the defendant physicians proceeded to perform open heart bypass surgery without the consent of Mr. Guintola's

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60. *Id.*
61. *Id.*
63. *Id.* at 726. Note that this case predates the Patient Self-Determination Act, which became effective in 1991.
64. *RESTATEMENT (SECOND) OF TORTS* § 46 (1965).
67. *Id.* at 1285.
68. *Id.* at 1284-85.
Unfortunately, Mr. Guintola had suffered irreversible brain damage during the arrest and remained unresponsive and dependent on life support.\textsuperscript{70}

In response to the family's repeated request that life support be discontinued, the physicians involved stated that they would not honor Mr. Guintola's living will and accused Mr. Guintola's wife and daughter of trying to kill Mr. Guintola. Mr. Guintola died one week after his arrival at the hospital.\textsuperscript{71}

The plaintiff brought an action against the hospital and the physicians alleging, among other issues, the intentional infliction of emotional distress.\textsuperscript{72} The Illinois Court of Appeals concluded that the defendant physicians "knew or had reason to know that... [Mr. Guintola's wife and daughter]... were extremely distraught, yet repeatedly accused them of trying to kill [Mr. Guintola]."\textsuperscript{73} The court held that a jury could deem the conduct of the defendants outrageous and, therefore, reversed the trial court's dismissal of the claims for intentional infliction of emotional distress.\textsuperscript{74} The defendants argued that they had a legitimate objective in sustaining Florian's life; however, the court stated that "[a]lthough a defendant may reasonably believe that his objective is legitimate, it does not provide him with carte blanche to pursue that objective by outrageous means."\textsuperscript{75}

In \textit{Westhart v. Mule},\textsuperscript{76} the patient Westhart was admitted to a hospital with severe, long-term impairments, including congestive heart failure, pneumonia, and organic brain syndrome.\textsuperscript{77} Because he could not communicate his wife of 45 years "took it upon herself" to convey to his doctors, Joseph Mule and Dennis Riff, his treatment decisions.\textsuperscript{78} She told the doctors that no extraordinary measures were to be taken, including use of a respirator or CPR because her husband was "a vegetable."\textsuperscript{79} The doctors agreed and recorded the orders in Mr.
Westhart's chart.80

Early in March, two hospital nurses called Mrs. Westhart by telephone and attempted to obtain her consent to the surgical placement of a feeding tube.81 According to the complaint, Mrs. Westhart was emotionally distressed and crying hysterically during the call.82 The nurses disagreed over whether Mrs. Westhart voluntarily consented, so one declined to sign the consent form.83 Nonetheless, the feeding tube was inserted.84

Mrs. Westhart sued for intentional infliction of emotional distress; however, the trial court dismissed her claim without granting leave to amend.85 The appellate court affirmed dismissal of the intentional infliction of emotional distress claim against the physicians.86 The court held that Mrs. Westhart's own failure to take action to avoid life-saving treatment for decedent foreclosed the claim, and that the conduct of which she complained did not rise to the extreme and outrageous level.87

**BATTERY**

A person commits a battery when he unlawfully strikes or touches another.88 In a medical setting, when a physician treats a person without consent, a physician may be liable for battery.89 Medical treatment without consent may be lawful under the doctrine of implied consent when a medical emergency requires immediate action to preserve the health or life of the patient.90 However, a patient may expressly refuse a particular treatment. If so, even in an emergency, the medical treatment is a battery.

In *Allore v. Flower Hospital*,91 Frank Allore, an asbestosis patient, was admitted to the defendant hospital in June 1994.92
He executed a living will directing his doctor to withhold "life-sustaining treatment" if he was either terminal or permanently unconscious. 93 The state statute required that the attending and one other physician certify that the patient's condition triggered the living will provisions. 94 Mr. Allore also executed a durable power of attorney for health care, naming his wife Mary to make decisions if he was unable to do so. At the time, the attending physician and the hospital knew of the directives. 95

In August, Mr. Allore was readmitted with multiple conditions, including severe chronic respiratory failure and congestive heart failure. 96 He was placed in the coronary care unit. His chart contained no Do Not Resuscitate order. 97 When he developed breathing difficulty, the attending physician ordered no interventions but the cardiologist (contacted subsequently by the nurse) ordered intubation. 98 On learning of the living will, the cardiologist provided orders eliminating intubation and ventilation. 99 However, the patient died about two days after these events. 100

Mrs. Allore brought an action alleging several claims, including negligence and battery, among others. She asserted that hospital and physicians were negligent in their care in that they disregarded her husband's wishes expressed in his living will; and that they committed a battery by the intubation and ventilation without consent of either the patient or herself as agent. 101 She also claimed loss of consortium and "severe emotional distress." 102

