Legal Issues in Withholding or Withdrawing Medical Treatment*

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It is often pointed out that the great modern advances in medical science and technology have presented us with choices and issues we never before had to confront. This is unquestionably true. The overall issue of this article is "When is it appropriate and necessary to use technology to prolong life?" Not many years ago, there would have been nothing to discuss. Those who were healthy enough to be saved should be saved, and the rest were beyond our control. As a result, it is often assumed that technological advances alone are responsible for the vast literature in law, medicine, and ethics that tries to analyze when these new lifesaving techniques should be used.

It is, however, not an entirely satisfactory explanation for the current interest in this area. Technological advances had occurred before, without producing the outpouring of discussion of the inappropriate use. For example, the use of iron lungs could have raised many of the same issues that the use of modern ventilators raise. One could well ask, why was there no discussion of what to do with a patient who asked to be removed from an iron lung? The full answer to this question is beyond the scope of this article. However, one must at least recognize the social forces that cause us to ask questions today that were not asked in the past.

First, very recent history has caused many people to realize that technological advances have costs as well as benefits. Nuclear reactors promised to be a great source of energy but also raise fears of contamination; computers offer great efficiency but fears of invasions of privacy; even the internal combustion engine, which offers great freedom of movement, has come to be seen as a source of pollution. Thus, the more experience we have with technology, the more we realize the need to examine its proper use to reduce its abuse. This is no less true in medicine than in other areas.

Second, for the first time in the United States, we have come to realize that our financial resources are not unlimited. As all readers of this journal recognize, there is a powerful movement to reduce medical care expenditures. This has led to an examination of the propriety of expending large sums of money and resources on patients who can derive minimal, if any, benefit.

Finally, we must realize the enormous legal strides society has taken in determining the rights of individuals. The past three decades have witnessed the civil rights movement, the women's rights movement, and several other advances in the rights of consumers, employees, prisoners, tenants, the handicapped, and others. All of these rights movements share the goal of giving more power to groups that have historically been relatively powerless. Of particular importance here is the patients' rights movement. For at least the past decade, the movement for patients' rights has attempted to give patients more power in decisions about medical care. It should come as no surprise that as patients received more power regarding decisions to obtain care, the issue of refusing care became more salient.

The Legal Right to Refuse Treatment

Although the term right to die is often used, it is an inaccurate characterization of the right under discussion. There is no common law or constitutional basis for a right to die. Indeed, it is not at all clear what a right to die means. The right discussed here is not the right to die but the right to refuse recommended medical treatment, which clearly has both a constitutional and a common law basis.

The common law basis for the right to refuse treatment comes from the law of civil battery. A battery is an unconsented-to touching. For physicians not to be liable for committing a battery on a patient, physicians must receive the patient's consent to be touched. Purely as a matter of logic, if one does not consent, such treatment becomes an unconsented to intrusion on the person's body. An early recognition of this point is seen in Judge Cardozo's much-cited holding:† "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."

In recent years courts have gone beyond the concept of simple consent and have developed the doctrine of informed consent. This doctrine recognizes that patients generally do not possess the knowledge necessary to make an informed health care decision, and,

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therefore, it is the physician's duty to provide information to patients prior to obtaining their consent. As the California Supreme Court has phrased it, while a physician knows the risks and benefits of treatment, he must disclose these risks and benefits to the patient because:

The weighing of those risks against the individual fears and hopes of the patient is not an expert skill. Such evaluation and discussion is a non-medical judgment reserved to the patient alone. [Emphasis added.]

It is clear that the doctrine of informed consent provides the patient with the right to decide whether or not to undergo treatment. Indeed, if patients do not have the right to refuse treatment, the doctrine of informed consent becomes a sham.

The constitutional basis for a patient's right to refuse treatment comes from the right of privacy as recognized in a long line of U.S. Supreme Court decisions culminating in the case Roe v. Wade. Roe held that the constitutional right of privacy forbade states from passing laws that make it illegal for women to obtain abortions. In essence the Supreme Court held that the decision whether to undergo an abortion was protected by the right of privacy, and that a state could not intrude into that decision—the decision was to be made by the woman and her physician, not by a state legislature. Several courts have held that the constitutional right to privacy applies to decisions to refuse medical decisions. For example, in the Karen Ann Quinlan case, the New Jersey Supreme Court held that the constitutional right of privacy is broad enough to encompass a patient's decision to decline medical treatment . . . .

