CONFLICT OF CONSCIENCE: REFUSAL OF A HEALTH CARE PROVIDER TO WITHDRAW LIFE SUPPORT

by Don R. Castleman[*]

I. INTRODUCTION

The 1976 New Jersey Supreme Court decision in *Quinlan* and the 1990 United States Supreme Court decision in *Cruzan*, settled the law in this country that withdrawal of artificial or mechanical life support from a terminally ill or irreversibly comatose patient does not constitute euthanasia, assisted suicide, or homicide.[1] Terminally ill persons have the right to refuse such medical treatment so long as they are competent.[2] This right may be based on the right to informed consent for medical care or based on the right to privacy found under the United States Constitution.[3] Further, if a terminally ill person executes an advance directive setting forth their wishes, but then later becomes incompetent and appoints another to refuse such treatment for them, the state will not, in its role as *Parens Patriae*, interfere.[4]

What is not so clear, however, is to what extent people have the right to enlist the aid of others in this regard if they—because of religious beliefs,

* Professor of Law, Wake Forest University Law School.

1. *See In re* Quinlan, 355 A.2d 647, 658 (N.J. 1976); *see also* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 333 (1990).

2. *Quinlan*, 355 A. 2d at 658.

3. *See Cruzan*, 497 U.S. 261 at 262; *see also* Griswold v. Connecticut, 381 U.S. 479, 485 (1965).

4. *Cruzan*, 497 U.S. at 262.

secular ethics, or as a matter of conscience—do not wish to be a party to any act that will result, even if only indirectly, in the death of a human being. Because the withdrawal of life support will almost always require the cooperation of some medical professional, this question seems to be crucial.

This article will explore potential civil liability, or other civil penalty, and potential judicial intervention when a health care facility or health care provider (physicians, nurses, and other medical professionals) refuses to carry out an advance directive to withhold life-sustaining treatment. But, this article will not be concerned with any refusal to *provide* such life sustaining treatment.[5] The article assumes that the patient has executed a valid "living will" or advance directive that satisfies any applicable statute and that any person purporting to act as surrogate for the patient has valid authority to do so.

The article will also assume that the patient is terminally ill or in a persistent vegetative state, and that the refusal of the health care facility or the health care provider is not based on any disagreement in that regard. The assumption will be that the refusal to honor the directive, or to follow the instruction from the surrogate pursuant to a directive, is based on religious, moral, ethical, or conscientious objections on the part of the health care provider either as a person or as an institution.

II. BACKGROUND: *QUINLAN* AND *CRUZAN*

While the seminal cases have been examined exhaustively about the right to refuse treatment, the purposes of this article require that these cases be revisited.[6]

On April 15, 1975, a few days before her twenty-first birthday, Karen Ann Quinlan lapsed into unconsciousness and stopped breathing for fifteen minutes.[7] Her friends called the police and emergency medical services.[8] When they arrived, Karen was still unconscious but breathing.[9] While they attended to her, Karen stopped breathing again for another fifteen minutes.[10] Emergency personnel took Karen to the emergency room at the Newton Memorial Hospital where doctors placed her on a respirator.[11] She was later transferred to St. Clare's Hospital.[12]

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5. *See* THE ROBERT POWELL CENTER FOR MEDICAL ETHICS, WILL YOUR ADVANCE DIRECTIVE BE FOLLOWED? (Dec. 2010), http://www.nrlc.org/euthanasia/AdvancedDirectives/WillYourAdvance DirectiveBe Followed.pdf (refusal of a health care provider to continue life sustaining treatment when requested).

6. *See* Rebecca C. Morgan, *The New Importance of Advance Directives*, 2 EST. PLAN. & CMTY. PROP. L.J. 1, 1–32 (2009); *see also* Dale H. Cowan, *United States Laws and the Rights of the Terminally Ill*, 28 MED. & LAW 519, 519–528 (2009).

7. *In re* Quinlan, 348 A.2d 801, 806 (N.J. Super. Ct. Ch. Div. 1975), *modified*, 355 A.2d 647 (N.J. 1976).

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.* at 807.

Doctors never established the cause of Karen's unconsciousness or cessation of her breathing.[13] She became comatose in a more or less fetal position.[14] While the cause of the coma has never been ascertained, it was undisputed by all parties that she had entered a persistent vegetative state with irreversible brain damage.[15] She was not brain dead, but the damage was so severe that Karen was unable to breathe without a respirator.[16]

On July 31, 1975, Karen's parents requested, in writing, that she be taken off the respirator and allowed to die.[17] In the same writing, they released the attending physicians, medical personnel, and hospital from all liability for complying with the request.[18] However, the attending physicians refused to comply with the request.[19] The doctors concluded that removing life support from a patient who was not already dead was inconsistent with a physician's required standard of care.[20]

Karen's father, Joseph, sought a declaratory judgment in state court appointing him guardian of her person and granting him specific authority to compel the removal of the respirator.[21] The Chancery Division of the Superior Court of New Jersey refused, concluding that any decision regarding proper medical treatment should be left to the physicians and that such decision "may be concurred in by the parents but not governed by them."[22]

The court also concluded that performing an intentional act that could reasonably be expected to cause the death of a living person, regardless of the motive, would be grounds for conviction under state laws regarding homicide.[23] The court cited cases from New Jersey, Montana, and California.[24]

The court also dismissed the claim that interference with Karen's right of self-determination would be a violation of the right of privacy expressed in *Griswold*.[25] The court concluded that even if the *Griswold* right of privacy extended to include Karen's rights in this regard, the State of New Jersey, as *Parens Patriae*, had a sufficiently compelling interest in the preservation of life and the protection of an incompetent citizen, which trumped any claim of privacy.[26] The court also dismissed on other grounds that are not relevant to

13. *Id.* at 806.
14. *Id.* at 807.
15. *Id.* at 811.
16. *Id.* at 810.
17. *Id.* at 813–14.
18. *Id.* at 814.
19. *Id.*
20. *Id.*
21. *Id.* at 806.
22. *Id.* at 819.
23. *Id.* at 820.
24. *Id.*
25. *Id.* at 821–22 (citing Griswold v. Connecticut, 381 U.S. 479 (1965)).
26. *Id.* at 822.

this article.[27] Joseph then argued that refusal to allow removal of the respirator constituted an interference with the family's free exercise of religion.[28]

Joseph appealed to the New Jersey Supreme Court.[29] The court appointed a guardian ad litem to represent Karen's interests.[30] The State of New Jersey, the County of Morris, St. Clare's Hospital, and the attending physicians were also represented at trial.[31] The case was argued on January 26, 1976, and the decision was announced on March 31, 1976.[32]

