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HEALTH CARE SURROGATE STATUTES: ETHICS PITFALLS THREATEN THE INTERESTS OF INCOMPETENT PATIENTS

*Aaron N. Krupp**

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I. INTRODUCTION

Assume these facts:[1] It is midnight. Joe, age 60, lies motionless on a bed in the intensive care unit of the local hospital. Just three hours earlier Joe was partying with some of his buddies at his favorite bar. On his way home from the bar, Joe's car was sideswiped by another car, and he ran into a tree. Joe was unconscious when the paramedics arrived at the scene and has not regained consciousness since.

Joe's wife, children, parents, cousins, and other relatives anxiously waited to hear from Joe's physician. Unfortunately, the news could not have been worse.

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1 The following story about Joe is only a hypothetical.

The physician told family members that Joe suffered irreversible brain damage as well as two collapsed lungs. Joe is being kept alive by a respirator and there is a 95% chance that he will never regain consciousness. If Joe does regain consciousness, he will be completely dependent on others.

This is only the beginning of Joe's story. Joe and his wife, Mary, have a stormy marriage. Over the past three years, they have separated twice. They constantly fight over finances and extra-marital affairs. Although Mary is unemployed, she has made a number of large purchases, and as a result, she and Joe are in deep debt. In addition, Mary caught Joe having sex with her best friend. Mary was so infuriated that she threatened to kill him if she ever caught him cheating on her again. It is also important to note that Joe has purchased a substantial life insurance policy.

Now, consider these additional facts. Dr. Brown, the attending physician who is overseeing Joe's hospital care, is 65 years old. Dr. Brown believes that it is his duty as a physician to do whatever possible to keep a patient alive. Furthermore, Dr. Brown, who is a member of the "old school of thought," likes to make all the health care decisions for his patients. He believes, as a physician, he knows what is best for his patients. Incidentally, Joe has not executed a living will or a durable power of attorney. His future now lies in the hands of others.

Joe's story poses issues that could not be more real. Thousands of patients lack the capacity to make health care decisions for themselves. These same patients did not execute living wills or durable powers of attorney to express their wishes regarding health care before they became incapacitated. Therefore, other individuals must make health care decisions for these patients.

The recent development of state health care surrogate statutes[2] enables family members, close friends, or guardians to make important health care decisions for patients who are incapable of making health care decisions for themselves[3] and who did not execute prior directives (living wills or durable powers of attorney). These statutes evolved out of the belief that family and friends are the ones who are best suited to ensure that patients receive the health care they desire. However, although the intentions behind the health care surrogate statutes are commendable, there are several flaws with the statutes which create the prospect that unethical conduct will interfere to the prejudice of the interests of incompetent terminally ill patients.

This Article addresses the ethical flaws of state health care surrogate statutes. Part II of this Article focuses on the background of health care surrogate statutes. Part II is divided into three subparts. Subpart A summarizes some of the

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[2] I will refer to all the statutes that this Article addresses as "health care surrogate statutes."

[3] Patients who are incapable of making health care decisions for themselves are often referred to as incapacitated or incompetent patients.

most important cases that have addressed the rights of individuals to make health care decisions on the part of incompetent patients. Subpart B points out the ways that legislatures have generally responded to the issue of health care decision-making by passing living will, durable power of attorney, and health care surrogate statutes. Subpart C is a general overview of how the health care surrogate statutes are structured. Part III identifies the ethical flaws of the statutes as they relate to the surrogate decision-makers themselves, caused by financial incentives, religious beliefs, and family conflict. Part IV examines the ethical problems of the statutes as they pertain to physicians involved in carrying out surrogate decisions, caused by financial incentives and paternalism. In the conclusion, Part V, the Article proposes some changes that can be made to the health care surrogate statutes that may help minimize unethical conduct on the part of surrogates and physicians.

II. BACKGROUND TO ENACTMENT OF HEALTH CARE SURROGATE LAWS

"Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity."[4]

Everyday, millions of patients must make decisions regarding the type of medical treatment they want to receive. However, some patients are incapable of making these decisions for themselves. Several states have passed health care surrogate statutes that enable certain individuals to act as surrogates and make health care decisions for patients who lack the capacity to make decisions for themselves.[5] Advances in medical technology have amplified the need for these health care surrogate statutes. Medical technology can now delay an individual's death for an uncertain, and sometimes lengthy amount of time.[6] However, in the event of a terminal illness, many individuals do not want their deaths prolonged by

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4 Rasmussen v. Fleming, 741 P.2d 674, 678 (Ariz. 1987) (en banc).

5 Several states have enacted health care surrogate statutes. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3231 (West 1993 & Supp. 1997); ARK. CODE ANN. § 20-17-214 (Michie 1991); FLA. STAT. ANN. § 765.401 (West 1997 & Supp. 1998); 755 ILL. COMP. STAT. ANN. 40/25 (West 1992 & Supp. 1998); ME. REV. STAT. ANN. tit. 18-A, § 5-805 (West 1964); MD. CODE ANN., HEALTH-GEN. I § 5-605 (1994 & Supp. 1998); N.M. STAT. ANN. § 24-7A-5 (Michie 1997); N.Y. PUB. HEALTH LAW § 2965 (McKinney 1993 & Supp. 1998); W. VA. CODE § 16-30B-7 (1998).

6 *See* Michael L. Closen and Joan E. Maloney, *The Health Care Surrogate Act in Illinois: Another Rejection of Domestic Partners' Rights*, 19 S. ILL. U. L. J. 479 (1995); *see also* Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 637 (Mass. 1986) (noting that the longest recorded survival by a comatose patient with artificial feeding is thirty-seven years); Don Colburn, *The 40-Year Vigil for Rita Greene*, WASHINGTON POST, March 12, 1991, at z10 (noting that Rita Greene has lived on artificial nutrition and hydration in a persistent vegetative state since 1951).

artificial means.[7] Health care surrogate statutes can be an important tool for incapacitated terminally-ill patients who do not want to be maintained by artificial means.

Health care decision-making for patients has a curious history in the United States. Initially, physicians exerted virtually exclusive control over decision making in the care of patients.[8] Doctors were believed to be the most qualified individuals to make health care decisions for patients. However, about a generation ago, there was a significant shift in this belief.[9] Individuals began going to court to obtain the right to make health care decisions for family members who were incapable of making decisions for themselves.[10] As an outgrowth of these court decisions, states enacted statutes authorizing living wills and powers of attorney for health care. These statutes allowed individuals to put in writing the type of medical treatment they desire in the event they become incompetent. However, these statutes did not go far enough, and as a result, some states passed health care surrogate statutes. These statutes enable certain individuals, without having to go to court, to act as surrogate decision-makers for incompetent patients.

A. Case Law

Until the recent development of living will statutes, durable power of attorney statutes, and health care surrogate statutes, medical decision-making was in the hands of physicians or courts. Throughout history, physicians made all health care decisions without regard to patients' wishes.[11] "In the mid-1970's, patients and their families began going to court to uphold their right of self-determination in medical decision making."[12] There were a few landmark court decisions which set the foundation for states enacting health care surrogate statutes.

In 1976, the New Jersey Supreme Court had to resolve the conflicting wishes of the father of a woman who was in a "chronic persistent vegetative state" and her attending physicians. In *In re Quinlan*,[13] the court had to determine

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7 *See* Closen & Maloney, *supra* note 6, at 479-80.

8 *See* Norman G. Levinsky, *The Purpose of Advance Medical Planning -- Autonomy for Patients or Limitation of Care?*, 335 NEW ENG. J. MED. 741, 742 (1996).

9 *See id.*

10 *See generally In re* Estate of Longeway, 549 N.E.2d 292 (Ill. 1989); *In re* Quinlan, 355 A.2d 647 (N.J. 1976).

11 *See* Levinsky, *supra* note 8, at 742.

12 Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1259 (1993).

13 355 A.2d 647 (N.J. 1976).

whether the state's interest in the "preservation and sanctity of human life" outweighed the patient's rights to privacy and freedom of choice concerning her bodily integrity.[14] The father sought to be appointed guardian of his daughter so he could withdraw the life-support systems that were sustaining his daughter's vital processes.[15] On the other hand, the attending physicians contended that removal of the life-support systems would not conform to medical practices, standards and traditions.[16] The court ultimately held that the patient's right of privacy outweighed the countervailing state interests and permitted the father to end his daughter's vegetative state by disconnecting the respirator and gastronomic feeding tube that sustained her life.[17] The court noted that "[such a privacy] right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."[18]

In the 1989 case of *In re Estate of Longeway*, the Supreme Court of Illinois addressed the issue of whether the guardian of an incompetent seriously ill patient may exercise a right to refuse artificial nutrition and hydration on behalf of his ward and, if so, how this right may be exercised.[19] In *Longeway*, a daughter petitioned the court to enter an order permitting her to withdraw the artificially administered nutrition and hydration that was sustaining her mother.[20] The mother did not execute an advance directive.[21] In its analysis, the court held that in Illinois the common law right to refuse medical treatment includes, under appropriate circumstances, artificial nutrition and hydration.[22] The court found that the Probate Act impliedly authorized a guardian to exercise the right to refuse artificial sustenance on her ward's behalf.[23] The court adopted the substituted judgment

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14 *Id.* at 663.

