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Sol Wachtler

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## ARTICLES

### THE PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT: THE NEW YORK VIEW

*The Honorable Sol Wachtler\**

This article, which I am pleased to dedicate to my friend, Professor Josephine Y. King, deals with the evolving caselaw in the State of New York concerning a patient's right to decline medical treatment. New York, like many other states, has been struggling with cases involving this troublesome area of the law. The New York State Court of Appeals consistently expressed the belief that these cases are best resolved by the Legislature and that the court's role should be limited to deciding only the cases which come before it. As a result of the court's persistence in this regard, the New York State Legislature has recently enacted certain statutes which have gone far toward resolving the myriad of problems presented by these cases. It has enacted laws which allow a patient to provide that he or she is not to be resuscitated and has allowed an individual to execute a form of proxy which permits a surrogate to make these decisions in the event the patient is incompetent to do so.

One of the strengths of the common law process is its ability to adjust to changes in our way of life. A tradition that began in the darkest recesses of the middle ages has been able to keep pace with changes brought about by the printing press, the steam engine, electricity, and the many technological advances in transportation, communication, and medical science. But the radical advances in life sustaining equipment and procedures developed by the medical profession in the last twenty years have taxed the common law process in ways that it has never been tested before.

Many feel this is a self-imposed burden. In their view, the courts are intruding into an area which should be reserved for the patients, their families, and medical professionals. But this is not a role which the judiciary has assumed for itself. It has been thrust upon the courts by advances in medical treatment which can extend life, or at least keep the major organs functioning, well beyond medical and legal precedent. For centuries we could say

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\* Chief Judge, Court of Appeals, State of New York.

with confidence, both medically and legally, that death occurs when heart and lungs cease to function. Now that medical science can artificially maintain respiration and heartbeat for extended periods, we are no longer so sure. Illnesses and injuries that a few short years ago led inexorably to death now may be cured or treated and contained but at a cost which many patients find exorbitant financially, physically, and psychologically. Others reject the treatments because they find them offensive to their religious or personal sensibilities. If the patient declines medical treatment necessary to sustain life, is it suicide? If the doctor honors the patient's wishes, is the doctor implicated in the suicide? If the patient is incompetent but the family members and doctors agree that continued treatment would be futile, are they all guilty of manslaughter? If the patient has left a living will or appointed a surrogate to decline the treatment, would this provide a defense? And if the doctor does not honor the patient's wishes, has he or she violated the patient's common law or constitutional rights? Is there a right to die?

Until a few years ago there were no clear answers to these questions under existing law. As a result, doctors, patients, and family members facing such choices frequently came to court to determine in advance whether a decision to administer, withhold, or discontinue a particular medical treatment may subject them to civil or criminal liability.

The first cases to reach the courts came like a surprise attack for which we had no contingency plan. Our precedents drawn from the venerable traditions of the common law, where a life or death decision usually meant a criminal execution, did not anticipate and could not anticipate the legal consequences of discontinuing a respirator for a person in a persistent vegetative state. Of course, the Legislature has powers of foresight which are denied to the courts, because the Legislature alone has the power to identify potential problems and provide solutions before they arise. However, in this state, and most others, there were few statutes specifically tailored or even generally helpful in resolving the many legal problems posed by the new technology. Although it was often asserted that constitutional rights were involved, sometimes described as the individual's right of privacy, usually pitted against the state's interest in preserving life, the Supreme Court remained silent for many years while the state courts struggled with the problems and developed an independent body of law.

The decisions from the state courts are diverse and often controversial. Now, in *Cruzan v. Director, Missouri Department of Health*,<sup>1</sup> the Supreme Court has spoken and it appears that the diversity will continue.