The court concluded that the *Griswold* right of privacy included the right to make one's own decisions regarding medical treatment.[33] The court recognized the interests of physicians to not be required to act contrary to their professional judgment regarding treatment of their patients, and the interests of the state in preserving human life.[34] The court balanced these competing interests and concluded that as the patient's condition becomes more degraded and the required medical treatment becomes more invasive, the more prevalent the patient's right of privacy and self-determination becomes.[35] "We think that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."[36]

The court also concluded that having established Karen's right (exercisable through her guardian) to be removed from the respirator, the act of the physicians, medical personnel, or the hospital would not be an unlawful act and that death would result not from that act but from natural causes, and thus there would be no civil or criminal penalty imposed upon anyone for such removal.[37] The court remanded the case to the Superior Court with instructions that Joseph be appointed as guardian of the person for Karen, and that if the attending physicians determined Karen's condition was irreversible and the hospital's Ethics Panel concurred, then upon the orders of the family, Karen should be removed from the respirator.[38]

The decision of the lower court in *Quinlan* was based in part on its conclusion that the removal of life support could only occur legally once the patient was dead.[39] Since the 1968 report by the Ad Hoc Committee of the

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27. *See id.* at 823–24 (discussing the inapplicability of the Constitutional protection against cruel and unusual punishment).

28. *Id.* at 822–23; *see infra* Part III (discussing Joseph's argument that refusal to remove the respirator constituted an interference with the family's free exercise of religion).

29. *In re* Quinlan, 355 A.2d 647, 657 (N.J. 1976).

30. *Id.*

31. *Id.*

32. *Id.* at 647.

33. *Id.* at 664.

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.* at 670.

38. *Id.* at 671.

39. *Id.* at 656.

Harvard Medical School, the test for death was "brain death," which is essentially the absence of any brain functions.[40]

The attending physician, Dr. Morse, made his decision to refuse Mr. Quinlan's request for removal of the respirator based upon his own conception of medical standards, practice, and ethics.[41] Dr. Sydney Diamond, a neurologist called as a witness for the State, testified that "no physician would have failed to provide respirator support at the outset and none would interrupt its life-saving course thereafter, except in the case of cerebral death."[42]

The court, however, concluded that the time had come to depart from the standard of brain death and decided to allow the withholding of extraordinary means whenever the attending physician determines and a satisfactory review mechanism, such as an ethics committee, agrees that there is no reasonable possibility of the patient ever emerging from a present, comatose condition to a cognitive, sapient state.[43] Moving the focus from brain death to irreversible condition as the point of distinction between homicide or suicide and an exercise of the "right to die," has been universally accepted.[44] Some later cases have either eschewed or rejected the extension of the *Griswold* "right of privacy" theory but have reached the same conclusion regarding the right to refuse medical treatment on the basis of the common law right of "informed consent."[45]

A few years after *Quinlan*, the Missouri Supreme Court had a similar "life-support" conflict to decide.[46] On January 11, 1983, twenty-five-year-old Nancy Cruzan lost control of her car on a country road in Jasper County, Missouri.[47] The car overturned and she was thrown face down into the shallow water of a roadside ditch.[48] When paramedics arrived she was unconscious, not breathing, and had no heartbeat.[49] They were able to restore her heartbeat and breathing at the scene.[50] She remained unconscious and was transported to a hospital where she was determined to be comatose as a result of her brain being deprived of oxygen between twelve to fourteen minutes while she was face down in the water.[51] She remained in a coma for about three weeks then progressed to a state of permanent unconsciousness.[52] Surgeons implanted a

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40. *Id.*
41. *Id.* at 657.
42. *Id.*
43. *Id.* at 671.
44. *See id.* at 667.
45. Application of Eichner, 423 N.Y.S.2d 580, 591 (N.Y. Sup. Ct. 1979), *modified sub. nom.* Eichner v. Dillon, 426 N.Y.S.2d 517 (N.Y. App. Div. 1980).
46. *See* Cruzan v. Harmon, 760 S.W.2d 408, 408 (Mo. 1988).
47. *Id.* at 410–11.
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. *Id.* at 431.

gastrostomy feeding tube.[53] Her husband, who obtained a divorce a few months after the accident, authorized all of her medical treatment.[54] Nancy was later transferred to Mount Vernon State Hospital and her medical care was provided by the state.[55] After all efforts to revive her had failed, and it was clear that she would never awaken from her "persistent vegetative state," her parents, as her legal guardians, asked that the feeding tube be removed.[56] The employees and the administrator of the state hospital refused to remove the feeding tube without a court order.[57] The parents sought a declaratory judgment in the Circuit Court of Jasper County, Probate Division, and the court ordered the removal of the feeding tube.[58] The court concluded that the guardians could exercise Nancy's right of self-determination, and to the extent the Missouri Statute deprived Nancy of that right, the statute was unconstitutional.[59] Both the State of Missouri and the guardian ad litem, appointed for Nancy, appealed the decision and the case was heard en banc by the Missouri Supreme Court.[60]

Justice Robertson, writing for the majority, began the opinion with rather strong language:

> But this is not a case in which we are asked to let someone die. Nancy is not dead. Nor is she terminally ill. This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration. . . . We are asked to hold that the cost of maintaining Nancy's present life is too great when weighed against the benefit that life conveys both to Nancy and her loved ones and that she must die.[61]

This statement is consistent with the apparent legislative policy embodied in the Missouri "right to die" legislation.[62] The Missouri legislature enacted a "living will" statute in 1986, codifying the right to make decisions regarding medical treatment and the right to give advance directions in anticipation of the loss of capacity to continue to make such decisions.[63] As the court points out, the Missouri statute is modeled on The Uniform Rights of the Terminally Ill Act (URTIA) "but with substantial modifications which reflect this State's strong interest in life."[64] First, URTIA uses the term "life-sustaining treatment"

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53. *Id.* at 411 (noting that a gastrostomy feeding tube performs the same function as a nasal-gastric tube but it is surgically implanted through an opening cut in the abdomen).

54. *Id.*

55. *Id.*

56. *Id.* at 410.

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.* at 412.