15 *See id.* at 657.

16 *See id.* at 655. It should be noted that the medical consensus was that the daughter was in a chronic and persistent "vegetative" state, having no awareness of anything or anyone around her and existing at a primitive reflex level. *Id.*

17 *See id.* at 663. The claimed interests of the State were the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment. *Id.*

18 *Quinlan*, 355 A.2d at 663 (citing Roe v. Wade, 410 U.S. 113 (1973)).

19 *In re* Estate of Longeway, 549 N.E.2d 292, 294 (Ill. 1989).

20 *See id.* at 293.

21 *See id.*

22 *See id.* at 297.

23 *See id.* at 298. Because the court was concerned not with the right of a patient's personal refusal of medical treatment, but rather with the exercise of this common law right through a surrogate, the court

theory to ascertain an incompetent patient's wishes.[24] The court explained that under substituted judgment, a surrogate decision-maker attempts to establish, with as much accuracy as possible, what decision the patient would make if he were competent to do so.[25] The surrogate tries to determine if the patient had expressed explicit intent regarding the type of medical treatment prior to becoming incompetent.[26] Under this approach, where no clear intent exists, the patient's personal value system must guide the surrogate.[27]

In 1990, the United States Supreme Court had an opportunity to address the issue of medical decision-making through the case of *Cruzan v. Director, Missouri Department of Health*.[28] In *Cruzan*, the patient was incompetent and stayed in a Missouri state hospital in what was referred to as a persistent vegetative state.[29] The patient was unable to consume food and water on her own and, as a result, had to be sustained through a gastronomy feeding and hydration tube.[30] After five years with no significant change in the patient's medical status, her parents petitioned for the removal of the artificial nutrition and hydration tube.[31] Since it would result in death, hospital employees refused to honor the request of

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examined relevant provisions of the Probate Act to determine if a guardian may act as a surrogate. *See id.*

[24] *See Longeway*, 549 N.E.2d at 299. Courts generally have adopted one of two theories in ascertaining an incompetent patient's wishes: "best interests" or "substituted judgment." *Id.* Under the best interests test, a surrogate decision-maker chooses for the incompetent patient which medical procedures would be in the patient's best interests. *See id.* Several courts have utilized the best interests approach. *See, e.g., In re* Drabick, 200 Cal.App.3d 185 (Cal. 1988); Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); *In re* Torres, 357 N.W.2d 332 (Minn. 1984).

[25] *See Longeway*, 549 N.E.2d at 299.

[26] *See id.*

[27] *See id.* In discussing the process of ascertaining a person's personal value system, the New Jersey Court stated,

> [E]ven if no prior specific statements were made, in the context of the individual's entire prior mental life, including his or her philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death, that individual's likely treatment/nontreatment preferences can be discovered.

In re Jobes, 529 A.2d 434, 445 (N.J. 1987).

[28] 497 U.S. 261 (1990).

[29] *See id.* at 266. Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner. *See Jobes*, 529 A.2d at 438.

[30] *See Cruzan*, 497 U.S. at 266.

[31] *See id.* at 267-68.

the patient's parents to terminate all artificial nutrition and hydration without court approval.[32] The Missouri Supreme Court refused to grant the parents' petition, reasoning that the patient's intent to have all life supporting medical treatment withdrawn must be shown by clear and convincing evidence.[33] The Supreme Court granted certiorari. The Court began its analysis from the position that the right to refuse medical treatment exists.[34] The Court reasoned that a competent person's right to self determination in medical treatment exists as a liberty interest under the Fourteenth Amendment.[35] Pertaining to the case's central issue -- whether the state of Missouri had violated the Fourteenth Amendment's Due Process Clause by imposing the clear and convincing standard to determine the patient's wishes -- the Court held that there was no violation of due process.[36] The Court supported its holding by noting that where both the state and patient have significant interests, as opposed to situations where simply money damages are at stake, the imposition of the clear and convincing standard of proof is not unreasonable.[37]

B. General Legislative Responses

As these cases demonstrate, courts have grappled "with the question of how, and by whom, decisions about withholding or withdrawing life-sustaining medical treatment can be made."[38] However, many people did not endorse the concept that judicial intervention should be the process by which an individual obtains the right to make health care decisions for another. In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended, that for patients who lack decisional capacity, families, professionals, and health care institutions should be permitted to make decisions regarding life-sustaining medical treatment without going to court.[39] Furthermore, the court in *Longeway* recognized that "[t]he slow, deliberate nature

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32 *See id.* at 267.

33 *See* Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988).

34 *See Cruzan*, 497 U.S. at 277.

35 *See id.* at 278; *see also* Vitek v. Jones, 445 U.S. 480, 494 (1980) (transfer to mental hospital coupled with mandatory behavior modification treatment implicated liberty interests); Parham v. J.R., 442 U.S. 584, 600 (1979) ("[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment").

36 *See Cruzan*, 497 U.S. at 282-83.

37 *See id.*

38 Stephen M. Fatum et al., *A Review of the Illinois Health Care Statute*, 80 ILL. B.J. 124, 124 (1992).

39 *See id.* at 125.

of the court system may frustrate the family and loved ones of the patient."[40] The court also stated that the legislature is "the appropriate forum for the ultimate resolution of the questions surrounding the right to die."[41]

1. Living Will Statutes

States responded to the inadequacy of the court system by adopting statutes generally referred to as "living will" legislation.[42] Living will statutes provide for a written, witnessed statement to delineate the type of medical treatment a patient wishes to have when that individual sustains a terminal injury or illness and can no longer provide a verbal directive to medical personnel.[43] The statutes, now adopted in over 40 states,[44] vary widely across jurisdictions. Variations between jurisdictions generally pertain to when a living will may be

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40 *In re* Estate of Longeway, 549 N.E.2d 292, 301 (Ill. 1989).

41 *Id.*

42 Barry R. Furrow et al., *Bioethics: Health Care Law and Ethics* 263 (1991).

43 Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103, 125 (1993).

44 Many states have enacted living will statutes. *See, e.g.*, ALA. CODE §§ 22-8A-1 to -10 (1990); ALASKA STAT. §§ 18.12.010 (1991); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3262 (Supp. 1992); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie 1991); CAL. HEALTH & SAFETY CODE §§ 7185-7194.5 (West Supp. 1 1993); COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1992); CONN. GEN. STAT. §§ 19a-570 to -580c (1193 & Substitute Bill 7244, signed June 29, 1993); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.101-.401 (West Supp. 1993); GA. CODE ANN. §§ 21-23-1 to -12 (Supp. 1992); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1992); IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1992); 755 ILL. COMP. STAT. ANN. § 35/1 (West 1992); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1990); IOWA CODE ANN. §§ 144A.1-.12 (West 1989 & Supp. 1993); KAN. STAT. ANN. §§ 65-28, 101- 109 (1992); KY. REV. STAT. §§ 311.622-.644 (Michie/Bobbs-Merrill Supp. 1992); LA. REV. STAT. ANN. § 40:1299.58.10 (West Supp. 1992); ME. REV. STAT. tit. 19-A, §§ 5-701 to -714 (West Supp. 1992); MD. CODE ANN. HEALTH-GEN. §§ 5-601 to -618 (1990 & H.B. 1243, signed May 11, 1993); MINN. STAT. §§ 145B.01-.17 (Supp. 1993 & S.F. 40, signed May 20, 1993); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1992); MO. REV. STAT. §§ 459.010-.055 (Vernon 1992); MONT. CODE ANN. §§ 50-9-101 to -111, -201, -206 (1991); NEB. REV. STAT. §§ 20-401 to -416 (Supp. 1992); N.H. REV. STAT. ANN. §§ 137-H:1-:16 (1990 & Supp. 1992); N.J. STAT. ANN. §§ 26.2H-53 to -78 (West Supp. 1992); N.M. STAT. ANN. §§ 24-7-1 to -11 (Michie 1991); N.C. GEN. STAT. §§ 90 -320 to -322 (1990); N.D. CENT. CODE §§ 23-06.44-01 to -14 (1991); OHIO REV. CODE ANN. §§ 23133.01-15 (Anderson Supp. 1992); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1993); OR. REV. STAT. §§ 127.605-.650 (1990 & S.B. 286, signed August 31, 1993); PA. STAT. ANN. tit. 20, §§ 5401-5416 (Supp. 1993); R.I. GEN. LAWS §§ 23-4.11-1 to -13 (Supp. 1992); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1992); S.D. CODIFIED LAWS ANN. §§ 34-112D-1 to -22 (Supp. 1992); TENN. CODE ANN. §§ 32-11-101 to -112 (Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (West 1992); UTAH CODE ANN. §§ 75-2-1101 to -1119 (Supp. 1992 & H.B. 299, signed March 10, 1993 & S.B. 133, signed March 15, 1993); VA. CODE ANN. §§ 16 54.1-2981 to -2993 (Michie Supp. 1992); WASH. REV. CODE ANN. §§ 70.122.010-.920 (Supp. 1993); W. VA. CODE §§ 16-30-2 to -13 (1991 & Supp. 1992); WIS. STAT. ANN. §§ 154.01-.15 (West 1989 & Supp. 1992); WYO. STAT. §§ 35-22-101 to -108 (Supp. 1992).

