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The Application of Out-Of-Hospital Do Not Resuscitate Order Legislation to Commercial Airline Travel

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THE APPLICATION OF “OUT-OF-HOSPITAL” DO NOT RESUSCITATE ORDER LEGISLATION TO COMMERCIAL AIRLINE TRAVEL

AMANDA CHRISTINE DAKE

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I. THE RELATIONSHIP OF BIOETHICS TO THE LAW

MANY PRACTITIONERS may be surprised to find a Comment dealing with a bioethics issue in a law journal, much less in a journal traditionally devoted to issues of aviation law. Bioethics,\(^1\) however, is finding a firm place in legal discussions as technology advances and medical propositions are con-

\(^1\) See Daniel Callahan, *Bioethics*, in *1 The Encyclopedia of Bioethics* 247, 248 (Warren T. Reich et al. eds., 1995) (narrowly describing bioethics as “one more new field that has emerged in the face of great scientific and technological changes”).

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fronted by legal issues and policy questions. The kinds of questions asked because of these technological advances are "among the oldest that human beings have asked themselves." These questions are described by The Encyclopedia of Bioethics as "turn[ing] on the meaning of life and death, the bearing of pain and suffering, the right and power to control one’s life, and our common duties to each other and to nature in the face of grave threats to our health and well-being."

As the field of bioethics has developed it has become obvious that an interdisciplinary approach is needed to address rising moral concerns. An important contribution to this interdisciplinary approach would be made by law.

Although there are four general areas of inquiry in the field of bioethics, the focus of this Comment will be on regulatory

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2 See id. at 248. “[Bioethics] has reached into law and public policy; into literary, cultural, and historical studies; into the popular media; into the disciplines of philosophy, religion, and literature; and into the scientific fields of medicine, biology, ecology and environment, demography, and the social sciences.” Id.

3 Id.

4 Id.

5 See id. at 249.

6 See id. “Ample room would also have to be made for the law and for the social and policy sciences. Moral problems have important legal, social, political, and policy implications; and moral choices would often be expressed through court decisions, legislative mandates, and assorted regulatory devices.” Id. at 249-50. See also George P. Smith, II, Bioethics and the Law: Medical, Socio-Legal and Philosophical Directions for a Brave New World, Preface (1993).

The contemporary challenge of Bioethics is rather simple and direct in its mandate, but exceedingly complex in its application. The legal and ethical evaluations and constructions of law, medicine, biotechnology and genetic engineering need to be set within a continuing dialogue that is tied to a basic understanding of and respect for human rights and human dignity. Moreover, what is needed today is a new human rights debate among not only the members of the legal community, but among scientists and technologists—a debate that would, of necessity, consider anew the extent to which the plethora of medical, legal scientific and technological considerations of the brave new world would either challenge or complement both the traditional rights of humanity and those being redefined according to contemporary values and standards.

Id.

7 See Callahan, supra note 1, at 250-51 (listing the varieties of bioethics as theoretical bioethics, clinical ethics, regulatory and policy bioethics, and cultural bioethics).
and policy bioethics. Through state regulation of out-of-hospital "do not resuscitate orders," (DNR orders) this bioethics question is thrust directly into the realm of legal interpretation, analysis, and application. The questions and policy issues that follow give rise to the questions of application addressed here, in a journal focused on air law. Lack of caselaw provides us with an opportunity to hypothesize what the answer to a bioethics problem would be when presented in the context of commercial air-travel—a backdrop uncommon to its application.

II. INTRODUCTION

As medical technology progresses, it allows doctors more latitude in their ability to keep patients alive in the most adverse of circumstances. Faced with this widening latitude of life-saving and maintaining procedures and mechanisms, people are becoming more and more concerned with having a say in how their medical care treatment will be handled. This voice is now being heard through the use of living wills, durable powers of attorney, and DNR orders, to name a few. The use of advance directives is a way for people to recapture control of their own being—as the growing technology has changed the way Americans are dying.

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8 See id. "The aim of regulatory and policy bioethics is to fashion legal or clinical rules and procedures designed to apply to types of cases or general practices . . . ." Id. at 250.


Most Americans think of medicine as an ancient profession. While this is true, it is not true of the medical technology which now allows us to keep patients alive by doing the work of failing body organs. This ability is recent, originating from the massive scientific undertakings of World War II.

Id. at 26.

10 See id.


We no longer die at home. Starting in the 1930s, the locus of our dying moved from the home to the hospital or some other health-care facility. On the surface, it seemed like the logical thing to do . . . . Dying people came to be viewed as sick people. And sick people went to the hospital.

That simple move from dying person to sick person, from the home to the hospital, had hidden, undreamed-of consequences. When we left our homes, we lost power over our own deaths and over the deaths of those we love. Once inside the hospital walls, dying became the sole province of medicine, and this has had a
The media devotes a great deal of energy in covering right-to-die issues, putting them on the forefront of the American consciousness. These issues, however, bring with them a plethora of legal and ethical challenges. Here, the legal issues surrounding do not resuscitate orders will be examined, particularly focusing on the relatively new issuance of out-of-hospital DNR orders.

Until recently, patients upon whom DNR orders were issued were so ill that the prospect of them traveling, or even leaving the hospital for that matter, was so slim that most doctors and legislators were not concerned with the transfer of these DNR orders outside of hospital or nursing home settings. Medical technology and the nature of terminal illnesses, however, have changed this. Patients with advanced AIDS and cancer, for example, remain mobile for much of their disease's progression. They may decide, after consultation with their physician, that if they go into cardiovascular failure, they do not want to be resuscitated. Legislatures in many states have passed statutes regulating out-of-hospital DNR orders. These out-of-hospital DNR orders bring with them many questions of enforceability and liability. This Comment focuses on these issues, coupled with the jurisdictional issues surrounding their application to air travel.

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profound effect on the deathwatch. The deathwatch has almost disappeared.

Id. (citations omitted).

12 There is immense coverage of the actions of Dr. Kevorkian and his assistance in suicides of terminally ill patients. Also, NBC's series ER recently dealt with the issue of do not resuscitate orders. ER (NBC television broadcast, Oct. 31, 1996).

13 See Keith Shiner, Note, Medical Futility: A Futile Concept?, 53 WASH. & LEE L. REV. 803, 834 (1996) (in which Shiner addresses the ethical parameters surrounding the treating physicians: "Maintaining the ethical integrity of the medical profession is one of the principal considerations involved in decisions regarding the use of life-sustaining treatment. Requiring physicians to provide certain treatment can violate the ethical integrity of the medical profession and the integrity of the profession's judgements . . . .")

III. A REAL WORLD HYPOTHETICAL

A mother and her child need to travel from city A to city B.\textsuperscript{15} The nature of their trip is not pleasure, it is pain. Literally. The hospital they seek care from is located in city B. Hence, they set out on their journey.

The mother calls to make reservations for the two of them to fly to city B. Over the telephone she informs the ticket agent that her son is ill and has been assigned an out-of-hospital DNR order. The agent types this information into his computer.

The mother and son arrive at the airport for departure. The mother does not have the child’s DNR papers with her, and the child is not wearing a medical identity bracelet or necklace. The two check-in with the desk clerk and wait to board the plane. The desk clerk prints the passenger list and gives it to the head flight attendant. On this list is the information about the boy with the out-of-hospital DNR order.\textsuperscript{16} As he hands the list to the flight attendant he snidely comments that “he wouldn’t want to touch the child, let alone resuscitate him.”

The child, you see, is in the advanced stages of AIDS. He is emaciated, pale, and covered with lesions. His hair is thin to the point of non-existence. His eyes are dark and sunken. He is a very sick little boy, obviously suffering.