62. MO. REV. STAT. §§ 459.010–.055 (1986).

63. *See id.*

64. *Cruzan*, 760 S.W.2d at 419; *see* MO. REV. STAT. § 459.010 (1986); *see also* UNIF. RIGHTS OF THE TERMINALLY ILL ACT, *available at* http://www.law.upenn.edu/bll/archives/ulc/fnact99/1980s/urtia89.pdf

defined as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process."[65] The Missouri statute terms such treatment as a "Death-prolonging procedure" defined as:

> [A]ny medical procedure or intervention which, when applied to a patient, would serve only to prolong artificially the dying process and where, in the judgment of the attending physician pursuant to usual and customary medical standards, death will occur within a short time whether or not such procedure is utilized. *Death-prolonging procedure shall not include* the administration of medication or the performance of medical procedure deemed necessary to provide comfort, care or to alleviate pain nor *the performance of any procedure to provide nutrition or hydration*.[66]

URTIA defines a terminal condition as "an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time."[67] The Missouri statute defines a terminal condition as "an incurable or irreversible condition which . . . is such that death will occur within a short time regardless of the application of medical procedures."[68]

The court reviewed *Quinlan* and its progeny in great detail.[69] The court concluded first that there is no generalized right to privacy contained in the Missouri Constitution and questioned whether the general right of privacy announced in *Griswold* should have as broad of an application as held by courts in many cases in other jurisdictions.[70] In the end, the court concluded that even if the right of privacy does extend to decisions regarding medical care choices such as the one at issue, neither that right nor the common law right of informed consent are absolute.[71] The court concluded that the competing interests of the state in the preservation of life requires a balancing test and that under the circumstances of this case, neither the burden of medical treatment nor the invasion of Nancy's privacy outweigh the interests of the state.[72]

> Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment, whether that right proceeds from a constitutional right of privacy or a common law

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(being adopted at the 1989 Annual Conference of the National Conference of Commissioners on Uniform State Laws and approved by the American Bar Association at the Los Angeles meeting on February 13, 1990).

65. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1(4) (1989).
66. § 459.010(3) (emphasis added).
67. MO. REV. STAT. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1(9).
68. § 459.010(6).
69. MO. REV. STAT. *Cruzan*, 760 S.W.2d at 413 (reviewing *In re* Quinlan, 355 A.2d 647 (N.J. 1976)).
70. *Id.* at 418.
71. *Id.* at 417–19.
72. *Id.* at 419–24.

> right to refuse treatment, outweighs the immense, clear fact of life in which the state maintains a vital interest.[73]

After concluding that the state had a vital interest, the court then turned away from that issue entirely and rested its decision instead upon the fact that Nancy refused nothing (she is comatose) and that her guardian was without authority to exercise any substituted judgment for her.[74]

> We therefore do not decide any issue in this case relating to the authority of competent persons to suspend life-sustaining treatment in the face of terminal illness or otherwise. Our focus here is expressly limited to those instances in which the person receiving the life-sustaining treatment is unable to render a decision by reason of incompetency.[75]

The court reviewed the Missouri statute governing the authority of guardians and found nothing in the language of the statute that would authorize the guardian of an incompetent to refuse life-sustaining treatment.[76] The court concluded that if a guardian could have that authority, it would have to have been granted by the incompetent while still competent and that it would have to be reliably proven.[77]

> Assuming, *arguendo*, that the right of privacy may be exercised by a third party in the absence of strict formalities assigning that right, the risk of arbitrary decision making and grave consequences attaches all the more when the third party seeks to cause the death of an incompetent. Just as the State may not delegate to any person the right to veto another's right to privacy choices, no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here.[78]

The court reversed the order of the circuit court and denied the request for authority to remove the feeding tube.[79] The parents petitioned the United States Supreme Court for writ of certiorari, which was granted, and on June 25, 1990, the United States Supreme Court upheld the decision.[80] Chief Justice Rehnquist, writing for the 5-4 majority, concluded that there is a right to refuse medical treatment protected by the U.S. Constitution, but that it is more properly considered a liberty interest under the Fourteenth Amendment than an

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73. *Id.* at 424.
74. *Id.* at 424–26.
75. *Id.* at 424.
76. *Id.* at 412.
77. *Id.*
78. *Id.* at 425.
79. *Id.* at 426–27.
80. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990).

extension of the right of privacy.[81] Moreover, the Court held that Missouri committed no constitutional error in requiring clear and convincing evidence of a guardian's authority to make such a decision, and that there was no constitutional error in refusing to allow anyone else, including the parents, to make the decision in the absence of substantial proof that the patient would, if capable, agree.[82]

The Court announced its decision on June 25, 1990.[83] Two months later, Nancy's parents petitioned Judge Teel of the Jasper County Circuit Court for a rehearing.[84] In September, the State of Missouri withdrew announcing it had no further interest in the case (apparently other than having obtained confirmation of its right to require clear and convincing evidence).[85] In November 1990, after hearing new evidence, Judge Teel authorized the removal of the feeding tube.[86] Doctors removed the feeding tube in mid-December, and Nancy died on December 26, 1990.[87]

III. CONFLICT OF CONSCIENCE

The *Cruzan* decision ends any debate regarding the legal right of a patient to choose to refuse medical treatment but does not end the debate regarding the moral or ethical correctness of making such a choice.[88] The Missouri Supreme Court drew a distinction between sustaining life and causing death.[89] There is widening discussion about the difference between the withdrawal of mechanical life support, such as a respirator that performs a bodily function when the body is no longer capable of doing so, and the denial of nutrition and hydration.[90]

Once Karen Quinlan was removed from the respirator, she remained comatose but breathed on her own and was kept alive for several years by a nasal gastric feeding tube.[91] At the time of the litigation, no request was made or considered regarding removal of the feeding tube.[92] Joseph Quinlan, a

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81. *Id.*

82. *Id.* at 279, 285–86.

83. *Id.* at 261.

84. Priscilla King, *Courting Death: Euthanasia and the Courts*, PREGNANT PAUSE, Sept. 9, 2000, *available at* http://www.pregnantpause.org/euth/courtsum.htm.

85. *Id.*

86. *Id.*

87. *Id.*

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

89. *See* Cruzan v. Harmon, 760 S.W.2d 408, 427 (Mo. 1988), *aff'd*, 497 U.S. 261, 287 (1990) (explaining the holding as "err[ing] on the side of life" over allowing guardians to "choose the death of their ward").

90. *See id.*

91. Tony Long, *June 11, 1985: Karen Quinlan Dies, But the Issue Lives On*, June 6, 2008, http://www.wired.com/science/discoveries/news/2008/06/dayintech_0611.

