STATE OF WISCONSIN
COURT OF APPEALS
DISTRICT IV
Case No. 2014 AP 135

DISABILITY RIGHTS WISCONSIN,
Plaintiff-Appellant,

v.

UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS, DONNA KATEN-BAHENSKY, UW SCHOOL OF MEDICINE AND PUBLIC HEALTH, BOARD OF REGENTS OF THE UNIVERSITY OF WISCONSIN SYSTEM, AND KEVIN P. REILLY,
Defendants,

GREGORY P. DEMURI, M.D., MARGO HOOVER-REGAN, M.D., NORMAN FOST, M.D., JIM MUEGGENBERG, M.D., AND JULIA WRIGHT, M.D.,
Defendants-Respondents.

ON APPEAL FROM A FINAL ORDER OF THE
DANE COUNTY CIRCUIT COURT DATED DECEMBER 3, 2013,
THE HONORABLE C. WILLIAM FOUST PRESIDING

BRIEF OF *AMICUS CURIAE* WISCONSIN CATHOLIC MEDICAL GUILDS

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I. INTRODUCTION

Every human being is endowed with a fundamental constitutional right to life. Physicians, via both *a priori* ethical obligations and the law, have a duty to protect and support their patients' lives to the best of their knowledge and ability. State-employed physicians have an even greater responsibility. Yet the treatment of both patients here, as alleged in Plaintiffs' Amended Complaint, flies in the face of this duty. After only one meeting, and with no physical exam, observation of his daily life, or consultation with his long-term care team, Dr. Hoover-Regan agreed to limit Patient 1's future care given his "poor prognosis and poor quality of life." (14:9, ¶¶29-31; App. 144). Defendant physicians took Patient 1 under their care; cut off his antibiotics, nutrition, and hydration; and sent him to hospice to die. (14:12, ¶¶52-54; App. 147). Similarly, after accepting responsibility for Patient 2, Dr. Wright continued to pressure her family to limit treatment and send her to hospice, even in the face of Patient 2's improvement and her family's resistance.[1] (14:17-19, ¶¶85, 92, 96; App. 152-54). Neither was in an end-of-life situation. At no time was an ethics committee convened. Simply put, the treatment of these patients was unethical, immoral, and unconstitutional.

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[1] Yet medical consent is considered a process, not an event. *See* Philip M. Farrell & Norman C. Fost, *Long-term Mechanical Ventilation in Pediatric Respiratory Failure: Medical and Ethical Considerations*, 140 AMER. REV. OF RESPIRATORY DISEASE S36 (1989).

II. EVERY HUMAN BEING IS ENDOWED WITH A FUNDAMENTAL RIGHT TO LIFE.

Article 1, §1 of the Wisconsin Constitution grants "inherent" "life" and "liberty" rights.[2] This fundamental right to life and a corresponding "unqualified" state interest in "the protection and preservation of human life" are universal in American law. *See Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 280, 282, 110 S.Ct. 2841 (1990); *West Virginia v. Barnette*, 319 U.S. 624, 638, 63 S.Ct. 1178 (1943) (the right to life is "withdraw[n]...from the vicissitudes of public controversy[,]...beyond the reach of majorities and officials" and are "to be applied by the courts"). The right cannot be a right to *begin* life, as rights cannot be exercised prior to existence, but must be a right to *continued* life.

The right at issue is not a right to procedural due process or to treatment. Plaintiffs do not claim that the state must "ensure that every possible technological medical procedure...be used to maintain" life. *In the Matter of the Guardianship of L.W.*, 167 Wis.2d 53, 83, 482 N.W.2d 60 (1992) ("*L.W.*"). But once a physician has begun to treat a patient and incurs a duty to continue basic treatment, intentional removal of the most fundamental requirements of life with the intent to kill and outside the direction of a legally authorized guardian, is no less homicide

[2] Echoing the Declaration of Independence in considering life the first of the unalienable rights, these Wisconsin rights are at least as protective as those in the U.S. Constitution, Fourteenth Amendment. *See State v. Doe*, 77 Wis.2d 161, 171-72, 254 N.W.2d 210 (1977) ("[I]t is the prerogative of the State...to afford greater protection...than...the Fourteenth Amendment.").

than would be abandoning the patient in the Northwoods without clothing.[3] And when this is done by a state employee, it is unconstitutional.[4] This is true no matter how disabled the patient may be. *See, e.g., In the Matter of the Guardianship and Protective Placement of Edna M. F.*, 210 Wis.2d 558, 568-69, 576, 563 N.W.2d 485 (1997) ("*Edna*") (refusing to extend *L.W.* to people "with incurable or irreversible conditions").

