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Liability for Life

by Carl E. Schneider

Marshall Klavan headed the Obstetrics and Gynecology Department of the Crozer-Chester Medical Center.¹ He deeply feared strokes, perhaps because his father had been savaged by one. In 1993, Dr. Klavan wrote an advance directive which said that (as a court later put it) “he ‘absolutely did not want any extraordinary care measures utilized by health care providers.’”

On April 29, 1997, Dr. Klavan tried to kill himself. He left suicide notes and a note refusing resuscitation. The next morning, medical center employees found him unconscious and took him to the emergency room, where he was resuscitated. By May 2, Dr. Klavan had fallen into a persistent vegetative state. His family and his lawyer told the center about his notes and his advance directive. On May 4, the center “agreed to provide care in accordance with” the advance directive, but on May 5 Dr. Klavan’s condition worsened and the center again resuscitated him. He “then suffered a stroke that rendered him mentally and physically incompetent.”

A suit was brought on Dr. Klavan’s behalf in federal court. It claimed that his fourteenth amendment right to refuse medical treatment was being denied. The fourteenth amendment, however, restricts only governments, not private institutions. Had the government so deeply implicated itself in the center’s activities that it had effectively become a governmental institution? The court thought not, leaving Dr. Klavan’s representative only with state-law

claims. The federal court had discretion to take jurisdiction of those claims, but it refused: “While Dr. Klavan’s situation cries out for prompt and definitive judicial resolution, we nevertheless decline to exercise our discretion . . . precisely because of the gravity of his case.”

How did this sad case reach this unsettling result? First, the story I have told may be false.² *Klavan* was decided before a trial could determine what had actually happened. To decide whether it had jurisdiction, the court accepted as true everything Dr. Klavan’s representative had alleged. The court concluded that even if all the allegations were true, it should not grant the relief Dr. Klavan’s representative sought. Therefore we have no idea what the medical center’s defense was or how any factual disputes would have been resolved in a trial. (And even had there been a trial, we could not be *sure* of its conclusions.)

More broadly, however, the *Klavan* court’s reluctance to address the dispute was typical of the judicial reaction to the (uncommon) attempts to enforce living wills. Such attempts are of two kinds. First, people locked in a dispute about treating an incompetent patient can ask a court to settle the disagreement. In doing so, the court can look at the living will and any other relevant evidence. Second, after a patient dies, the family might sue to recover the damages the patient suffered because the living will was disobeyed. Why have courts not embraced either kind of litigation?

In part, courts’ hesitation to enforce living wills reflects a judicial aversion to

disputes about treating the dying. Such disputes demand a speed courts can rarely attain. The patient has often died by the time lawyers have been consulted, non-legal solutions have been exhausted, a decision to litigate has been reached, and legal documents and evidence have been prepared. Just as bad is the “standards” problem: These decisions raise issues the law addresses too obscurely to guide courts. And given the complexity and perplexity of end-of-life decisions, more illuminating rules probably are impossible.

So courts have acquiesced—tacitly and sometimes expressly—in relegating these decisions to an informal process in which doctors and families work toward a consensus that the time has come to let the patient die. Courts may be right to do so: Evidence is spotty, but it hints that patients’ families are generally satisfied with this process and that their dissatisfactions would not be soothed by litigation.

But if the problem is speed, don’t living wills solve it? If families can sue physicians who have ignored living wills, can’t families enforce living wills simply by threatening to sue after the patient died? Don’t doctors fear litigation so acutely that they will succumb to mere menace?

In *Duarte v. Chico Community Hospital*, the patient’s family brought such a suit.³ Although the patient had no living will, she had said emphatic things while she was competent. Nevertheless, the court rejected the suit because of a California statute which said that even if a surrogate appointed in a power of attorney orders a physician to stop treatment, the physician “is not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to withdraw health care necessary to keep the principal alive.”

Why? The law rarely pursues any goal maximally. We want to reduce automobile pollution, but not so much that we cripple car makers, or double car prices, or take jobs from workers, or walk to work. We don’t even do all we could to eliminate crime, since we don’t want to spend the money or live in a police state. The law therefore rarely

contemplates eliminating wrongdoing and usually structures incentives to mediate among our conflicting goals.

That is presumably what California's legislature was doing. It obviously cherished people's right to refuse treatment; it had recently passed a "Natural Death Act" authorizing people to "execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment." But it obviously thought people's lives should not be ended improvidently, even if they are very ill or even dying.

Thus the legislature presumably wanted a structure of incentives that would balance the pressures on people making end-of-life decisions so that acquiescing to anyone who wanted to stop treatment would not be the course of least resistance and greatest safety for doctors. Perhaps the legislature did not find the right balance, but it did find the right method. A bane of law-making is the irrepressible tendency to make policy wholly in response to the latest horror story—in our example, Dr. Klavan's case. No legal regime will ever prevent all bad results: the goal is the system that prevents the fewest.