92. *See In re* Quinlan, 348 A.2d 801, 812 (N.J. Super. Ct. Ch. Div. 1975) (discussing the parents' request to remove the respirator, but never mentioning a request to remove the feeding tube), *modified*, 355 A.2d 647 (N.J. 1976).

devout Catholic, was very concerned about the position of the church regarding the removal of the respirator.[93] According to the record, Mr. Quinlan decided to remove the respirator because he was satisfied that removal complied with the ordinances of the Catholic Church.[94] The New Jersey Supreme Court recounted Joseph's inquires of the church and the responses he received and confirmed that it would not violate Catholic principles to remove the respirator.[95] The court recounted his inquires not for the support of its decision, but rather as evidence of Mr. Quinlan's good faith, sincerity of purpose, and suitability to serve as guardian of Karen's person.[96] But Quinlan never made any inquiry nor sought any advice from his priest or bishop concerning the position of the church with regard to the removal of the feeding tube.[97] We do not know what the response would have been had he done so in 1976, but the position of the church is now clearly established.[98]

The *Quinlan* opinion provides the following information regarding the position of the Catholic Church on removal of the mechanical respirator:

> It was in this sense of relevance that we admitted as *amicus curiae* the New Jersey Catholic Conference, essentially the spokesman for the various Catholic bishops of New Jersey, organized to give witness to spiritual values in public affairs in the statewide community. The position statement of Bishop Lawrence B. Casey, reproduced in the *amicus* brief, projects these views:
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> (a) The verification of the fact of death in a particular case cannot be deduced from any religious or moral principle and, under this aspect, does not fall within the competence of the church; — that [sic] dependence must be had upon traditional and medical standards, and by these standards Karen Ann Quinlan is assumed to be alive.
>
> (b) The request of plaintiff for authority to terminate a medical procedure characterized as "an extraordinary means of treatment" would not involve euthanasia. This upon the reasoning expressed by Pope Pius XII in his "allocutio" (address) to anesthesiologists on November 24, 1957, when he dealt with the question:
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> Does the anesthesiologist have the right, or is he bound, in all cases of deep unconsciousness, even in those that are completely hopeless in the opinion of the competent doctor, to use modern artificial respiration apparatus, even against the will of the family?
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> His answer made the following points:

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93. *See id.* at 813.
94. *Id.*
95. *Id.*
96. *Id.* at 824.
97. *See id.*
98. *See generally Religiously-based Restrictions on End-of-Life Care Options: Will the Terri Schiavo Case Change Patient's Rights?,* www.mergerwatch.org/pdfs/schiavo_qa.pdf (last visited March 8, 2011) (discussing the position of the Catholic Church on end-of-life care and life-sustaining treatment).

> 1. In ordinary cases the doctor has the right to act in this manner, but is not bound to do so unless this is the only way of fulfilling another certain moral duty.
> 2. The doctor, however, has no right independent of the patient. He can act only if the patient explicitly or implicitly, directly or indirectly gives him the permission.
> 3. The treatment as described in the question constitutes extraordinary means of preserving life and so there is no obligation to use them nor to give the doctor permission to use them.
> 4. The rights and the duties of the family depend on the presumed will of the unconscious patient if he or she is of legal age, and the family, too, is bound to use only ordinary means.
> 5. This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect."[99]

IV. DIRECTIVE 58—U.S. CONFERENCE OF CATHOLIC BISHOPS

The position of the Catholic Church regarding the removal of a feeding tube has been a topic of discussion and recent decision.[100]

The Pontifical Academy for Life and the World Federation of Catholic Medical Associations met in an International Congress on Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas in March 2004, at Vatican City in Rome.[101] In his address, Pope John Paul II asserted that the word "permanent" in describing a patient's "vegetative state" was a medical guess, not a certainty, and in fact that the application of the term vegetative to a human life offended the dignity of the life God has given.[102] He further stated, and the Joint Statement of the Congress posited, that the withholding of water and food, even when it can only be provided by artificial means, is euthanasia and a serious violation of the Law of God.[103] The Pope also declared that withholding food and water could not be justified by a balancing test because no evaluation of psychological, social, or economic costs could ever outweigh the value of human life.[104]

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99. *In re* Quinlan, 355 A.2d 647, 658 (N.J. 1976).

100. *See infra* notes 101–07 and accompanying text.

101. Pontifical Academy for Life World Federation of Catholic Medical Associations, International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas," Joint Statement on the Vegetative State (March 10–17, 2004), http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc_20040320_joint-statement-veget-state_en.html.

102. John Paul II, Address to Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" Joint Statement on the Vegetative State (March 20, 2004) http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_ 20040320_congress-fiamc_en.html.

103. *Id.*; Joint Statement on the Vegetative State, *supra* notes 101–02.

104. John Paul II, *supra* note 102.

The Pope did not mention the responsibility of the patient, but the Joint Statement suggested "personal autonomy can never justify decisions or actions against one's own life."[105]

Pope Benedict reaffirmed this position, as did Directive 58, issued in November 29, 2009 by the U.S. Conference of Catholic Bishops.[106] The directive, addressed to all Catholic medical care facilities, requires that in the case of any person needing a feeding tube to stay alive, the feeding tube must be surgically inserted and maintained indefinitely.[107]

The difference between the position of the church regarding removal of a mechanical respirator and the position of the church regarding the removal of a feeding tube is a distinction that need not lie in religious doctrine, but can equally be justified in logic and secular ethos.[108] If a patient who is removed from a mechanical respirator dies because of the failure of the body to perform respiration on its own, a doctor can trace the cause of death to the original injury or disease that destroyed the body's natural ability to perform this function. However, if a patient dies from the lack of nutrition and hydration because the body cannot feed and hydrate itself, then the patient did not die as the result of a natural bodily function. Sustenance and hydration must be externally introduced to the body, and the failure to do so will likely cause death. One cannot help but recall the words of Justice Robertson of the Missouri Supreme Court: "This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration."[109]

In addition to the foregoing distinction, there would seem to be a possible difference in how the "balancing," discussed in both *Quinlan* and *Cruzan*, of state interests in the preservation of human life and the interests of medical providers in complying with professional standards are weighed against the degree of invasion of the patient's personal privacy.[110] A patient connected to a mechanical device, which only functions by forcing the body to do something such as breathing, would arguably be a significantly greater invasion of personal privacy than the placement of a nasal gastric tube and the periodic introduction of fluids.

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105. Joint Statement on the Vegetative State, *supra* note 101.

106. United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services (Nov. 17, 2009), *available at* http://www.usccb.org/meetings/2009Fall/docs/ERDs_5th_ed_091118_FINAL.pdf.

107. *See* Sandra Johnson, *The Catholic Bishops, The Law, and Nutrition and Hydration: An Historical Footnote*, 19 ANNALS HEALTH L. 97, 97–99 (Special Edition 2010) (discussing #58 of the Ethics and Religious Directives for Catholic Health Care Services).

108. *See id.*

109. Cruzan v. Harmon, 760 S.W.2d 408, 412 (Mo. 1988).

110. *Id.* at 420–24; *In re* Quinlan, 355 A.2d 647, 662–69 (N.J. 1976).