Not only is the State prohibited from directly violating the right to life, it may leverage its interest in life to enact legislation prohibiting others from violating it. *See, e.g., Washington v. Glucksberg*, 521 U.S. 702, 728, 117 S.Ct. 2258 (1997) ("prohibition on assisted suicide, like all homicide laws...reflects and advances [State] commitment to this interest.").

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[3] Defendants protest that there is a difference between action and inaction. Recent case law has found otherwise. "All acts are affirmative, including standing still when one could save a person by warning of some impending danger." *Slade v. Board of School Directors of the City of Milwaukee,* 702 F.3d 1027, 1030 (7th Cir. 2012). Defendant Dr. Fost, similarly, has written on "passive euthanasia," stating, "The [physician's] duty [to care] may also derive from the physician's initial undertaking of care...," and explaining why parents cannot terminate that duty by refusing consent. John A. Robertson & Norman Fost, *Passive Euthanasia of Defective Newborn Infants: Legal Considerations*, 88 J. OF PEDIATRICS 883 (1976). This is certainly the case in Wisconsin, where once a physician assumes treatment of a patient, he is expected to exercise "ordinary care," *Nowatske v. Osterloh*, 198 Wis.2d 419, 433-434, 543 N.W.2d 265 (1996) (internal citation omitted), defined as "'the obligation to use reasonable professional skill and attention' and 'to use due and reasonable skill and diligence' *in an effort to cure the patient*." *Id.* at 454 (emphasis supplied). *See also McManus v. W.F. Donlin,* 23 Wis.2d 289, 300, 127 N.W.2d 22 (1964) (outlining the circumstances under which a physician is relieved of his duty to care).

[4] *Slade*, 702 F.3d at 1029 (a state deprives a person of life "if the death was caused by the reckless act of an employee of the state acting within the scope of his or her employment") (internal citations omitted); *see also DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189, 195, 109 S.Ct. 998 (1989).

In contrast, there is no oppositional "right to die" in American law. In nearly every jurisdiction, it is a crime to assist suicide.[5] The Supreme Court has explicitly rejected a "right to die," concluding that a consistent and near-universal tradition rejects it. *See Glucksberg*, 521 U.S. at 723.

The limited right to "refus[e] life-sustaining medical treatment," *Cruzan*, 497 U.S. at 281, is not implicated here. In Wisconsin, a surrogate may refuse medically-indicated treatment only where a patient is diagnosed as persistent vegetative state ("PVS") and it is in the patient's best interest, he expressed a clear desire to refuse life-sustaining treatment prior to legal incompetency, or a statute or court specifically authorizes it. *See L.W.*, 167 Wis.2d at 81 ("stress[ing] that [the court's] opinion is limited in scope to persons in [PVS]"); *Edna*, 210 Wis.2d at 560; *Montalvo v. Borkovec*, 256 Wis.2d 472, 647 N.W.2d 413 (2002). Otherwise, physicians must continue to provide basic life-sustaining treatment. Guardians of "patients...with incurable or irreversible conditions" may not effect this right. *Edna*, 210 Wis.2d at 568. The right to refuse treatment "belongs to the patient. Until [he refuses treatment], 'physicians are under an ethical, moral and legal duty to treat...to advance [patient] recovery and alleviate his suffering.' Physicians must presume that life is preferable to death even if that means a severely disabled life." *Stewart-Graves v. Vaughn*, 162 Wash.2d 115, 137, 170 P.3d 1151 (2007) (internal citation omitted). Anything else would risk violating

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[5] *See, e.g.*, Jacob Gershman, *Vermont Lawmakers Approve Assisted-Suicide Bill*, WALL ST. J. (May 14, 2013).

the "independent right to liberty" "guarantee[d]...in Article I, §1 of the Wisconsin Constitution," *L.W.*, 167 Wis.2d at 67-69: "a positive constitutional right." *Id.* at 78, n.11. In short, there is a "presumption" that "continued life is in the [patient's] best interests," and the burden rests upon anyone seeking to demonstrate otherwise. *Id.* at 92-93.

