

2011

When Is Medical Care “Futile”? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care

Meir Katz

Georgetown University Law Center, mkatz@becketfund.org

Follow this and additional works at: <https://digitalcommons.unl.edu/nlr>

Recommended Citation

Meir Katz, *When Is Medical Care “Futile”? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care*, 90 Neb. L. Rev. (2013)

Available at: <https://digitalcommons.unl.edu/nlr/vol90/iss1/3>

This Article is brought to you for free and open access by the Law, College of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Nebraska Law Review by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

When Is Medical Care “Futile”? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care

TABLE OF CONTENTS

I. Narrative	2
II. Introduction	4
III. A Sample of the Case and Statutory Law Regarding the Futility Movement	8
A. Early Pivotal Cases	9
B. <i>Rideout v. Hershey Medical Center</i> and Claims for Emotional Distress	11
C. Claims Under the Emergency Treatment and Active Labor Act (EMTALA).....	13
D. Futile Care for Infant Patients	17
E. The Texas Advance Directives Act (TADA), a Robust Statutory Solution?.....	22
IV. On Institutional Competence, Bias, and Materialist Philosophy.....	24
A. The False Presumption of “Futility”.....	27
B. Institutional Incompetence and Bias in the Medical Profession	31
C. Non-Materialist Considerations	39
V. Rebuttal and Response	49

© Copyright held by the NEBRASKA LAW REVIEW.

* J.D., Georgetown University Law Center. Legal Fellow, Becket Fund for Religious Liberty. The views expressed in this Article are those of the author and do not represent the views of the Becket Fund. This Article is dedicated to the late Steven Goldberg, Professor at Georgetown University Law Center, whose insights, wisdom, and expertise on matters of law, religion, and science, contributed greatly to this article. I additionally express appreciation to my wife, without whom my attempt to write this Article would have been futile in every sense of the word.

A. Human Suffering for a Purpose and with Consent is Not Torture 50

B. ‘Physician Autonomy’ Does Not Define the Scope of a Physician’s Legal Responsibilities 54

C. The Allocation of Scarce Medical Resources 63

VI. Conclusion 68

“We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are *Life*,¹ Liberty and the pursuit of Happiness.”²

I. NARRATIVE

Moshe Schwab, an Orthodox Jew from Miami, and his family returned from a trip to Disney World on August 23, 2007.³ After cleaning up from dinner, Moshe called his children to ask them to take their showers and get ready for bed.⁴ His four-year-old daughter, Aliza, did not come.⁵ Concerned, Moshe quickly went to look for her—starting with the swimming pool.⁶ He found the life vest she wore the whole afternoon sitting beside the pool and then immediately spotted her lying on the bottom of the pool.⁷ In a moment, “the laughing, running, [and] playful” daughter the Schwabs had known became something else; her heart stopped beating.⁸ Medical personnel arrived quickly and successfully administered cardiopulmonary resuscitation (CPR), but Aliza never regained consciousness and remains on a respirator as she is no longer able to breathe independently.⁹

Eventually, Aliza’s hospital determined that further medical care on her behalf was “unethical” and thereby decided to “pull the plug.”¹⁰ The Schwabs sought rabbinic authority to guide both their emotional

1. “Life,” in the context of our Declaration of Independence, is generally understood to mean that the state may not impede upon the interest that each person has in his own life. That is, the state may not kill a person even if the benefits of doing so outweigh the costs. Capital punishment, an institution that predated the Declaration by thousands of years, presents an interesting exception to the general rule. The scope of that exception and its theoretical justifications are beyond the scope of this Article. Rather, I am interested in another potential exception: whether the important governmental interest of controlling health care costs provides a basis for the state to impede, under certain specified circumstances, upon the interests of an individual in his life.

2. DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) (emphasis added).

3. Toby B. Katz, *Clinging to Life*, MISHPACHA, Jan. 2, 2008, at 20.

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.* at 19, 20.

10. *Id.* at 21.

response as well as to instruct them how to approach the hospital; they were told to fight the hospital, which they did.¹¹ Aliza’s doctors objected, stating that they “saw no further value in continuing to keep . . . Aliza alive, when her organs could benefit other children who were also in desperate need.”¹² Accordingly, in disregard to the preferences and protests of the Schwab family, Aliza’s doctors instructed her family to prepare themselves for the death of their daughter and to inform whomever they desired.¹³ The Schwabs made many calls, not to make “final arrangements” but to ask total strangers who previously knew nothing of them, had never seen Aliza, and probably never would, to pray on her behalf that she might see another day.¹⁴ Apparently, thousands of these strangers responded as e-mail requests for prayers on behalf of Aliza quickly circulated the globe.¹⁵

The hospital agreed not to unilaterally terminate Aliza’s treatment, instead giving the Schwabs seven days to find a different care provider.¹⁶ Eventually, the hospital agreed to abandon the seven-day requirement as well because Aliza’s condition began to stabilize.¹⁷ Her parents decided to care for Aliza at home and transformed a room in their house into a mini intensive care unit.¹⁸ The hospital granted them some time to learn how to operate various pieces of complicated medical equipment.¹⁹ Sadly, their opportunity to care for their daughter at home did not last long. Within days, Aliza had to return to the hospital (wisely, her parents took her to a different area hospital) with a “massive” infection.²⁰ Aliza returned home weeks later but could no longer move her hands and feet.²¹ Despite Aliza’s desperate and dete-

11. *Id.* at 20.

12. *Id.* The objections of the hospital are rather unusual. I am personally not aware of another futility case in which the hospital wanted to terminate treatment for utilitarian reasons stated so explicitly. While cost savings and similar utility interests are always just under the surface in every futility case, hospitals usually couch their objections in other language. The reason they do so, I think, is obvious. No mentally balanced person would advocate kidnapping and killing people to harvest their organs. While using available organs to help others is a noble and valuable cause, any discussion regarding the availability and use of a given patient’s organs cannot begin until it is resolved that the patient is dead or close enough to being dead to satisfy legal and normative objections. Organ harvesting is not a legitimate basis to terminate treatment absent other considerations. This Article addresses whether the “futility” of continued aggressive medical care is a valid reason to force the termination of treatment for utilitarian or other purposes.

13. *Id.* at 20.

14. *Id.*

15. *Id.*

16. *Id.* at 21.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

riorating state, her siblings continue to show her love and affection with zeal.²² Her brothers and sisters run to her room upon returning from school to read to her, kiss her, tell her stories, and simply be her siblings.²³ And her parent's devotion to her care is heroic. For example, Aliza's parents significantly reduced their hours in their small business as part of an effort to devote much of their time and energy to Aliza's care.²⁴

Why does the Schwab family continue to care for their daughter with such devotion? One can understand that they love their daughter, even given that she exists as a mere shadow of her former self, but it may be hard for some to understand how that love is capable of driving Aliza's parents and family to these dramatic (and expensive) measures. For the Schwabs, there was no question. While Aliza is not responsive and may not be physically aware of her surroundings, her parents believe that her soul is fully aware, and that belief drives them. Her soul knows "how much her parents love her and how hard they are trying to make her life as good as it can possibly be. . . . Although she is not awake, her *neshama*²⁵ knows everything."²⁶ For the Schwabs, this is not science fiction, nor is it theoretical; it is a belief that will govern their daily lives for the foreseeable future. As the reporter sent to observe the Schwabs prepared to take leave, Aliza's mother gave her the following revealing message: "We're happy that . . . Aliza is here. Every day that she's here with us is a good day for us."²⁷

II. INTRODUCTION

The year 1987 began a revolution in the medical community. At around that time, doctors and hospitals began working to establish a policy through which physicians would be able to withhold or withdraw medical treatment when a patient or surrogate requests specific treatment over the objections of the patient's physician.²⁸ Under these new policies, doctors would be able to override "patient autonomy"²⁹ on the basis of their determination that further treatment is

22. *Id.* at 22

23. *Id.*

24. *Id.* at 21–22.

25. "Neshama" is Hebrew for "soul." See Milon: English Hebrew Dictionary, <http://www.milon.co.il/> (enter "neshama" in search bar and press "translate").

26. Katz, *supra* note 3, at 22 (footnote added).

27. *Id.* at 23.

28. Paul R. Helft et al., *The Rise and Fall of the Futility Movement*, 343 NEW ENG. J. MED. 293, 293 (2000).

29. The right of a patient to decline unwanted medical treatment, and thus the autonomy of the patient, was firmly established in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990). The autonomy of the patient is, of course, not without limits. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11,

“futile,” “inappropriate,” “nonbeneficial,” “ethically objectionable,” or “not medically indicated.”³⁰ These terms are all various ways of describing “medical futility.” While there does not seem to be a consensus definition of futility, proponents of a robust “medical futility” doctrine all agree that when it can be determined that further aggressive medical care is of no benefit to the patient (perhaps because there is no statistical chance of recovery, perhaps because any recovery seen will be qualitatively negligible, perhaps because the harm likely to be caused to the patient by continued treatment outweighs any benefit to the patient) there is no obligation to provide that treatment.³¹

A study in the early 1990’s illustrated the pervasiveness of the futility movement despite it being just a few years old. Dr. David A. Asch, Professor at the University of Pennsylvania, surveyed 879 doctors in intensive care units around the country and found that over 80% of responding doctors admitted to unilaterally withdrawing care that they considered futile without ever consulting family members regarding their intentions or offering them the opportunity to transfer the patient.³² These families never knew that their loved ones lost their lives before modern medicine lost the capacity to sustain them.

Perhaps surprisingly, a team of physicians writing for the *New England Journal of Medicine* sensed in 2000 that the futility movement, which took the medical community by storm in its early years, was dying and decided to unilaterally issue a do not resuscitate (DNR) order on the movement. In their article, *The Rise and Fall of the Futility Movement*, these authors claimed that the movement’s failure to reach consensus on important foundational matters was its death knell.³³ Despite this DNR order, the futility movement persists, and according to many accounts remains alive and well.³⁴ It persists “[l]ike some

24–30 (1905) (holding that an individual’s autonomy is not absolute and is sometimes subservient to legitimate public health concerns and upholding on constitutional grounds a state statute requiring immunization).