V. SECULAR RESERVATIONS REGARDING WITHHOLDING OF LIFE SUPPORT

The *Cruzan* opinion cited numerous state cases concerned with the question of withholding life support.[111] Nearly all of the state cases involved the refusal of physicians and health care providers to withhold life support due to the uncertainty of the legality of such measures.[112] Almost certainly on advice of legal counsel, the medical personnel involved required a court order before complying with a request to perform any act that could be considered the deliberate causing of the death of a human being with all the attendant civil and criminal liabilities.[113] However, some of the cases involved institutions or medical personnel who viewed any act that deliberately causes death as contrary to their professional responsibility, regardless of how the state might view it.[114]

In *Brophy v. New England Sinai Hospital, Inc.*, the attending physician refused to carry out the request for removal of a nasal gastric feeding tube because he believed that he would be willfully causing the patient's death.[115] The medical and nursing staff at the hospital, as well as the medical executive committee and the board of directors of the hospital, endorsed the physician's position.[116] The patient's family then brought suit seeking a court order for removal or clamping of the tube.[117] The trial court denied the request and enjoined the hospital and physicians from removing the tube.[118] The Supreme Judicial Court of Massachusetts concluded that Brophy had the right to refuse treatment and that his guardian could exercise substituted judgment on his behalf.[119] The court upheld the right of the medical personnel and hospital to refuse suspension of treatment but ordered the hospital to cooperate with and assist the guardian in transferring Brophy to another institution that would be willing to remove the tube.[120]

VI. *BARTLING I*: ACTION FOR INJUNCTIVE RELIEF

A California case cited in *Cruzan* involved a conflict between the patient's rights and the ethical and professional beliefs of the Glendale Adventist Medical Center and its physicians.[121]

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111. *Cruzan*, 760 S.W.2d at 414–16.
112. *Id.*
113. *Id.* at 434; *see also Quinlan*, 355 A.2d at 669–70.
114. *Cruzan*, 760 S.W.2d at 414–17.
115. Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 628–29 (Mass. 1986).
116. *Id.*
117. *Id.*
118. *Id.* at 629.
119. *Id.* at 638–39.
120. *Id.*
121. Bartling v. Superior Court, 209 Cal. Rptr. 220, 220 (Cal. Ct. App. 1984).

On April 8, 1984, 70-year-old William Bartling was admitted to Glendale Adventist Medical Center suffering chronic depression.[122] At that time, he also suffered from emphysema, atherosclerotic cardiovascular disease, coronary arteriosclerosis, abdominal aneurysm, and lung cancer.[123] During a needle biopsy on April 14, 1984, his lung collapsed and he was placed on a mechanical ventilator by way of a tracheostomy.[124] On several occasions afterward, he attempted to physically remove the ventilator and was restrained.[125]

On May 30, 1984, Bartling executed a living will specifically directing that the ventilator be removed and acknowledging that doing so could result in his death.[126] He also executed a Health Care Power of Attorney conferring decision-making power to his wife.[127] Thereafter, his wife directed the removal of the ventilator in accordance with his stated wishes.[128] Bartling, his wife, and his only child signed waivers releasing the hospital and the physicians from any civil liability for the result of removing the ventilator.[129]

The doctors attempted to wean Bartling from the machine but each time his breathing and/or heart began to fail, he was reconnected.[130] They refused to leave him unconnected and refused to release him from the restraints that prevented him from removing the ventilator.[131] The hospital attempted to locate a facility to transfer Bartling to, but no institution or physician was willing to accept the transfer.[132] In June 1984, the family sought an injunction requiring removal of the ventilator.[133]

The refusal of the hospital and the physicians to comply with the demand for removal was based on their view that to knowingly perform an act that would result in almost certain death of the patient was inconsistent with their institutional and personal beliefs.[134] "From an ethical standpoint, declarations were submitted to the effect that Glendale Adventist is a Christian hospital devoted to the preservation of life, and it would be unethical for Glendale Adventist's physicians to disconnect life-support systems from patients whom they viewed as having the potential for cognitive, sapient life."[135] The court did

122. *Id.* at 221–22.
123. *Id.* at 220.
124. *Id.* at 221.
125. *Id.*
126. *Id.* at 221–22.
127. *Id.*
128. *Id.* at 222–23.
129. *Id.* at 222.
130. *Id.* at 221.
131. *Id.* at 222.
132. *Id.*
133. *Id.*
134. *Id.* at 223.
135. *Id.*

not state who authored those declarations, but apparently they came from hospital officials and physicians.[136]

The trial court dismissed the petition for injunctive relief, concluding that Bartling was neither comatose nor terminally ill.[137] Relying on the decision in *Quinlan,* the court stated that a constitutional right issue existed only under circumstances of persistent vegetative state or terminal illness, and that as long as there was the possibility of restoring the patient to a "cognitive, sapient life," injunctive relief was inappropriate.[138]

Despite the fact that this action was rendered moot, insofar as injunctive relief, by reason of Bartling's death on November 6, 1984, the appellate court took the case because of the significant question presented; the court concluded that the constitutional right of self-determination on issues of medical treatment was not limited by *Quinlan* or otherwise to comatose or terminally ill patients, and that if Bartling had lived, the court would have ordered that he be allowed to remain in the hospital or to leave the hospital without restraint and without being connected to the ventilator.[139]

VII. *BARTLING II*: ACTION FOR DAMAGES

The family then brought an action against the hospital seeking damages for battery, breach of fiduciary duty, intentional infliction of emotional distress, and the violation of constitutional and federal civil rights.[140] All of the claims were dismissed for failure to state a cause of action.[141] The family appealed and the California Court of Appeals affirmed.[142] All of the claimed actions required a showing of something more than mere negligence and the court concluded that the state of the law was such that the actions of the hospital and the physicians did not rise to the level of "willful" disregard of Bartling's rights.[143] It is significant that the court based its decision in large part on the fact that all of the acts occurred prior to Bartling's death in November 1984, and the court had not rendered its decision in the earlier case until December 1984.[144] Referring to its earlier decision in *Bartling I*, the court said:

> There [in Bartling I], we concluded that the State's interests in preserving life, preventing suicide and maintaining the ethical integrity of the medical profession did not prevail over the right of a competent adult to discontinue his life support systems. While we vindicated Mr. Bartling's right to die, we

136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.* at 226.
140. Bartling v. Glendale Adventist Med. Ctr. (Bartling II), 229 Ca. Rptr. 360, 361 (Cal. Ct. App. 1986).
141. *Id.*
142. *Id.* at 366.
143. *See generally id.*
144. *Id.* at 360–62.