III. PHYSICIANS ARE SWORN TO A DUTY TO PROTECT PATIENT LIVES.

Corresponding to the patient's right to live is the physician's duty to care. Where an incompetent patient cannot personally refuse care and the surrogate has no legal authority to limit treatment, physicians are not authorized to deny basic life-sustaining measures,[6] and medical ethics require they be provided.

A. Medical Ethics Confirm Physicians' Duty to Life.

Medical ethics arose from the same historical understanding of the fundamental right to life and confirm that physicians have a duty to uphold that right. From the beginning of Western medicine, morality and tradition declared a duty to practice medicine within ethical boundaries such as the principle of non-maleficence or *primum non nocere* ("first, do no harm"). *See, e.g.*, C.M. Smith, *Origin and Uses of Primum Non Nocere – Above All, Do No Harm!*, 45 J. OF CLIN. PHARMACOL. 371 (2005). The earliest known Hippocratic Oath holds, "I will...benefit my patients according to my greatest ability and judgment, and I will

[6] Contrary to Defendants' attempt to recharacterize the issue away from their duties, physician "influence or override" of surrogate "treatment decisions" is utterly irrelevant where the surrogate does not have the authority to refuse care in the first place.

do no harm or injustice to them. I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan...." HIPPOCRATIC OATH, ORIGINAL (c. 400 BC). In the most common modern version, physicians swear to "apply for the benefit of the sick, all measures which are required" and "most especially...tread with care in matters of life and death.... [I]t may...be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God." HIPPOCRATIC OATH, MODERN (1964). The Hippocratic tradition of patient-oriented medical care coupled with a deep respect for the right to life continues today. Nearly every medical school still administers the Hippocratic or a similar oath. *See* Lisa R. Hasday, *The Hippocratic Oath as Literary Text: A Dialogue Between Law and Medicine*, 2 YALE J. HEALTH POL'Y L. & ETHICS 299, 301 (2002).

The 1948 Declaration of Geneva reaffirmed the commitment to medical ethics: "The health of my patient will be my first consideration." DECLARATION OF GENEVA (1948). "I will not permit considerations of age, disease[,] disability...or any other factor to intervene between my duty and my patient.... I will maintain the utmost respect for human life." *Id.*

The American Medical Association ("AMA") requires that physicians know and follow state law. AMA Opinion 8.081. "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." AMA, Principles of Medical Ethics, Art. IV(3)(c).

UWHC-credentialed physicians agree to abide by the Bylaws and Rules and Regulations of the Medical Staff, policies and procedures of the hospital and medical staff, Bylaws of the Board of Directors of the UWHC Authority, applicable laws, and AMA Principles of Medical Ethics. UWHC Medical Staff Bylaws, Art. III(2).

Separately, UWHC has issued detailed policies on the conditions for limiting treatment, UWHC Policy No. 8.25(IV)(C)(2), and when limiting treatment is unreasonable, UWHC Policy No. 8.25(IV)(C)(3) (14:13-14, ¶¶60-61; App. 148-149). During the investigation into Patient 1's care, UWHC instituted revised guidelines; they accurately state but then negate the law: "[O]ne Wisconsin court…stated that unless a child is [PVS,] parents do not have the right to withhold life-sustaining treatment. Nevertheless, practitioners are expected to practice medicine in the best interests of their patients in collaboration with caregivers…" UWHC Policy No. 8.25(IV)(G)(2)(e).