Not only does policy that reacts primarily to horror stories swing madly from one extreme to the other, but such stories may better represent the past than the future. Living wills are of their time and place, a time and place in which doctors seemed persistently and gruesomely to overtreat dying patients: "Although living wills are promoted as tools to extend personal decision making, from a practical standpoint they encourage a particular type of choice: the refusing of medical interventions perceived to be invasive and valueless near the end of life. . . . Nearly all living wills now written prohibit such behavior and attempt to prevent overtreatment."⁴

But if the issue is whether to enforce living wills, we must ask not just what problems afflicted the past, and not just what problems attend the present, but also what problems will infect the future. There is mounting evidence that overtreatment has abated markedly and should continue to diminish, if only be-

cause doctors and hospitals have ever fewer financial reasons to overtreat and ever more to undertreat. One physician puts the point vividly: "The medical community that insisted on continuing treatment of Karen Quinlan and Nancy Cruzan petitioned the courts to stop treatment of Helga Wanglie."⁵ All this makes it less urgent and even more hazardous to make living wills easier to enforce.

But aren't the arguments against enforcement irrelevant if patients can tell doctors, surrogates, and courts what treatments they will want when incompetent? In particular, doesn't the "standards" problem go away? Much depends on whether you think living wills dependably describe the decisions patients would have made. Here again the issue is not whether anyone can ever write a living will that captures the patient's "real" preferences; the issue is whether that happens often enough to justify imposing liability on physicians. On that issue, the case for skepticism is convincing. As Angela Fagerlin and I have argued, the empirical evidence now compels us to doubt that (1) people generally form sound and stable intentions about future medical preferences, (2) people reliably articulate those intentions accurately and comprehensibly, and (3) surrogates can ordinarily divine those intentions from the living will.⁶

Crucially, patients themselves seem so much to share these and other doubts that in one study 54 percent of the patients studied were willing to have their surrogates override even a "perfect" living will.⁷ No court should want to enforce a document whose authors are so ambivalent and so likely not to want the document to be binding.

Courts hesitate to enforce living wills for yet another reason. When lawyers think about liability, they ask what damages the wrongdoer should pay the victim. Thus in *Anderson v. St. Francis-St. George Hospital*—a case about enforcing a DNR order the patient himself had requested—the Ohio Supreme Court asked "what damages flow from the 'harm' caused the plaintiff" if an order is ignored.⁸ The "harm" is that the

patient is alive. The court doubted that life is a legal harm and that juries can intelligently set a price on unwanted life. The court concluded that "[t]here are some mistakes, indeed even breaches of duty or technical assaults, that people make in this life that affect the lives of others for which there simply should be no monetary compensation."

This is what lawyers call a *damnum absque injuria*, a "[l]oss, hurt, or harm without injury in the legal sense, that is, without such breach of duty as is redressible by an action."⁹ A suit to enforce a living will is a sign that horrible and irreconcilable differences polluted efforts to make decisions for a patient. It is unlikely that any such disaster can be adjudicated *post hoc* in ways that should make us comfortable assessing liability. An imprecise but illuminating analogy is no-fault divorce. Marriage creates legal liabilities that can be adjudicable, but most states have decided that fault is *ordinarily* distributed obscurely enough, that evidence is *ordinarily* hard enough to obtain and analyze, and that litigation *ordinarily* is so destructive that the legal rights marriage creates have been left unenforceable. In love and death alike, not all wrongs can be righted, and yet fewer can be righted by the law.

1. These facts are from *Klavan v. Crozer-Chester Medical Center*, 60 FSupp2d 436 (ED Penn 1999).

2. Even on its face, the story I have told has its puzzles. For example, if Dr. Klavan was already in a persistent vegetative state, how could a stroke "render" him mentally and physically incompetent?

3. 72 CalApp4th 849 (Calif Ct App 4th Dist 1999).

4. M.R. Tonelli, "Beyond Living Wills," *Bioethics Forum* 13 (1997): 6, 12 at 7.

5. T.J. Prendergast, "Advance Care Planning: Pitfalls, Progress, Promise," *Critical Care Medicine* 29 (2003): N34, N39 at N38.

6. A. Fagerlin and C.E. Schneider, "Enough: The Failure of the Living Will," *Hastings Center Report* 34, no. 2 (2004): 30-42, at 39.

7. P.B. Terry et al., "End-of-Life Decision Making: When Patients and Surrogates Disagree," *Journal of Clinical Ethics* 10 (1999): 286-93.

8. 671 NE2d 228 (1996).

9. *Black's Law Dictionary*.