30. Lawrence J. Schneiderman & Alexander Morgan Capron, *How Can Hospital Futility Policies Contribute to Establishing Standards of Practice?*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 524, 526 (2000).
31. See Helft et al., *supra* note 28, at 293. A further inquiry into definitions is beyond the scope of this Article as my interest is more broadly conceptual and, I believe, my objections are applicable to all the various definitions of futility.
32. Gina Kolata, *Withholding Care from Patients: Boston Case Asks, Who Decides?*, N.Y. TIMES, Apr. 3, 1995, at A1 (as appended Apr. 15, 1995).
33. Helft et al., *supra* note 28; see also Patrick Moore, Note, *An End-of-Life Quandary in Need of Statutory Response: When Patients Demand Life-Sustaining Treatment that Physicians are Unwilling to Provide*, 48 B.C. L. REV. 433, 454 (2007) (referring to the Helft article as the “de facto obituary” of the futility movement).
34. See *In re Howe*, No. 03 P 1255, 2004 WL 1446057 (Mass. Prob. & Fam. Ct. Mar. 22, 2004) (discussing futility); *Hudson v. Tex. Children’s Hosp.*, 177 S.W.3d 232, 235 (Tex. App. 2005) (noting that the lower court had denied plaintiff’s injunction to compel the hospital to continue life-preserving support pursuant to state statute); *Preston v. Meriter Hosp.*, 700 N.W.2d 158 (Wis. 2005) (discussing futility);

ghoul in a late-night horror movie that repeatedly sits up in its grave and shuffles abroad” wandering the halls of our nation’s hospitals, stalking health care jurisprudence, and frightening sick patients and their loved ones.³⁵

State public health agencies and hospitals around the country continue to adopt statutes and internal guidelines furthering the medical futility movement. For example, in 1999, the State of California adopted a statute that, in its simplicity and brevity (just forty-six words) captures the efforts of the futility movement.³⁶ It reads: “A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires *medically ineffective* health care or health care *contrary to generally accepted health care standards* applicable to the health care provider or institution.”³⁷ In its simplicity, the statute neglects to define what makes a procedure “medically ineffective” or “contrary to generally accepted health care standards.” If we read the statute to simply apply the generally accepted standard of care, which the latter phrase strongly implies, the statute grants the medical profession great latitude to decide whom and when to treat. Based on this statute, it appears that if the medical community were to reach consensus that a given procedure, dialysis for example, is too expensive to ever justify associated state expenditures, that community could lawfully unilaterally cease to provide that procedure.³⁸ Other states have adopted statutes that accomplish the same goals utilizing different language.³⁹ Concurrently, health care organizations around the coun-

Katz, *supra* note 9 (offering a factual account involving medical futility that played out in 2007); Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES, Mar. 27, 2005, at A1 (discussing growing tensions between patients and medical providers in popular media in 2005).

35. This simile is borrowed from *Lamb's Chapel v. Ctr. Moriches Union Free Sch. Dist.*, 508 U.S. 384, 398 (Scalia, J., concurring).
36. CAL. PROB. CODE § 4735 (West 2007).
37. *Id.* (emphasis added); *see also id.* § 4736 (describing the procedure that medical providers must take to notify a patient of a possible transfer and ultimately to transfer the patient to another medical provider).
38. *See* Schneiderman & Capron, *supra* note 30, at 528–29 (stating that California residents were concerned that the preferences of healthcare professionals might override the wishes of the general community).
39. *See* ME. REV. STAT. ANN. tit. 18-A, § 5-807 (1998); MD. CODE ANN., HEALTH–GEN. § 5-611 (West 2009); MASS. GEN. LAWS ANN. ch. 201D, §§ 14–15 (West 2004); N.Y. PUB. HEALTH LAW § 2984 (McKinney 2007); TENN. CODE ANN. § 68-11-1808 (West, Westlaw through 2010 First Ex. Sess. and 2010 Reg. Sess.); Texas Advance Directives Act, TEX. HEALTH & SAFETY CODE ANN. §§ 166.001–166.166 (West 2010); VA. CODE ANN. § 54.1-2990 (West, Westlaw through 2010 Reg. Sess. 2010); WASH. REV. CODE ANN. § 70.122.060 (West 2002); *See also* MD. CODE ANN., HEALTH–GEN. § 5-613 (West 2009) (pertaining to patient transfer).

try have been developing futile care policies⁴⁰ and informal surveys of hospital ethics specialists in 2005 indicated a significant increase in recent years of ethical clashes that pit families who are pushing for aggressive life support against doctors and nurses who oppose such measures.⁴¹ And new futility episodes arise on a nearly constant basis.⁴²

This Article will explore the notion of medical futility, arguing that it cannot (or should not) exist as a matter of medical ethics and that physicians cannot be permitted to serve as the final arbiters of life and death. Part III of this Article will examine the case law surrounding medical futility, showing that the case law is complicated and an attempt to formulate a concise statement of the law is elusive. Additionally, it will consider what is arguably the most rigorous state statute on the subject, the Texas Advance Directives Act,⁴³ as a possible model for future statutory medical futility programs. Part IV will discuss the bias inherent in words like “futile” and “inappropriate.” Additionally, it will consider the intuitional bias in the medical profession which clouds discussion about the futility movement and will attempt to show how some other modes of thought provide different answers to the question of “futility.” I will argue that because medical futility rests on a presumption against religious and supernatural theory, about which medical science has (or ought to have) no opinion, it fails as a logical argument. It is also distinctly inappropriate for addressing futility cases because it imposes a physiological objective on the patient where the patient’s goals might be entirely aphysiological. Part V will address three of the most powerful arguments in favor of the cessation of “futile” treatment: that aggressive treatment for patients who have a tremendously small chance of recovery (1) is often physically and emotionally painful, amounting to torture of the patient; (2) undermines physician autonomy, turning

40. Lawrence J. Schneiderman, *Letter to the Editor: The Rise and Fall of the Futility Movement*, 343 NEW ENG. J. MED. 1575, 1575 (2000); Schneiderman & Capron, *supra* note 30.

41. BELLUCK, *supra* note 34. For example, Dr. Lachlan Farrow, the director of ethics programs at Beth Israel Deaconess Medical Center in Boston, stated that around 1990, eighty percent of the ethics cases that came before him were right-to-die cases whereas in 2005, about eighty percent were right-to-life cases (including futility cases). *Id.*

42. Eleanor Harding, *Battersea Woman’s Life Support Cut ‘Without Family’s Permission’*, YOUR LOCAL GUARDIAN (Feb. 1, 2010, 7:00 AM) http://www.yourlocalguardian.co.uk/news/4881529.Wife_s_life_support_cut_without_family_s_permission/ (“Shun-Yuen Pang, a former British serviceman, asked for his wife Lai-Mei to be kept alive for two more days at Kings College Hospital so that her three sons could have a chance to say a last goodbye. . . . Mr Pang, 60, said: ‘The doctor told me, “it’s not you who decides—it’s the hospital. We are turning it off in 30 minutes.”’”).

43. TEX. HEALTH & SAFETY CODE ANN. § 166.001–166.166 (West 2010).

the physician from a moral agent into a complacent slave of his patient who acts regardless of his personal and moral objections; and (3) exhausts scarce medical resources which could be better spent on other patients.

III. A SAMPLE OF THE CASE AND STATUTORY LAW REGARDING THE FUTILITY MOVEMENT

Mary Wohlford did not want her doctors to sustain her if she ever suffered from severe medical complications.⁴⁴ To that end, she chose to memorialize her intentions to ensure that there would be no confusion in the future.⁴⁵ She had her instructions tattooed across her chest: "DO NOT RESUSCITATE."⁴⁶ Few patients express their desires so conspicuously and many may not even be consciously aware of their desires. The decision to undergo aggressive medical treatment or to welcome death over suffering is a complicated one, about which many patients may be conflicted.⁴⁷ But even where a patient knows exactly what she wants, as did Ms. Wohlford, the extent to which a physician must comply with his patient's wishes is unclear. A patient's autonomy is not absolute. In some circumstances, certain state interests will override a patient's clearly expressed interests.⁴⁸ Knowing what those limitations are, as a matter of law, is rather difficult because the body of law which has developed in the field of medical futility over the past two decades is fraught with inconsistency. Much of the case law indicates that courts are generally friendly to patients seeking an injunction that will compel treatment while they are still alive, but are less receptive to families seeking damages after "futile" care is withdrawn, as long as the withdrawal was consistent with prevailing standards of care.⁴⁹ This is unfortunate because "[n]owhere is clear enunciation of a physician's role more important than in the medical futility arena, where clinical scenarios place patient and physician values in (often) irreconcilable conflict."⁵⁰ This

44. Diane E. Hoffmann & Jack Schwartz, *Who Decides Whether a Patient Lives or Dies?*, TRIAL, Oct. 2006, at 30.

45. *Id.*

46. *Id.*

47. See John Hardwig, *Is There a Duty to Die?*, 27 HASTINGS CENTER REP. 34, at 34, 42(1997).

48. See *In re Fiori*, 652 A.2d 1350, 1354 (Pa. Super. Ct. 1995) ("Clearly, however, the right to self-determination as to one's own medical treatment is not absolute. The state has interests that are implicated in cases involving the termination of life[-]sustaining treatment.")

49. Schneiderman & Capron, *supra* note 30, at 530; Moore, *supra* note 33, at 436-37; Hoffman & Schwartz, *supra* note 44, at 37.

50. Judith F. Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J.L. & MED. 221, 223 (1995).

Part will attempt to outline existing law, recognizing that it may be difficult to offer a concise statement of the law.

A. Early Pivotal Cases

By most accounts,⁵¹ the first judicial opinion issued in the context of medical futility came in 1991 with *In re Wanglie*.⁵² In *Wanglie*, the hospital petitioned a court to enable it to withdraw life-sustaining care from a patient who was permanently unconscious, but did not ask the court for declaratory judgment on those grounds.⁵³ Instead, it asked the court to replace Mrs. Wanglie’s guardian, her husband of fifty-three years.⁵⁴ Mr. Wanglie strongly opposed the wishes of his wife’s attending physicians; rather than fighting him on the merits, they simply challenged his authority to speak on behalf of his wife.⁵⁵ The physicians made no attempt to show that (1) Mr. Wanglie was incompetent, (2) they shared Mrs. Wanglie’s religious and moral beliefs, (3) they were dedicated to promoting her welfare, or (4) any family members contested Mr. Wanglie’s ability to speak on his wife’s behalf.⁵⁶ The court characterized the question before it as follows: “[W]hether it is in the best interest of an elderly woman who is comatose, gravely ill, and ventilator-dependent to have decisions about her medical care made by her husband of fifty-three years or by a [court-appointed] stranger.”⁵⁷ Not surprisingly, the court chose to retain Mr. Wanglie as guardian.⁵⁸

51. See Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician’s Professional Conscience*, 44 HASTINGS L.J. 1241, 1259 (1993); Moore, *supra* note 30, at 441–43;

52. PX-91-283, (Prob. Ct. Minn. Dist. Ct. July 1, 1991), *reprinted in* 7 ISSUES L. & MED. 369 (1991) [hereinafter *Wanglie*].