In *Cruzan*, the parents of a young woman who was in a persistent vegeta-

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1. 110 S. Ct. 2841 (1990).

tive state following an automobile accident sought to discontinue the use of a nasogastric tube that provided food and water after she lost the ability to eat. The state, which was paying for the hospitalization, objected and the case went to the Missouri courts. The lower court held that the tube could be removed because that seemed to be what the patient would want based upon a casual conversation she had with a roommate several years earlier. The Missouri Supreme Court reversed, concluding that clear and convincing evidence was required and that the conversation with the roommate did not meet the standard. That decision was challenged in the United States Supreme Court on the ground that it violated the patient's constitutional rights, but the Court affirmed the decision. The Court noted that a person's decision to decline medical treatment would seem to implicate the due process liberty interest which required a balancing of the individual's rights against the interests of the State. Noting that the State had an interest in preserving life and that the patient was incapable of expressing her present wishes, the Court held that the State could require clear and convincing proof that the patient would want to forego treatment under these circumstances before permitting a surrogate to act for her.

In the course of its opinion the Supreme Court observed that other states take a more lenient view toward permitting the withdrawal of life support systems. But the Court implicitly disclaimed any need for uniformity. Instead it noted: "State courts have available to them for decision a number of sources—state constitutions, statutes, and common law—which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did."<sup>2</sup> The actual holding may be more narrow but the message is clear. This is an area in which the Court intends to defer to the states. In other words: Don't call us, we'll call you.

Deference in a time of crisis is not always welcome. But the Supreme Court's decision recognizes that the groundwork has begun and that many states have already devised rules on basic points reflecting the needs of their own citizens. Indeed, New York was cited as a state which has developed a distinctive point of view. That view was not so distinct in 1981, when the New York Court of Appeals first encountered these problems in two cases entitled *Eichner v. Dillon*<sup>3</sup> and *In re Storar*.<sup>4</sup>

*Eichner* involved an 83-year-old member of the Society of Mary, named Brother Fox, who was maintained on a respirator in a permanent vegetative

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2. *Cruzan*, 110 S. Ct. at 2851.

3. 52 N.Y.2d 363, 370, 420 N.E.2d 64, 67, 438 N.Y.S.2d 266, 269 (1981).

4. 52 N.Y.2d 363, 373, 420 N.E.2d 64, 68, 438 N.Y.S.2d 266, 270 (1981).

state. The local director of the Society applied, as Brother Fox's court-appointed guardian, to have the respirator removed on the ground that it was against the patient's wishes as expressed prior to his becoming incompetent. The district attorney argued against the termination of treatment, urging that the patient's right in this regard is outweighed by important State interests when the treatment is necessary to preserve the patient's life.

In *Storar*, a state hospital official applied for permission to administer blood transfusions to a profoundly retarded 52-year-old man with terminal cancer of the bladder. The patient's mother refused to consent on the ground that the transfusions would only prolong his discomfort and would be against his wishes if he were competent.

At the core of these cases was a tension between individual choice and the interest of the State in preserving life and deterring those who would take life. Despite the modern trimmings it is an age-old controversy which the common law resolved in favor of personal choice, at least where the patient was competent. As Judge Cardozo of our court stated: "Every person of adult years and sound mind has a right to determine what should be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault for which he is liable in damages."<sup>5</sup> That principle had been adopted in tort cases where the doctor was held liable in damages for acting without the patient's consent, but we held it was equally available when the doctor had honored the patient's wishes to decline treatment necessary to sustain the patient's life. We noted: "A state which imposes civil liability on a doctor if he violates the patient's right cannot also hold him criminally responsible if he respects that right."<sup>6</sup>

But what if the patient has become incompetent? Must he be sustained in a vegetative state even when he has previously said, while competent, that he would not want this kind of treatment, as was the case with Brother Fox? In *Eichner v. Dillon*, our court held that the patient's prior wishes can be honored, if they can be established by clear and convincing evidence.