The trial court granted summary judgment in favor of defendants on all counts. 103 The appellate court affirmed, holding that the cardiologist followed the standard of care employed in a life-threatening situation because he was uninformed of the living will and that there was no genuine

93. Id.
94. Id.
95. Id.
96. Id.
97. Id.
98. Id. at 561-62.
100. Id.
101. Id.
102. Id.
103. Id. at 563.
issue of material fact as to the decedent's implied consent because the doctor was unaware of the decedent's wishes and the decedent's primary physician had remained silent about the living will.\textsuperscript{104}

In another case, \textit{Wright v. Johns Hopkins Health Systems Corporation},\textsuperscript{105} Wright, who was suffering from complications of HIV/AIDS, executed a living will in February 1993 that directed the withholding or withdrawal of life-sustaining procedures upon the determination by two physicians that the patient was terminal and death was imminent.\textsuperscript{106} While hospitalized, Wright underwent a blood transfusion, and, "[w]ithin minutes [of its completion], Wright was found unresponsive and without a pulse."\textsuperscript{107} Wright was resuscitated, intubated, and transferred to an intensive care unit.\textsuperscript{108} Later the staff acknowledged the living will as well as a note in the chart that stated, "We will provide comfort care and make no further attempt to reintubate or resuscitate . . . again per his expressed wishes."\textsuperscript{109} Wright was comatose for two days and then regained some consciousness.\textsuperscript{110} He died ten days after his arrest.\textsuperscript{111}

Wright's estate and his parents asserted the following four-count complaint against multiple defendants:

1) wrongful life, alleging the administration of CPR was contrary to Wright's living will and that the staff failed to make a timely exploration into Wright's wishes;
2) wrongful death, alleging Wright's suffering that resulted from the resuscitation caused them emotional distress;
3) battery, alleging defendants engaged "intentional, non-consensual harmful . . . touching";\textsuperscript{112} and
4) lack of informed consent.\textsuperscript{113}

The circuit court entered summary judgment for the defendants on all counts.\textsuperscript{114} The court of appeals affirmed, but did note that an individual and his estate could assert a cause of action for a

\textsuperscript{104} \textit{Id.} at 564.
\textsuperscript{105} 728 A.2d 166 (Md. 1999).
\textsuperscript{106} \textit{Id.} at 172.
\textsuperscript{107} \textit{Id.} at 171.
\textsuperscript{108} \textit{Id.}
\textsuperscript{109} \textit{Id.}
\textsuperscript{110} \textit{Id.} at 172.
\textsuperscript{111} \textit{Wright,} 728 A.2d at 172.
\textsuperscript{112} \textit{Id.} at 173.
\textsuperscript{113} \textit{Id.}
\textsuperscript{114} \textit{Id.} at 174.
health care provider's failure to comply with an advance directive.\[115\]

**BREACH OF CONTRACT**

A family who feels that life support is continued inappropriately may decide to withhold payment for services, thereby breaching their contract with the health care provider. In this circumstance, the wrongful continuation of life support would be a defense to a breach of contract suit. Although this theory was unsuccessful in *Grace Plaza of Great Neck, Inc. v. Elbaum*,\[116\] the decision seems to turn on the facts involved. In the case where an advance directive exists, the theory may be more successful.

The facts of *Elbaum* are as follows:

> [T]he plaintiff nursing home agreed to provide certain services to Jean Elbaum, an unconscious patient who could not survive without artificial nutrition and hydration, on condition that the defendant Murray Elbaum pays for the services. Mrs. Elbaum [did not have] a living will. Mr. Elbaum entered into this contract knowing that the services to be provided by the plaintiff would include the maintenance of a gastrointestinal feeding tube, which had already been inserted...\[117\]

Some time later, Mr. Elbaum demanded that the nutrition and hydration be stopped, claiming that cessation would be in accordance with Mrs. Elbaum's wishes if she were able to communicate them.\[118\] The nursing home refused, stating "that there was no 'clear indication' of Mrs. Elbaum's [wishes]... and also asserting that [the nursing home's] ethical standards would... prohibit it from withdrawing life-saving medical treatment from one of its patients..."\[119\] The nursing home

115. *Id.*; see Estate of Leach v. Shapiro, 469 N.E.2d 1047 (Ohio Ct. App. 1984), *infra* note 126 through 136 and accompanying text for a more positive outcome on a claim of battery.