53. *See id.*

54. *Id.*; see Moore, *supra* note 30, at 441.

55. *Cf. Wanglie*, *supra* note 52.

56. *Id.* at 371–72.

57. *Id.* at 376.

58. *Id.* at 372. Other medical providers have been successful in their efforts to replace a guardian. This occurrence is rare and doing so seems to require a showing that the guardian chosen by the patient displays little interest in acting for the benefit of the patient, a very significant burden. See *In re Guardianship of Mason*, 669 N.E.2d 1081, 1085 (Mass. App. Ct. 1996). I am aware of but one case in which a court replaced a guardian simply because the guardian, opting for life instead of death, made the “wrong” decision for the patient. That case was decided by a Michigan probate court in 1993 and seems to be nothing more than a tragic anomaly. See James Bopp, Jr. & Richard E. Coleson, *Child Abuse by Whom?—Parental Rights and Judicial Competency Determinations: The Baby K and Baby Terry Cases*, 20 OHIO N.U.L. REV. 821, 822, 825–26 (1994) (citing *In re Achtabowski*, No. G93-142173-GD (Mich. Prob. Ct. July 30, 1993)). The probate court’s decision was affirmed by the Michigan circuit court, which refused to grant a stay pending further appeal, apparently in violation of Michigan state law. *Id.* at 827 n.49. This unusual decision violated state law, arguably federal

In 1995, the jury in *Gilgunn v. Massachusetts General Hospital*⁵⁹ was the first to explicitly assess monetary liability for failure to provide “futile” treatment.⁶⁰ *Gilgunn* involved:

A [seventy-two-year-old] alert white female with multiple medical problems including diabetes millitus for [thirty] years, megaloblastic anemia, chronic renal insufficiency, cerebrovascular accident, coronary artery disease, peripheral vascular disease, breast cancer and mastectomy, Parkinson’s disease, bilateral heel ulcers, and three previous hip replacements, [who] fell and broke her hip in May 1989.⁶¹

Because of the fall, Catherine Gilgunn needed hip surgery but her extensive illnesses made any operation life threatening.⁶² Eventually, her physicians were able to stabilize her other conditions so that they could operate on her hip, but that stabilization was short lived.⁶³ The day after they scheduled her operation, Ms. Gilgunn suffered a grand mal seizure, which was followed by a series of seizures over the succeeding five days.⁶⁴ By the time her seizures subsided, Ms. Gilgunn was no longer responsive to noise or pain.⁶⁵ A short time later, she had limited cognitive ability and her attending physicians recommended placing a DNR order on Ms. Gilgunn.⁶⁶ Her family objected, requesting “everything possible to save [Ms. Gilgunn’s] life regardless of cost.”⁶⁷ Dr. Edwin Cassem, chair of the hospital’s Optimal Care Committee, responded by writing a note that concluded: “[The family’s] confusion, anguish, misinformation, denial, and distress . . . do not justify *mistreating* the patient.”⁶⁸ Nevertheless, Ms. Gilgunn’s attending physician agreed to rescind the DNR order in response to her family’s objections. A while later, Ms. Gilgunn’s eyes opened, she was alert, and had some ability to communicate.⁶⁹ The objections of her family were vindicated.⁷⁰ Sadly, their vindication was also short lived. Ms. Gilgunn suffered more seizures, became unresponsive once

constitutional law, *see id.* at 826 n.46, normal standards of decency, and sensitivity, and is deserving of no further attention in this Article.

59. John J. Paris et al., *Use of a DNR Order Over Family Objections: The Case of Gilgunn v. MGH*, 14 J. INTENSIVE CARE MED. 41 (1999) (discussing the facts and holding in *Gilgunn v. Mass. Gen. Hosp.*, No. 92-4820 (Mass. Super. Ct. Apr. 21, 1995)).

60. *Id.*

61. Paris et al., *supra* note 59, at 41.

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.* at 42. Presumably, they were referring to costs incurred by the hospital and asked the hospital to do everything within its physical ability, even if that meant incurring untold financial liability.

68. *Id.* (emphasis added).

69. *Id.*

70. *See id.*

again, and suffered vomiting and gastroenterological bleeding.⁷¹ The hospital attempted a second time to issue a DNR order and was less responsive to the objections (sometimes including violent threats and verbal obscenities)⁷² of Ms. Gilgunn’s family.⁷³ Dr. Cassem wrote: “[T]he family protests the exclusion of CPR, a procedure which is medically contraindicated, inhumane, and unethical [under the circumstances].”⁷⁴ Her neurologist described her prognosis for functional recovery as “nil” and the director of the hospital’s intensive care unit declared that further medical interventions were “futile.”⁷⁵ On August 7, 1989, the family was informed that the hospital’s decision to remove ventilation was final and would take place over the next several days.⁷⁶ Ms. Gilgunn was pronounced dead the morning of August 10.⁷⁷

Ms. Gilgunn’s family sued for damages on a theory of negligence.⁷⁸ After just two hours of deliberation, the jury agreed that Ms. Gilgunn would have requested CPR and other aggressive medical procedures if she were sufficiently competent to do so, but that such treatment would be “futile.”⁷⁹ The jury found further that the actions of the hospital and the physicians were in accord with the standard of care and were thus not negligent.⁸⁰ The plaintiffs filed an appeal but later withdrew it for reasons unknown.⁸¹

B. *Rideout v. Hershey Medical Center*⁸² and Claims for Emotional Distress

Claims against hospitals and physicians for emotional distress (either negligent or intentional) have been rare. The case of Brianne Rideout is an exception.⁸³ At the age of two, Brianne was diagnosed with a malignant brain tumor.⁸⁴ She had surgery in February of 1992 to remove the tumor but, shortly thereafter, began to suffer from a stupor and respiratory difficulty.⁸⁵ Brianne’s parents were informed that her condition was not curable but decided to pursue aggressive

71. *Id.*

72. *Id.* at 43.

73. *Id.* at 42

74. *Id.* at 42.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.* at 45.

79. *Id.*

80. *Id.*

81. *Id.*

82. 30 Pa. D. & C.4th 57 (Pa. Com. Pl. 1995).

83. *See id.*

84. *Id.* at 59.

85. *Id.*

medical treatment nonetheless.⁸⁶ On April 13, 1992, Brianne was placed on a mechanical ventilator, which, from the prospective of her doctors, did nothing but “prolong” her death (that is, the process of dying).⁸⁷ On May 20, 1992, the Rideouts learned that their health insurance was about to be exhausted and, if Brianne’s aggressive medical treatment was to continue, it would have to be with financial assistance.⁸⁸ The next day, Brianne’s attending physician, apparently aware of Brianne’s disappearing medical insurance coverage,⁸⁹ decided to issue a DNR order on Brianne.⁹⁰ The Rideouts objected, demanded continuing aggressive medical treatment, and responded: “It’s okay for some people who don’t regard life and may want their child dead for insurance, [sic] but we value Brianne and her life.”⁹¹ By July 13, 1992, Brianne’s condition worsened and her attending physician, Dr. Lucking, decided that “the most prudent course of action would be to remove Brianne’s ventilator” because continued ventilatory support was, in his mind, “futile and inappropriate.”⁹² He called the Rideouts at around 8:30 a.m. on July 14 to inform them that he intended to remove Brianne’s ventilator later that day.⁹³ The Rideouts objected, in part because they felt Dr. Lucking was acting in violation of their religious beliefs.⁹⁴ Given their objections, he agreed to delay one day.⁹⁵

The morning of July 15, the Rideouts arrived at the hospital to try to stop Dr. Lucking from removing Brianne’s ventilatory support.⁹⁶ When Dr. Lucking learned that they were present he was poised to disengage the ventilator; he asked his staff to order them to come to Brianne’s room so they could attend their daughter’s death.⁹⁷ Her parents, still attempting to force Dr. Lucking to desist, did not come to Brianne’s room.⁹⁸ At 1:45 p.m., without her parents present, in clear violation of her parent’s wishes, and without court order, Dr. Lucking unilaterally removed Brianne’s ventilatory support.⁹⁹ The hospital’s chaplain, who was with Brianne at the time, announced over the hospital’s intercom: “they turned her off, they turned her off!”¹⁰⁰ The

86. *Id.*

87. *Id.* at 59–60.

88. *Id.* at 60.

89. *See id.* at 60–61.

90. *Id.* at 60.

91. *Id.*

92. *Id.* at 61–62.

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.* at 62.

97. *Id.* at 63.

98. *Id.*

99. *Id.*

100. *Id.*

Rideouts heard the announcement and ran to Brianne’s room crying hysterically and screaming that their child had been murdered by her doctor.¹⁰¹ Mr. Rideout was so upset that he suffered an acute asthma attack.¹⁰² But Brianne was not dead.¹⁰³ She was able to breathe independently after the ventilator was removed.¹⁰⁴ Another doctor present opined that because Brianne was breathing, it would not be necessary to place her back on the ventilator.¹⁰⁵ Tragically, that doctor was wrong. Brianne died two days later in the presence of her parents.¹⁰⁶

In their complaint, the Rideouts stated that as a result of the incident, in addition to the asthma attack suffered by Mr. Rideout, the Rideouts suffered from “intense headaches, nausea, depression, nightmares, nervousness, insomnia, stress, anxiety, upset stomach, [and] hysteria.”¹⁰⁷ The defendants demurred to the Rideout’s complaint, and in so doing defeated some of the Rideout’s causes of action.¹⁰⁸ The causes of action that survived demurrer were negligent infliction of emotional distress,¹⁰⁹ intentional infliction of emotional distress,¹¹⁰ lack of informed consent,¹¹¹ violation of privacy-based parental rights,¹¹² free exercise of religion,¹¹³ and a claim for punitive damages.¹¹⁴ Apparently, this case never went to trial. My efforts to obtain information about a possible settlement or further judicial pronouncement on the merits of the case have been fruitless.

C. Claims Under the Emergency Treatment and Active Labor Act (EMTALA)¹¹⁵

EMTALA has proven to be a great friend to plaintiffs in medical futility cases. This friendship, however, is accompanied with great controversy. EMTALA was designed as a mechanism to prevent hospitals from “dumping” patients whom they did not wish to treat, usu-

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* at 63.

107. *Id.* at 64.

108. *Id.*

109. *Id.* at 68.