> also stressed the sincerity of Glendale Adventist's position. As a pro-life oriented hospital, a majority of Glendale Adventist's doctors viewed disconnection of life support in a case like this as incongruous with the healing obligations of physicians. We further noted that Glendale Adventist tried to effect a compromise between their own position and the desires of the Bartlings by seeking to find another hospital which would admit Mr. Bartling. Unfortunately, this effort failed. Indeed, "none of the medical ethics "experts" who submitted declarations in support of the [Bartlings] were willing to undertake [Mr. Bartling's care].[145]

The court noted that "Bartling's own attorney [had indicated] that many institutions refused Mr. Bartling as a patient due to potential medical costs they might have to absorb or for fear of criminal and civil liability."[146]

"As we stated in *Bartling I*, respondents were acting in conformance with what they believed to be their professional and religious obligations. We find no factual support for appellants' claim that respondents' actions were extreme and outrageous or that they warranted an assessment of general or punitive damages."[147]

Similarly, the court dismissed a claim based on 42 U.S.C. Section 1985(3), "conspiracy to deprive . . . Bartling of his [civil] rights," because, among other things, such a claim requires a showing of "invidious discriminatory animus."[148] For the same reasons as stated above, the court concluded that the physicians and the hospital were acting in good faith to save Bartling's life.[149]

One can only wonder what the court would do, after having issued *Bartling I*, if the same facts were to arise today. Presumably, Glendale Adventist and its physicians would still have the same reservations about terminating Bartling's treatment and could again find it impossible to move him to another facility. The court's pronouncement in *Bartling II* that it would "order" the facility to remove the respirator was dictum since Bartling was already dead.[150] If the court were to enter such an injunction requiring the hospital and its physicians to perform an act that was ethically objectionable to them, it would be a rarity among cases and seems unlikely in light of statutory developments since then.[151]

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145. *Id.* at 362.
146. *Id.*
147. *Id.* at 364.
148. *Id.* at 365–66.
149. *Id.*
150. *Id.* at 361–62.
151. *See infra* Part VIII.

VIII. "UNIFORM" STATUTES

In 1999, California enacted its version of the Uniform Health Care Decisions Act.[152] Under Section 4734 of the Act, a physician or a health care facility may decline to carry out the terms of an advance directive for reasons of conscience.[153] In that event, the physician or institution is required to make "reasonable efforts" to transfer the patient to another physician or institution willing to comply.[154] Section 4740 provides full immunity for civil liability, criminal liability, or disciplinary action for such refusal, as long as the physician or institution has complied with the statute by making reasonable efforts to transfer the patient to another physician or institution.[155] The Act does not address the circumstances where it is impossible to transfer the patient despite reasonable efforts.[156]

The California statute is fairly typical of statutes modeled on the Uniform Health Care Decisions Act of 1993, which requires health care providers to make a reasonable effort to transfer the patient in cases of refusal to withhold life support.[157] A few states only require the health care provider to notify the

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152. CAL. PROBATE CODE § 4670 (West 2009).
153. § 4734.
154. § 4736.
155. § 4740.
156. *See generally* §§ 4670–4743.
157. The following statutes all grant immunity for refusal to comply as long as the health care provider makes reasonable efforts to transfer the patient to another provider:
ALA. CODE § 22-8A-8(a) (1975).
ARIZ. REV. STAT. ANN. § 36-3205(c) (1956).
COLO. REV. STAT. § 15-18-113(5) (2010).
CONN. GEN. STAT. § 19a-580a (1958).
D.C. CODE § 7-627(b) (2010).
FLA. STAT. ANN. § 765-1105(i) (2003).
HAW. REV. STAT. § 327E-7(g) (2007).
IOWA CODE ANN. § 144A.1 (West 1989).
KAN. STAT. ANN. § 65-28,107(a) (2008).
LA. REV. STAT. ANN. § 40:1299.58.7(D) (1979).
MD. CODE ANN. HEALTH – GEN. § 5-613(a) (2010).
MICH. COMD. LAWS § 459.031 (1986).
MONT. CODE ANN. § 2009 50-9-23 (2009).
NEV. REV. STAT. § 449.628 (2009).
N.H. REV. STAT. ANN. § 137-Ji7(iv) (1955).
N.J. STAT. ANN. § 26:2H-65(b) (West 1993).
N.D. CENT. CODE § 23-06.5-09(2) (2009).
OKLA. STAT. ANN. tit. 63, § 3101.9 (2005).
R.I. GEN. LAWS § 23-4.11-7 (1956).
S.C. CODE ANN. § 44-77-100 (1976).
S.D. CODIFIED LAWS § 34-12D-11 (2004).
TEX. HEALTH & SAFETY CODE ANN. § 166.001 (1999).
TENN. CODE ANN. § 32-11-101 (2010).
UTAH CODE ANN. § 75-2a-115(2) (1953).
VT. STAT. ANN. tit. 18 § 9707(c) (2000).
VA. CODE ANN. § 54.1-2987 (West 1950).
WIS. STAT. ANN. § 154.07 (West 2006).

patient or the surrogate that it will not comply with the advance directive, and then the surrogate is responsible for arranging the transfer and the health care provider must only cooperate or "not impede" the transfer.[158] The Washington statute provides immunity for refusal to comply with a directive as long as the health care provider informs the patient or surrogate as soon as the provider becomes aware of an advance directive, and provides a statement in writing of what plan of action the provider will follow in the event the circumstances described in the advance directive shall arise. The statute does not mention transfer but implicitly leaves that decision to the patient or the surrogate.[159]

Only one statute addresses directly the question of responsibility for the costs of a transfer necessitated by the refusal of the health care provider to honor a directive.[160] The Florida statute requires the health care provider to transfer the patient within seven days and to pay for the cost of the transfer.[161] Most do not address the situation, present in *Bartling*, where transfer is impossible.[162] Both the New York and Massachusetts statutes provide for refusal on religious principles by an individual health care professional or a private health care institution to honor a directive if the patient is transferred to another provider, and if such a transfer is not available, then the professional or institution must either seek judicial guidance or comply with the directive.[163] The Florida statute requires the health care provider to comply with the directive if transfer is not possible.[164] The Pennsylvania and Indiana statutes provide that the health care provider may still refuse to follow the directive if they have made reasonable efforts to transfer the patient.[165] The Michigan

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WYO. STAT. ANN. § 35-22-408 (2009).

158. ALASKA STAT. § 13.52.060 (2010).
ARK. CODE ANN. § 20-17-207 (2005).
DEL. CODE ANN. tit. 16, § 2508(g) (2003).
GA. CODE ANN. § 31-32-8 (2009).
IDAHO CODE ANN. § 39-4513 (2002).
755 ILL. COMP. STAT. § 35-11-6 (2007).
KY. REV. STAT. ANN. § 311.633 (Lexis Nexis 2007).
ME. REV. STAT. ANN. tit. 18A § 5-807(g) (1998).
MINN. STAT. ANN. § 145c.11 (West 2005).
MISS. CODE ANN. § 41-41-215(7) (2009).
NEB. REV. STAT. ANN. § 30-3428 (2010).
N.C. GEN. STAT. ANN. § 90-312(k) (West 2009).
OHIO REV. CODE ANN. § 2133.10(A) (West 2005).
OR. REV. STAT. ANN. § 127.635 (West 2009).
PA. CONS. STAT. ANN. § 20-5424 (West 2005).
W. VA. CODE ANN. § 16-30-12 (Lexis Nexis 2005).