The right to refuse treatment is not absolute. Many courts have at least mentioned a variety of interests that a state might have to override the exercise of this right. For example, some courts have mentioned that the state has a right to prevent suicide. At the same time, courts have come to recognize that refusing treatment that might be lifesaving does not constitute suicide. To commit suicide, an individual must "purposelyset in motion a death-producing agent with the specific intent of effecting his own destruction." A patient who refuses treatment rarely meets both of these criteria, and often meets neither. As the New Jersey court puts it, "we would see a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful, and certain imminent death."

Courts have also discussed the possibility of requiring treatment when the patient has minor children who may suffer as a result of a parent's refusal of treatment. For example, there are at least two cases of court intervention to require a woman to undergo cesarean section for the benefit of the fetus. Whether it is ever proper for a court to order treatment of one person for the benefit of another is highly controversial and unresolved.

What is becoming increasingly clear is that courts do allow competent patients to refuse treatment, even when that refusal will shorten life. Thus, competent people have been permitted to refuse amputation of gangrenous legs, a patient dying of ALS was found to have the right to have his mechanical ventilator removed, and one court made it clear that patients could refuse kidney dialysis.

It is now clear beyond dispute that competent adults have the right to refuse treatment. There might be some circumstances in which this right can be abridged, but that is the exceptional case, not the rule.

INCOMPETENT PATIENTS

The much more difficult issue concerns how to make treatment decisions for incompetent patients. Competence is the ability to understand that one has a disease or condition that needs treatment and to understand the risks and benefits of the treatment. All people are presumed to be competent until proved otherwise, and the burden of proof is on those trying to demonstrate incompetence. One is not incompetent simply because he is old or sick or because he disagrees with a physician's advice. It is extraordinarily serious for an individual to be deemed incompetent, for at that moment he loses his legal right to make important decisions for himself. Physicians must be sensitive to this fact and not treat patients as incompetent simply because they are difficult, demanding, or vacillating in their decisions.

Once a patient is properly found to be incompetent, may treatment be legally withheld or terminated? In proper circumstances, the answer is "yes." The most famous case involved Karen Quinlan, who was in a chronic vegetative state with no chance of recovery. The court held that where there was no reasonable possibility of Ms. Quinlan's returning to a cognitive, sapient state, the respirator could be lawfully removed. Indeed, if the decision were approved by a hospital ethics committee, such action could never be the subject of either a civil or criminal action.

The Massachusetts Supreme Judicial Court approved the withholding of chemotherapeutic agents from a 67-year-old profoundly retarded man who suffered from acute myeloblastic monocytic leukemia. In this case, Superintendent of Belchertown v. Saikewicz, the court essentially found that had Mr. Saikewicz been competent, he would have decided that the serious risks and discomforts of the treatment outweighed the limited benefits that the treatment would have offered. This is referred to as the "substituted judgment" doctrine. It means that one should attempt to determine what the incompetent person would decide if he were competent, "but taking into
account the present and future incompetency of the individual as one of the factors that would necessarily enter into the decision-making process of the competent person." At times the substituted judgment test will be extremely difficult to apply, but when seen as a goal, it is sensitive to individual patient needs. At times it may be simple to apply. For example, if an incompetent patient had written a "living will" or similar document prior to becoming incompetent, we would know what that patient would want done, even if we do not believe that it conforms to our sense of his "best interests." Alternatively, a patient may have communicated orally with relatives or friends what his wishes would be if he became incompetent. For example, where a priest had made it clear to other members of his religious community that if he were ever in a chronic vegetative state like that of Karen Ann Quinlan, he would want to be removed from a respirator, it was held that his wishes must prevail.

A great deal of uncertainty could be alleviated if physicians dealing with patients who suffer from chronic degenerative illnesses would discuss with the patient what the treatment alternatives will be when the patient becomes incompetent. While no one would deny the emotional difficulty of undertaking this task for both the physician and patient, such a discussion would remove uncertainty from future decisions that will have to be made by physicians and relatives and would maximize the patient’s right to self-determination.

The cases and commentary make it clear that substituted judgment is to be used whenever possible. If it cannot be used, physicians, family, and friends must use the "best interests" of the patient test to try to determine if the risks and burdens of the treatment outweigh the benefits. There is now a significant body of law that has permitted the withdrawal or withholding of various lifesaving procedures, including chemotherapy, mechanical ventilation, and dialysis. Indeed, there is only one case I am aware of in which a court has refused to allow the wishes of a patient’s family and physician to stop a lifesaving therapy, blood transfusion. In this case, blood transfusions were needed to restore blood loss from cancerous lesions in the incompetent’s bladder. Because the cancer had metastasized and the patient was clearly terminally ill, his mother and physicians asked the court for permission to terminate the transfusion. The blood would clot in his bladder and cause him great pain. The court refused to permit the termination of this treatment. This is a widely criticized case, and it has not been followed by other courts.