110. *Id.* at 70.

111. *Id.* at 73.

112. *Id.* at 84.

113. *Id.* at 87. I am not aware of another case which relied on the Free Exercise clause to overturn a medical provider’s decision to withdraw care on the basis of its “futility.” The Free Exercise clause requires that “Congress shall make no law . . . prohibiting the free exercise [of religion].” U.S. CONST. amend. I.

114. *Rideout*, 30 Pa. D. & C.4th at 96.

115. 42 U.S.C. § 1395dd (2006).

ally because those patients were not able to finance their medical care.¹¹⁶ The purpose of EMTALA is “to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat.”¹¹⁷ Accordingly, EMTALA should not be misconstrued as a federal malpractice statute.¹¹⁸ Nonetheless, several courts have found in EMTALA a cause of action for futility plaintiffs.¹¹⁹ EMTALA is a fairly large statute that has generated a great body of case law; a thorough review of its provisions is beyond the scope of this Article.¹²⁰

In 1994, the Court of Appeals for the Fourth Circuit expressly held that EMTALA required physicians to provide aggressive medical care to a baby girl, Baby K, born with severe malformation and cognitive deficiency, which was certain to claim her life.¹²¹ Baby K was afflicted with anencephaly, a prenatal condition that rendered her permanently unconscious and without the ability to “see, hear, or . . . interact with her environment.”¹²² Typically, anencephaly causes infant death within a matter of days.¹²³ Baby K’s mother insisted that her daughter receive mechanical respiration despite protests by her medical providers that doing so was “inappropriate.”¹²⁴ The hospital tried, unsuccessfully, to transfer Baby K to another hospital.¹²⁵ Eventually, the hospital was able to stabilize Baby K and sent her to a nursing home.¹²⁶ Following her transfer to the nursing home, Baby K required periodic readmission to the hospital due to breathing abnormalities that were caused by her anencephaly.¹²⁷ Following the second readmission, the hospital sought declaratory relief stating that it would not be obligated to treat Baby K in the future.¹²⁸

116. See *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996).

117. *Id.*

118. *Id.*; see also, e.g., *In re Baby K*, 16 F.3d 590, 593 (4th Cir. 1994) (stating that the purpose of the statute was to prevent hospitals from “dumping” patients); *Preston v. Meriter Hosp., Inc.*, 700 N.W.2d 158, 176 (Wis. 2005) (stating that the federal statute was not meant to create federal medical malpractice liability).

119. See, e.g., *Baby K*, 16 F.3d at 592.

120. For a good analysis of the provisions of EMTALA, see generally Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145 (2004); Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator’s Guide*, 27 ST. MARY’S L.J. 463 (1996).

121. *Baby K*, 16 F.3d at 592, 598.

122. *Id.* at 592.

123. *Id.*

124. *Id.* at 593.

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.*

The court found that the “plain language” of EMTALA required the hospital to treat, at its expense, anencephalic patients like Baby K whenever presented to the hospital in distress, stating that Congress rejected a case-by-case approach to determining when emergency treatment would be required.¹²⁹ In the court’s words: “EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients.”¹³⁰

Baby K has been excessively criticized.¹³¹ The specific critiques are beyond the scope of this Article, but I will discuss one of them here because it is particularly instructive. Professor George Annas critiqued the trial court for drawing comparisons between the baby girl suffering from anencephaly and other terminal patients who were in need of emergency care for unrelated injuries (such as an AIDS patient in a car accident), stating that the comparison “was chillingly wrong.”¹³² He argued, as did the dissent in *Baby K*,¹³³ that Baby K’s illness for which her family wanted attention was not respiratory failure but anencephaly, a condition for which there is no cure or medically cognizable treatment.¹³⁴ He wrote: “It is because of her anencephaly itself that Baby K *cannot benefit* from any medical intervention.”¹³⁵ While Annas is certainly correct that the comparison between Baby K and any comatose patient is overly simplistic, he made a logical error that plagues discourse in medical futility. There is a very big difference between stating that medical intervention cannot cure a child with anencephaly and stating that such a child can experience no *benefit* as a result of that treatment. The nature of that distinction will be a topic of discussion in Part IV of this Article.

The Fourth Circuit returned to EMTALA in 1996 with *Bryan v. Rectors & Visitors of the University of Virginia*.¹³⁶ However, *Bryan* was different from *Baby K* as it involved a suit for damages in which

129. *Id.* at 598–99. I am unaware whether the hospital objected to treating Baby K generally (regardless of who was paying) or merely to treating Baby K at the hospital’s expense (as charity care). In this case, the question was merely academic because EMTALA, if applicable, would have required the hospital to initially bear the expenses. 42 U.S.C. § 1395dd(b) (2006) (setting forth the hospital’s obligation to stabilize the patient with its staff and equipment).

130. *Baby K*, 16 F.3d at 598. The court quoted the relevant portion of EMTALA, which states that when a patient presents an emergency medical condition, the hospital staff must either stabilize that patient or transfer her to another hospital, provided that certain criteria are met. *Id.* at 594 (citing 42 U.S.C. § 1395dd(b)(1)).

131. *See, e.g., Moore, supra* note 30, at 446.

132. George J. Annas, *Asking the Courts to set the Standard of Emergency Care—The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1543 (1994).

133. *Baby K*, 16 F.3d at 592, 598–99 (Sprouse, J., dissenting).

134. Annas, *supra* note 132, at 1543.

135. *Id.* (emphasis added).

136. 95 F.3d 349 (4th Cir. 1996).

the patient had already died.¹³⁷ The court in *Bryan* found for the defendants, dismissing the complaint for failure to state a claim under the *Federal Rules of Civil Procedure*.¹³⁸ In *Bryan*, the patient, Mrs. Robertson, was transferred to defendant hospital in respiratory distress.¹³⁹ Her husband asked the hospital to “take all necessary measures to keep [his wife] alive and trust in G[-]d’s¹⁴⁰ wisdom.”¹⁴¹ The hospital attempted to stabilize Mrs. Robertson for twelve days, was unsuccessful, and, on February 17, 1993, issued a DNR order over the objections of Mr. Robertson.¹⁴² Mrs. Robertson died on February 25 from complications that were not treated pursuant to the DNR order.¹⁴³ The court held that EMTALA is not intended to preempt state malpractice laws and that EMTALA does not require a hospital to attempt to stabilize a patient indefinitely.¹⁴⁴ The hospital’s efforts to stabilize Mrs. Robertson for twelve days were sufficient under EMTALA, and accordingly, there could be no recovery for failure to provide indefinite treatment.¹⁴⁵

In 2002, the Ninth Circuit adopted *Bryan* and then held that once a patient is admitted to the hospital he is deemed “stable” for the purposes of EMTALA: “We hold that EMTALA’s stabilization requirement ends when an individual is admitted for inpatient care.”¹⁴⁶ The Ninth Circuit’s reasoning is troubling. It implies that a hospital can discharge its obligations under EMTALA simply by admitting its emergency patients into its general facility. Indeed, the Ninth Circuit seems to over-read *Bryan*, which is a highly fact-bound decision. *Bryan* relies extensively upon the length of time that Mrs. Robertson was in the E.R. and the time and energy that her hospital expended attempting to stabilize her.¹⁴⁷

In 2009, the Sixth Circuit had the opportunity to offer its opinion on EMTALA in *Moses v. Providence Hospital*.¹⁴⁸ In a well-reasoned decision, the Sixth Circuit expressly held that a hospital does *not* satisfy its obligations simply by admitting a patient and treating him for six days.¹⁴⁹ In the court’s words:

137. *Id.* at 350.

138. *Id.* (citing FED. R. CIV. P. 12(b)(6)).

139. *Id.*

140. The name of G-d is hyphenated throughout this Article. I have done this to comply with provisions of Jewish law.

141. *Bryan*, 95 F.3d at 350 (footnote added).

142. *Id.*

143. *Id.*

144. *Id.* at 351.

145. *Id.* at 351, 53; see also *Causey v. St. Francis Med. Ctr.*, 719 So.2d 1072, 1075 n.2 (La. Ct. App. 1998) (approving of the decision in *Bryan*).

146. *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1168 (9th Cir. 2002).

147. *Bryan*, 95 F.3d at 350–52.

148. 561 F.3d 573 (6th Cir. 2009), *cert. denied*, 130 S.Ct. 3499 (2010).

149. *Id.* at 582.

The statute requires “such treatment as may be required to stabilize the medical condition,” and forbids the patient’s release unless his condition has “been stabilized.” A patient with an emergency medical condition is “stabilized” when “no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during” the patient’s release from the hospital. Thus, EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient’s release, no further deterioration of the condition is likely.¹⁵⁰

Moses is not a futility case as the patient was a psychiatric patient who ultimately committed murder after being released prior to stabilization.¹⁵¹ However, its holding may finally open the door for consistency in the law by providing a basis for a damages award in future futility cases.¹⁵²

D. Futile Care for Infant Patients

Shemika A. Burks arrived at a Wisconsin hospital in 1999 pregnant just twenty-two weeks and complaining of cramps and contractions.¹⁵³ One hour after arrival, she gave birth to a baby girl who weighed seven ounces.¹⁵⁴ Less than three hours after delivery, her young helpless daughter died in her arms.¹⁵⁵ The girl was born with a heartbeat and had the ability to breathe but, being extremely premature, needed aggressive medical assistance to survive.¹⁵⁶ The hospital staff refused to treat the baby, despite Ms. Burks’ requests, stating that doing so would not be “appropriate.”¹⁵⁷ A neonatologist at the hospital, Dr. Karlo Raab, wrote in an affidavit filed in conjunction with the trial that “no attempt was made to resuscitate Shemika Burks’ fetus” and that “resuscitation was not medically indicated for [the] fetus and in fact is medically inappropriate” for a child the size of Ms. Burks’ daughter,¹⁵⁸ who was apparently also known as a “fetus.”¹⁵⁹

150. *Id.* (citations omitted).

151. *Id.* at 575–76.

152. For further analysis on EMTALA and the Sixth Circuit’s holding, see *infra* notes 413–15 and accompanying text. At the time of this writing, the Centers for Medicare & Medicaid Services (CMS) is deliberating whether to issue new regulations that would clarify whether, and under what circumstances, EMTALA applies to inpatients. 75 Fed. Reg. 80762, 80765 (Dec. 23, 2010) (to be codified at 42 C.F.R. pt. 489).

153. *Burks v. St. Joseph’s Hosp.*, 596 N.W.2d 391, 392 (Wis. 1999).