Here, Defendants' choices and recommendations violated both the overarching respect for life and specific guidelines of universal and local medical ethics. The doctors did not apply all measures required, but recommended and did withdraw basic care. Considerations of disability and quality of life skewed the doctors' duty of care in direct contravention of medical ethics. They decided to play God.

B. The Weight of Physician Influence Demands Great Care and Deference to the Right to Life.

Physicians' ability to influence patient decisions has long been known. The President's Commission for the Study of Ethical Problems in Medical and Biomedical and Behavioral Research report *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (1982) recognized that "words," "tone[,] emphasis," and "fram[ing]" can decrease or "heighten the appeal of a particular course of action." More recently, physicians and nurses have been the most-trusted source of Affordable Care Act information. *See, e.g.*, Kaiser Family Foundation, *Preventive Services for Women and the Affordable Care Act*, 311 JAMA 1846 (2014).

This leads to a special duty to exercise great care and deference to the right to life. In diagnosis, prognosis, treatment, and management, medicine is complex and technical. With their knowledge and technical expertise, physicians are experts in this field; they often maintain unequal power relationships with patients, who are likely to defer to their recommendations. Less overtly, patients are susceptible to adopting a physician's outlook, influencing their decisions. Bioethicists have expressed concern regarding undue physician influence.[7]

A physician's outlook and influence is especially influential for patients with disabilities. Physicians often see patients only when they are sick and needing

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[7] *See, e.g.*, Norman Fost, *Counseling Families Who Have a Child with a Severe Congenital Anomaly*, 67 PEDIATRICS 321 (1981); *see also* Norman Fost, *Parental Control over Children*, 103 J. OF PEDIATRICS 571 (1983).

care, leading to a risk of a skewed viewpoint. And numerous studies have shown that the more serious the disability, the more negative a physician's opinion regarding expected quality of life, and the more likely he is to recommend withholding treatment. For example, in one study of children with intraventricular hemorrhage ("IVH"), "physicians would encourage parents to seek medical treatment...for the infant with [least severe] IVH but were neutral or would discourage parents from seeking treatment for the infant with [most severe] IVH" because survival can be expected for these infants only with significant disability. Gary N. Siperstein, et al., *Physicians' Prognoses About the Quality of Life for Infants with Intraventricular Hemorrhage*, 12 DEVELOPMENTAL AND BEHAV. PEDIATRICS 148 (1991); *see also, e.g.*, Gary N. Siperstein et al., *Professionals' Prognoses for Individuals with Mental Retardation: Search for Consensus Within Interdisciplinary Settings*, 98 AMER. J. ON MENTAL RETARDATION 519 (1994) (and referenced studies). But disability-based discrimination has no place in the medical profession. *See, e.g.*, Anita Silvers & Leslie Pickering Francis, *Playing God with Baby Doe: Quality of Life and Unpredictable Life Standards at the Start of Life*, 25 GA. ST. U. L. REV. 1061 (2009); Martha A. Field, *Killing "The Handicapped" – Before and After Birth*, 16 HARV. WOMEN'S L.J. 79, 87-88 (1993) ("[Q]uality-of-life arguments...very often...are based upon prejudice against the handicapped, and even more often...upon ignorance.... [P]arents and judges will often project...their own horror of handicap."). Yet here, the doctors'

recommendation to deny care was based upon the patients' disabilities' presumed effect on quality of life rather than their treatability.

Basing recommendations to deny or withhold life-sustaining care on disabilities or quality of life contradicts both the general principle of pursuing a patient's best interests and specific medical ethical guidelines. *See argument supra*. Medical ethics require promoting a patient's best interests and fundamental right to life, and with the incredible influence physicians wield, they have a special duty to err on the side of life by providing basic, life-sustaining treatments as required by law.[8]

IV. THE EXPANSION OF SURROGATE ELECTION TO LIMIT CARE WOULD BE DANGEROUS.

In *L.W.*, *Edna*, and *Montalvo*, Wisconsin clearly articulated the strict limitations on surrogate authorization to withhold or withdraw medically indicated treatment. *See supra* §II. Outside of these clearly-defined boundaries, no surrogate may authorize withholding or withdrawing care.