This situation presents a dilemma for the flight crew. The airline does not have an existing policy regarding treatment of in-flight DNR orders. If the child were to go into cardiovascular failure, the crew is unclear whether they should resuscitate the passenger or honor the DNR order.

A. IS RESUSCITATION PROBABLE IN THE SKIES?

Hypothetically, it is possible that the flight crew would be able to successfully resuscitate the passenger if the passenger were to go into cardiovascular failure. Each member of the flight crew has completed training in CPR (cardio-pulmonary resuscitation). Every airplane that is given approval for dispatch must contain a first aid kit and a medical kit.\textsuperscript{17} To ensure that the required materials are on-board each plane, a special procedure

\begin{footnotes}
\footnote[15]{The names of the passengers and the airline have been omitted for the privacy and respect of the parties involved.}
\footnote[16]{The DNR information is indicated on the passenger list in much the same way that a child under the age of 12 traveling alone would be indicated.}
\footnote[17]{See Interview with Michael Smarr Haney, Maintenance Operational Controller, AMR Eagle (Oct. 25, 1996).}
\end{footnotes}
is mandated for kits where the seal has been broken.\textsuperscript{18} Additionally, each plane has an oxygen tank with portable breathing capacities.\textsuperscript{19} Specifications for the first aid kit are rigid,\textsuperscript{20} as are those for the medical kit.\textsuperscript{21} There is disagreement, however, about the probability of successfully resuscitating a passenger without the use of a portable electronic defibrillator. An article in the \textit{Chicago Tribune} recently examined the critical moments


Quantity indicated in the Minimum Equipment Required for Departure column are always required. If kit seal is broken, it must be verified that the minimum contents are in the kit. This check shall be performed by the captain and an “Info to Maintenance” entry in the AML made in the discrepancy column indicating the kit seal was broken and a complete inventory of the kit has been made and found to be complete. The captain will sign his name with employee number.

\textsuperscript{19} See Haney, supra note 17.

\textsuperscript{20} ATR 42/72 indicates the specifications for the first aid kits are as follows:

\begin{center}
\begin{tabular}{ll}
\hline
\textbf{Contents} & \textbf{QTY} \\
\hline
Adhesive bandage compress 1 inch & 16 \\
Antiseptic swabs & 20 \\
Ammonia inhalants & 10 \\
Bandage compress 4 inch & 8 \\
Triangle bandage compress 40 inch & 5 \\
Arm splint, noninflatable & 1 \\
Leg splint, noninflatable & 1 \\
Roller bandage 4 inch & 4 \\
Adhesive tape 1 inch standard roll & 2 \\
Bandage scissors & 1 \\
Protective latex gloves or equivalent nonpermeable gloves & 1 pair \\
\hline
\end{tabular}
\end{center}

\textsuperscript{21} See id. at 25-11. The necessary items for the required medical kit include:

\begin{center}
\begin{tabular}{ll}
\hline
\textbf{Contents} & \textbf{QTY} \\
\hline
Blood pressure cuff (sphygmomanometer) & 1 \\
Stethoscope & 1 \\
Oropharyngeal airways (3 sizes) & 3 \\
Syringes (sizes to administer required drugs) & 4 \\
Basic instruction booklet & 1 \\
Needles (sizes to administer required drugs) & 6 \\
50% Dextrose injection 50cc & 1 \\
Epinephrine 1:1000 injection (single dose) & 2 \\
Diphenhydramine HCL injection & 2 \\
Nitroglycerin tablets & 10 \\
Protective latex gloves or equivalent nonpermeable gloves & 1 pair \\
Red lock seal & 1 \\
Green lock seal & 1 \\
\hline
\end{tabular}
\end{center}
after cardiac arrest in the sky. According to the Tribune, only two international airlines currently have the defibrillators on their planes and no U.S. airline employs the defibrillators. Although airlines stock their medical kits with drugs to aid resuscitation, specialists seem to agree that the only effective method of really saving lives is to use a defibrillator. These arguments, however, should not supersede an individual’s right to self-determination, especially in relation to whether the passenger would consent to the use of a defibrillator to resuscitate him even if available.

B. INDICATION OF THE DNR ORDER/LIABILITY FOR THE RESPECT OF THE ORDER

This case is especially problematic as the crew’s only indication of the DNR order for the child was transmitted to them on the passenger list. Are they to trust information relayed through a third person? If they do respect the “listed” DNR order and it is not valid, what liability does the airline face and what liability do each of the crew members face individually? Alternatively, what if they do not respect the order and resuscitate the passenger against the passenger’s express wishes? Would the airline and the individual members of the crew face liability in this situation?

Luckily, this particular occurrence did not advance to the stages where these life and death decisions had to be made.

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In cases of cardiac arrest the best hope for survival, and often the only hope, is immediate defibrillation. But despite the increasing affordability of portable electronic defibrillators, only two international airlines currently carry the lifesaving machines.

One is Qantas, the Australian airline . . . [the] second airline, British-based Virgin Atlantic Airways . . . .

23 See id.

24 See id.

It is difficult to find a specialist in emergency medicine or cardiology who doesn’t agree that placing defibrillators on commercial airplanes is more important than providing flight attendants with training in CPR, as most airlines do now.

“You’re going to save lives by putting defibrillators on the plane,” declares the University of Chicago’s Dr. Lance Becker, who chairs the American Heart Association’s Committee on Basic Life Support . . . . Becker cautions that “the likelihood of being able to save someone’s life just with drugs alone is very, very limited.”

Id.
However, it raised the consciousness of the airline to the issue of do not resuscitate orders and the implications made upon the airlines by such.\textsuperscript{25} Other airlines have yet to follow suit. Southwest Airlines, for example, has no existing policy.\textsuperscript{26}

Additionally, this problem raises questions regarding the human dimension. What if a flight attendant has moral or religious problems with letting a passenger die—even by the passenger’s own directive? Also, consider the effect on the other passengers aboard the aircraft. Is 35,000 feet above the ground in an enclosed space an appropriate place to let someone die, especially with numerous bystanders witnessing the tragedy? What if children are on board? Should they be exposed to such a trauma—people watching someone else die without taking measures to resuscitate? We must consider the values these children would be subjected to—would they be harmed by witnessing such abandonment of a human life?

IV. ADVANCE DIRECTIVES: AN OVERVIEW

Measures considered under the realm of the advance directive “umbrella” are living wills,\textsuperscript{27} durable powers of attorney, euthanasia,\textsuperscript{28} and DNR orders. Advance directives are a way an individual can make medical decisions for future application.\textsuperscript{29}

\textsuperscript{25} The airline on which this hypothetical actually occurred adopted the policy that unless the passenger is in possession of the DNR order, the crew should resuscitate first and ask questions later.

\textsuperscript{26} See Telephone Interview with Marilyn Strictland, General Counsel for Southwest Airlines (Sept. 23, 1996) (on file with author).

\textsuperscript{27} See Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases (Rev. 2d ed. 1993) [hereinafter Guidelines]. The Guidelines define a living will as “a document in which a decisionally capable person expresses in advance his or her wish not to receive certain life-sustaining treatments in the event that he or she becomes decisionally incapable in the future.” Id.

\textsuperscript{28} See Lieberson, supra note 9, at 421-22.

Assisted suicide, commonly referred to as “euthanasia,” is the practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy. A request for euthanasia takes the form of an advance medical directive: “I request that unless I change my mind, on such a day, at such a time, in such a manner, you will assist me to end my own life.” Id.

\textsuperscript{29} See id. at 2. See also Guidelines, supra note 27.