154. *Id.*

155. *Id.*

156. *See id.*

157. *Id.*

158. *Id.* (emphasis added).

159. I cannot help but comment on the insensitivity exhibited by Dr. Raab. Even if we accept as a given that Dr. Raab was under no legal or moral obligation to treat a non-viable child, and we accept his conclusion that there was absolutely no way that he could have helped Ms. Burks’ child, that does not give medical professionals a license to write in a manner likely to aggravate the grief of family members

Ms. Burks filed a complaint, alleging negligent medical practice, negligent infliction of emotional distress, and a violation of EMTALA.¹⁶⁰ The parties agreed to a partial settlement and a dismissal of the first two causes of action.¹⁶¹ Litigation proceeded on the question of whether a state fund was obligated to pay part of the damages,¹⁶² apparently presuming the applicability and possible violation of EMTALA. The Supreme Court of Wisconsin ruled that its state fund¹⁶³ is obligated to pay damages for an EMTALA violation when the underlying harm was based on a “medical decision” not to provide treatment.¹⁶⁴ It held that failure to treat in this case was a “medical decision” and subject to disbursement out of the state fund.¹⁶⁵

The Supreme Court of Wisconsin had the opportunity to revisit the applicability of EMTALA to premature infants in *Preston v. Meriter Hospital*.¹⁶⁶ Shannon Preston arrived at the hospital in her twenty-fourth week of pregnancy.¹⁶⁷ The following morning she gave birth to a boy who weighed just 700 grams.¹⁶⁸ According to Preston’s com-

in a document that they are likely to see. Perhaps “fetus” is the technically correct word under prevailing convention within the medical community. But I am not sure why that should matter. Referring to a live child as a “fetus” is a rhetorical maneuver that presupposes the answers to important questions about life and its function. As I argue later in Part IV, the medical community has no institutional competence with which to answer these important questions and ought to adopt a rhetoric that reflects its intellectual limits. And Dr. Raab personally should be held responsible for not refraining from the use of convention (assuming that, in fact, “fetus” is the appropriate term under prevailing convention) knowing that his language would be likely to exacerbate the grief of a mourning parent.

160. *Burks*, 596 NW.2d at 392–93.

161. *Id.* at 393.

162. *Id.*

163. Wisconsin’s “Patient Compensation Fund” (the name of the fund at the time of the *Burks* litigation) is now the “Injured Patients and Families Compensation Fund.” See Office of the Commissioner of Insurance, Injured Patients and Families Compensation Fund, <http://oci.wi.gov/pcf.htm> (Mar. 15, 2011). It was created by statute in 1975 “to provide excess medical malpractice coverage for Wisconsin health care providers.” *Id.*; see WIS. STAT. § 655.001–655.019 (2009–10). Most health care providers are obligated by statute to obtain primary medical malpractice insurance from private insurance companies. WISCONSIN LEGISLATIVE FISCAL BUREAU, INJURED PATIENTS AND FAMILIES COMPENSATION FUND 1 (2011), available at http://legis.wisconsin.gov/lfb/Informationalpapers/86_Injured%20Patients%20and%20Families%20Compensation%20Fund.pdf. The Fund covers malpractice liability in excess of that amount. *Id.* WISCONSIN LEGISLATIVE FISCAL BUREAU, INJURED PATIENTS AND FAMILIES COMPENSATION FUND 1 (2011), available at http://legis.wisconsin.gov/lfb/Informationalpapers/86_Injured%20Patients%20and%20Families%20Compensation%20Fund.pdf.

164. *Burks*, 596 N.W.2d at 402.

165. *Id.* at 401–02.

166. *Preston v. Meriter Hosp., Inc.*, 2005 WI 122, 284 Wis.2d 264, 700 N.W.2d 158.

167. *Id.* at ¶ 6.

168. *Id.* at ¶ 7.

plaint, the hospital was aware of the birth of the child and that he urgently needed medical care but “failed, refused, and neglected to provide any care whatsoever to the newborn infant.”¹⁶⁹ The complaint alleged further that the hospital knew that without aggressive medical intervention, “the infant child had virtually no medical chance to survive, but nevertheless intentionally withheld all treatment for the infant child who therefore died after two and one half hours of life.”¹⁷⁰ Preston sued for medical negligence, failure to obtain informed consent, a state law claim for neglect of a patient, and violation of EMTALA.¹⁷¹ The trial court dismissed all four claims on summary judgment for procedural reasons.¹⁷² However, the EMTALA claim went through a series of appeals, the most recent, and apparently the final, installation of which was decided in January 2008,¹⁷³ over eight years after the child’s death in November 1999.

The Supreme Court of Wisconsin found that EMTALA, which pertains to emergency patients, was applicable despite that the baby was never taken to the emergency room.¹⁷⁴ The court noted that EMTALA refers to a patient coming to an “emergency department”¹⁷⁵ and “a hospital’s emergency department encompasses its birthing center” as is compelled by both the legislative history of EMTALA and the statute’s implementing regulations.¹⁷⁶

On remand, the Court of Appeals of Wisconsin (an intermediate appellate court) examined the legislative history of EMTALA and the statute’s implementing regulations further and ruled that EMTALA applies only to new patients presented to the hospital in distress, not to inpatients.¹⁷⁷ The court found that Mrs. Preston’s newborn baby

169. *Id.* at ¶ 8.

170. *Id.*

171. *Id.* at ¶ 9.

172. *Id.*

173. *Preston v. Meriter Hosp., Inc.*, 2008 WI App 25, 307 Wis.2d 704, 747 N.W.2d 173, *cert. denied*, 2008 WI 40, 308 Wis.2d 611, 749 N.W.2d 662.

174. *Preston*, 284 Wis.2d 264, ¶ 38, 700 N.W.2d 158, 170.

175. EMTALA reads: “[I]f any individual . . . comes to the *emergency department* and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s *emergency department*.” 42 U.S.C. § 1395dd(a) (2006) (emphasis added).

176. *Preston*, 284 Wis.2d 264, ¶ 25, 700 N.W.2d 158, 167 (“Indeed, it is a ridiculous distinction, one which places form over substance, to state that the care a patient receives depends on the door through which the patient walks.” (citing *McIntyre v. Schick*, 795 F. Supp. 777, 781 (E.D. Va. 1992))).

177. *Preston*, 307 Wis.2d 704, ¶ 54, 747 N.W.2d 173, 187. In truth, the question of whether EMTALA covers inpatients is not as simple as Wisconsin’s courts implied. Prior to a 2003 regulation, a split between the federal circuits arose regarding this question. See, e.g., *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1167 (9th Cir. 2002) (EMTALA does not apply to inpatients); *Thornton v. Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990) (EMTALA does, in some circum-

was an inpatient and thus excluded him from protection under EMTALA.¹⁷⁸ “[T]o conclude that [the child] was not an inpatient at the hospital under EMTALA even though his laboring mother was, would defy common sense.”¹⁷⁹ Moreover, the court ruled that the question of whether a mother and her newborn child are inpatients is a question of law, not fact.¹⁸⁰ Stated succinctly, “when a hospital provides inpatient care to a woman that involves treating her fetus simultaneously, the unborn child is a second inpatient, admitted at the same time as the mother.”¹⁸¹ As a result, the Court of Appeals rejected Shannon Preston’s claim for damages under EMTALA.¹⁸² The Supreme Court of Wisconsin declined to review this important decision.¹⁸³

The persuasive authority of *Preston* remains unclear following a 2002 amendment to EMTALA known as the Born Alive Infant Protection Act (BAIPA)¹⁸⁴ and regulations issued in 2003.¹⁸⁵ The principle facts of *Preston* occurred in 1999 and so the Wisconsin courts did not consider the 2002 and 2003 legal changes.¹⁸⁶ Under the new rules, a “born alive” infant is deemed an “individual” and, presumably, must be assessed separately from the infant’s mother.¹⁸⁷ If so, it should follow that an unborn fetus cannot be an inpatient but rather must be admitted to the hospital at birth.¹⁸⁸ Indeed, CMS concluded in a guidance statement issued on the interaction between EMTALA and BAIPA that where a labor and delivery ward qualifies as a “dedicated emergency department” (defined by the 2003 regulations), a child born alive in that ward may be covered by EMTALA.¹⁸⁹ Assuming that to

stances, apply to inpatients). The 2003 regulations and the Supreme Court’s denial of certiorari in a 2008 case seem to have resolved that split consistent with Wisconsin’s ruling. Thaddeus M. Pope, *EMTALA: Its Application to Newborn Infants*, 4 ABA HEALTH eSOURCE, Mar. 2008, available at <http://ssrn.com/abstract=1121373> (last visited Aug. 29, 2008) (citing 42 C.F.R. § 489.24(d)(2); *Morgan v. N. Miss. Med. Ctr.*, 552 U.S. 1098 (2008) (denying certiorari)). For more on these developments, see *id.*

178. *Preston*, 307 Wis.2d 704, ¶ 57, 747 N.W.2d 173.

179. *Id.* at ¶ 55.

180. *Id.* at ¶ 56–57.

181. *Id.* at ¶ 57.

182. *Id.* at ¶ 1.

183. *Preston v. Meriter Hosp., Inc.*, 2008 WI 40, 308 Wis.2d 611, 749 N.W.2d 662.

184. Pub. L. No. 107-207, 116 Stat. 926 (2002) (codified at 1 U.S.C. § 8 (2006)).

185. 42 C.F.R. § 489.24(d)(2)(i) (2010) (stating that EMTALA does not apply to patients admitted in good faith as inpatients).

186. See *Preston*, 307 Wis.2d 704, 747 N.W.2d 173.

187. See 1 U.S.C. § 8 (2006); see also 42 C.F.R. § 489.24(d)(2)(i) (2010) (stating that the exemption applicable to inpatients applies to those “individual[s]” who had been previously screened).