executed and when certain medical treatments may be terminated.[45]

The common elements of virtually every living will statute include: 1) Who may make a declaration (what competency level is required for competent execution of the document); 2) the manner of execution of the document; 3) definitions; 4) revocation procedures; 5) a declaration that the intentions expressed in the living will supersede any previous declaration; 6) a declaration that the patient be transferred if the attending physician will not comply; and 7) a declaration that complying physicians shall be protected from all civil and criminal liability which may arise from their compliance with the terms of the living will.[46]

2. Durable Power of Attorney Statutes

Although it was a move in the right direction, it became evident that living wills had a major shortcoming. Living wills were too inflexible to meet adequately the needs of individuals wishing to make comprehensive advance health care directives.[47] Thus, states enacted durable power of attorney statutes that specifically authorize an individual to appoint an agent to make medical treatment decisions.[48]

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45 *See* Christopher J. Condie, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 105, 123-29 (1988).

46 *See id.* at 107.

47 *See* Fatum, *supra* note 38, at 125.

48 Many states have enacted durable power of attorney statutes. *See, e.g.*, CAL. CIV. CODE §§ 2430 -2445 (West Supp. 1993 & A.B. 346, signed July 19, 1993); CONN. GEN. STAT. §§ 1-43 to 1-54a (Supp. 1992); D.C. CODE ANN. §§ 21-2201 to -2213 (1989 & Supp. 1992); FLA. STAT. ANN. §§ 765.201-.205 (West Supp. 1993); GA. CODE ANN. §§ 31-36-1 to -13 (Supp. 1992); HAW. REV. STAT. §§ 551D-1 to -7 (Supp. 1992); IDAHO CODE §§ 39-4505 to -4509 (1985 & Supp. 1992); 755 ILL. COMP. STAT. ANN. §§ 45/4-1 to 4-12 (West 1992); IND. CODE ANN. §§ 30-5-1-1 to 30-5-10-4 (Burns Supp. 1992); IOWA CODE ANN. §§ 144B.1-.12 (West Supp. 1993); KAN. STAT. ANN. §§ 58 --625 to -632 (Supp. 1992); KY. REV. STAT. ANN. §§ 311.970-.986 (Michie/Bobbs-Merill Supp. 1992); LA. CIV. CODE ANN. art. 2997 (West Supp. 1993); ME. REV. STAT. ANN. tit. 18-A, §§ 5-501 to -506 (West Supp. 1992); MD. CODE ANN. HEALTH-GEN. §§ 5-601 to -618 (1990 & H.B. 1243, signed May 11, 1993); MASS. GEN. LAWS ANN. ch. 201D, §§ 145B.01-.17 (Supp. 1993); MICH. COMP. LAWS ANN. §§ 700.496 (West 1993); MINN. STAT. §§ 145C.01-.15 (S.F. 40, signed May 20, 1993); MISS. CODE ANN. §§ 41-41-151 to -183 (Supp. 1992 & S.B. 2830, signed March 16, 1993); MO. REV. STAT. 404.800-.870 (Supp. 1993); MONT. CODE ANN. §§ 72-5-501 to -75-5-502 (1991); NEB. REV. STAT. §§ 30-3401 to -3432 (Supp. 1992 & L.B. 782, signed June 10, 1993); NEV. REV. STAT. §§ 449.800-.860 (1991); N.H. REV. STAT. ANN. §§ 137-J:1-:16 (Supp. 1992); N.J. STAT. ANN. §§ 26:2H-53 to -78 (West Supp. 1992); N.M. STAT. ANN. §§ 45-5-501 to -502 (Michie Supp. 1991); N.Y. PUB. HEALTH LAW §§ 2980-2994 (McKinney Supp. 1993); N.C. GEN. STAT. §§ 32A-15 to -26 (1991 & H.B. 1043, ratified July 24, 1993); N.D. CENT. CODE §§ 23-06.5-.01 to -18 (1991 & S.B. 2417, signed March 26, 1993); OHIO REV. CODE ANN. §§ 1337.11-.17 (Anderson Supp. 1992); OR. REV. STAT. §§ 127.505-.585 (1990); PA. STAT. ANN. tit. 20 §§ 5601-5607 (Supp. 1992); R.I. GEN. LAWS §§ 23-4.10-1 to -12 (Supp. 1992 & H.B. 6313, signed July 6, 1993); S.C. CODE ANN. §§ 62-5-501 to -505 (Law Co-op Supp. 1992); S.D. CODIFIED LAWS ANN. §§ 59-7-2.1-.8, 59-7-8 (Supp. 1992); TENN. CODE ANN. §§ 34-6-201 to -215 (1991); TEX. CIV. PRAC. & REM. CODE ANN. §§ 135.001-.018 (West Supp. 1993); UTAH CODE ANN. §§ 75-2-1106 to -1118 (1992); VT. STAT. ANN. tit. 14, §§ 3451-3467 (1989 & Supp. 1992); VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie Supp. 1992); WASH. REV. CODE ANN. §§ 11.94.010 (West Supp. 1993); W. VA. CODE §§ 16-30A-1 to -20 (1991); WIS. STAT. ANN. §§ 155.01-.80 (West Supp. 1992); WYO. STAT. §§ 3-5-201 to -213 (Supp. 1992).

An individual can grant an agent appointed under a health care power of attorney "statute more comprehensive health care decision-making authority than he or she may authorize by executing a living will."[49] However, one of the shortcomings of durable power of attorney statutes is that the agent who was specifically appointed by the patient to make health care decisions must be available when circumstances dictate that a decision needs to be made.

3. Health Care Surrogate Statutes

Despite the significance of the previous two statutes, they do not address the rights of patients who lack decision-making capacity and have not executed an advance directive. In order to fill this void, some states passed health care surrogate statutes. Surrogate statutes are based on the principle that a patient's health care interests should be attended to, even in the absence of a written document executed by the patient for such a purpose.[50] These statutes provide the means by which certain individuals are authorized to make health care decisions for incompetent patients who have not executed an advance directive.

C. *Structural Analysis of Health Care Surrogate Statutes*

Although there are differences among the various health care surrogate statutes, there are some common features that are found in all the statutes. First, the statutes only apply when the patient lacks the capacity to make health care decisions.[51] The health care provider must determine whether the patient lacks decisional capacity. Second, the surrogate statutes only apply when the patient has not executed an advance directive (living will or power of attorney for health care) which designates an agent to make health care decisions or the designated agent is no longer available.[52]

If the patient lacks decisional capacity and there is no available agent under an advance directive, the health care provider must make reasonable efforts to contact individuals who may serve as a surrogate according to a prioritized listing such as:

1) the patient's guardian of the person;
2) the patient's spouse;
3) any adult son or daughter of the patient;

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49 Fatum, *supra* note 38, at 125.

50 *See* Hamann, *supra* note 43, at 130-32.

51 *See* statutes cited *supra* note 5.

52 *See id.*

4) either parent of the patient;
5) any adult brother or sister of the patient;
6) any adult grandchild of the patient;
7) a close friend of the patient;
8) the patient's guardian of the estate.[53]

The statutes provide a procedure to follow where there are multiple surrogate decision makers at the same priority level.