117. *Id.*

118. *Id.*

119. *Id.*
encouraged Mr. Elbaum to transfer Mrs. Elbaum to another facility; and, while there was no evidence that Mr. Elbaum made efforts to transfer, the nursing home did make an unsuccessful attempt to locate another facility. Other facilities "would not admit a patient for the sole purpose of removing the [feeding] tube." Mr. Elbaum then refused to pay for any of the services provided, thereby breaching his contract with the nursing home. The nursing home brought a claim for breach of contract, and Mr. Elbaum responded with a claim of battery. The lower court denied the plaintiff's motion for partial summary judgment on the issue of liability and dismissed the defendant's counterclaim for battery. The court of appeals reversed the decision as to Mr. Elbaum's liability to pay fees and affirmed the decision to dismiss the battery claim. The court stated that absent a court order, the plaintiff had committed no legal wrong and forfeited no fees.

**INFORMED CONSENT**

In *Estate of Leach v. Shapiro*, Edna Marie Leach entered a hospital in July of 1980 suffering from respiratory distress. Mrs. Leach took a turn for the worse, however, as the following facts explain:

Mrs. Leach subsequently suffered a... cardiac arrest, and though her heartbeat was restored, she remained in a chronic vegetative state. [She] was placed on life-support systems to sustain her breathing and circulation. In October 1980, Mrs. Leach's husband, as her guardian, petitioned... for an order to terminate the life-support measures. The court issued this order on December 18, 1980. On January 6, 1981, the respirator was

120. *Id.*
121. *Id.*
123. *Id.*
124. *Id.*
125. *Id.*
126. *Id.*
128. *Id.* at 1051.
disconnected, and Mrs. Leach died.\textsuperscript{129}

Mrs. Leach's survivors sued for damages for the interval of life support, asserting that no consent was given for the life-support first provided to the patient.\textsuperscript{130} The plaintiffs alleged that Mrs. Leach was first placed on life-support systems in August 1980, when she was already in a chronic vegetative state, and that this treatment was performed without the consent of Mrs. Leach or her family.\textsuperscript{131} The plaintiffs alleged that Mrs. Leach expressly advised the defendants that she did not wish to be kept alive by machines and that "[a]bsent an emergency, the defendants had an obligation to secure consent for Mrs. Leach's treatment from one authorized to act on her behalf, since Mrs. Leach was not capable of consenting, or by court order."\textsuperscript{132} A five-count complaint filed by the plaintiffs was based upon the notion that the defendants acted wrongfully in placing and maintaining Mrs. Leach on life-support systems contrary to the express wishes of Mrs. Leach and her family.\textsuperscript{133}

The defendants filed a motion to dismiss or for summary judgment, which the lower court granted without the support of affidavits or other evidence.\textsuperscript{134} The court of appeals reversed holding that:

1) A patient's right to refuse treatment was absolute, and the existence of consent or refusal of treatment and the nature of treatment provided were factual questions precluding a motion to dismiss;

2) The claimants stated causes of action required factual determination for non-disclosure, pain and suffering, punitive damages, and unreasonable delay in compliance with the court order to terminate life support; and

3) Dismissal of the mental anguish claim was improper.\textsuperscript{135} An invasion of privacy claim failed because the personal right lapsed on the patient's death.\textsuperscript{136} The court agreed that the doctrine of informed consent included the right to refuse treatment and that the breach of such a duty could support an

\textsuperscript{129} Id. \textsuperscript{130} Id. \textsuperscript{131} Id. at 1052. \textsuperscript{132} Id. at 1053. \textsuperscript{133} Estate of Leach, 469 N.E.2d at 1051. \textsuperscript{134} Id. \textsuperscript{135} Id. \textsuperscript{136} Id. at 1050.
action for battery.\textsuperscript{137}

\textbf{VIOLATION OF FEDERAL CIVIL RIGHTS ACT SECTION 1983}\textsuperscript{138}

Recovery for a violation of an individual's constitutional right to refuse medical treatment requires that the plaintiff establish that 1) the physician or hospital is a state actor and 2) the defendant hospital or physician intended to violate his or her constitutional rights.\textsuperscript{139} If successful, there is a possibility of recovery of attorney's fees.\textsuperscript{140} In \textit{Gray v. Romeo},\textsuperscript{141} the plaintiff, Glenn Gray, recovered damages under a section 1983 action for the defendant's refusal to withdraw a feeding tube from Glenn's wife, Marcia.\textsuperscript{142}

