STATE OF WISCONSIN
IN SUPREME COURT
Case No. 2014 AP 135

DISABILITY RIGHTS WISCONSIN,
Plaintiff-Appellant-Petitioner,

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.

BRIEF OF *AMICUS CURIAE* WISCONSIN CATHOLIC MEDICAL GUILDS IN SUPPORT OF PLAINTIFF-APPELLANT'S PETITION FOR REVIEW

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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, with no physical exam of Patient 1, observation of his daily life, or consultation with his long-term care team, Dr. Hoover-Regan agreed to limit his future care given his "poor prognosis and poor quality of life." (14:9, ¶¶29-31; App. 144). Defendant physicians took him 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 patient 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. Even the circuit court here admitted that based on the facts, "guardians exercised th[e] right [to refuse] without authorization."

[1] Dr. Wright's actions contravened the principle that medical consent is a process, not an event. *See* Philip M. Farrell & Norman C. Fost, *Long-term Mechanical Ventilation in Pediatric Respiratory Failure*, 140 AMER. REV. OF RESPIRATORY DISEASE S36 (1989).

(26:14 n.6; App. 123). The appellate court erred in dismissing these shocking and fundamentally relevant facts as "not matter[ing] to the respective legal positions" (slip op. at ¶5).

I. 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) (fundamental rights life are "withdraw[n]…from the vicissitudes of public controversy[,]…beyond the reach of majorities and officials" and are "to be applied by the courts").

Contrary to Respondents' and the appellate court's misconstruction (slip op. at ¶17), the right at issue is *not* a right to procedural due process or to government treatment. Plaintiffs do not claim 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.*").

[2] Echoing the Declaration of Independence in considering life the first unalienable right, these rights are at least as protected under Wisconsin law as they are under the Fourteenth Amendment to the U.S. Constitution. *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.").

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, outside the direction of a legally authorized guardian, is no less homicide than would be abandoning the patient in the Northwoods without clothing.[3] When done by a state employee, it violates the patient's fundamental, substantive due process rights.[4] Based on directly relevant case law,[5] 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 "incurable or irreversible conditions").

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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*, 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…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).

[5] While the appellate court held that *L.W.* and *Edna* had "nothing pertinent to say" (slip op. at ¶24), this is patently incorrect based on their plain language.

Not only is the State prohibited from directly violating the right to life, it may further its interest in preserving life by enacting legislation to protect 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.").

In contrast, there is no oppositional "right to die" in American law. In nearly every jurisdiction, including Wisconsin,[6] it is a crime to assist suicide.[7] 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 when there is a persistent vegetative state ("PVS") diagnosis, a patient expressed 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…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 affect the right to refuse treatment, *Edna*, 210 Wis.2d at 568; it "belongs to the patient. Until [he refuses treatment], 'physicians

[6] Wis. Stat. § 940.12.
[7] *See, e.g.*, Jacob Gershman, *Vermont Lawmakers Approve Assisted-Suicide Bill*, WALL ST. J. (May 14, 2013).

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 the "independent right to liberty," *L.W.*, 167 Wis.2d at 67-69, "a positive constitutional right." *Id.* at 78, n.11. There is a "presumption" that "continued life is in the [patient's] best interests"; the burden rests upon anyone seeking to demonstrate otherwise. *Id.* at 92-93.

II. PHYSICIANS HAVE A SWORN DUTY TO PROTECT PATIENTS' LIVES.

Appurtenant to the patient's right to live is the physician's duty to care. Where a 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.[8]

A. Medical Ethics Confirm Physicians' Duty to Preserve Life.

Medical ethics arose from a historical understanding of the fundamental right to life, and ethical norms 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 that is reflected in the essential principle of non-maleficence or *primum non nocere* ("first, do no harm"). *See,*

[8] Contrary to Defendants' attempt to deflect the issue away from their duty of care, physician "influence or override" of surrogate "treatment decisions" is utterly irrelevant when the surrogate has no authority to refuse care in the first place.

e.g., C.M. Smith, *Origin and Uses of Primum Non Nocere*, 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 do no harm or injustice to them. I will not give a lethal drug to anyone…, 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*, 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, applicable laws, and AMA Principles of Medical Ethics. UWHC Medical Staff Bylaws, Art. III(2).

UWHC has issued specific 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 state 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' recommendations violated both the law's overarching respect for life and both universal and local medical ethics. The doctors did not apply all measures required, but recommended and eventually withdrew basic care. Considerations of disability and quality of life skewed the doctors' actions in direct contravention of medical ethics. They decided to play God.