Advance Directives: Instructions from a decisionally capable individual regarding decisions about future medical treatment in the event that he or she becomes decisionally incapable. An advance directive may specify medical treatment the individual consents to or refuses, designate a surrogate decision maker, or both.
Health care advance directives provide a plain-language definition:

A Health Care Advance Directive is a document in which you give instructions about your health care if, in the future, you cannot speak for yourself. You can give someone you name (your "agent" or "proxy") the power to make health care decisions for you. You also can give instructions about the kind of health care you do or do not want. . . . [A] Health Care Advance Directive is not limited to cases of terminal illness. If you cannot make or communicate decisions because of a temporary or permanent illness or injury, a Health Care Advance Directive helps you keep control over health care decisions that are important to you. In your Health Care Advance Directive, you state your wishes about any aspect of your health care, including decisions about life-sustaining treatment, and choose a person to make and communicate these decisions for you.\(^{30}\)

One rationale behind the use of advance directives is that competent adults have the right to control "decisions about . . . health care."\(^{31}\) Alan D. Lieberson discusses an individual’s rights:

The individual has the right to accept or forsake medical care. The concept of informed consent suggests these decisions should be made after discussing potential benefits and risks of proposed care with physicians. Unfortunately, illness frequently intrudes on this process, limiting patient ability to determine or carry out

\[^{30}\] The Guidelines refer the reader to the definition of durable power of attorney.

Durable Power of Attorney: A legal instrument empowering a designated person to act on another’s behalf. Unlike the traditional power of attorney, the “durable” power does not lapse if the person who executed it becomes decisionally incapable. Originally intended to permit financial or property transactions, durable powers of attorney are also used to delegate medical decisionmaking authority.


[If adults with decision-making capacity can personally accept or refuse medical or surgical treatment, there should be no legal or other reason why they should not be able to accept or refuse it through a directive or even through an agent in advance of the loss of such capacity.

\[^{Id}\]
their wishes. When this happens, the right is maintained even though the ability to express the right is lost.\textsuperscript{32}

Caselaw supports this general right of refusal of medical treatment. The court in \textit{Superintendent of Belchertown State School v. Saikewicz} held that “[r]ecognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores . . . .”\textsuperscript{33}

Historically, this ability to exert self-determination seems to be thought of as a benefit of being an American. John Stuart Mill elaborated on this principle in American society:

\begin{quote}
[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant . . . . The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.\textsuperscript{34}
\end{quote}

V. THE FOUNDATION OF THE RIGHT TO DIE

Entwined in the realm of advance directives is the notion that an individual has the right to die. The foundation of this principle, however, is under debate. One view is that the right stems from common law roots. Alternatively, some believe it is founded on constitutional rights.

A. THE COMMON LAW APPROACH

As Irving Sloan states in \textit{The Right To Die: Legal and Ethical Problems}, “[t]he common law has long recognized the principle that a competent adult usually has the right to accept or refuse medical treatment.”\textsuperscript{35} The common law foundation for advance directives (a patient exercising his right of self-determination with regard to potential medical treatment) comes from the tort

\begin{footnotes}
\item[	extsuperscript{32}] \textsc{Lieberson}, \textit{supra} note 9, at 2.
\item[	extsuperscript{33}] 370 N.E.2d 417, 426 (Mass. 1977).
\item[	extsuperscript{34}] \textsc{John Stuart Mill}, \textit{On Liberty} 13 (Curtin V. Shields ed., 1956).
\item[	extsuperscript{35}] \textsc{Irving J. Sloan}, \textit{The Right To Die: Legal and Ethical Problems} 5 (1988). See also \textsc{Alan Meisel}, \textit{The Right To Die} 56 (2d ed. 1995) (“Most courts ground the right to die in the common-law right to be free from unwanted intrusion on or invasion of bodily integrity, protected through the legal requirements of consent and informed consent to treatment.”).
\end{footnotes}
laws of assault and battery. Justice Cardozo issued an opinion in support of this notion that an individual should have the unquestionable, total control of his own body, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."37

Several courts have followed Cardozo's lead. For example, in Velez v. Bethune,88 the court recognized that a physician's act of discontinuing life-sustaining treatment on an infant without the parents' informed consent could be comparable to an intentional tort.9 A physician is under a common law duty to provide treatment once a doctor-patient relationship has been formed.40

There are many tort cases in which a patient sued his doctor because the physician did not solicit and receive consent to perform a procedure. The cases become as particular as a physician gaining consent from a patient to operate on one ear and then during surgery discovering the problem is with the other ear—and hence performing the surgery on the ear that needs correction, but on which the physician does not have the patient's consent to operate. Although the physician may see this as saving the patient money and the potential danger of undergoing a second surgery, the patient has the right to refuse the physician the leeway to operate on any part of the patient's body that is not approved prior to the patient being put under anesthesia.41

36 See Berger, supra note 31, at 13 ("The doctrine of informed consent emerged in the courts from the tort law of assault—the apprehension of contact with someone's person without consent—and battery—the actual and intentional contact . . . .").


40 Under common law, once a physician-patient relationship has been established and the patient consents to treatment, the physician is obligated to preserve the patient's life by using the skills and means ordinarily applied by physicians in similar cases. Under such circumstances, a failure to treat the patient may give rise to the same liability as wrongful or negligent treatment.

Id. (citations omitted).

41 See Mohr v. Williams, 104 N.W. 12, 16 (Minn. 1905).
A parallel right to that of individual consent is the right of refusal:

The individual’s common law right to exercise informed consent before being subjected to medical treatment carries with it as a necessary corollary the right of informed refusal of treatment. This right may be exercised even if the treatment refused would have saved the individual’s life, in the absence of an overriding reason for the state to veto the refusal.42

There are reasons for which the state would veto a patient’s refusal of medical treatment. These limitations to the common law right of self-determination include: (1) protection of various social interests;43 (2) protection of the patient’s own life or health;44 (3) a threat to the public health;45 and (4) the protection of minor children or dependents.46 Arthur Berger finds an additional limitation to be protection of the ethics of the medical profession.47 Each of these limitations are within the police powers of the state to control.48 A state will decide whether to curtail the rights of an individual by balancing the aforementioned state interests.49

[T]he [state’s] principal concern underlying and limiting the right of a patient to withdraw or withhold life-sustaining treatment, particularly through a surrogate, is a respect for life—both the sanctity of life in general and preservation of the life of the particular patient. Thus, courts will err on the side of preserving life. . . . The Court recognized the presumption in favor of life by noting that an incorrect decision not to end life merely preserves the status quo, allowing for possible developments that may correct or ameliorate the effect of the erroneous decision. However, because an incorrect decision to withdraw life-sustaining treatment results in death, it is impossible to correct the decision or limit its effects.50

42 Sloan, supra note 35, at 6.
43 See id.
44 See id.
45 See Excerpts, supra note 40, at 282.
46 See id.
47 See Berger, supra note 31, at 21 (“Courts often acknowledge that one of the interests of the state is the maintenance of the ethical standards of the medical profession and the safeguarding of its integrity.”).
49 See McKay v. Bergstedt, 801 P.2d 617, 622 (Nev. 1990) (holding that the common law right to refuse treatment and due process liberty interests are not absolute and are subject to the balancing of relevant state interests).
50 Shiner, supra note 13, at 811-12 (citations omitted).
The courts, however, do conduct a balancing of interests that can be considered utilitarian in intent, acknowledging a person's right to self-determination in hopeless situations.51

B. CONSTITUTIONAL FOUNDATIONS AND THE RIGHT TO PRIVACY

Constitutional foundations of the right to die focus on "privacy" and "liberty" interests, and particularly on the difference between and balancing of these two interests by the courts.