But what of the retarded adult, like John Storar, who has always had an infant's mentality? Can anyone realistically determine whether he would want to discontinue blood transfusions while suffering from terminal cancer? In the *Storar* case, our court held that under those circumstances the patient must be legally viewed as a child who cannot be denied ordinary life sustaining treatments even when a well-intentioned parent feels that is in his best interests.

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5. *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

6. *Storar*, 52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273.

Our next case also involved the rights of parents to make medical care decisions for their children, but in a completely different setting. In that case, known as the *Baby Jane Doe* case,<sup>7</sup> the parents and doctor agreed that an infant with multiple disabilities should not receive a brain and spine operation that may prolong her life, but would not cure the disabilities and might well aggravate them. The question was whether a complete stranger could compel them to perform the operation. Our court held that the stranger had no standing to intrude into the family counsels, or seek the aid of the courts to do so. We noted that the Legislature had given certain agencies the authority to determine whether parents were neglecting a child's medical needs and that the responsible agencies in this case had determined that judicial scrutiny was not required.

In all of these cases the patient was unquestionably alive, although suffering from some brain damage. But what if the patient has suffered a complete cessation of all brain function, a condition known in the medical profession as "brain death"? Is the patient legally dead at that point even if the resuscitators are able to artificially keep the heart and lungs functioning? That question was presented to us in *People v. Eulo*,<sup>8</sup> a criminal case where the defendants were charged with murder and claimed that the doctors "did it" when they shut off the machines. The defendants were found guilty, and we affirmed the convictions, finding the "brain death" standard an acceptable and necessary method for determining death because a dead body attached to a machine may exhibit demonstrably false indicia of life.

The patients in the next case to reach our court were not suffering from any physical illness and were fully capable of making their own medical decisions, or so they claimed. The problem was that they had been committed to a state mental institution where they were receiving drug treatments to which they objected, but which they had no right to refuse under the existing regulations. We noted in *Rivers v. Katz*<sup>9</sup> that mental illness does not necessarily rob a person of the ability to make any rational choices, and held that they were entitled to procedural safeguards and the right to decline the treatments if they had sufficient capacity to do so. This was also the first case in which we had to decide whether the patient's right to decline treatment was guaranteed by the Constitution, because if it was not, the regulations the State had adopted would bar its exercise. We held that the right was protected under the due process clause of the State Constitution, but hastened to add that recognizing its constitutional status did not make the right abso-

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7. *Weber v. Stony Brook Hosp.*, 60 N.Y.2d 208, 456 N.E.2d 1186, 469 N.Y.S.2d 63 (1983).

8. 63 N.Y.2d 341, 472 N.E.2d 286, 482 N.Y.S.2d 436 (1984).

9. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

lute, and that it could be outweighed by the State's need in an emergency to medicate a patient who posed an immediate danger to himself or others.

The New York view, as is evident from these cases, places great emphasis on permitting the patient to determine the course of his or her own treatment even when the patient is suffering from some mental deficiencies or has subsequently become completely incompetent. But what is to be done when the patient's wishes are not entirely clear? That was the situation confronting the Court of Appeals in a case entitled *In re O'Connor*.<sup>10</sup>

Mary O'Connor was a 78-year-old woman who had suffered several strokes and, as a result, became mentally incompetent and suffered certain physical disabilities making it impossible to care for herself. The last stroke had also deprived her of her gag reflex so that she was unable to eat or drink without medical assistance. The doctors at the hospital wanted to insert a nasogastric tube to keep her from dying of thirst and starvation. Her daughters opposed the application, claiming that it would be against the patient's wishes.

There was no doubt that Mrs. O'Connor had made various statements over the years to the effect that she never wanted to become a burden on anyone and would not want to be kept alive by artificial means if she were unable to take care of herself. The statements were made during the terminal illnesses of a close relative or friend. But Mrs. O'Connor was not suffering from a terminal illness, except in the sense that she was aged and infirm. And although incompetent, she was alert and conscious, able to respond to simple commands and not experiencing any pain. What would she want done under these circumstances?