B. Because Physicians Wield Great Influence, Their Duty of Care Must Weigh Heavily on the Side of the Right to Life.

Physician influence, combined with increasing socio-economic pressures to limit treatment,[9] is resulting in decisions to cease medical care that saves lives.

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 recognized as 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 extraordinary trust leads to a special duty to exercise great care and deference to the right to life – both for the patient's sake and the physician's own.[10] At all stages – diagnosis, prognosis, treatment, and management – medicine is complex and technical. With their special knowledge and technical expertise,

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[9] There is now a push for advance directives, "physician orders for life-sustaining treatment," and physician-assisted suicide, which are about treatment *limitation*, not provision. *L.W.*'s and *Edna*'s assumption that physicians are valiantly doing everything possible to save all lives, and needed special permission in PVS cases to deviate from that norm, is no longer correct. Patients now sorely need legal protections from medical professionals working on their behalf.

[10] *See, e.g.*, Jane G. Tillman, *Patient Suicide: Impact on Clinicians*, PSYCHIATRIC TIMES (Dec. 31, 2014) (discussing the impact of patient suicide on physicians and intrinsically raising questions about the impact of patient death generally).

physicians are experts in this field and generally maintain unequal power relationships with patients, who are highly likely to defer to their recommendations. Even when physicians express their views less overtly, patients are susceptible to adopting their outlook. Consequently, bioethicists have long expressed concern about undue physician influence.[11]

A physician's outlook and influence are especially important when a patient has a disability. Because physicians often see patients only when they are ill, their viewpoint may be skewed. And numerous studies show that the more serious the disability, the more negative a physician's opinion regarding the patient's expected quality of life, and the more likely he will recommend withholding treatment. In one study of infants, "physicians would encourage parents to seek medical treatment…for [the less ill]…but were neutral or would discourage…treatment" for those whose survival was expected 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*, 98 AMER. J. ON MENTAL RETARDATION 519 (1994) (citing studies).

Disability-based discrimination has no place in the medical profession. *See, e.g.*, Anita Silvers & Leslie Pickering Francis, *Playing God with Baby Doe*, 25

[11] *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).

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…ignorance…. [P]arents and judges will often project...their own horror of handicap."). Here, the doctors' recommendation to deny care was based upon the patients' disabilities' presumed effect on their quality of life rather than their treatability.

Basing recommendations to deny or withhold life-sustaining care on a patient's disabilities or "quality of life" contradicts both the general principle of pursuing a patient's best interests and medical ethical guidelines. These rules require physicians to promote a patient's best interests and fundamental right to life. Physicians' incredible influence imposes on them a special duty of care to err on the side of life.[12]

III. EXPANDING SURROGATES' ABILITY TO LIMIT CARE ENDANGERS VULNERABLE PATIENTS.

In *L.W.* and *Edna*, this Court strictly limited surrogates' authority to withhold or withdraw treatment. Outside of their boundaries, no surrogate may authorize limited care due to the great potential for abuse.

This is not only Wisconsin law and the controlling standard of care, but also good public policy that supports state interest in human life and "in protecting

[12] *See, e.g.*, Farrell & Fost, *Long-term Mechanical Ventilation*, *supra* at n.1.

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).

The U.S. Supreme Court has affirmed that the decision to withhold 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.[13]

A surrogate's 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. For example, non-treatment of an infection 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 obligated to provide such care until a legally-authorized refusal occurs.

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

Plaintiffs simply expect physicians to follow the law and ethics of their profession rather than their own subjective and hypothetical perception of a patient's future quality of life. If an unauthorized party attempts to request an unethical action, a physician must refuse, as the staff at Patient 1's long-term care facility did. (14:11, ¶¶42-44; App. 146).

CONCLUSION

By allowing non-authorized persons to direct the treatment of vulnerable patients under their care, Defendants shirked their ethical duties here. As state employees, they violated patients' fundamental right to life. *Amici* urge this Court to reverse and to enjoin Defendants' illegal practice of limiting basic life-sustaining medical treatment for patients with disabilities.

Dated this 26th day of January, 2015.

Respectfully submitted,

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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 26th day of January, 2015.

Signed:

Catherine Glenn Foster

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Catherine Glenn Foster
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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 2996 words.

Dated this 26th day of January, 2015.

Signed:

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CERTIFICATE OF SERVICE

I hereby certify that on January 26, 2015, 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 26th day of January, 2015.

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