1. Privacy Interests

The tort notion of privacy underlies the principles expounded by the Supreme Court. However, as David A. Elder points out:

The Restatement (Second) of Torts frankly recognizes that the law of privacy is a loosely-connected potpourri of invasions of psychic and proprietary interests: As it has developed in the courts, the invasion of the right of privacy has been a complex of four distinct wrongs, whose only relation to one another is that each involves interference with the interest of the individual in leading, to some reasonable extent, a secluded and private life . . . .52

The right to privacy is basic in the foundation of American principles.53 David M. O'Brien comments:

Precisely because historically Americans have understood personal privacy to involve a "right to be let alone," the right of pri-

51 See id. at 812-13.

Although courts acknowledge the importance of life, they recognize that a state's interest in life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims," and a patient's right to privacy and self-determination then prevails over the state's interest in life.

Id. See also Geary, supra note 14, at 86.

Technology can sustain the life of a patient with massive and irreversible brain damage or failed lungs for years . . . . The value of human life, however, must be balanced against respect for basic human dignity. Respect for human dignity demands that medical science not prolong life when a person is incapable of experiencing life, or would not want it to be so prolonged.

Id. (citations omitted).


53 See DAVID M. O'BRIEN, THE RIGHT OF PRIVACY: ITS CONSTITUTIONAL & SOCIAL DIMENSIONS: A COMPREHENSIVE BIBLIOGRAPHY ii (1980) (quoting Mr. Clinton Rosseter: "Privacy is a special kind of independence, which can be understood as an attempt to secure autonomy in at least a few personal and spiritual concerns, if necessary in defiance of all the pressures of modern society.").
Privacy exemplifies basic tenets of "the American way of life" and vision of liberalism, or, rather, dedication to individualism, the rule of law, and freedom from unwarranted governmental intrusions into individuals' private affairs. Americans' particular fascination with and understanding of privacy as a political ideal, as much as the practical problems attendant technological and sociopolitical changes, inexorably promoted litigation, legislation, and public debate over the elusive nature of personal privacy and the vexatious difficulties of defining the scope of legally protected privacy interests.\footnote{Id.}

Heightened scrutiny under Constitutional Due Process is applied if fundamental liberty interests are threatened.\footnote{See David L. Sloss, Note, The Right to Choose How to Die: A Constitutional Analysis of State Laws Prohibiting Physician-Assisted Suicide, 48 STAN. L. REV. 937, 941-42 (1996) (citation omitted) ("Laws that infringe ‘fundamental’ liberty interests merit heightened scrutiny under the Due Process Clause. A particular liberty interest will be deemed ‘fundamental’ if the court concludes that the right is ‘deeply rooted in this Nation’s history and tradition.’")} The control of one's own person is clearly a fundamental right and from this should obviously stem the right of self-determination when it comes to medical decisions—even in this age of life-extending medical technology.\footnote{See id. at 942.} This was confirmed by the Supreme Court over 100 years ago: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others."\footnote{Id. (citation omitted).}

Justice Scalia disagrees with this proposition.\footnote{See id. at 947.} He has constructed a "bright-line test" to determine if a right is fundamental. His theory is that "[i]f there is no deeply rooted tradition of laws protecting a right, that right cannot be fundamental."\footnote{Id. (citation omitted).} The science and medical technology that would preserve a patient today has no history of laws surrounding it, as it is so new. Therefore, application of Scalia's "bright line test" would negate self-determination in this specific area because it would not

\footnote{Id.}
qualify as a fundamental right. Application of the Fourteenth Amendment in this way would be short-sighted. In establishing a fundamental right, it seems the correct method of assessment would be to apply the basic principles of the Amendment to the situations we face today. Americans through the Constitution have basic rights of self-determination and control of their bodies. This premise has been upheld by the United States Supreme Court. The basic principles surrounding this should be applicable whatever the current state of technology. The fact that there would be a lesser likelihood of surviving fifty years ago should not give one less control over one's own fate today.

The Court has attempted to mesh these variable principles into a view of privacy that is compatible with our continuously changing culture. One critic contends that the Supreme Court in Griswold v. Connecticut "extended the right to privacy to the right to die." This seems to be stretching the Court's holding to an extreme interpretation. In Griswold, the Court ruled that Connecticut's state law prohibiting the sale of contraceptives should be struck down. True, this case establishes a right of privacy, but it is a leap in reasoning to transform this holding into establishing a right to die. The critical reasoning in question, by Sloan in The Right to Die: Legal and Ethical Problems, is also extended to the issue of abortion. Sloan equates the Court's hold-

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60 See id.

Applying this rule to the refusal of life-sustaining treatment, one could argue that the right of a competent, terminally ill patient to refuse life-sustaining medical treatment cannot qualify as a fundamental right, because artificial life-support measures are too recent an invention for there to be a deeply rooted tradition of laws protecting the right to refuse such measures.

Id. at 947-48. Sloan criticizes Scalia's theory:

This argument hinges on two assumptions: (1) that one must describe the right at issue in the narrowest possible terms—e.g., as a right to refuse life-sustaining medical treatment, rather than a right to refuse medical treatment in general; and (2) that a tradition must date back to at least the nineteenth century, when the Fourteenth Amendment was ratified, to qualify as deeply rooted.

Id. at 947 (citations omitted).

62 See id. at 948.

63 See id. at 948.

64 381 U.S. 479 (1965).


66 See id.
ing in *Roe v. Wade*\(^7\) with this same theory of the right to privacy being extended to the right to die.\(^8\) Although I agree with Sloan that these opinions regarding the right to privacy have medical undertones, it does not seem crystal clear, as Sloan apparently thinks it to be, that the rights of privacy granted by the Court are equivalent to the right to die. It is in instances such as these that the state interest, which is part of the common law formation, enters into the equation. The state interest provides a difficult argument for those who think the foundation is rooted in the right to privacy arguments alone.

Sloan finds a more rational foundation in his discussion of *In re Quinlan*,\(^9\) in which he “concluded that the constitutional right of privacy recognized in the contraception and abortion cases is ‘broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances’ . . . .”\(^70\)

2. **Liberty Interests**

The liberty right is discussed in *Cruzan v. Director, Missouri Department of Health*.\(^71\) This case “established that a competent person has a constitutionally protected liberty right to refuse life-sustaining treatment.”\(^72\) The reliance seems to be shifting from the right of privacy to the constitutional right of liberty, or at least toward a commingling of the two.

The “zone of privacy,” so to speak, that is now safeguarded by the Constitution when state action is involved has been enlarged in recent years. It embraces not only the interests protected by the common law action . . . but it also protects to a considerable extent the autonomy of the individual to make certain important decisions of a very personal nature.\(^73\)

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\(^{67}\) 410 U.S. 113 (1973).


\(^{69}\) 355 A.2d 647 (N.J. 1976).


\(^{71}\) 497 U.S. 261 (1990).

\(^{72}\) Susan Beth Jacobs, Note, *Cardiopulmonary Resuscitation: Authorize Emergency Medical Technicians to Effectuate a “Do Not Resuscitate” Order for Patients at Home; Provide a “Do Not Resuscitate” Order Form and an Identifying Bracelet, Anklet, or Necklace to be Worn by Patients at Home; Provide for Notification or Revocation of Cancellation of a “Do Not Resuscitate” Order*, 12 Ga. St. U. L. Rev. 223, 224 (1995). See also Meisel, *supra* note 35, at 63 (“The Supreme Court’s decision in *Cruzan v. Director* signaled a shift away from the right of privacy to the Fourteenth Amendment’s guarantee of personal liberty as a basis for the right to refuse life-sustaining treatment . . . .”).