Once a surrogate is established, he or she is supposed to make health care decisions that conform as closely as possible to the patient's wishes.[54] This is referred to as "substituted judgment."[55] If the patient's wishes are not known, the surrogate is supposed to make decisions that he or she believes are in the best interests of the patient.[56]

III. ETHICAL FLAWS PERTAINING TO SURROGATES

"Choices about life and death are profound ones, not susceptible of resolution by recourse to medical or legal rules. It may be that the best we can do is to ensure that these choices are made by those who will care enough about the patient to investigate his or her interests with particularity and caution."[57]

Surrogate statutes require surrogate decision-makers to make decisions that are in accordance with the patient's individual wishes. If the surrogate is unaware of any individual wishes, he or she is supposed to make decisions that are in the patient's best interests. Close family members are located at the tops of statutes' priority lists based on the premise that it is the patient's family or other loved ones who support and care for the patient and who best understand the patient's personal values and beliefs.[58] Hence, they will be best able to know what the patient wanted or to make a substituted judgment for the patient.[59] However, although most

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53 755 ILL. COMP. STAT. ANN. § 40/25 (West 1992) (Illinois' surrogate prioritized listing is fairly representative of all the health care surrogate statutes.). For some significant variations in the prioritized listing *see* ARIZ. REV. STAT. § 36-3231 (1993) (lists patient's domestic partner as a possible surrogate); N.M. STAT. ANN. § 24-7A-5 (Michie 1991) (lists an individual in a long-term relationship of indefinite duration with the patient as a possible surrogate).

54 *See In re* Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989).

55 *Id.*

56 *See id.*

57 Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 354 (1990).

58 *See In re* Jobes, 529 A.2d 434, 445 (N.J. 1987).

59 *See id.*

surrogates are loving individuals who will do whatever the patient desires or is in the best interest of the patient, the statutes do not guard against surrogates who have unethical motives. In some unfortunate situations, family members will not act to protect a patient.[60]

Reliance on relatives or close friends to make life-and-death decisions for non-autonomous patients obviously entails risk.[61] "Some experts raise concerns that conflicts of interest (e.g., an inheritance) invariably complicate the role of family members as surrogates."[62] Even patients who have advance directives cannot be entirely safeguarded from questionable motives, conflicts of interest, or unreasonable requests on the part of their surrogate decision-makers.[63]

Proxies, especially if they are family members, are liable to have potential conflicts of interest because incompetent patients tend to be both emotional and financial burdens.[64] "The proxy's decisions may be based on his or her own interests rather than on the wishes of the patient."[65] According to Buchanan and Brock, "[t]he family, more than anyone else, may have a serious conflict of interest that distorts their testimony about what the patient would want."[66] As Emanuel and Emanuel point out, "[s]uch conflicts may be more frequent than we know, because the range of acceptable practices is so broad that the absence of explicit statement of patients' preferences makes it difficult to discern such conflicts."[67] There are legal cases that demonstrate instances in which family members violated patients' wishes regarding medical treatment.[68]

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60 *See id.* at 447.

61 *See* Robert F. Weir and Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients: Ethical Standards and Legal Liability for Physicians After Cruzan*, 264 JAMA 1846, 1849 (1990). Some courts have required the involvement of parties to a case other than the patient's surrogate to guard against self-interested or malicious decisions by surrogates. *See* Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Quinlan, 348 A.2d 801 (N.J. 1976); *In re* Guardianship of Hamlin, 689 P.2d 1372 (Wash. 1984); *In re* Colyer, 660 P.2d 738 (Wash. 1983).

62 Deon Cox Haley et al., *Ethical and Legal Issues in Nursing Home Care*, Archives of Internal Medicine, 1996, at 7, *available in* DIALOG, AMA-JNLS.

63 *See* Margot L. White and John C. Fletcher, *The Patient Self-Determination Act: On Balance, More Helpful Than Hindrance*, 266 JAMA 410, 411 (1991).

64 *See* Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy Decision Making for Incompetent Patients*, 267 JAMA 2067, 2068 (1992).

65 *Id.*

66 *Id.* (quoting A.E. BUCHANAN AND D.W. BROCK, DECIDING FOR OTHERS Ch. 2 (1989).

67 *Id.*

68 *See, e.g.*, Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978) (daughter of patient who refused to consent to an operation to have leg amputated sought appointment of herself as temporary guardian with authority to consent to the operation on behalf of her mother); *In the Matter of Spring*, 405 N.E.2d 115

One of the flaws of the health care surrogate statutes is that they do not effectively ensure that surrogates make health care decisions that are in accordance with the patient's wishes or in the patient's best interests. Unless the physician believes that the surrogate is not acting in accordance with the statute's requirements, the physician must abide by the surrogate's decision. Even if a surrogate makes a decision that is not in accordance with the statute's requirements, the physician will usually have no way of knowing it. Consider the following scenario: A patient is in a persistent vegetative state and being kept alive by a respirator. The patient's spouse, who is the only available surrogate decision-maker, decides to discontinue all life-sustaining measures. Unbeknownst to the physician, the surrogate's decision is financially motivated. Nevertheless, the physician must discontinue treatment because there is no indication that the surrogate's decision is contrary to the patient's wishes or against the patient's best interests.

A. Financial Incentives

Individuals frequently make decisions based on financial reasons. These decisions are not only common but perfectly acceptable. However, it is unacceptable for surrogate decision-makers to make health care decisions for their own financial gain. One of the ethical flaws of health care surrogate statutes is that there is no safeguard against surrogates deciding to discontinue life-sustaining treatment for their own financial gain.

The possibility that surrogates may be financially motivated is by no means rooted in fiction. Allegations of this type of unethical behavior have surfaced in actual cases. *In re Martin*[69] is an example of one such case. In *Martin*, Michael Martin sustained debilitating injuries in an automobile-train accident.[70] The injuries significantly impaired his physical and cognitive abilities, left him unable to walk or talk, and rendered him dependent on a colostomy for defecation and a gastrostomy tube for nutrition.[71] Martin's wife was appointed legal guardian and sought to have her husband's life-sustaining medical treatment withdrawn.[72] She claimed that her husband "was always bothered by, and intolerant of, people

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(Mass. 1980) (wife and son of patient, who while competent acquiesced in hemodialysis treatment, filed a petition for an order that the treatments be discontinued).

69 538 N.W.2d 399 (Mich. 1995).

70 *See id.* at 402.

71 *See id.*

72 *See id.* The hospital's bioethics committee concluded that withdrawal of Martin's nutritive support was both medically and ethically appropriate, but that court authorization would be required before the hospital would assist in the procedure. *See id.*

who were disabled or dependent on others and often stated that he would rather die than be dependent on people and machines."[73] Martin's mother and sister opposed the petition requesting authorization to remove the life-sustaining treatment and also filed a petition asking that Martin's wife be removed as guardian.[74]

Pertinent to the issue of surrogates making financially-motivated health care decisions, in *Martin* there were accusations from both sides that concerns about what Michael Martin would want were not as large a motivation as getting a share of his estate.[75] Depending on his life span, Michael Martin would receive up to $1.6 million from an out-of-court settlement from CSX railroad.[76] Martin's two children and his wife each received separate settlements from the railroad.[77] Ultimately, the court did not authorize the removal of the life-sustaining treatment due to the absence of clear and convincing evidence of Martin's pre-injury statement expressing his decision to refuse life-sustaining medical treatment under the present circumstances.[78]

In re Martin is not the only case where an individual's health care decision has been challenged based on the prospects of financial gain. Patrick Yetzke's story[79] further exemplifies the possibility that surrogates may make health care decisions that are financially motivated. Patrick Yetzke was in a persistent vegetative state due to a traffic accident.[80] Yetzke's wife, as guardian, sought to withhold his nutrition because she contended it was in his best interests.[81] However, Yetzke's father went to court to have her removed as guardian.[82] He contended that she was not making decisions in Patrick's best interests and that she

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73 *Id.*

74 *See Martin*, 538 N.W.2d at 402.

75 *See Right-to-Die Decision 'Absurd,' Wife Says. Mary Martin Says Her Husband Never Wanted to be Dependent on Anyone Else*, The Grand Rapids Press, August 24, 1995, at B1.