In \textit{Gray}, the patient, 37-year-old wife Marcia, was admitted to Rhode Island Hospital, a state facility, in January 1986, with a major cerebral hemorrhage. Despite surgery, she experienced severe brain damage and prolonged unconsciousness.\textsuperscript{143} Twelve days later, the patient's husband Glenn gave consent to the use of breathing and feeding tubes.\textsuperscript{144} Marcia continued to deteriorate to a persistent vegetative state and was transferred to another state facility.\textsuperscript{145} After about four months, the family asked for artificial support to be withdrawn,\textsuperscript{146} but the facility refused citing its opposition as a matter of policy to the denial of nutrition and hydration.\textsuperscript{147} Staff members who cared for Marcia joined the institution in its opposition.\textsuperscript{148}

Glenn, acting as legal guardian, brought a Sec. 1983 action for violation of his wife's civil rights, seeking an order to withdraw her feeding tube.\textsuperscript{149} The court held that Ms. Gray had a constitutional right to privacy, which included a right to refuse life-sustaining medical treatment, including the right to have the

\begin{itemize}
\item \textsuperscript{137} \textit{Id.}
\item \textsuperscript{139} \textit{Id.}
\item \textsuperscript{140} 42 U.S.C. § 1988(b) (2005).
\item \textsuperscript{141} \textit{Gray v. Romeo}, 697 F. Supp. 580 (D. R.I. 1988).
\item \textsuperscript{142} \textit{Id.} at 590.
\item \textsuperscript{143} \textit{Gray}, 697 F. Supp. at 582.
\item \textsuperscript{144} \textit{Id.}
\item \textsuperscript{145} \textit{Id.}
\item \textsuperscript{146} \textit{Id.} at 585.
\item \textsuperscript{147} \textit{Id.}
\item \textsuperscript{148} \textit{Gray}, 697 F. Supp. at 583.
\item \textsuperscript{149} \textit{Id.}
\end{itemize}
feeding tube removed. 150 The court observed that the patient and her family had no notice of her loss of rights to consent to and refuse care attendant on admission to the facility. 151 The court concluded that if Marcia could not be admitted to a facility that would honor such choice, then this state facility that admitted her must abide by her wishes. 152

VIOLATION OF SECTION 504 OF THE REHABILITATION ACT (29 U.S.C. SECTION 794)153

WRONGFUL LIFE

In Anderson v. St. Francis-St. George Hospital, 154 Mr. Winter was admitted to the defendant hospital complaining of chest pain in 1988. 155 After a discussion with his physician, Mr. Winter stated that he did not want any extraordinary lifesaving measures and his physician entered a "No Code Blue" order on his chart. 156 However, when Mr. Winter experienced a potentially fatal heart rhythm, a nurse defibrillated him. 157 Two days later he suffered a stroke that left him paralyzed on the right side until his death in 1990. 158

Mr. Winter's estate alleged battery, negligence, and wrongful life claims, stating that "by keeping [Mr.] Winter alive, [the hospital] caused him '. . . pain, suffering, emotional distress, and disability as well as medical and other . . . expenses.'" 159 The Ohio Supreme Court concluded that Mr. Winter had not suffered a compensable injury from the hospital's failure to follow the no code order. 160 The Anderson court held: "[The estate's] attempt to create a wrongful-living cause of action fails because life is not a compensable harm." 161 On appeal after remand, the appellate court clarified what it meant in holding

150. Id. at 586.
151. Id.
152. Id.
153. See generally Hargrave, 340 F.3d 27.
156. Id.
157. Id.
158. Id.
159. Anderson, 614 N.E.2d at 843.
160. Id.
161. Id. at 846.
that wrongful living is not a compensable harm: "By that we mean that he cannot recover general damages just for finding himself still alive after unwanted resuscitative measures."162

The Ohio Supreme Court agreed, stating "In its simplest form, the question [presented by a wrongful living claim] becomes: Is 'continued living' a compensable injury?"163 The court concluded that it is not; even if the plaintiff could show a breach of a duty and the resulting prolongation of life.164

**BATTERY**

*Bartling v. Glendale Adventist Medical Center,*165 provides an unsuccessful cause of action in battery for failure to withdraw care pursuant to an advance directive. In *Bartling,* patient William was admitted to the defendant hospital for treatment of severe chronic depression, with numerous serious physical conditions including emphysema, heart disease and lung cancer.166 Six days later, the patient's lung collapsed in a procedure and he was placed on a ventilator.167 William resisted the ventilator and had to be restrained to prevent him from removing the tubes.168

About two weeks later, William executed a living will169 and a health care power of attorney naming his wife as agent. He also stated that he found it intolerable to continue living on the ventilator and requested it be discontinued.170 He also executed a power of attorney for health care instrument naming his wife as his agent.171 "He, his wife and his daughter also executed documents ... releas[ing the hospital] and its physician from any claim of ... liability. ..."172