159. WASH. REV. CODE ANN. § 70.122.060(4) (West 2002).

160. FLA. STAT. ANN. § 765-1105 (2)(b) (West 1994).

161. *Id.*

162. *See* Statutes, *supra* notes 157–58.

163. N.Y. Pub. Health Law § 2984 (McKinney 2007); Mass. Gen. Laws ch. 201D § 14,15 (neither statute makes any provision for refusal by a public institution).

164. *See* Statutes, *supra* notes 157–58.

165. 20 PA. CONS. STAT. ANN. § 5424(d) (West 2007); IND. CODE ANN. § 16-36-4-13 (West 2006).

statute makes no provision for the refusal of anyone to comply with a directive.[166] The statute simply provides that:

> [a] person providing care, custody, or medical or mental health treatment to a patient is bound by sound medical, or, if applicable, mental health treatment practice and by a patient advocate's instructions if the patient advocate complies with sections 5506 to 5515, but is not bound by the patient advocate's instructions if the patient advocate does not comply with these sections.[167]

Most statutes simply do not address the circumstance where transfer is impossible or completely impractical.[168] If the statutes are intended to be an accumulation of the law, then all common law and equitable remedies should be available; however, most statutes provide that where the "reasonable efforts" to transfer have been satisfied, the health care provider shall be immune from "civil or criminal" penalties.[169]

IX. ACTIONS FOR DAMAGES

By the time *Cruzan* was decided in 1990, many courts had recognized the right to refuse treatment; however, no damages were being awarded for failure of a health care provider to comply with a request for removal of life support.[170] Courts still do not frequently award damages against health care providers.[171] In 1996, a Michigan jury awarded Brenda Young and members of her family $16.5 million in damages for pain and suffering, medical care costs, and emotional harm for keeping her on mechanical life support, which included nutrition and hydration for over two months.[172] The trial judge reduced the award to $1.4 million.[173] Both parties filed notice of appeal but the case was settled.[174]

A Florida jury returned a $150,000 verdict against a nursing home for failing to formulate proper procedural guidelines regarding life support, which

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166. MICH. COMP. LAWS ANN. § 700.5111(3) (West 2002).

167. *Id.*

168. *See, e.g.*, *id.*

169. *See, e.g.*, PA. CONS. STAT. ANN. § 5424(d); *see, e.g.*, IND. CODE ANN. § 16-36-4-13.

170. *See* M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499, 500-04 (1992); *see* Steven I. Addestone, *Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy*, 46 VAND. L. REV. 1255, 1258-60 (1993).

171. *See* Mark Strasser, *A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right of Bodily Integrity*, 36 SAN DIEGO L. REV. 997, 998 (Fall 1999) (discussing Brenda Young in great detail).

172. *Id.* at 1041.

173. *See* Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives*, 20 J. LEGAL MED. 1, 49 (Mar. 1999) (discussing the Brenda Young damage reduction to 1.4 million).

174. *Id.* at 31.

is different than the circumstances in Michigan.[175] The Michigan case involved egregious conduct on the part of the physicians who dismissed the patient's mother's questions and instructions.[176] In numerous cases, the health care provider refused to comply with instructions for removal of life support because there were valid questions regarding the surrogate's authority.[177]

In *Duarte v. Chino Community Hospital*, the family of Martha Duarte sought monetary damages from the hospital and the attending physician for professional negligence and intentional infliction of emotional distress.[178] On June 3, 1991, Mrs. Duarte suffered a severe brain injury from an automobile accident.[179] Upon arrival at the hospital she was placed on a respirator.[180] By June 8th, neurologists determined she was in a persistent vegetative state.[181] On June 12th, the family requested that Mrs. Duarte be removed from the respirator.[182] Her attending physician, Dr. Ou, refused to do so unless she was brain dead or the family obtained a court order.[183] On June 13th, Dr. Ou asked the family to authorize a tracheotomy and gastrostomy in preparation for Mrs. Duarte's transfer to a long-term care facility.[184] The family refused and was in the process of seeking a court order when she was declared brain dead on July 3rd.[185] The family then filed suit and the jury found for the defendants on all counts.[186] The family appealed the denial of their motion for judgment notwithstanding the verdict.[187] The court of appeal affirmed, noting that the California Health Care Power of Attorney statute grants immunity to any health care provider who refuses to comply with instructions from an attorney-in-fact to withdraw health care necessary to keep the principal alive.[188] In this case, Mrs. Duarte had not executed a power of attorney and the court concluded that the immunity provided in the statute should be available to the physician and the hospital.[189] The court rejected the argument that damages were appropriate because the California Health and Safety Code section 7191(a) makes it a

175. Estate of Neumann v. Morse Geriatric Ctr., 2007 WL 1159236 (Cir. Ct. Palm Beach Co., FL, Mar. 16, 2007).

176. Rodriguez, *supra* note 173, at 28 (discussing cases regarding suing health care providers).

177. *See generally In re* AB, 768 N.Y.S. 2d 256 (N.Y. 2003); *In re* Tavel, 661 A.2d 1061 (Del. 1995); *In re* Martin, 517 N.W.2d 749 (Mich. App. Ct. 1994); *In re* Christopher I, 131 Cal. Rptr. 2d 122 (Cal. Ct. App. 2003); *In re* Edna M.F., 563 N.W.2d 485 (Wis. 1997); *In re* Fiori, 673 A.2d 905 (Pa. 1996); D.K. v. Com. ex rel. Cabinet for Health and Family Servs., 221 S.W.3d 382 (Ky. Ct. App. 2007); *In re* Blersack, not reported in N.E.2d, 2004 WL 2785963 (Ohio Ct. App. 2004).

178. Duarte v. Chino Community Hosp., 85 Cal. Rptr. 2d 521, 521 (Cal. Ct. App. 1999).

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.* at 523.

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. *Id.* at 524 (referencing CAL. PROB. CODE § 4750(c) (West 2000)).