VI. DO NOT RESUSCITATE ORDERS

Do not resuscitate orders fall under the guise of advance directives.74

Do-Not-Resuscitate (DNR) Order: A directive by a physician to withhold cardiopulmonary resuscitation in the event that a patient experiences cardiac or respiratory arrest.75

The issue of DNR orders arises when a terminally ill patient goes into cardio-pulmonary failure. Unless a DNR order has been implemented, it is normal procedure for medical personnel to resuscitate the patient.76 Resuscitation in such an instance is typically by CPR.77 Because of the timing necessary to save a patient's life if she goes into cardio-pulmonary failure, it is understandable that immediate CPR has become the standard procedure for treatment of such an occurrence in American

74 See Lieberson, supra note 9, at 489-90. ("Do-Not-Resuscitate (DNR) orders are medical orders left on the patient's chart by an attending physician which instruct other health care providers not to use or order specific methods of therapy, collectively referred to as 'cardio-pulmonary resuscitation,' or 'CPR,' on the particular patient."); see also Meisel, supra note 35, at 546 ("[I]f CPR is to be withheld, it must be prearranged by the attending physician writing an order in the patient's medical record to withhold CPR in case of a cardiopulmonary arrest.").

75 Guidelines, supra note 27, at 7.

76 See Berger, supra note 31, at 63 ("Because patients do not have the ability to make known their wishes concerning CPR when such arrest [cardiac or respiratory] occurs, their consent to these measures is implied since the situation constitutes an emergency."); see also Lieberson, supra note 9, at 492. Lieberson cites the 1986 revised guidelines of the National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care:

It is generally accepted that resuscitation is a form of medical therapy that, like most others, is indicated in some situations, but not in others. When doubt exists, however, resuscitation should be instituted. One . . . situation in which CPR is usually not indicated is the case of the terminally ill patient for whom no further therapy for the underlying disease process remains available and for whom death appears imminent . . .

Id.

77 See Lieberson, supra note 9, at 490.

CPR includes those therapies employed when a patient experiences sudden loss of oxygen supply to the brain, either because of inadequate uptake from the lungs or inadequate blood flow. CPR always arises in an emergency situation, because loss of oxygen supply to the brain quickly results in death, but not all emergencies are referred to as CPR. Only those that relate to the lungs, heart and circulation.

Id.
As Meisel comments, "[I]t gradually became, without any forethought, an accepted medical practice for CPR to be administered to all patients who suffer an arrest and not merely those whose arrest was unexpected and who stood a reasonable chance of recovery if CPR were administered." Patients are not able to communicate decisions for themselves under such circumstances, and taking the time to contact family members would prove fatal. Some patients, however, do not wish to undergo CPR. The reasons for this include the fact that CPR may be futile or unsuccessful.

Do not resuscitate orders, although ethically challenging in any circumstance, are most easily dealt with in an in-hospital situation. This ethical difficulty arises from the fact that DNR orders are orders to withhold treatment, when doctors are commonly viewed as exclusively giving orders to perform treatment. In the in-hospital setting, a patient's condition is constantly monitored by health care professionals. The documentation of the "no code" is easily accessible to any personnel that might be called forward to resuscitate the patient. For years, DNR orders were so controversial that they were not recorded by doctors. They were carried out when a physician

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78 See Meisel, supra note 35, at 545 ("There is rarely if ever any possibility of attempting to determine once an arrest occurs whether CPR should or should not be administered.").

79 Id. at 550.

80 See id. at 545-46. Meisel discusses the factors relating to the use of standing orders:

Because of the conditions under which CPR must be administered, the presumption in favor of CPR is eminently sensible. First, a patient who suffers an arrest is, at least by virtue of the arrest, in no position to decide whether CPR should be administered. Second, if CPR is not administered, the patient almost certainly will die. Finally, if permission to administer CPR is sought from a surrogate, as should ordinarily be the case, the delay occasioned thereby could easily result either in death or severe brain damage.

Id. (citations omitted).

81 See id. at 543 ("CPR is a treatment that some patients wish to avoid.").

82 See id. ("[W]hen patients are terminally ill, CPR might be futile in the sense that although it might temporarily restore the patient's circulation and respiration, death will soon ensue anyway either from the patient's underlying condition or from another cardiac or pulmonary arrest.") (citations omitted).

83 See Berger, supra note 31, at 64.

84 See Meisel, supra note 35, at 551.

85 See Guidelines, supra note 27, at 7.

86 See Meisel, supra note 35, at 546.
thought treatment would be futile. Such unilateral actions proved to be unacceptable.

"In 1974, the American Medical Association recommended that decisions not to resuscitate a patient be formally entered into the medical record, a practice that had already become widespread."  In the same year, the National Conference on Standards for Cardio-Pulmonary Resuscitation and Emergency Cardiac Care issued a monograph stating that:

The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. Cardio-pulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected. . . . For hospitalized patients, the conference recommended noting the inappropriateness of CPR in the patient’s progress notes as well as providing a written order not to resuscitate for the benefit of nurses and other personnel who may be called upon to initiate or participate in cardiopulmonary resuscitation.

Additionally, legislation began to be enacted to regulate the use of DNR orders. As Meisel points out, "[T]he dominant legislative purpose in enacting statutes authorizing and regulating DNR orders is to assure health care professionals that in certain situations it is appropriate and legal not to attempt resuscitation."

Liability is of great concern to both hospitals and health care workers. The legislative statutes are helpful in addressing this issue. Typically, they provide that issuing or honoring a DNR order is not the equivalent of euthanasia. Part of the trade-off

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87 See id. at 544.

Questions concerning the withholding or administration of CPR frequently arise in hospitals and nursing homes. At one time, withholding CPR was considered to be so controversial that DNR orders were not openly discussed and were often unwritten. This in turn led, in at least one hospital, to procedures so shoddy that a grand jury described them as "shocking procedural abuses." This kind of concern and the need to clarify the procedures for writing DNR orders led to the enactment of detailed statutes in a growing number of states.

Id. (citations omitted).

88 LIBERSON, supra note 9, at 491.

89 Id. (citation omitted).

90 MEISEL, supra note 35, at 555-56.

91 See id. at 576 ("Generally, the DNR statutes include provisions stating the statute does not authorize mercy killing or euthanasia. This means that death resulting from honoring an DNR order or directive is not the basis for the imposition of civil or criminal liability."); see also SLOAN, supra note 35, at 53-59 (dis-
for the protection the legislation affords physicians and hospitals is the requirement of "informed consent" before a DNR order is made.\textsuperscript{92} Unilateral decisions are no longer accepted.

This trend is made apparent in the case of \textit{Velez v. Bethune},\textsuperscript{93} in which a doctor unilaterally discontinued life support resulting in the death of a premature infant. The parents brought a wrongful death suit claiming that the physician had not obtained their informed consent to terminate life-sustaining measures for their child.\textsuperscript{94} The court held, "Dr. Velez had no right to decide, unilaterally, to discontinue medical treatment even if, as the record in this case reflects, the child was terminally ill and in the process of dying. That decision must be made with the consent of the parents."\textsuperscript{95}

The legislation of out-of-hospital DNR orders naturally follows this logic relating to the concern regarding liability.\textsuperscript{96} When a patient is not in the hospital setting, it is much more difficult to control the resuscitation efforts or absence thereof of patients that go into cardio-pulmonary failure. In a setting beyond the campus of a hospital or nursing home, many questions arise as to the treatment of DNR orders. These orders are also commonly referred to as "pre-hospital" DNRs.\textsuperscript{97} "The [DNR] order

cussing criminal liability facing physicians in situations where a physician may choose not to treat a terminally ill patient).\textsuperscript{92} See Guidelines, supra note 27, at 10.

Informed Consent: A legal term that refers to a person's consent to a proposed medical intervention after being provided information deemed relevant to that decision. The information that is legally required includes: diagnosis, nature and purpose of proposed intervention, risks and consequences of proposed treatment, probability that the treatment will be successful, feasible treatment alternatives, and prognosis if the treatment is not given.