76 *See id.*

77 *See id.*

78 *See Martin*, 538 N.W.2d at 413. The court did make it clear that "where the surrogate decisionmaker can establish by clear and convincing evidence that the conscious incapacitated individual, while competent, made a statement of his desire to refuse life-sustaining medical treatment under these circumstances, then the surrogate must be allowed to effectuate the incapacitated individual's expressed preference." *Id.*

79 John Hogan, *New Guardian Appointed for Victim of Brain Injury*, The Grand Rapids Press, August 27, 1993, at C1.

80 *See id.*

81 *See id.*

82 *See id.*

stood to gain financially from his death.[83] Ultimately, the court appointed an "impartial, neutral" person to make treatment decisions for Patrick Yetzke.[84]

Some readers may claim that the previous two cases only involved allegations of unethical financial motivation, and one cannot conclude from the cases that surrogates would actually discontinue medical treatment for their own financial gain. However, do not underestimate the power of the almighty dollar. Consider the case where an individual was convicted for the murder of his brother's estranged wife.[85] The Defendant was convicted based on circumstantial evidence.[86] Part of the circumstantial evidence was that the Defendant's brother would receive $75,000 under two insurance policies on his wife's life and would also be the beneficiary of a reduced pension to be received at her death.[87] Also, "the [Defendant] and his brother admitted to having financial difficulties at the time of the victim's death."[88] Lastly, the Defendant "told his boss's wife that he could kill someone if the price were right."[89]

Mitchell v. State of Indiana[90] is another example where money played a role in the murder of an individual. As in *O'Donnell*, the Defendant was convicted of murder based on circumstantial evidence.[91] The evidence showed that the Defendant was the sole beneficiary of a document purporting to be the victim's will and the beneficiary of two of the victim's life insurance policies.[92] "The two had engaged in sexual acts."[93] Furthermore, several months before the killing, the Defendant offered to pay a man three thousand dollars to kill the victim so that he could inherit his money.[94] He also told a girl friend that in the event of the victim's

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83 *See id.*

84 *See* Hogan, *supra* note 79, at C1.

85 O'Donnell v. State, 374 S.E.2d 729 (Ga. 1989).

86 *See id.* at 730.

87 *See id.*

88 *Id.*

89 *Id.*

90 541 N.E.2d 265 (Ind. 1989).

91 *See id.* at 267.

92 *See id.*

93 *Id.*

94 *See id.*

death he would inherit enough money for them to marry.[95]

These cases illustrate the real possibility that a surrogate may be motivated by greed. Furthermore, the surrogate statutes do not safeguard against a surrogate making a financially-motivated health care decision. Unless there is evidence that a surrogate is not making a decision in accordance with the patient's desires or in the patient's best interests, the physician must comply with the surrogate's decisions.[96]

There are a couple of reasons why a surrogate would be financially motivated to decide to discontinue life-sustaining treatment. First, the surrogate may receive money under the patient's will and/or life insurance policy. Due to the surrogate-prioritized list in the surrogate statutes, it is likely that the surrogate will be a close family member of the patient.[97] Therefore, it is probable that the surrogate will be a beneficiary under the patient's will and/or insurance policy. On the most basic level, surrogates may decide to discontinue treatment so they can more rapidly receive their portion under a will and/or life insurance policy. Furthermore, some surrogates will realize that it is in their best financial interest to discontinue the patient's treatment as soon as possible. This is due to the expensive nature of medical treatment.[98] As the duration of treatment increases, the health care expenses may drain the patient's savings. Therefore, there will be less available for the surrogate under the patient's will and/or life insurance policy. Lastly, a surrogate whose own finances are low may have an additional incentive to decide to discontinue treatment.

Surrogates may also decide to discontinue life-sustaining treatment because they do not want the burden of some of the costs associated with maintaining a patient in the hospital.[99] When a patient's savings are depleted, family members are often relied upon to pay some of the high medical costs. Due to the surrogate statutes' priority lists, it is likely that a surrogate decision-maker will be a family member of the patient. Therefore, if the surrogate is a family

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95 *See Mitchell*, 541 N.E.2d at 267.

96 *See In re* Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989).

97 *See supra* note 53 and accompanying text.

98 *See* Ezekiel J. Emanuel & Linda L. Emanuel, *The Economics of Dying: The Illusion of Cost Savings at the End of Life*, 330 NEW ENG. J. MED. 540, 540 (1994). Studies

> demonstrate that 27 to 30 percent of Medicare payments each year are for the 5 to 6 percent of Medicare beneficiaries who die in that year . . . [I]n 1988, the mean Medicare payment for the last year of life of a beneficiary who died was $13,316, as compared with $1,924 for all Medicare beneficiaries (a ratio of 6.9:1). Payments for dying patients increase exponentially as death approaches, and payments during the last month of life constitute 40 percent of payments during the last year of life.

Id

99 *See id.*

member who is contributing some of his or her own finances to pay for the health care costs, the surrogate may decide to discontinue life-sustaining treatment because he or she is no longer willing to accept the burden of the medical costs. This will hold true especially if the surrogate's own finances are running low.

B. Religious/Personal Beliefs

Strong religious and/or personal beliefs often guide individuals when they make important decisions in their lives. This is another potential conflict that the health care surrogate statutes do not effectively address. Surrogates may refuse to make any health care decisions that conflict with their own religious/personal beliefs. In essence, surrogates may impose their own religious/personal beliefs on to the patient. This would violate the health care surrogate statutes' requirements that surrogates make health care decisions that are in accordance with the patient's wishes or in the patient's best interests. Some individuals are guided by their religious beliefs when they make health care decisions. In *In the Matter of McCauley*,[100] religion played a significant role in the health care setting. In *McCauley*, physicians made an initial diagnosis of leukemia in an eight year old girl.[101] In order to determine with greater certainty whether the girl had leukemia, the physicians needed to perform a bone marrow aspiration.[102] This bone marrow aspiration required that the physicians give the girl a blood transfusion.[103] The girl's parents were Jehovah's Witnesses.[104] A principal tenet of their religion is a belief that the act of receiving blood or blood products precludes an individual from resurrection and everlasting life after death.[105] Consistent with their religious beliefs, the parents refused to consent to the administration of blood or blood products to their daughter.[106]

Similarly, in *In re Baby Boy Doe*, a pregnant woman was told by an examining physician "that something was wrong with the placenta, and that the approximately 35-week, viable fetus was receiving insufficient oxygen."[107] The

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100 565 N.E.2d 411 (Mass. 1991).

101 *See id.* at 412.

102 *See id.*

103 *See id.*

104 *See id.*

105 *See McCauley*, 565 N.E.2d at 412.

106 *See id.* The court ultimately held that the interests of the daughter and of the State outweighed her parents' rights to refuse medical treatment. *See id.* at 413.

107 *In re* Baby Doe, 632 N.E.2d 326, 327 (Ill. App. Ct. 1994).

physician recommended immediate delivery by cesarean section, which in his opinion was the safest option for the fetus.[108] Alternatively, the physician recommended immediate delivery by induced labor.[109] The woman told the physician "that because of her personal religious beliefs, she would not consent to either procedure. Instead, given her abiding faith in God's healing powers, she chose to await natural childbirth."[110]

These cases illustrate the significant role religion plays in some individuals' lives. These individuals abide by their religion, even if they are risking serious harm or death. This religious concept may extend to surrogate decision-makers. For example, a surrogate may be a Jehovah's Witness and not believe in blood transfusions.[111] The incompetent patient, who is not a Jehovah's Witness, may need a blood transfusion for a particular medical procedure. The surrogate may refuse to consent to the blood transfusion because his or her religion prohibits it. In order to comply with the statute's requirements, however, the surrogate may outwardly claim that the blood transfusion is against the patient's wishes or not in the patient's best interests.

In addition to the risk that some surrogates may act according to their own religious beliefs, it is equally possible that other personal beliefs may guide surrogates in their decision making process. For instance, surrogates often have to decide whether to discontinue life-sustaining treatment. Some surrogates may strongly support the "right-to-life" cause.[112] They may find themselves in a situation where their own convictions conflict with that of the patient's. Therefore, unwilling to compromise their own beliefs, some surrogates will attempt to keep the patient alive, regardless of whether it is against the patient's wishes or not in the patient's best interests.

C. *Family Conflicts*

The health care surrogate statutes do not effectively safeguard against a

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108 *See id.*

109 *See id.*

110 *Id.* The court held that a woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus. *See id.* at 330.

111 In addition to the previously discussed case, there are several examples where individuals have refused blood transfusions or blood products because they were Jehovah Witnesses. *See, e.g.,* Stamford Hosp. v. Vega, 674 A.2d 821 (Conn. 1996); Harrell v. St. Mary's Hosp., Inc., 678 So.2d 455 (Fla. Dist. Ct. App. 1996); *In re* Brooks Estate, 205 N.E.2d 435 (Ill. 1965); Clark v. Perry, 442 S.E.2d 57 (N.C. Ct. App. 1994); Perkins v. Lavin, 648 N.E.2d 839 (Ohio Ct. App. 1994).