188. Pope, *supra* note 177.

189. Memorandum from Director, Survey and Certification Grp., Ctrs. for Medicare & Medicaid Servs., to State Survey Agency Directors 5 (Apr. 22, 2005), available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-26.pdf>.

be true, EMTALA appears to categorically require covered medical providers to treat newborn infants that present an emergent condition, regardless of where the infant is born or the legal status of the mother. To my knowledge, the courts have yet to address this question.¹⁹⁰

Another case originating in the late 1990s yielded very different results from those in *Preston*. Ryan Nguyen was born in a Washington State hospital with kidney, lung, and intestinal problems and possible brain damage.¹⁹¹ His doctors decided that aggressive treatment was futile and opted to discontinue vital kidney dialysis.¹⁹² They removed Ryan from the dialysis machine; he remained in that state for eleven long days until Ryan's parents were able to compel dialysis with a court order.¹⁹³ Eventually, the Nguyens located a doctor in Portland who would accept care of Ryan, perform the necessary surgery, and slowly wean Ryan off dialysis.¹⁹⁴ Ryan went home to his family just four months after his transfer to Portland.¹⁹⁵ Although he had to return to the hospital with high fevers and infections on several occasions thereafter, he was apparently able to lead a relatively normal life for the next four years.¹⁹⁶ In 1999, after four and one half years of life, Ryan finally succumbed to his condition.¹⁹⁷ The decision by Ryan's parents to continue care and eventually bring Ryan home was arguably a tremendous success.¹⁹⁸ Ryan had the opportunity to learn from his parents and develop over the next four years while his parents got the pleasure of teaching their son and building a relationship with him. After Ryan's death, his father remained "baffled" that he had to work so hard to keep his son alive and be his father for those four years.¹⁹⁹ Further, he continues to blame Ryan's first doctors for hastening Ryan's death by neglecting him those eleven days very early in his life.²⁰⁰

190. As indicated, *infra* note 152, CMS may issue additional regulations on this topic, which would likely provide helpful clarification on the applicability of EMTALA to newborn infants.

191. *Nguyen v. Sacred Heart Med. Ctr.*, 987 P.2d 634, 635 (Wash. Ct. App. 1999).

192. *Id.*

193. *Id.*

194. Carol M. Ostrom, *Baby Ryan's Legacy—A Debate over Life*, SEATTLE TIMES, Apr. 27, 1999, at A1.

195. *Id.*

196. *Id.*

197. *Id.*

198. See *infra* note 426 and accompanying text. *Contra* Ostrom, *supra* note 194.

199. Ostrom, *supra* note 194.

200. *Id.*

E. The Texas Advance Directives Act (TADA),²⁰¹ a Robust Statutory Solution?

In September 1999, Texas became the first²⁰² state to adopt a statutory framework for a formalized and well-defined review process pertaining to medical futility.²⁰³ Texas's success in transforming the legal landscape is questionable.²⁰⁴ A survey conducted in 2004 of the 409 hospital members of the Texas Hospital Association revealed that just 30% of responding hospitals (approximately 48% of the hospitals surveyed returned responses)²⁰⁵ utilized the statute in an actual case and that 19% of respondents were unaware that the statute even existed.²⁰⁶

Under TADA, when a physician refuses to honor an advance directive or other request for medical treatment from a patient desiring aggressive medical care, the physician must inform the patient (or the patient's surrogate) of his desire not to provide said aggressive care.²⁰⁷ After the patient or surrogate receives at least forty-eight hours notice, an ethics committee holds a hearing to review the physician's decision and, following the hearing, provides the patient or surrogate with a written explanation of the committee's findings.²⁰⁸ If the committee agrees with the physician, aggressive care will continue for another ten days (courts also have the authority to grant an extension under certain circumstances) during which time the patient or surrogate, with the help of the physician and hospital, will have to find another physician to render care.²⁰⁹ If, after the ten days (or the extended period), no willing physician was found, the attending physician may cease aggressive medical treatment²¹⁰ and is shielded from liability.²¹¹ If, however, the parties were able to locate a willing phy-

201. TEX. HEALTH & SAFETY CODE ANN. § 166.001–166.166 (West 2010).

202. For a look at some other state statutes, see *supra* notes 36, 37, 39.

203. See Martin L. Smith et al., *Texas Hospitals' Experience with the Texas Advance Directives Act*, 35 CRITICAL CARE MED. 1271 (2007).

204. The purpose of this section is to address the efficacy of TADA as a response to the problem of medical futility. Accordingly, I have made no attempt to analyze the statute on legal grounds or explore the case law generated by TADA. It is noteworthy that the constitutionality of this statute has been questioned on the grounds that its safe harbor provision violates the dictates of procedural due process. See generally, e.g., Nora O'Callaghan, *Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act*, 60 BAYLOR L. REV. 527 (2008).

205. Smith et al., *supra* note 203, at 1272.

206. *Id.* at 1271–72.

207. TEX. HEALTH & SAFETY CODE ANN. §§ 166.046, 166.052(a) (West 2010).

208. *Id.*

209. *Id.*

210. *Id.*

211. *Id.* § 166.045(d); Sadath A. Sayeed, *The Marginally Viable Newborn: Legal Challenges, Conceptual Inadequacies, and Reasonableness*, 34 J.L. MED. & ETHICS 600, 604 (2006).

sician, the hospital will arrange to transfer the patient at the patient’s expense.²¹²

From 1999 to 2004, hospitals reported 178 TADA cases in which the reviewing committee agreed with the attending physician’s decision to withhold treatment.²¹³ Of those, the status of eight patients (less than 5%) improved sufficiently to warrant a reversal of the physician’s recommendation prior to the conclusion of the ten-day waiting period.²¹⁴ Astonishingly, those eight cases were concentrated in just three hospitals,²¹⁵ suggesting that the review processes in these hospitals were inadequate. In all three hospitals, the review committee, so designated under TADA, was simply the hospital’s general ethics committee and was not necessarily counseled by competent medical personnel.²¹⁶ TADA does not specify who must sit on the review committee and, as a result, a great deal of disparity exists among the surveyed hospitals.²¹⁷ For example, physicians were not represented in 3% of committees, ethicists were present on just 45%, lawyers on 42%, clergy on approximately 16%, social workers on approximately 13%, and people identified as “patient advocate[s]” on less than 1%.²¹⁸

The survey reported 187²¹⁹ cases in which the reviewing committee agreed with the attending physician and resolution was achieved before the ten-day statutory period expired.²²⁰ In 78 cases, the patient died within those ten days.²²¹ Of the remaining 109 cases, 65% of patients or surrogates who had previously opposed the physician’s determination agreed to discontinue treatment, 28% transferred to another healthcare facility, and the health of 7% improved.²²² These numbers are significant for at least two reasons. First, they establish that, for at least a significant minority of patients who desire to do so, transfer to another hospital is a real option. Some commentators previously hypothesized that “[w]hen both the treatment team and the ethics committee come to the conclusion that further treatment is futile, it is extraordinarily unlikely that another facility will accept the

212. TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (West 2010).

213. Smith et al., *supra* note 203, at 1274–75.

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.* at 1272.

218. *Id.*

219. For an acknowledgement and possible resolution of the apparent incongruity between the statement that there were 178 *total* cases, see Smith, et al., *supra* note 203, at 1274–75 and *supra* note 213 with its accompanying text, and the present statement that there were 187 cases which were resolved during the ten day period, see Smith, et al., *supra* note 203, at 1273 (discussing how respondents may have viewed listed outcomes as overlapping rather than mutually exclusive).

220. Smith et al., *supra* note 203 at 1274–75.

221. *Id.* at 1274 fig.1.

222. *Id.* at 1273, 1274 fig.1.

patient.”²²³ This empirical study suggests that those commentators were wrong; patients for whom treatment was deemed futile are often able to find a physician who is willing to provide the treatment they desire.²²⁴

Second, these data reveal that a significant number of patients or surrogates who previously opposed their physicians so adamantly that they forced their hospital through a complicated administrative procedure simply changed their minds in response to the reviewing committee’s decision. This either suggests that the TADA is effective in communicating to patients or surrogates just how futile further treatment would be, enabling them to come to terms with reality, or that the fear of being unilaterally terminated after ten days is sufficiently intimidating and coercive to make patients or surrogates submit to the requests of physicians and agree to terminate treatment over their own moral, religious, ethical, emotional, irrational, or other personal objections.²²⁵

IV. ON INSTITUTIONAL COMPETENCE, BIAS, AND MATERIALIST PHILOSOPHY

In the fall of 1995, Sonya Causey suffered complications during childbirth, which left her a quadriplegic.²²⁶ Following transfer to a nursing home where she developed respiratory distress in October 1996, she was transferred back to the Louisiana hospital where her child was born—but this time she was in a coma.²²⁷ Her doctor said that with dialysis and a ventilator she had a 1–5% chance of regaining consciousness and, with treatment, was likely to survive another two

223. Robert L. Fine & Thomas W. Mayo, *Letter to the Editor: The Rise and Fall of the Futility Movement*, 343 *NEW ENG. J. MED.* 1575, 1576 (2000); see also Daar, *supra* note 50, at 1270 (referring to patients who cannot come to terms with their physicians as “ethical hot potatoes” and stating that for these patients “transfer becomes a near impossibility”).

224. A reviewer of an earlier version of this Article inquired how the patients who successfully transferred fared following their transfer. I do not know the survival rate although presume it to be at or close to 0%. The success of the treatment is not the point. Rather, I merely try to show that the patients got what they wanted: a chance.

225. See Fine & Mayo, *supra* note 223, at 1576 (stating that TADA helps “persuade the family of the appropriateness” of palliative care). This persuasion is not always benign. “Indeed, Dr. [David A.] Asch added, most of the time doctors call the shots. ‘When you get patients to agree, there’s so much subtle or not so subtle coercion’ he said.” Kolata, *supra* note 32. One physician rather candidly lamented that TADA “relies on a due-process approach that is more illusory than real and that risks becoming a rubber-stamp mechanism for systematically overriding families’ requests that seem unreasonable.” Robert D. Truog, *Tracking Medical Futility in Texas*, 357 *NEW ENG. J. MED.* 1, 3 (2007).

226. Causey v. St. Francis Med. Ctr., 30732-CA, p. 2 (La. App. 2 Cir. 8/26/98), 719 So.2d 1072, 1073 n.1 (La. App. 1998).