The hospital refused to disconnect the ventilator but made a number of unsuccessful attempts to wean him from the

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164. *Id.*
165. 229 Cal. Rptr. 360 (Cal. Ct. App. 1986). *See also* Foster v. Toutellotte, 704 F.2d 1109 (9th Cir. 1983) (affirming district court's denial of damages and attorney's fees for unwanted respirator care).
166. *Id.*
167. *Id.*
168. *Id.*
169. *Id.*
170. *Id.*
171. *Bartling,* 229 Cal. Rptr. at 361.
172. *Id.* at 362.
ventilator.\textsuperscript{173} Attempts to find another facility to accept Mr. Bartling were unsuccessful.\textsuperscript{174} “Plaintiffs attempted to plead a cause of action for conspiracy to deprive Mr. Bartling of his constitutional rights to privacy, liberty and self-determination, in violation of Federal Civil Rights Act, 42 U.S.C. section 1983(3).”\textsuperscript{175} However, the court determined that that there was no discriminatory intent on the part of the hospital.\textsuperscript{176}

**Wrongful Withholding of a Dead Body**

In *Strachan*,\textsuperscript{177} the parents of a suicide victim who was maintained on life support for a period of time despite the parents' request for removal, brought suit against defendants, the hospital and its administrator, for wrongfully withholding the body of their dead son from burial.\textsuperscript{178} A jury awarded the plaintiffs $70,000 in damages on this theory.\textsuperscript{179} The appellate court reversed, holding that although infringement of plaintiffs' quasi right in property to bury their dead son's body could be redressed by an action in damages, plaintiff's right did not vest until the life support system was disconnected.\textsuperscript{180} Because defendants made the body available for burial immediately upon disconnection of life support, the court held that defendants committed no actionable wrongdoing.

**Abuse of Process**

In some of the most egregious cases that occurred, providers have taken affirmative action to circumvent the directions of a health care agent by instituting guardianship proceedings to have someone other than the agent appointed as a decision-maker for the principle, or have improperly made a claim of elder abuse. While these may be appropriate if the agent is acting in bad faith, is it certainly inappropriate where the provider simply disagrees with the agent's decisions. In this situation, in addition to the claims pertinent to the principle, the

\begin{itemize}
  \item \textsuperscript{173} *Id.*
  \item \textsuperscript{174} *Id.*
  \item \textsuperscript{175} *Id.* at 365.
  \item \textsuperscript{176} *Id.* at 366.
  \item \textsuperscript{177} *Strachan*, 507 A.2d 718.
  \item \textsuperscript{178} *Id.* at 723-27.
  \item \textsuperscript{179} *Id.* at 723.
  \item \textsuperscript{180} *Id.*
\end{itemize}
agent may bring an action for abuse of process. Abuse of process is a common law intentional tort.

Abuse of process is committed by "[o]ne who uses a legal process, whether criminal or civil, against another to accomplish a purpose for which it is not designed . . . ." \(^{181}\) The elements of abuse of process are:

(1) "a purpose other than that which the process was designed to accomplish"\(^ {182}\); and
(2) "a subsequent misuse of the process, even though the process was properly instituted."\(^ {183}\)

The Wisconsin Supreme Court explains the elements as follows:

The essential elements of abuse of process, as the tort has developed, have been stated to be: first, an ulterior purpose, and second, a willful act in the use of the process not proper in the regular conduct of the proceeding. Some definite act or threat not authorized by the process, or aimed at an objective not legitimate in the use of the process, is required; and there is no liability where the defendant has done nothing more than carry out the process to its authorized conclusion, even though with bad intentions. The improper purpose usually takes the form of coercion to obtain a collateral advantage, not properly involved in the proceeding itself, . . . The ulterior motive or purpose may be inferred from what is said or done about the process, but the improper act may not be inferred from the motive . . . .\(^ {184}\)

In cases where it seems clear that the provider has taken improper legal measures to impede an agent's authority, this cause of action should be considered.

**CONCLUSION**

While acceptance of advance directives has become much wider over the last decade, there is still a significant percentage of

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182. Id. at 166.
183. Id.
184. Id. (citations omitted).
situations where an advance directive fails to meet the needs of the client, either through statutory impediments or provider inaction. Drafting and executing an advance directive for a client should not be engaged in pro forma. Given the potentially weighty decisions involved, detailed and specific language describing your client's intentions will provide the best position for enforcement if these documents should be challenged or an agent's decisions ignored. Likewise, including specific language will provide the needed foundation to overcome any statutory obstacles to your client's plans for future health care. Active enforcement of these documents will result in the satisfaction of your client's goals in the most critical periods of their lives.