189. *Id.* at 525.

misdemeanor to willfully fail to transfer the patient to another facility if there is a refusal to honor an advance directive.[190] However, this section contains no immunity provision.[191] Mrs. Duarte had not executed an advance directive; therefore, the court determined this section to be inapplicable.[192] The court discussed the difference between the two sections in the California Code and the apparent legislative intention that immunity be much narrower in cases of failure to comply with an advance directive, rather than the refusal to follow the directions of a surrogate without an advance directive.[193] Based on the facts of this case, it is not likely that the court would have found the failure to transfer "willful," since the physician sought permission to perform the medical procedures necessary to make the transfer and the family refused.[194]

Other unsuccessful claims, which included sovereign immunity, were when the state's attorney general was sued for resisting a petition by the guardian of an incompetent state hospital patient for removal of life support; failure to state a cause of action for elder abuse or for unfair business practices under state statutes; no cause of action existing under state law for "wrongful living"; and no demonstrated causal relation between resuscitation and subsequent medical problems.[195] In other cases, the patient did not validly execute the advance directive in accordance with the state statute or the patient did not notify the attending nurse and cardiologist of an advance directive, and the patient signed a standard "Consent to Treatment" form upon admission to the hospital.[196]

X. ACTIONS FOR INJUNCTIVE RELIEF

Similarly, no reported decision exists, other than *Bartling,* where a health care provider sought injunctive relief requiring the health care provider or institution to remove life support.[197] Even the very public and fractious battle regarding the feeding tube for Theresa Schiavo was a conflict between her

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190. *See id.* (referencing CAL. HEALTH & SAFETY CODE § 7191(a) (West 2000)).

191. *Id.* at 527.

192. *Id.*

193. *See id.*

194. *See id.*

195. Blouin ex rel. Estate of Poullet v. Spitzer, 356 F.3d 348 (2d. Cir. 2006); Furlong v. Catholic Healthcare West, 2004 WL 2958274 (Cal. Ct. App. 2004); Anderson v. St. Francis-St. George Hosp., Inc., 671 N.E. 2d 225 (Ohio 1996). In this case, the court concluded that an action for battery could be made out in a case of unwanted medical treatment, but recovery would be limited to the injuries caused by the treatment. *Id.* In a case such as resuscitation, damages could include burns from the paddles or bruises from thrashing about, but it is difficult to imagine injury being shown by the refusal to remove a gastric tube. *See id.* For a criticism of the rejection of a "wrongful living" cause of action, *see* Holly Fernandez Lynch, Michele Mathis & Nadia N. Sawicki, *Compliance with Advance Directives, Wrongful Living and Tort Incentives*, 29 J. LEGAL MED. 133 (2008).

196. *See* Haymes v. Brookdale Hosp. Med. Ctr., 278 A.D.2d 486 (N.Y.A.D. 2 Dept. 2001); *see also* Allore v. Flower Hosp., 699 N.E.2d 560 (Ohio App. 6 Dist. 1997); *see also* McCroskey v. Univ. of Tenn., Not Reported in S.W.2d, 1995 WL 329133 (Tenn. App. 1995).

197. Bartling v. Superior Court, 209 Cal. Rptr. 220, 220 (Cal. Ct. App. 1984).

husband and her parents—eventually joined by political interests—and the health care providers were simply caught in the middle.[198] In the *Schiavo* case, the judge directed the guardian, not the provider, to withdraw or cause the withdrawal of the hydration and nutrition tube.[199]

XI. FEDERAL PATIENT SELF DETERMINATION ACT

The Patient Self Determination Act of 1990, hereinafter referred to as "the PSD Act," amended Chapter 42 of the United States Code (42 U.S.C.A. 1395cc) to require that all providers of medical services receiving either Medicare or Medicaid funding put in place written policies to assure that all patients are advised of their rights under state law to make decisions regarding their health care and to provide advance directives regarding their decisions.[200] The PSD Act further requires all providers "to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization[.]"[201]

The view of the Vatican and the American Council of Bishops is that withholding nutrition and hydration constitutes euthanasia or mercy killing.[202] Additionally, the position of the Adventist hospital in *Bartling I* was that cooperating in the removal of the ventilator would constitute assisting or permitting suicide.[203] Furthermore, section 14406 of the PSD Act provides that nothing in the Act shall be construed

> (1) to require any provider or organization, or any employee of such a provider or organization, to inform or counsel any individual regarding any right to obtain an item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of the individual, such as by assisted suicide, euthanasia, or mercy killing; or

198. *In re* Schiavo, 851 So.2d 182, 183 (Fla. Dist. Ct. App. 2003).

199. *Id.* at 187.

200. Omnibus Budget Reconciliation Act of 1990 §§ 4206, 4751, 42 U.S.C.A. § 1395cc (West 1997).
(f) Maintenance of written policies and procedures
(1) For purposes of subsection (a)(1)(Q) of this section and sections 1395i-3(c)(2)(E), 1395*l*(s), 1395w-25(i), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—
(A) to provide written information to each such individual concerning—
(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and
(ii) the written policies of the provider or organization respecting the implementation of such rights

201. *Id.* at (f)(1)(D).

202. *See* Johnson, *supra* note 107.

203. *See* Bartling v. Superior Court, 209 Cal. Rptr. 220, 220 (Cal. Ct. App. 1984); *see also supra* Part VI.

> (2) to apply to or to affect any requirement with respect to a portion of an advance directive that directs the purposeful causing of, or the purposeful assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.[204]

However, Sec. 14402 forecloses the injection of personal or institutional ethical views:

> Nothing in subsection (a) of this section, or in any other provision of this chapter (or in any amendment made by this chapter), [referring to suicide, euthanasia or mercy killing] shall be construed to apply to or to affect any limitation relating to—
>
> (1) the withholding or withdrawing of medical treatment or medical care;
>
> (2) the withholding or withdrawing of nutrition or hydration[.][205]

Presumably, the failure or refusal of a health care provider to comply with the requirements of the statute could result in the loss of Medicare funding.[206] However, there is nothing in the statute that would suggest a private cause of action in the patient or the family of the patient in the event of such failure or refusal.[207]

XII. CONCLUSION

Clearly, a properly executed advance directive and health care power of attorney will preclude any de jure interference with an individual's right to refuse life sustaining treatment, but there appears to be no reason why any health care provider, individual or institution, cannot refuse for reasons of conscience, ethics, or religious belief, to participate or cooperate in the exercise of that right.[208] As long as the refusal to so participate or cooperate is timely communicated, and the individual or institution arranges, assists, or does not interfere with the transfer of the patient to another provider, as the statute may require, there should be no civil or criminal liability or disciplinary action for such refusal. In most jurisdictions, it is not clear who will be responsible for the costs of such a transfer, and it would be prudent for any health care provider with reservations regarding such matters to make a note of those reservations in the intake paperwork and agreement addressing the issue. Likewise, it may be

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204. 42 U.S.C.A. § 14406.
205. 42 U.S.C.A. § 14402.
206. *See id.*
207. *See id.*
208. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 261 (1990); *see also supra* Part I.

unclear what the responsibility of the health care provider will be in the event a transfer cannot be arranged. Therefore, there should be a written agreement at the outset setting forth the responsibilities of the parties in the event a transfer cannot be arranged.