227. *Id.*

years in a coma.²²⁸ He concluded that further treatment was of “no benefit” and recommended withdrawing her from aggressive medical care.²²⁹ Causey’s family objected and her doctor tried, unsuccessfully, to transfer her to another medical facility.²³⁰ After consulting with the hospital’s Morals and Ethics Board, Mrs. Causey’s physician removed her feeding tube and ventilator.²³¹ She died the same day after just thirty-one years of life.²³² Mrs. Causey’s family sued for damages and the trial court found for the defendants, stating that they “acted in accordance with professional opinions and professional judgment.”²³³

As part of its analysis of the case, the appellate court contrasted situations in which a patient requests treatment that is harmful or literally has no effect and treatment that does have an effect but which can confer no “benefit” to the patient.²³⁴ An extreme example of the first type might involve performing a heart transplant for a patient with no cardiovascular problems and complaining of a headache. Such a medical decision would have no *effect* on the patient’s condition, barring potential complications associated with surgery.²³⁵ It is precisely because of the absence of possible effect that no reasonable surgeon would consider performing such an operation. In contrast, many of the treatment plans labeled “futile,” including the medical treatment requested by Mrs. Causey, present a reasonable—even if unlikely—possibility of affecting the patient by extending her life. As reported above, the treatment proposed for Mrs. Causey was likely to grant her an additional two years.²³⁶ By declaring such treatment “futile,” Mrs. Causey’s physician rendered an opinion that is couched not in the doctrines of medical science but rather in those of his personal moral code. He *believed* that this treatment, which was likely to have an effect, offered her no “benefit,” and ought not to be provided.²³⁷

Any assessment rendered by any person of the benefits of medical care likely to affect the dying process (perhaps by delaying the moment of death) will necessarily be “grounded in beliefs and values about which people disagree. Strictly speaking, if a physician can keep the patient alive, such care is not medically or physiologically

228. *Id.* at p. 1, 719 So.2d at 1073.

229. *Id.*

230. *Id.*

231. *Id.* at p. 2, 719 So.2d at 1074.

232. *Id.* at p. 2, 719 So.2d at 1073–74.

233. *Id.* at p. 1, 719 So.2d at 1073.

234. *Id.* at p. 3, 719 So.2d at 1074.

235. *Id.*

236. *See id.* at p. 1, 719 So.2d at 1073.

237. *Id.* at p. 2, 719 So.2d at 1073–74.

'futile.'²³⁸ The *Causey* Court observed that "[f]utility is a subjective and nebulous concept which . . . incorporates value judgments. Obviously, in this case, subjective personal values of the benefit of prolonging life with only a slight possibility of improvement dictated" the decisions of Mrs. Causey's physician and hospital.²³⁹ Despite these insightful observations, the *Causey* Court found for the defendants, stating that the decision by Mrs. Causey's physician and hospital to withdraw treatment constituted a "medical procedure" consistent with prevailing standards of care and was therefore not negligent.²⁴⁰

Causey was not the first court to recognize that courts cannot judge the value of human life in a quantitative or scientific manner. In its seminal *Saikewicz* decision, the Supreme Judicial Court of Massachusetts questioned whether it was appropriate to put a severely mentally retarded patient through a painful medical procedure in order to extend his life.²⁴¹ The court considered Mr. Saikewicz's likely quality of life following the suggested procedure and wrote, without elaboration: "To the extent that this [analysis] equates the value of life with any measure of the quality of life, we firmly reject it."²⁴² This Part will show that the medical futility movement has adopted the position expressly and "firmly" rejected in *Saikewicz*.

The first section will consider the various presumptions that underlie futility assessments. The second section will take a closer look at bias within the medical community and will argue that it is quite poorly equipped to assess requests for medical treatment that have no justification within the field of its expertise. Science is well equipped to discover and describe the physical world, not to answer philosophical, metaphysical, normative, or moral questions.²⁴³ When a patient appeals to a discipline outside the expertise of the medical community, that community ought to have no opinion and any opinion that it expresses ought to be suspect due to underlying bias. Section three will explore further the tension between theological philosophy and the

238. *Id.* at p. 3, So.2d at 1074.

239. *Id.* at p. 4, So.2d at 1075.

240. *Id.* at p. 7, So.2d at 1076. The relevant standard was negligence because the plaintiff premised her suit on the tort theory of negligence. Had the plaintiff asserted a different theory (assuming necessary alterations of the relevant facts), such as a violation of EMTALA, or perhaps intentional or negligent infliction of emotional distress, *see supra* sections III.B–D, the court could not have relied solely on compliance with a customary standard of care and may have reached a different result.

241. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 423–24 (Mass. 1977).

242. *Id.* at 432.

243. For example, science describes the mechanism by which the addition of pure sodium to water results in a violent exothermic (explosive) reaction. However, it is beyond the capacity of that discipline to speculate why the combination of sodium and water *ought* to be highly explosive.

materialist philosophy that has been largely adopted by the medical community.

A. The False Presumption of “Futility”

Doctors and hospitals making decisions in the name of medical futility have confused what should not be done with what cannot be done.²⁴⁴ They have concluded that further treatment *should* not be offered to the patient in question and thus proceed on the notion that they are *unable* to provide that treatment. This is a problem because any discussion of what should or should not be done on behalf of a terminal patient involves a moral judgment on the nature, function, value, and purpose of human life.²⁴⁵ “[S]tating that a medical intervention is futile only begs the question: why? There can only be agreement on so-called qualitative futility if all parties at the decision-making table share the same assumptions about what gives life value in the first place.”²⁴⁶ The physician approaches the question with his life experience and moral code and then renders a decision based upon those non-medical considerations that greatly handicaps the patient’s autonomy and may be contrary to the teachings generated by the patient’s life experience and moral code.

Medical ethicists Robert M. Veatch and Carol Mason Spicer identified this problem. They concluded that a clinician is not able to describe requested medical care as “futile” relying exclusively on his medical expertise.²⁴⁷ They argue that declaring treatment “futile” is meaningless as a matter of medical science.²⁴⁸ This is true, in part, because it is virtually impossible for a clinician to conclude that a given medical treatment will have absolutely *no* physiological effect.²⁴⁹ Rather, clinicians who declare “futility” often base their decisions in statistics.²⁵⁰ Perhaps a given clinician declaring “futility” is expressing his opinion that the requested care has less than a one in one-hundred (or one in one-million) chance of achieving the desired effect.²⁵¹ But because the initial threshold question (what probability of success is too little?) does not lend itself to absolute answers and cannot be resolved scientifically, it is a normative judgment.²⁵² Whether to draw the proverbial line at one in one-hundred, one in one-million, or any other figure is to be determined by an appeal to some

244. See Sayeed, *supra* note 211, at 604.

245. See *supra* notes 133–34 and accompanying text.

246. Sayeed, *supra* note 211, at 604.

247. Robert M. Veatch & Carol Mason Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 16–17 (1992).

248. *Id.*

249. *Id.* at 17–18.

250. See *id.* at 18–19.

251. See *id.*

252. See *id.*

external source, belief, or moral code. Accordingly, the “futility” assessment necessarily rests on a normative–non-scientific–judgment rendered by the physician *ad hoc*, without peer review or input from the patient.

Additionally, the value judgments that often underlie futility assessments suffer from an hermeneutic problem. Those who are more inclined to value life for its own sake might set the requisite probability many orders of magnitude higher than those who take a more utilitarian approach to assigning value to human life. Many patients facing death might find a one in one-hundred chance of recovery to be extremely encouraging and would be inclined to demand treatment. Many physicians are likely to consider a one in one-hundred chance not worth pursuing and thereby declare treatment to be “futile.” Under such circumstances, the patient and physician do not speak the same language. For example, a given patient might be encouraged even by a one in one-*million* chance but, when hearing her doctor declare that treatment is “futile” (which she assumes to mean that there is *no* chance of success), she will abandon hope.²⁵³ This failure to communicate does not merely obstruct efficient communication, it coerces patients into ill-informed decisions.

Perhaps one way to address both problems is by mandating complete disclosure. Rather than declaring a given treatment to be “futile,” physicians would be required to make an assessment on probability of recovery and present that figure to the patient or surrogate. While this would, in my view, represent an improvement in the state of the law, it will not be satisfying for any party given the other significant problems described in this Part.

Even when all parties are communicating effectively and efficiently, a physician’s declaration of “futility” may have little meaning for patients and legal decision-makers. Frequently, a “futility” declaration does not mean that the treatment will not achieve the desired effect, but rather that the desired effect itself is either of no “benefit” or does not justify the financial costs likely to be imposed on the medical provider. There may be a very high probability of a particular treatment generating a physiological effect, but the benefit of “pro-

253. Claims that physicians acting in this capacity avoid instilling “false hope” in the family of a terminal patient and are thus helping the patient and her family prepare for the inevitable are of no moment. The value of a one in one-million chance of living another year is dependent upon determining the value of life for that year. If the value of a year of life is exceptionally high, the value of a one in one-million chance of living another year is also high and may be higher than the costs associated with effectuating that chance. Accordingly, the argument that a one in one-million chance of another year of life is a false hope and, as a result, physicians should avoid apprising their patients of the existence of that chance simply places physicians in charge of valuing the lives of their patients—a task that they are poorly suited to perform.

longing death”²⁵⁴ is deemed low-value or may result in the diversion of resources from other, more “deserving,” patients.²⁵⁵ The clinician declaring “futility” in this context is making a value judgment, weighing the value of an extended life to his patient against the costs to that patient, society, or others. He is certainly entitled to his opinion, but he has no normative authority to impose his position on his patient.²⁵⁶

The physician who declares a patient’s goals to be futile inflicts an injury not just against the patient but also against the medical community itself and against society at large. By rendering a value judgment in the name of medicine (suggesting that some neutral principle yields the physician’s “futility” conclusions), the physician teaches society that the medical community’s medical determinations need not always be taken seriously. Some medical declarations are well-founded in science. Others are policy judgments disguised as scientific conclusions. But the physician makes no differentiation between them. The observer is left to decide whether a given medical declaration is based on science, theology, ethics, or some other discipline. The public is thus taught to mistrust the medical community. It would be far more appropriate for a physician rendering a “futility” declaration to declare the requested treatment “‘religiously inappropriate,’ ‘morally inappropriate,’ or even ‘socially inappropriate’”²⁵⁷ as doing so would properly couch his opinion outside his field of expertise and alert the patient and others that the physician’s opinion is a personal judgment.

Some futility plans make value judgments more explicitly, as if they are aware of the non-physiological implications of their decisions. A good example is the policy adopted by the UCLA Medical Center in 1993. The policy states initially that “some patients or surrogates will not be offered treatment that they might want.”²⁵⁸ Up to that point, the policy is no different from any other, but then the policy discusses specific medical conditions. Regarding a patient who is in a persistent vegetative state, the policy declares: “[N]o further medical treatment need be offered because it could not be currently (or in the future) *meaningful* to the patient.”²⁵⁹ Here again, the hospital is rendering a non-medical decision. The hospital would be fully justified in declaring that further treatment will not help the patient recover, but

254. This phrase is borrowed from the proponents of withdrawing aggressive medical treatment from futility patients. Their decision to use the words “prolonging death” is itself indicative of a value judgment, strongly suggesting that the patient is already conceptually dead.