\textit{Id.}\textsuperscript{93} 466 S.E.2d 627 (Ga. Ct. App. 1995).

\textit{Id.}\textsuperscript{94} at 628.

\textit{Id.}\textsuperscript{95} at 629; \textit{see also In re Doe}, 418 S.E.2d 3, 5 (Ga. 1992) (citation omitted) (stating that "the right to refuse treatment or indeed to terminate treatment may be exercised by the parents or legal guardian of the infant after diagnosis that the infant is terminally ill with no hope of recovery . . .").

\textit{See ALAN D. LIEBERSON, ADVANCE MEDICAL DIRECTIVES 240 (Supp. 1996).}

A number of states have now passed legislation intended to extend the use of DNR orders to out-patient situations. Under the prescribed protocols, emergency personnel called to attend to such identified patients are directed not to resuscitate the patient if a cardio-pulmonary arrest has occurred and relieved of legal liability for forsaking CPR.

\textit{Id.}\textsuperscript{97} \textit{See BERGER, supra note 31, at 73}. Prehospital DNR orders:
DO NOT RESUSCITATE ORDERS

must be presented to the EMS personnel when they respond to a call. The statutes described by Berger refer to EMS personnel when designating authority to honor a DNR order. A caveat to this statement in relation to our “real world hypothetical,” posed previously, is whether the flight attendants on-board an airplane in-flight could constitute “EMS personnel” for purposes of the statute. Another problematic issue is the presentation of the actual DNR order to the EMS personnel when they respond to a call. If the order must be presented, it naturally follows that there has to be a third party present in addition to the patient and the EMS personnel because the patient would be unable in such a situation to present the documents to the EMS personnel himself. Additionally, the third party must have knowledge of and easy access to, the DNR order documentation for it to be effective. If a third party that meets these requirements is not present, the patient will most likely be resuscitated even though it is against his or her individual wishes. This goes back to the earlier discussion of the timing involved for successful CPR.

The requirement for presentation of the DNR order to EMS personnel when they respond to a call is founded in public policy. EMS workers should not have to bear such a heavy weight in these matters. In a case described by Leslie Nicholson, a woman unsuccessfully sued a first aid squad, individual members of the squad, a hospital and two paramedics for trying “to revive her husband without her permission.”

[allow EMS personnel, although obliged to save and maintain life, to respect the wishes of those who choose to expire in their homes. The statutes do not grant EMS personnel authority to honor living wills; they allow them to honor a prehospital do-not-resuscitate order which constitutes a determination regarding the patient’s physical condition and course of treatment. The order, which must be signed by the attending physician, directs EMS personnel to withhold CPR although they may provide the patient with limited medical care when they respond to a call for assistance.

Id.

98 Id. at 74.

99 See id.

100 See Leslie Nicholson, Under Examination, 13 Med. Malpractice L. & Strategy 8 (1996). (“Ellen Moskowitz, an attorney and ethicist at Briarcliff Manor, N.Y.’s Hastings Center, a bioethics research group, said it would be ‘unsound as a matter of public health policy to have [EMS] workers forgoing life-prolonging care based upon family requests.’”).

101 Id.
The plaintiff's husband had a history of heart ailments and had been hospitalized twice in the month before his death. After he collapsed at the couple's home, his wife called the first aid squad and told the dispatcher her husband had died and she needed assistance lifting his body to the bed, where it could repose "with dignity" while awaiting a representative from the medical examiner's office. Instead, upon arrival, rescue squad members felt obligated by state-mandated procedures to perform CPR, despite the wife's objections.\textsuperscript{102}

Nicholson continues, "Medical Ethicists who commented on the case said the ruling points to the need for people to stipulate in advance their medical treatment preferences."\textsuperscript{103}

State-by-state legislation is being enacted to help in these situations.\textsuperscript{104} Unless there is legislation on the subject, EMS workers are not permitted to honor these DNR orders.\textsuperscript{105} Therefore, the question becomes not one of whether the EMS personnel are allowed to act on an advance directive, but whether they would honor an advance directive of their own volition, knowing the liability they could potentially face.

Texas has recently passed legislation creating an out-of-hospital do not resuscitate statute.\textsuperscript{106} The statute's definition of "out-of-hospital DNR order" provides a list of life-sustaining proce-

\textsuperscript{102} Id. (referring to Mulligan v. Allamuchy-Green Township First Aid Squad, 146 N.J. 70 (1996)).

\textsuperscript{103} Id. ("Anna Moretti, a lawyer with Choice in Dying in New York, said a study by the group found that EMS workers still have concerns about what they are supposed to do, even when presented with a do-not-resuscitate (DNR) order.").

\textsuperscript{104} See id. (However, there are only 27 states that currently have statutes recognizing non-hospital DNR orders.).

\textsuperscript{105} See ABA Commission on Legal Problems of the Elderly (visited Sept. 14, 1996) <http:www.abanet.org/elderly/pdsa.html> ("EMS personnel are generally required to institute cardio-pulmonary resuscitation and other life saving treatment unless a doctor physically present instructs them not to do so. Without legislation to permit them to comply with Advance Directives requesting no resuscitation, EMS personnel have generally not followed Advance Directives."); see also Stephen P. Williams et al., Do Not Resuscitate Orders and Emergency Medical Services, S.C. Law., Mar.-Apr. 1996, at 21, 22.

[C]itizens with terminal illnesses continued to face problems regarding their wishes not to receive resuscitative treatment from emergency medical personnel. Because of their statutory and regulatory duties, emergency medical services (EMS) workers could not legally follow these directives and were required to always provide resuscitative measures, in contravention of the patient's advance directives.

The identity of a valid DNR order is provided through the statute's address of identification devices. The statute provides that "[a] person who has a valid out-of-hospital DNR order under this chapter may wear a DNR identification device around the neck or on the wrist . . . ."

The Texas statute refers to "responding health care professionals" throughout the code. The question then becomes, as mentioned before in the hypothetical, would a flight attendant qualify as a "responding health care professional"? In the statute's definition of a "health care professional," there does not seem to be an inlet for an interpretation such as this. This could be to an advantage to airlines and flight attendants as far as liability is concerned. It can be argued that, because they do not fall under the statute's definition of "health care professionals" and because it is this group that the statute is addressing, the airline and flight attendants may not be held to any particular standard of care. The only standard of care that they would then be responsible for following would be the standard operating procedures of the airline itself. This analysis, however, addresses only legal standards, and does not focus on the ethical standards that are most certainly involved also.

For a complete analysis, it is necessary to address common law tort doctrine as well as the statutory provisions previously discussed.

107 See Tex. Health & Safety Code Ann. § 674.001 (14)(A) (Vernon Supp. 1997) (The procedures that are not to be initiated or continued are: "(i) cardiopulmonary resuscitation; (ii) endotracheal intubation or other means of advanced airway management; (iii) artificial ventilation; (iv) defibrillation; (v) transcutaneous cardiac pacing; (vi) the administration of cardiac resuscitation medications; and (vii) other life-sustaining procedures specified by the board under Section 674.023(a) . . . .").

108 See id. § 674.010(b).

The presence of a DNR identification device on the body of a person is conclusive evidence that the person has executed or issued a valid out-of-hospital DNR order or has a valid out-of-hospital DNR order executed or issued on the person's behalf. Responding health care professionals shall honor the DNR identification device as if a valid out-of-hospital DNR order form executed or issued by the person were found in the possession of the person.

Id.