112 *See supra* note 75, at B1. Michael Martin's wife accused Martin's sister and mother of wanting to keep Martin alive because of their belief in "right-to-life". *Id.*

surrogate using his or her decision-making power as a means of seeking revenge on another surrogate. Essentially, the statutes do not prevent surrogates from using patients as pawns.

There are two potential scenarios in which surrogates may unethically use their decision-making power in this context. Joe's story, which was presented at the beginning of this Article, will provide a good foundation to demonstrate this point. Both scenarios are premised on the fact that Joe's two adult children, Dan and Mike, are the only available surrogates under the applicable health care statute. Furthermore, Dan and Mike detest each other and will stop at nothing to inflict punishment on one another.

Under the first scenario, Joe has always favored Dan. Several years ago Joe made it known that he left a significant amount of money under his will for Dan, while he left nothing for Mike. Mike has realized that he can utilize his power as a surrogate decision-maker to inflict monetary pain upon Dan. Mike has decided that he will seek any medical treatment possible for Joe so the medical bills will drain Joe's savings. This in turn, will decrease the amount of money Dan will ultimately receive under the will. Mike also knows that if Dan does not agree with one of Mike's health care decisions, the medical bills will continue to mount as the conflict is resolved.

The second scenario is more simplistic but no less unethical. Under this scenario, Mike has devised a plan to inflict mental anguish upon Dan. Mike has decided that he will attempt to make all health care decisions which directly conflict with Dan's desires. For instance, if Dan wishes to maintain Joe on a respirator, Mike will vote to discontinue any life-sustaining treatment. Mike knows this will create additional problems for Dan in an already difficult situation. Both scenarios outlined above are possible where surrogates disdain each other to the extent that they will stop at nothing to inflict pain on one another.

IV. ETHICAL FLAWS PERTAINING TO PHYSICIANS

"Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make."[113]

Health care surrogate statutes enable individuals other than the physician to make health care decisions for an incapacitated patient.[114] The statutes require surrogate decision-makers to make health care decisions that are in accordance with

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[113] Dr. Karen Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 8 (1975).

[114] *See* statutes cited *supra* note 5.

the patient's wishes to the extent known.[115] Otherwise, surrogates are required to make decisions that are in the patient's best interests.[116] Physicians are required to follow a surrogate's decision.[117] However, the statutes contain a provision that allows a physician to intercede in the decision-making process if the physician believes that the surrogate is making a decision that is not in accordance with the patient's wishes or in the patient's best interest.[118]

Although this provision is intended to protect the patient, physicians may utilize this provision to advance their own interests. There may be circumstances where a physician refuses to honor a surrogate's decision because the physician claims that the decision is not in accordance with the patient's wishes or in the patient's best interest. However, in reality the physician has other motives for refusing to honor the surrogate's decision.

In light of the fact that there have been cases where medical personnel have not honored patients' express wishes, it is likely that physicians will not always honor surrogates' health care decisions. The case of *Anderson v. St. Francis-St. George Hospital, Inc.* is an example where a patient's express wishes were not honored.[119] In *Anderson*, a patient sued a hospital for damages allegedly resulting from the wrongful administration of life-prolonging treatment.[120] After being admitted to the hospital, the patient told his physician that he did not want to be resuscitated.[121] The physician indicated the order not to resuscitate on the patient's chart.[122] The patient's reason for not wanting to be resuscitated stemmed from his fear of suffering the same fate as his wife, who had deteriorated following

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115 *See id.*

116 *See id.*

117 *See id.*

118 *See id.*

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

120 *See id.* at 226. There are at least three civil actions relating to the beginning and the extension of life: "wrongful life," "wrongful birth" and "wrongful living." *Id.* at 227. "Generally, a claim for 'wrongful life' is brought by a child seeking damages against a physician or hospital for negligently failing to properly sterilize the parent." *Id.; see also* Bowman v. Davis, 356 N.E.2d 496, 499 (Ohio 1976). "A 'wrongful birth' action is a claim brought by the parents of an impaired child seeking to recover damages for the birth of a child. The parents claim that due to the negligence of the physician, they were prevented from exercising their right to terminate the pregnancy or avoid conception altogether." *Anderson,* 671 N.E.2d at 227; *see also* Johnson v. University Hospitals of Cleveland, 540 N.E.2d 1370, 1372 (Ohio 1989). "In a claim for 'wrongful living,' . . . the plaintiff does not assert a claim based on a life coming into being. Rather, the plaintiff asserts a right to enforce an informed, competent decision to reject life-saving treatment." *Anderson,* 671 N.E.2d at 227.

121 *See Anderson,* 671 N.E.2d at 226.

122 *See id.*

a resuscitation.[123] A few days after giving the order not to resuscitate, the patient slipped into a potentially fatal rhythm.[124] Despite the "Do Not Resuscitate" order, a nurse revived the patient with a defibrillator.[125] In this particular case, although the nurse was the individual who actually acted contrary to the "Do Not Resuscitate" order, there was no indication that the physician made any effort to insure that the patient's wishes were honored. This violated the physician's fiduciary duty he owed to his patient. Unfortunately, *Anderson* is not an isolated case of a physician acting contrary to a patient's wishes.[126]

There is even more evidence that medical personnel do not always honor patients' desires. A study of terminal patients by the Journal of the American Medical Association indicated that surprisingly few of the patients had their health care wishes honored even at the five top medical centers that were featured in the JAMA study.[127] Perry Elfmont's story corroborates the JAMA study's findings.[128] In the Spring of 1994, Perry Elfmont was brought to a hospital by his wife Sabina -- suspecting that he had a stroke.[129] After they spent 12 hours in the emergency room before Perry was admitted, Sabina decided to go home for the night.[130] She decided to go home only after hearing assurances that her husband's wishes were known and would be respected.[131] Perry Elfmont recorded in a living will that he wanted no cardiac resuscitation, nor any life-sustaining treatment, including feeding tubes and respirators.[132] When Sabina returned, she found her husband on oxygen and receiving intravenous antibiotics -- two interventions she claimed were against his written wishes.[133]

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123 *See id.*

124 *See id.*

125 *Id.*

126 *See generally* Estate of Leach, 469 N.E.2d 1047 (Ohio Ct. App. 1984) (plaintiffs claimed physicians acted wrongfully in placing patient on life-support systems and in maintaining her thereon contrary to the express wishes of the patient and her family); Winters v. Miller, 446 F.2d 65 (2d Cir. 1971) (patient was given medication over her continued objections due to her religious beliefs); Lacey v. Laird, 139 N.E.2d 25 (Ohio 1956) (patient claimed physician operated on her nose over her remonstrance).

127 *See* The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591, 1594 (1995).

128 *See* Susan Brink, *The American Way of Dying*, U.S. News & World Report, Dec. 4, 1995 at 70.

129 *See id.* at 71.

130 *See id.*

131 *See id.*

132 *See id.*

133 *See* Brink, *supra* note 128, at 70.

A. Financial Incentives

Just as surrogate decision-makers may be influenced by the almighty dollar, physicians may make health care decisions based on financial motives. The health care surrogate statutes do not effectively safeguard against physicians making financially-motivated decisions.[134] Although the statutes enable individuals to act as surrogate decision-makers for incompetent patients, surrogates do not have complete control over the decision-making process.[135] The statutes do not require the physician to implement the surrogate's health care decision if the physician believes that the surrogate's decision is not in accordance with the patient's desires or not in the patient's best interest.[136] While this provision may help safeguard against surrogates who have unethical motives, physicians may use this provision to advance their own interests. Some physicians may refuse to obey a surrogate's decision because they pretextually claim that the surrogate's decision is not in accordance with the patient's wishes or not in the patient's best interests. However, the truth is that these physicians are not trying to protect the patient's interests, but rather they are trying to advance their own financial positions.

Because of health care reform, patients' interests are threatened now more than ever. Managed care has increased the risk that physicians will have a financial conflict with their patients. The ostensible goals of health system reform are morally laudable.[137] However, many individuals believe that managed care is threatening patient-centered medical ethics.[138] Patient-centered medical ethics is being threatened because

> physicians are being told by a variety of sources that they must take into account interests other than those of their patients, that as the stewards of scarce health care resources, physicians have responsibilities toward other patients, toward society, and toward

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134 *See* statutes cited *supra* note 5.