We granted the hospital's application, concluding that there was not clear and convincing evidence that she would want to decline treatment when she was not terminally ill. We noted that many aged persons suffered similar disabilities and before becoming incompetent often stated a general desire not to become a burden. If such statements were treated as clear and convincing proof of a desire to decline medical treatment once the person lost the ability to care for himself or herself, few nursing home patients would ever receive medical care.

In *O'Connor*, we emphasized that as a matter of New York law the inquiry in such cases is limited to ascertaining and then effectuating the patient's expressed wishes. We rejected the "substituted judgment" standard adopted by some other courts because it is inconsistent with our fundamen-

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10. *In re Westchester County Medical Center ex rel. Mary O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

tal commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another.

Our most recent case, *Fosmire v. Nicoleau*,<sup>11</sup> should have been the first case to reach our court because it raised the fundamental question underlying all of our prior decisions. Can a competent adult facing death decline medical treatment for a treatable condition?

Mary Nicoleau lost a massive amount of blood after giving birth by Caesarean section. But on religious and personal grounds she refused to consent to a blood transfusion which in her doctor's opinion was essential for her survival. There was no question that she was competent. In fact, both she and her husband were nurses fully aware of the risks. Nor was there any question that she had made a conscious choice to decline the treatment. She had informed the hospital in advance at the time of admission that she would not consent to a transfusion and persisted in her decision after the transfusion became necessary.

The hospital applied for a court order authorizing the transfusion. In support of the application the hospital argued that the State had an interest in preserving her life because she was a young woman who was in good health except for the loss of blood, which would be completely cured with a transfusion. The hospital urged that the right to decline essential medical care should be limited to persons suffering from terminal illnesses in which case the State would have little or no interest in preserving life. We rejected this argument, noting that in our prior decisions the condition of the patient had only been relevant because the patient was incompetent but had left instructions to decline life sustaining treatments under certain circumstances. Thus, in those cases it was necessary to assess the patient's present medical condition to determine whether it was the type of condition in which the patient wanted those instructions to go into effect. In this case we did not have to make any such inquiry because the patient was able to state her present wishes, nor was her condition relevant to the exercise of her right to decline treatment. We stated: "The right of a patient to decline life-sustaining treatment was recognized in these cases, not because the State considered their lives worthless, but because the State valued the right of the individual to decide what type of treatment he or she should receive under particular circumstances."<sup>12</sup>

The hospital's primary argument in *Fosmire* was that the State had an interest in preserving the patient's life because she was now the mother of a young child which she was not free to abandon. This is an argument that

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11. 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990).

12. *Fosmire*, 75 N.Y.2d at 229, 551 N.E.2d at 82-83, 551 N.Y.S.2d at 881-82.

had been accepted by some other courts, but we found no support for it under existing New York law. The right of patient autonomy had been well settled in this state, by the courts and the Legislature, and had never been subject to such a qualification. We also observed that the various statutory and court imposed obligations on parents did not go so far as to require them to avoid all choices which involved an element of risk to the parent.

Litigation in these cases has served to expose the problems and deficiencies of existing law. We know now that it is not a single problem with a single solution but a number of problems with a number of solutions, some of which are still debatable. We also know that the courts are unsuited and ill-equipped to serve as the sole forum, or even the primary one, for the resolution of the many problems generated by advances in medical technology. It is an area in which the Legislature can and must play an important role.

Because courts can only decide the actual cases brought before them, they cannot provide answers for all, most, or even the more common problems. Oddly, many people who originally criticized the courts for making what they considered an unwarranted intrusion into the sickroom, now criticize the courts for not going far enough to settle the law, or predict the outcome, in cases that have not yet reached the courts. Obviously what is needed is a broad body of law which can provide clear guidelines for the public and medical professionals, not only in the cases that have arisen, but in those which are likely to arise in the future. Only the Legislature has the authority and capacity to initiate such rules.