109 Id. § 674.010(a).

110 See id. § 674.001 ("'Health care professionals' means physicians, nurses, and emergency medical services personnel and, unless the context requires otherwise, includes hospital emergency personnel.").
Deeply rooted in the law of negligence is the difference between "misfeasance" and "non-feasance." This is the difference between actively causing harm and passive inaction that results in a harm. Consequently, the law has been slow in recognizing liability for non-feasance. However, "[d]uring the last century, liability for 'nonfeasance' has been extended still further to a limited group of relations, in which custom, public sentiment and views of social policy have led the courts to find a duty of affirmative action." This liability has been imposed "reluctantly" and because of this reluctance to countenance "nonfeasance" as a basis of liability, the law has persistently refused to impose on a stranger the moral obligation of common humanity to go to the aid of another human being who is in danger, even if the other is in danger of losing his life.

General laws that would impose "neighborly duties" seem to be unpopular because of the possible infringement of personal pri-

112 See Keeton, supra note 72, at 373.
113 See id.
114 The reason for the distinction may be said to lie in the fact that by "misfeasance" the defendant has created a new risk of harm to the plaintiff, while by "non-feasance" he has at least made his situation no worse, and has merely failed to benefit him by interfering in his affairs.
Id. (citation omitted).
Anglo-American tort law generally provides that a person is under no duty to help another avoid injury from a foreseeable risk, even if helping would entail little or no risk or cost. The no-duty-to-act rule has sometimes been restated in terms of the different legal effects of nonfeasance and misfeasance. In these terms, the rule provides that an actor is liable for negligent misfeasance, but not for negligent nonfeasance.
Id.
116 Keeton, supra note 72, at 373-74.
117 Id. "The remedy in such cases is left to the 'higher law' and the 'voice of conscience,' which, in a wicked world, would seem to be singularly ineffective either to prevent the harm or to compensate the victim." Id. (citation omitted). See also Galligan, supra note 113, at 448. "Although the non-actor may find punishment in the next life, his victim has no legal recourse in this one . . . . With purely moral obligations the law does not deal." Id. Galligan continues, "[u]nder the common law, one historical justification for holding a party liable for misfeasance but not for nonfeasance was the difficulty in thinking of nonfeasance as causing injury." Id. (citation omitted).
This has proved unacceptable in many circumstances. Thus, in limited situations—mostly those in which someone holds themself out in a public position—a duty has been imposed by law. As such, "a carrier has been required to take reasonable affirmative steps to aid a passenger in peril ...." This duty was originally intended for passengers of railroads and buses, but should be easily translated to today's more modern form of travel, airplanes.

Modern tort law also imposes a duty to act on employers and other "caretakers." The master of a vessel must rescue a sailor in his charge who falls overboard at sea, and a jailer must aid a prisoner. Similarly, a teacher has an obligation to exercise reasonable care to protect her students. These are all duties in which a party depends upon another to give care. It seems that the role of a flight attendant would fall into line with those upon whom a duty has been imposed. A flight attendant could be considered a "caretaker" as it is her responsibility to provide for the care and safety of the passengers during their trip. Passengers are dependent upon a flight attendant for guidance and direction in much the same way that a student is dependent upon his teacher. For these reasons, in

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Laws that attempt to balance autonomy and a minimally acceptable level of neighborliness by imposing affirmative duties to help others are unpopular because they interfere with personal autonomy and the American "obsession with privacy." Even the most well-intentioned balance seems to prefer soulless individualism to creeping involuntary servitude and "unforeseen partnership."

Id. (citations omitted).

119 KEATON, supra note 72, at 376; see Galligan, supra note 113, at 449-50 ("The common law imposes a duty to aid wherever a special relationship exists between the potential actor and the victim. Even in the early days of the common law those who undertook a public calling were obligated to protect their customers."); see also Korn v. Tamiami Trail Tours, Inc., 133 S.E.2d 616 (Ga. Ct. App. 1963) (finding duty breached where bus driver knew of passenger's handicap, failed to warn her about step outside bus terminal, and failed to get medical assistance after passenger was injured). This scenario can be read to impose liability if the flight attendant in our hypothetical tries to resuscitate the passenger as the flight attendant is on notice of the out-of-hospital DNR order and fails to take the appropriate action (or non-action) if the passenger goes into cardiac-arrest.

120 Galligan, supra note 113, at 450.

121 See Arthur Leavens, A Causation Approach to Criminal Omissions, 76 CAL. L. REV. 547, 557 (1988). "Relationships in which one party depends on the other to provide care often gives rise to a criminally enforceable duty to provide such care." Id.
addition to the fact that a common carrier is responsible for its passengers, a flight attendant would be the most appropriate person to render care to a passenger during an in-flight occurrence. Hence, if an ordinary passenger were to go into cardiac arrest or need any other emergency medical treatment a flight attendant would have an affirmative duty to provide care to the best of her ability.\(^{122}\) Our hypothetical situation, however, is the direct inverse of this scenario.

In our situation, a passenger is requesting NOT to be cared for. Disregarding the legislation regarding the honor of out-of-hospital DNR orders, a flight attendant would have the duty to resuscitate. However, taking into account the possible legislation and the passenger’s request, would the duty take a 180-degree turn into a duty not to resuscitate? Does a statutory duty trump the common law duty to assist?

In considering these questions, it is interesting to ask why one would come to the assistance of another. Is it for altruistic\(^{123}\) reasons, or does a person aid another in peril to further his own self interest?\(^{124}\) The determination of such motivation is key in the creation and application of tort law.\(^{125}\)

In our hypothetical, it should be clear that a flight attendant would perform a self-serving action by ignoring the passenger’s

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\(^{122}\) See Keeton, supra note 72, at 377.
Where the duty to rescue is required, it is agreed that it calls for nothing more than reasonable care under the circumstances . . . .
He will seldom be required to do more than give such first aid as he reasonably can, and take reasonable steps to turn the sick person over to a doctor or to those who will look after him until one can be brought.

Id.

\(^{123}\) See Merriam Webster’s Collegiate Dictionary 34 (10th ed. 1996) (defining altruism as “unselfish regard or devotion to the welfare of others”).

\(^{124}\) See Galligan, supra note 113, at 474. “I examine why people help others. Do they help to further their own self-interest or do they help altruistically, out of a desire to help another?” Id.

\(^{125}\) See id. at 475.
Tort law depends, in part, on why people do what they do. To the degree that people act out of self-interest, tort rules premised on deterrence can be very effective. A rule threatening liability may trigger beneficent, or at least efficient, behavior.

If people act out of altruism, however, what is the need for legal rules? . . . Therefore, recognizing a duty to act when people might be expected to act, albeit altruistically, is to state something about human nature, to expressly recognize our capacity for compassion, something the law has not typically done.

Id. (citations omitted).
valid out-of-hospital DNR order and initiating a rescue. The flight attendant would try to resuscitate the passenger, not out of duty to the passenger (as duty to the passenger would require affirmative non-action) but out of duty to the flight attendant’s own needs—whether they be moral or ethical problems with allowing someone to die right before them or a mere guilty conscience. However, the act of resuscitation is what should give the flight attendant a guilty conscience in this situation. Through the out-of-hospital do not resuscitate order the passenger has given explicit instructions not to be resuscitated if he goes into cardio-pulmonary arrest. As such, the moral decision should be to not resuscitate. Additionally, with legislation in place giving out-of-hospital do not resuscitate orders validity, the liability could be placed upon the person who does not honor the order. Determination of such liability, however, is dependent upon the state legislation of the matter. The choice of law is therefore of crucial importance as some states may impose liability while others may not.

VIII. JURISDICTION

A major question for the application of state statutes to the issue of out-of-hospital DNR orders on airplanes is that of jurisdiction. Jurisdiction and choice of law questions could prove integral to the determination of liability, which is of extreme importance to both the airlines and the flight attendants involved in such situations. So, in exactly which jurisdiction is a plane in-flight deemed to be?