135 *See id.*

136 *See id.*

137 *See* Edmund D. Pellegrino, *Ethics*, Archives of Pathology and Laboratory Medicine, Nov. 1994, at 7, *available in* DIALOG, AMA-JNLS.

138 *See* Paul Clay Sorum, *Ethical Decision Making in Managed Care* 156 Archives of Internal Medicine 2041, 2041 (1996). Patient-centered medical ethics has three basic tenants: (1) physicians' primary goal should be to promote the health and well-being of their patients; (2) patients should be fully informed about their condition and their treatment options; and (3) patients, in conjunction with their physicians, should in most cases make the decisions about what treatments to undertake. *See id.*

the health care plans to which their patients belong.[139]

Physicians are expected to balance the interests of their patients with the interests of other patients.[140] When deciding whether to order a test or procedure for a patient, the physician must consider whether the slot should be saved for another patient or not used at all, in order to conserve the plan's resources.[141]

In the context of health care surrogate statutes, there is even a greater risk that physicians may be influenced by financial considerations. This is because health care surrogate statutes are often utilized during the end stages of life. There are high medical costs and expenditures associated with the end stages of life.[142] Many groups in society -- including payers, insurers, health plans, policy analysts, and ethicists -- are pressing physicians to curb rising health care costs by not "wasting" medical resources on patients who are statistically unlikely to recover.[143] As managed care comes to dominate medical practice, broad social concern about excessive expenditures becomes even more forcefully and sharply focused through the economic and administrative pressures that managed care plans can exert on physicians.[144] It is easy for the physician, perhaps unconsciously, to accede to these pressures and to omit appropriate efforts to preserve life and restore health.[145]

Even though different finance and delivery systems do not alter a physicians' fiduciary obligations to a patient, "different conflicts of interest are engendered by different systems."[146] "Fee-for-service systems create incentives for overutilization; managed care and managed competition create incentives for underutilization, especially if physicians bear financial risk and have financial incentives to limit care."[147]

Managed care plans entice physicians to make cost-conscious treatment

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139 *Id.* at 2041-42.

140 *See* Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330, 331 (1995).

141 *See id.* at 332.

142 *See* Levinsky, *supra* note 8, at 742.

143 *Id.*

144 *See id.*

145 *See id.*

146 John La Puma, *Anticipated Changes in the Doctor-Patient Relationship in the Managed Care and Managed Competition of the Health Security Act of 1983*, Archives of Family Medicine, Aug. 1994, at 2, *available in* DIALOG, AMA-JNLS.

147 *Id.* at 2-3.

decisions through the use of financial incentives.[148] The plans often compensate physicians with capitation fees or a salary.[149] Furthermore, plans typically use incentives for physicians to limit their use of diagnostic tests, referrals to other physicians, or hospital care.[150] For example, managed care plans often pay bonuses to physicians, with the amount of the bonus increasing as the plans' expenditures for patient care decrease.[151] Also, many plans withhold a fixed percentage of their physicians' compensation until the end of the year to cover any shortfalls in the funds budgeted for expenditures on patient care.[152]

B. Paternalism

> *"Historically, physicians made all definitive decisions concerning the proper treatment for their patients. Patients readily accepted and trusted their physicians treatment decisions because their physicians' education, authority, and title as 'doctor' meant they knew what was best. Physicians made these decisions regardless of a patient's expressed or unexpressed wishes. This type of ultimate physician control characterized the era of physician paternalism."*[153]

With the evolution of living will statutes, durable power of attorney statutes, and health care surrogate statutes, patients have more control over health care decisions. These statutes provide the legal means for patients or surrogates to make health care decisions. However, even with these statutes there remains the danger that physicians may simply override the patient's or the surrogate's decisions.[154] While theory may emphasize the patient's values, there is increasing evidence that physician values may be a more decisive factor than patient values in health care decisions.[155]

Another flaw of the health care surrogate statutes is that they do not effectively prevent physicians from interjecting paternalistic attitudes into the

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148 *See supra* note 140, at 331.

149 *See id.*

150 *See id.*

151 *See id.*

152 *See id.*

153 Robert J. Dzielad, *Physicians Lose the Tug of War to Pull the Plug: The Debate About Continued Futile Medical Care*, 28 J. MARSHALL L. REV. 733, 737 (1995) (book review).

154 *See* David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101, 2102 (1992).

155 *See id.* at 2101.

decision-making process.[156] Some physicians may attempt to override a surrogate's decision because it conflicts with their own beliefs and/or values. For example, a physician may pretextually assert that a surrogate's decision to discontinue life-sustaining treatment is not in accordance with the patient's wishes or in the patient's best interests. In reality, the physician's reason for not wanting to discontinue treatment may be the "old school" belief that patients are not capable of making complex medical decisions regarding life-sustaining treatment because they lack medical training and expertise.[157] However, many individuals, including this author, believe that life-sustaining treatment decisions are value-based and do not require medical knowledge.[158] Furthermore, the physician may believe it is his or her duty to do whatever is medically possible to keep the patient alive.

"Doctors are sometimes accused of carrying heroic measures too far, a result, perhaps, of their natural instinct and training."[159] According to Dr. O.J. Sahler of the University of Rochester School of Medicine and Dentistry, "Saving a life is a very primitive reflex for a physician."[160] Many doctors believe that the Hippocratic code is still literally valid.[161] Dr. Marshall L. Brumer of Ft. Lauderdale, Fla. believes that it is his duty to do everything he can to sustain lives.[162] "Brumer would not withhold treatment from a victim of incurable cancer who is in pain and says he wishes to die."[163] "Cures can come down the pipeline at

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156 *See* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 110 (1984) (indicating that hard paternalism is causing resistance to patient efforts to exercise some degree of autonomy in decisions about their medical treatment). "Hard paternalism . . . . accepts the proposition that it is morally justifiable for others to protect competent adults, against their will, from the harmful consequences of their fully voluntary choices." Ben A. Rich, *The Values History: A New Standard of Care*, 40 EMORY L. J. 1109, 1118 n.34 (1991).

157 David Orentlicher, *Trends in Health Care Decisionmaking: The Limits of Legislation*, 53 MD. L. REV. 1255, 1293 (1994). Research studies have concluded that a significant number of physicians question the ability of patients to make decisions at the end of life. *See* Kent W. Davidson et al., *Physicians' Attitudes on Advance Directives*, 262 JAMA 2415, 2416 Table 3 (1989) (indicating that 58.8 percent of responding doctors strongly agreed that "[a] potential problem with advance directives is that patients could change their minds about 'heroic' treatment after becoming terminally ill" and 32.4 percent strongly agreed that "[t]he training and experience of physicians gives them greater authority than patients in decisions about withholding 'heroic' treatment").

158 *See* Orentlicher, *supra* note 157, at 1293.

159 Matt Clark et al., *When Doctors Play God*, Newsweek, Aug. 31, 1981 at 48, 49.

160 *Id.* at 49.

161 *See id.*

162 *See id.*

163 *Id.*

any hour of the day," Brumer says.[164] "To stand idly by and watch a person die is intolerable. Where does it stop? Where do you draw the line?"[165]

Paternalism can also take on a different form. Believing they know what is best for a patient, some physicians may want to discontinue treatment. Consider the case of Helga Wanglie.[166] Helga Wanglie, eighty-six, developed respiratory failure and was placed on a respirator.[167] She later experienced a cardiopulmonary arrest, and physicians believed she had severe and irreversible brain damage.[168] "Because of her age, previously prolonged hospital stay, . . . multiple medical complications, ultimately unsuccessful weaning from the respirator, and neurologic condition, the medical staff caring for Mrs. Wanglie viewed her prognosis as extremely poor."[169] They believed continued use of the respirator could not serve her interests.[170] The hospital's medical director stated, "We do not believe that the hospital is obliged to provide inappropriate medical treatment that cannot advance a patient's personal interest."[171] However, the immediate family insisted that all forms of treatment be continued.[172] Helga Wanglie's husband claimed that his wife always told him that "if anything ever happened to her so that she could not take care of herself, she did not want anything done to shorten her life."[173]

The case of Baby L further exemplifies the conflict that can arise when a physician believes continued medical treatment is no longer in the best interests of a patient.[174] Baby L was a two-year-old girl who was blind, deaf, and quadriplegic.[175] She was also fed through a gastrostomy.[176]. At the age of 23

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164 Clark, *supra* note 159, at 49.

165 *Id.*

166 *Helga Wanglie's Ventilator*, 21 Hastings Center Report 23, 23 July-August 1991.

167 *See id.* at 23.

168 *See id.*

169 *Id.*

170 *See id.*

171 *Helga Wanglie's Ventilator*, *supra* note 166, at 24.