On several occasions reference has been made to "withholding or withdrawing treatment." Questions have been raised as to whether there is a legal distinction between withdrawing and withholding treatment. While it may be emotionally more traumatic to physicians to withdraw treatment than not to commence it, neither the law nor ethics find importance in this distinction. As the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded:

"whatever considerations justify not starting should justify stopping as well. Thus the Commission concludes that neither law nor public policy should mark a difference in moral seriousness between stopping and not starting treatment."

No court has ever found this distinction of any significance; and one court that directly confronted the issue stated:

"Characterizing conduct as active or passive is often an elusive notion, even outside the context of medical decision-making. . . . We . . . reject any distinction between withholding and withdrawing life-sustaining treatment."

This holding has even more force when one realizes that it was made in a case that held that the nasogastric feeding tube may be removed from incompetent persons in appropriate circumstances.

FEAR OF LIABILITY

Physicians may surmise that with all the court cases cited, there must be a good deal of legal risk in this area. There appears to be no case ever brought to court in which it was alleged that a physician was guilty of malpractice for withdrawing or withholding treatment. This should come as no surprise, since these decisions are taken seriously, thought about long and hard, are reserved for the most serious cases, and are made with the input and consent of the family who would be the only available plaintiffs.

The threat of potential criminal liability is also present in the minds of physicians. Indeed, two physicians were indicted in California for the removal of a mechanical ventilator and IV feeding tubes. In that case there was some question as to the patient’s condition, and the family claimed it was not properly informed. But even in this case the charges were dismissed, with the Court approving the appropriate removal of IV nutrition.

In another case, the Massachusetts Supreme Judicial Court noted:

"Little need be said about criminal liability; there is precious little precedent, and what there is suggest that the doctor will be protected if he acts on a good faith judgment that is not grievously unreasonable by medical standards. [Emphasis added."

This standard of criminal responsibility is very pro-physician. The medical profession itself sets the standard of care, and the physician must act grievously unreasonably by medical standards. It is hard to imagine a physician acting in good faith who would meet this standard for criminal liability.

Since there are no malpractice suits, and only one unsuccessful criminal case, how do these cases get into court? Virtually all got to court because either the
physician or hospital refused to follow the wishes of the patient or family, and the patient or family had to go to court for a declaration of their rights. For example, the Quinlan case was brought to court by Ms. Quinlan's father because her physician would not remove her from the respirator as her father requested. It is not clear why physicians and hospital authorities refuse to follow patients' and family wishes, forcing them to go to court to have their wishes followed. Some physicians may believe that their ethical values do not allow them to follow the patients' or family's wishes. Probably more often, physicians and hospitals fear the legal consequences of withdrawing or withholding treatment. This is somewhat ironic given the earlier discussion of legal risks. Probably almost everything else physicians and hospitals do in the care of patients puts them at more legal risk than these nontreatment issues. If it is true that physicians would like to comply with patient and family wishes but do not because of fear of legal repercussions, this is particularly unfortunate, because courts have been very supportive in the situation where the physician, patient and/or family agree as to the best course of action. Physicians who do not follow the course of action they believe is medically and ethically correct because of fear of legal intervention must obtain competent legal advice to make sure they are correct. If they ask a lawyer if there are any risks associated with withholding or withdrawing treatment, any lawyer should answer, "Yes, there are risks," because there are risks to literally everything. What is needed is an objective and fair assessment of the risks. If one is acting in accordance with good medical practice and with consent of the patient or family, the risks of liability in these cases are vanishingly small.

CONCLUSION

The law regarding patient refusal of treatment or the withholding or withdrawing of treatment from an incompetent patient is still in the process of developing. The clear trends at this time are that the competent patient can refuse treatment, and that nontreatment is appropriate and lawful for certain incompetent patients. The courts have fully appreciated the difficulties that these issues present to the society as a whole and to the medical profession in particular. On the whole, the courts have been supportive of the patient's right to refuse treatment, particularly when the patient and physician make the decision together, or the physician and family when the patient is incompetent. It is the very model of decision making with which physicians should be most comfortable.

REFERENCES

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12. Id. at 431
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