This is Wisconsin law and standard of care, and it is good public policy that supports the state's interest in human life and "in protecting the integrity and ethics of the medical profession." *Glucksberg*, 521 U.S. at 731; *see also* Louise Harmon, *Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1, 71 (1990). In any other context, there is great potential for abuse.

[8] *See, e.g.*, Farrell & Fost, *Long-term Mechanical Ventilation.*

The U.S. Supreme Court affirms that the decision to withhold medical treatment rests solely with the patient: "[F]amily members may [not be] entirely disinterested...there is no automatic assurance that the view of...family members will necessarily be the same as the patient's...." *Cruzan*, 479 U.S. at 286.[9] The uncertainty that a substituted judgment will actually follow patient wishes weighs against allowing a surrogate refusal of treatment.

A surrogate decision to refuse care can lead to unwanted, unwarranted death, as with Patient 1. Fortunately, death is not guaranteed. Patient 2's medical condition improved even after medications and nutrition were discontinued. (14:18 ¶91; App. 153). Similarly, in *In re David L. Hockenberry*, a patient recovered and no longer needed a ventilator. 60 Pa. 550, 2 A.3d 505 (Pa. 2010).

Refusal of care can also increase pain and suffering. Although one can survive an infection, for example, non-treatment can cause permanent scarring of the lungs, while denial of fluid can cause permanent kidney damage. *Brief of* Amici Curiae *Dr. George Isajiw, et. al., at 4*, *Hockenberry*, No. 98 MAP 2009 (60 Pa. 550). "The special commitment of the physician is to sustain life and relieve suffering." AMA Opinion 2.20. Because denying basic medical care risks death and increasing pain and suffering, physicians are ethically obligated to provide such care until legally authorized refusal can occur.

Plaintiffs do not seek to convert physicians into policemen, but expect physicians to follow the law and ethics of their profession rather than their own

[9] Bioethicists have studied this issue, as well. *See, e.g.*, Fost, *Parental Control.*

subjective ideologies about patient quality of life. Anything less would violate trust in the medical profession. If an unauthorized party attempts to request an unethical action, a physician must refuse. The staff at Patient 1's long-term care facility did. (14:11, ¶¶42-44; App. 146). Even the circuit court here admitted that based on the facts, "guardians exercised th[e] right [to refuse] without authorization." (26:14 n.6; App. 123).

V. CONCLUSION

In following the limiting requests of non-authorized persons as to patients they had taken under their care, Defendants here shirked their duty. As state employees, they violated patients' right to life. For the reasons set forth herein, *Amici* request this Court reverse the circuit court so it may take appropriate steps to enjoin Defendants' extraordinary practice of illicitly limiting basic life-sustaining medical treatment for patients with disabilities.

Dated this 19th day of May, 2014.

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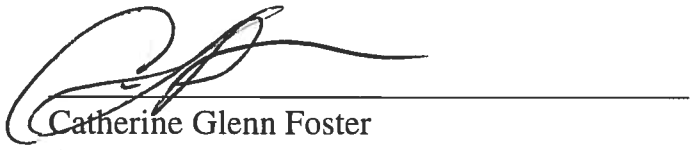
CERTIFICATION OF COMPLIANCE WITH RULE 809.19(12)

I hereby certify that I have submitted an electronic copy of this brief, which complies with the requirements of § 809.19(12). I further certify that this electronic brief is identical in content and format to the printed form of the brief filed as of this date.

A copy of this certificate has been served with the paper copies of this brief filed with the court and served on all opposing parties.

Dated this 19th day of May, 2014.

Signed:



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CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. § 809.19(8)(b) and (c) for a brief produced with a proportional serif font. The length of this brief is 2979 words.

Dated this 19th day of May, 2014.

Signed:

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CERTIFICATE OF SERVICE

I hereby certify that on May 19, 2014, true and correct copies of BRIEF OF *AMICUS CURIAE* WISCONSIN CATHOLIC MEDICAL GUILDS were served upon all counsel of record via U.S. First-Class Mail.

Dated this 19th day of May, 2014.

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