172 *See id.* at 23.

173 *Id.*

174 *See* John J. Paris et al., *The Case of Baby L.*, 322 NEW ENG. J. MED. 1012, 1012 (1990).

175 *See id.* at 1013.

176 *See id.*

months the child required mechanical ventilation and cardiovascular support.[177] During those 23 months, the mother had continued to demand that everything possible be done to ensure the child's survival.[178] Because a child with such extensive neurologic deficits could experience only pain, the medical staff agreed unanimously that further medical intervention was not in the best interests of the patient.[179] "In their opinion, further intervention would subject the child to additional pain without affecting the underlying condition or ultimate outcome."[180] Thus, they requested the mother's permission to discontinue certain treatment.[181] The mother refused to discontinue treatment.[182]

Additionally, there have been several studies which demonstrate the glaring presence of paternalism within the medical community.[183] One such study was a survey conducted in California to determine the number of physicians who would neither honor patients' valid directives nor transfer them to the care of one who would.[184] Eleven percent of the responding physicians indicated that they

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177 *See id.*

178 *See id.* at 1012.

179 *See* Paris, *supra* note 174, at 1012.

180 *Id.* at 1013.

181 *See id.*

182 *See id.*

183 There are a number of studies that support the notion that physician beliefs and values may be a more decisive factor than patient beliefs and values in health care decisions. *See* Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882 (1992) (In a prospective study conducted over a two-year period, nursing home patients were asked to complete advance directives expressing their wishes regarding medical treatment. In an analysis of hospitalization or death in the nursing home, researchers found that care was consistent with previously expressed wishes 75 percent of the time. *See id.* at 882. The researchers concluded that "some of the care decisions that were inconsistent with advance directives appeared to be based on principles of beneficence and proportionality. Thus, the data suggested that in caring for incapacitated patients, physicians balanced respect for autonomy with other competing ethical principles in order to make what they believed were the wisest decisions." *Id.*); Nicholas G. Smedira et al., *Withholding and Withdrawal of Life Support from the Critically Ill*, 322 NEW ENG. J. MED. 309 (1990) (In a study conducted over a 1-year period, researchers studied all patients treated in one of two intensive care units. *See id.* at 309. Approximately 7% of the patients had life-sustaining treatment withheld or withdrawn. *See id.* at 310. The researchers found that "[t]he issue of withdrawal or withholding usually arose during the work rounds of the primary care and intensive care teams; only 6% of withdrawals or withholdings were initiated by requests of the patient or family." Orentlicher, *supra* note 154, at 2102. "[Additionally], patients or families rejected the physician's recommendation to withhold or withdraw care in only 2% of cases." *Id.*); Barbara J. McNeil et al., *Fallacy of the Five-Year Survival in Lung Cancer*, 299 NEW ENG. J. MED. 1397 (1978) (In a study of treatment for bronchogenic carcinoma, the choice of surgery versus radiation appeared to be influenced more heavily by physician risk preferences than by patient risk preferences.).

184 *See* Diane Lynn Redleaf et al., Note, *The California Natural Death Act: An Empirical Study Of Physicians' Practices*, 31 STAN. L. REV. 913, 924-26 (1979). The survey was distributed in the form of a questionnaire to 920 physicians. *See id.* The physicians were members of the Santa Clara, California

would administer artificial life support to an eighty-year-old heart attack victim in violation of a legally binding advance directive.[185] Fourteen percent of the responding physicians indicated that, in the case of a severely brain-damaged patient who was legally dead under California law, they would ignore an advance directive and place the patient on a respirator.[186] Lastly, nineteen percent of the responding physicians indicated that when a terminally ill patient consciously and competently declines treatment, despite needing a transfusion, the physicians would attempt to contravene the patient's refusal.[187]

One can draw several conclusions from these studies regarding paternalism within the medical community. Since physicians are vigorously trained to treat sick and dying patients, many physicians believe that because of this extensive training they know what is best for their patients. Many of these same physicians believe that they must do whatever is in their power to extend a patient's life. On the other hand, some physicians believe that discontinuing treatment in certain circumstances is what is best for a patient. The bottom line is that some physicians believe they should have ultimate control over all health care decisions. "If there is a problem with physician respect for patient preferences, it may simply reflect a natural lag between a change in theory and changes in practice. The principle that patient values should govern medical decision making is a relatively recent concept in medicine."[188] Nevertheless,

> [i]t is as presumptuous and ethically inappropriate for doctors to suppose that their professional expertise qualifies them to know what kind of life is worth prolonging as it would be for meteorologists to suppose their professional expertise qualifies them to know what kind of destination is worth a long drive in the rain.[189]

Medical Society as internists, general and family practitioners, neurologists, surgeons, and emergency room physicians. *See id.* These specialties were chosen because they were likely to involve terminally ill patients. *See id.* Thirty-one percent returned the survey, and 275 of those responses were analyzed for the study. *See id.*

185 *See id.* at 937.

186 *See id.*

187 *See id.*

188 Orentlicher, *supra* note 154, at 2101.

189 Felicia Ackerman, *The Significance of a Wish*, 21 Hastings Center Report 27, 28 July-August 1991.

V. CONCLUSION

This Article began with Joe's story. His case presents a variety of issues that may arise when a person loses decision-making capacity. Although the issues have always existed, the means for resolving them have changed. In the past, the attending physician would have made all health care decisions for Joe. Furthermore, if Joe's wife wanted to discontinue life-sustaining treatment she likely would have needed a court's approval. Fortunately, however, there has been a significant shift in our culture regarding who should make health care decisions for individuals like Joe. Several states have enacted health care surrogate statutes that empower a surrogate decision-maker to make certain health care decisions.[190] The statutes are a positive legislative development which have increased the possibility that health care decisions will be in conformity with patients' wishes or beliefs.

However, although health care surrogate statutes have significantly contributed to protecting incompetent patients' rights, they contain flaws which threaten the interests of incompetent patients. The statutes do not effectively safeguard against surrogates making health care decisions that are not in accordance with patients' wishes or in patients' best interests. Likewise, the statutes do not effectively prevent physicians from interjecting themselves into the decision-making process and advancing their own interests.

In order to minimize potential abuses by surrogates and physicians, changes must be made to the health care surrogate statutes. One potential change that may curb abuses by surrogates relates to the priority list contained in the statutes. As explained previously in this Article, a physician must follow a prioritized listing in order to determine who may serve as a surrogate.[191] The lists prioritize different family members at different levels (e.g., a patient's spouse is listed above a patient's child and parent). Under the statutes' current structures, an individual family member, as the highest ranking individual on the prioritized listing, may assume exclusive control over health care decisions. The current structure creates the prospect that a surrogate may make a decision that is not in accordance with a patient's wishes or in a patient's best interests.

States can address possible surrogate abuses by amending their statute's prioritized listing. States should amend the listing to include all family members on the same priority level. This amendment is based on the premise that all immediate family members of a patient (e.g., spouse, children, parents, and siblings) may possess relevant information that should be considered before making any significant health care decisions. This author contends that a child or parent is just as likely as a spouse to possess knowledge of a patient's wishes regarding medical treatment. Furthermore, there is no reason not to consider all

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190 *See* statutes cited *supra* note 5.

191 *See supra* note 53 and accompanying text.

pertinent information when a patient's life stands in the balance. The inclusion of all family members on the same priority level will prevent an individual family member who may have unethical motives from being the sole decision-maker. In the event family members disagree over how medical treatment should progress, the statutes should require family members to present all relevant information to an attorney provided by the health care facility. After considering all relevant information, the attorney would make a binding decision.

This Article also discussed how health care surrogate statutes do not effectively safeguard against unethical behavior on the part of physicians. As articulated earlier in this Article, the statutes do not require a physician to carry out a surrogate's decision if the physician believes the surrogate is not acting in accordance with the statute.[192] Unfortunately, some physicians may utilize this clause to advance their own interests. Therefore, this author believes that states should amend the statutes to impose heavy burdens upon physicians before they can override a surrogate's decision. The statutes should require a physician to carry out a surrogate's decision unless the physician has "substantial" evidence that the surrogate is not acting in accordance with the statute. This amendment may alleviate some abuses by physicians.

There is no question that health care surrogate statutes are an important tool for incompetent terminally-ill patients. The statutes are a significant step toward ensuring that health care decisions are made in accordance with the patient's wishes or in the patient's best interests. However, state legislatures should not rest on their laurels just because they have passed health care surrogate statutes. More must be done to protect the interests of incompetent patients.

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192 *See* statutes cited *supra* note 5.