The available caselaw seems to indicate that the passengers aboard an airplane are in the jurisdiction of the airspace in which the plane is flying. In *Grace v. MacArthur*, 126 the court was asked to decide whether “the passengers on a commercial aircraft are within the territorial limits of the State over which the plane happens to be flying at a particular time.” 127 The court found that “it is clear that an aircraft flying over a State is within that State and is subject to its jurisdiction.” 128 The policy behind such a decision may be seen in the policy presented by *Smith v. New England Aircraft Co.* 129 In its opinion, the court stated that “[i]t is essential to the safety of sovereign States that they possess

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127 Id. at 444.
128 Id.
129 170 N.E. 385 (Mass. 1930).
jurisdiction to control the air space above their territories. It seems to us to rest on the obvious practical necessity of self-protection.\textsuperscript{130} It seems, therefore, that even if an airplane took off in Dallas and was scheduled to land in New York, it would not necessarily be classified as being in Texas or New York for the entirety of the trip. If it were flying over Tennessee en route, even though 30,000 feet above the ground, it would be in the jurisdiction of Tennessee because it was operating in Tennessee’s airspace.

On point as to jurisdiction in a tort action, the court in \textit{Grace} states, “a number of the States have adopted the Uniform Aeronautics Act . . . . Section 74-111 provides that all crimes, torts, and other wrongs committed by or against a pilot or passengers while in flight over the lands and waters of the State shall be governed by its laws . . . .”\textsuperscript{131}

This leads to the presumption that, in application to the earlier stated hypothetical, the flight crew of an in-flight plane could be held accountable for the requirements provided by a specific state’s DNR statute if the state has legislated on that issue.\textsuperscript{132} This would appear to place a substantial burden on airline crews to be versed in the legislations of each state over which they fly. For this reason, it would seem fruitful for airlines to devise standard procedures to be used at all times in these situations—whereby the standard procedure would mesh with all jurisdictional requirements.

The court in \textit{Grace} addressed another valid issue, “Apart from any supposed effect of the Air Commerce Act of 1926, . . . an aircraft flying over a State is within that State and is subject to its jurisdiction.”\textsuperscript{133} Thus, choice of law issues become of great importance.

\textbf{IX. CHOICE OF LAW}

Eugene Scoles provides a description of the concept of conflict of laws:

\textsuperscript{130} \textit{Id.} at 389.
\textsuperscript{131} \textit{Grace}, 170 F. Supp. at 445.
\textsuperscript{132} At this point, I am analyzing the hypothetical in segments. This does not mean that when the variables of the problem are put together that this particular point will be persuasive.
\textsuperscript{133} \textit{Grace}, 170 F. Supp. at 444 (referring to the Air Commerce Act of 1926, 49 U.S.C. \S 171, as amended by the Civil Aeronautics Act of 1938, 49 U.S.C. \S 401).
The term "Conflict of Laws" describes generally the body of law dealing with the questions of when and why the courts of one jurisdiction take into consideration the elements of law or fact patterns in a case or consider the prior determination of another state or of a foreign nation in a case pending before them. It is not uncommon to say that the substantive rules of decision of two states related to a transaction are "in conflict" when there are circumstances which apparently justify the application of the rule of either state.134

Our focus pushes us toward an examination of the choice of law issues surrounding tort liability.135 The traditional approach to choice of law in tort cases has been a territorial one.136 "The fortuitous place of injury ... became all-important."137

There are varied justifications for this territorial approach to the choice of law in a given situation. David Cavers gives an overview of these reasons in his book, The Choice of Law Process.138 Cavers expresses the first reason as not allowing a visitor to a territory's greater privileges while also not holding him to the higher standard of liability that accompanies wrongdoing in the territory.139

Where the liability laws of the state of injury set a higher standard of conduct or of financial protection against injury than do the laws of the state where the person causing the injury has acted or had his home, the laws of the state of injury should determine

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135 See id. § 17.21, at 587-88. "[T]ort issues are to be determined by the law of the state which has the 'most significant relationship' to the occurrence and the parties." Id.
136 See id. § 17.2, at 552-53.
137 See id. § 17.2, at 553.
139 See id. at 141. "The defendant who is held to the higher standard is not an apt subject for judicial solicitude. He cannot fairly claim to enjoy whatever benefits a state may offer those who enter its bounds and at the same time claim exemption from the burdens." Id.
the standard and the protection applicable to the case, at least where the person injured was not so related to the person causing the injury that the question should be relegated to the law governing their relationship.\textsuperscript{140}

A state undertakes a perspective such as this to provide for the "general security" of its citizens.\textsuperscript{141}

Cavers articulates his second theory, which is similar to his first in that it is concerned with standards of conduct provided by the state.

Where the liability laws of the state in which the defendant acted and caused an injury set a lower standard of conduct or of financial protection than do the laws of the home state of the person suffering the injury, the laws of the state of conduct and injury should determine the standard of conduct or protection applicable to the case, at least where the person injured was not so related to the person causing the injury that the question should be relegated to the law governing the relationship.\textsuperscript{142}

In this theory there is concern for the people whose activities might cause the harm as well as for those actually harmed.\textsuperscript{143}

Here we look to the state's consideration of conduct as wrongful.\textsuperscript{144} This appears to be an especially intriguing theory in relation to our look into the liability that would potentially face a flight attendant who resuscitated a patient against their DNR order or who did not resuscitate when the situation mandated that they should engage in heroic measures. This type of conflicts theory would be favored by the flight attendants, as it would allow them more flexibility in their actions. They would not necessarily be bound by the law of the state in which the order was issued, as the cardio-pulmonary arrest could occur within another jurisdiction during travel, and that jurisdiction's laws could be radically different from the one in which the order was issued. Thereby, while one state would call for resuscitation, another may recognize the order and find tort liability for a resuscitation. This particular theory meshes with the current policy

\textsuperscript{140} Id. at 139 (emphasis omitted).
\textsuperscript{141} See id. at 139-40. "Our territorially organized governments undertake by means of laws and regulations governing conduct to provide for 'the general security,' to use Dean Pound's term, to safeguard the health and safety of people and property within their bounds." Id. (citations omitted).
\textsuperscript{142} See id. at 146 (emphasis omitted).
\textsuperscript{143} See id.
\textsuperscript{144} See id. at 152. "Its laws may reflect a purpose to encourage risk-taking by relieving activities in a certain field from the hazard of civil liability either entirely or at least until the case against the way they are conducted is a clear one." Id.
of our hypothetical airline, stating that the flight attendant should resuscitate first and ask questions later if unclear about any aspect of the situation.

Cavers's third theory addresses specialized regulation. Where the state in which a defendant acted has established special controls, including the sanction of civil liability, over conduct of the kind in which the defendant was engaged when he caused a foreseeable injury to the plaintiff in another state, the plaintiff, though having no relationship to defendant, should be accorded the benefit of the special standards of conduct and of financial protection in the state of the defendant's conduct, even though the state of injury had imposed no such controls or sanctions.

X. CONCLUSION

In attempting to tie the main issues of this topic together, it becomes obvious that any solution hypothesized will be highly indeterminative as so much hinges upon the DNR legislation of individual states. However, regardless of what the applicable state statute mandates, it is highly unlikely that, in any circumstance, a flight attendant will watch a passenger go into cardiac arrest without attempting to come to her aid. This scenario narrows the issue to the main underlying theory—moral choice. Although a flight attendant may make her own moral choice to resuscitate a passenger, should the flight attendant realize that a terminally ill passenger should be able to exercise his own moral choice in not wanting to be resuscitated? It is a sad state, however, that fear of liability will often times negate the moral choice made by a terminally ill patient.

145 See supra note 25 and accompanying text.
146 CAVERS, supra note 137, at 159 (emphasis omitted).