255. See *infra* section IV.C.

256. For further elaboration on this point, see *infra* section IV.B.

257. See Veatch & Spicer *supra* note 247, at 21.

258. Daar, *supra* note 50, at 235.

259. *Id.* (emphasis added) (quoting UCLA Medical Center Life Sustaining Treatment Policy, Policy No. 0027, at 2 (May 1, 1993)) (internal quotation marks omitted).

it cannot declare that further treatment will or will not be “meaningful” because that statement presumes a great deal that is not known or knowable by science. The medical providers who wrote the policy were obviously unable to access the mental, psychological, and metaphysical processes of a patient in a persistent vegetative state in order to determine how the patient reacts to various forms of treatment on a psychological, emotional, or spiritual level.

Similarly, we cannot fully understand what a human being goes through at the moment of death and no patient is able to credibly communicate that process to us after experiencing it. If the process is emotionally, physically, or spiritually painful, it cannot be said that delaying the process of death is without meaning. And if one believes in an afterlife, the time and circumstance in which a person enters the afterlife hangs in the balance. Certainly, under these assumptions, the decision to continue treatment is full of meaning. In any event, treating a terminal “futile” patient cannot be presumed, without more, to be “meaningless.”

This analysis is not merely semantic. My use of language to drive the discussion is more illustrative than determinative. Indeed, there is no consensus on an appropriate working definition for “futility.”²⁶⁰ Nevertheless, the American Medical Association (AMA) put forward a good composite that seems to capture what the various theories of futility attempt to achieve.²⁶¹ It argued succinctly that all medical intervention that had the primary purpose of simply “prolonging death,” with no other physiological benefit, should be avoided because it confers no benefit.²⁶² The problem with this approach is that no person or group has successfully explained why prolonging death (or extending *life*?) is not beneficial. If, in fact, extending life is an admirable goal, the AMA’s policy is unjustified. Of course, it is very difficult for us to know whether extending life has any independent value. The futility movement deals with this problem by simply assuming it away, refusing to address the question. But until that question—which logically precedes the futility rhetoric—is answered, discussions about “futility” cannot begin.

To be clear, notwithstanding my emphasis on the word “futility” throughout this Article, my analysis is not at all dependent upon whether actors relying upon a doctrine of medical futility actually use the word “futility.” The recent trend is not to use value-laden words like “futile” and “futility.”²⁶³ Indeed, TADA does not contain the

260. See, e.g., Helft et al., *supra* note 28.

261. See Council on Ethical & Judicial Affairs, Am. Med. Ass’n, *Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs*, 281 JAMA 937 (1999) [hereinafter AMA Report].

262. See *id.* at 938. For commentary, see *supra* note 254.

263. See TEX. HEALTH & SAFETY CODE ANN. § 166.001–166.166 (West 2010).

words “futile” or “futility.”²⁶⁴ This is, of course, a rhetorical decision probably motivated by a realization that the word “futile” is unpopular. The use of different words to discuss “futility” is a mere cosmetic change, as my discussion in Part III suggests. The faulty presumptions that underlie “medical futility” are present regardless of whether those making the presumptions ever use the word “futility.” Window dressing, as such, ought not to obfuscate our analysis.

B. Institutional Incompetence and Bias in the Medical Profession

This section, building upon the prior one, will explore further the institutional competence of the medical profession and inquire whether physicians, as a community, have the capacity to answer futility questions.

The institutional competence of the medical profession extends to matters of physiology, psychology, and medicine. That is, after all, the particular expertise of physicians. Education in ethics and philosophy or instruction on the differing worldviews that various patients might bring with them into a doctor-patient relationship is dramatically lacking from medical education. No doubt, the medical community acknowledges the importance that ethics plays in the practice of medicine in the twenty-first century. This is reflected by the fact that the Liaison Committee on Medical Education (LCME), the national crediting authority for M.D. programs, requires medical schools to include bioethics in their curricula.²⁶⁵ But not all schools have a course dedicated to that purpose and on average, medical schools require just 35.6 hours of bioethics instruction, with some schools reporting as few as 9 hours of required instruction.²⁶⁶ Similarly, the Association of American Medical Colleges (AAMC) wrote in 2008 that on average, its 126 affiliated schools provide 19.2 mandatory “sessions” on “medical ethics” (without specifying the number of hours in a session).²⁶⁷ Further, it appears that no medical school requires instruction in philoso-

264. *Id.*

265. See Govind C. Persad et al, *The Current State of Medical School Education in Bioethics, Health Law, and Health Economics*, 36 J.L. MED. & ETHICS 89, 89 (2008).

266. *Id.* at 90. The researchers surveyed all 125 schools affiliated with the Association of American Medical Colleges (AAMC). *Id.* at 90–91. Of those, fifty-nine responded with data that the researchers could use. *Id.* They reported a range in bioethics instruction of 9–125 mandatory hours with a median of just 27.5 hours and a mean of 35.6 hours. *Id.* For schools that did not have a dedicated course in bioethics, the mean falls to just 34.4 hours of bioethics instruction. *Id.*

267. ASS’N OF AM. MED. COLLS., 2008 LCME PART II ANNUAL MEDICAL SCHOOL QUESTIONNAIRE, discussed in E-mail from Barbara Barzansky, LCME Sec’y, Dir. Undergraduate Med. Educ., to Christopher Kortum, Exec. Editor, NEBRASKA LAW REVIEW (Mar. 10, 2011, 09:29 CST) (on file with author).

phy or the worldviews and philosophical positions of their patients.²⁶⁸ And while 83 of the 126 AAMC schools have mandatory instruction on “gay, lesbian, bisexual, and transgender (GLBT) health issues” (without elaboration), none appear to have mandatory instruction in “religious health issues.”²⁶⁹

Thirty-six hours of bioethics instruction does not make physicians experts in medical ethics. It certainly does not make them expert in ethics defined more broadly. Or of philosophy. While their background in medical school is likely to make them sensitive to relevant issues, they have no particular competence through which to opine on the ethical questions that pervade futility cases.

Rather, the expertise of physicians permits them to opine on whether and how a patient might recover. If a competent physician feels that the patient is highly unlikely to experience a physiological recovery, his opinion should be taken seriously and factored into the patient’s ultimate decision. But the physician’s opinion should not be given artificial significance by attaching to it some normative authority not due to the physician as a result of his office.

Further, the medical community’s ethical conclusions frequently do not comport with the moral and ethical positions of the population that the medical community seeks to represent. America is a very diverse country that is home to many religious people.²⁷⁰ Indeed, over 80% of Americans pray at least a few times a month.²⁷¹ While ethics is not, and should not be, a popularity contest, an ethical code imposed upon society must attempt to accurately represent the positions of that society. Yet, many religious thinkers, among others, seem to find that the prevailing ethics surrounding end-of-life medical care is generally not consistent with their theology.²⁷²

Perhaps the reason for the tendency of many members of the medical community to conflate their normative views with their medical expertise lies in a misconception regarding how to define recovery

268. *Id.* While all schools have required instruction in “cultural diversity,” that appears to refer to racial and ethnic diversity rather than to philosophical diversity. See, e.g., Center for the Study of Cultural Diversity in Healthcare, <http://cdh.med.wisc.edu/> (last visited Feb. 21, 2010).

269. *Supra* note 267.

270. Indeed, America is “the most religiously diverse place on earth, and, among developed nations, the most religious.” Charles C. Haynes, *From Battleground to Common Ground: Religion in the Public Square of 21st Century America*, in RELIGION IN AMERICAN PUBLIC LIFE: LIVING WITH OUR DEEPEST DIFFERENCES 97 (Azizah Y. Al-Hibri et al. eds., 2001).

271. PEW FORUM ON RELIGION & PUB. LIFE, U.S. RELIGIOUS LANDSCAPE SURVEY, RELIGIOUS AFFILIATION: DIVERSE AND DYNAMIC 177 (question 41) (2008) [hereinafter PEW SURVEY], available at <http://religions.pewforum.org/pdf/report-religious-landscape-study-full.pdf>; see *infra* notes 281–87 and accompanying text.

272. See, e.g., Wesley J. Smith, *Does Human Life Have Intrinsic Value Merely Because it is Human?*, 13 TRINITY L. REV. 45, 95–101 (2006); *infra* section IV.C.

from illness. Physiological recovery from illness is not necessarily co-extensive with *total* recovery from illness. Total recovery is defined by the patient or by appeal to the patient’s wishes and desires. Many individuals do not judge the value of an outcome exclusively by measuring its physiological benefits. For some, the value of a successful medical procedure may be measured more by the patient’s ability to communicate with family members than by the extent of the patient’s purely physiological recovery.²⁷³ A “futility” assessment should take into account psychological and emotional measures of recovery, to the extent that they are valuable to the patient. But the biases internal to and largely created by the daily practice of medicine may influence the decisions of medical providers in ways that are not consistent with the moral positions of society or with the definition of total recovery as I have advanced it here.²⁷⁴

This point might be characterized as advocating a “goals oriented analysis.” Essentially, success and failure are defined not with respect to some objective standard—i.e., normal physiological function—but some subjective goal set by the patient or surrogate. If the goal is to simply *remain alive*, then any treatment that sustains life is, by definition, a complete success. And if the objective is to help the patient, then the patient’s goals (as expressed by the patient or through her surrogate) are the only goals that are morally relevant in a futility analysis.

Physicians are trained to treat medical conditions with procedures and devices that bring about physiological recovery. Indeed, under normal circumstances, treatment decisions are informed primarily (perhaps exclusively) with the objective of physiological recovery in mind. Generally, the treatment that is most likely to bring about physiological recovery is the one most beneficial to the patient and the one that should be used. As a result of their daily practice and the necessity of their keen expertise in matters of physiology, they are trained (both in school and by virtue of their experience) to approach their patient’s medical needs primarily (perhaps exclusively) as physiological episodes. Given this approach to medicine and the socialization that occurs during medical education and practice, it is not

273. See AMA Report, *supra* note 261, at 938. Perhaps the distinction between “physiological recovery” and non-physiological benefit is a little subtle. The ability to communicate following debilitating illness undoubtedly requires physiological recovery. One cannot speak if a whole slew of physiological systems are not functioning properly. However, the ability to communicate is characterized in large part by processes that are psychological and emotional, not exclusively physiological. The ability to continue to engage in emotional interactions (which need not necessarily involve verbal communication) may be extremely valuable to certain patients, even if those patients never see meaningful physiological recovery.

274. I do not suggest that medical providers who have worked over the past nearly twenty years to develop modern medical futility policies act in bad faith.

surprising that when no treatment option is likely to facilitate physiological recovery, the physician recommends that no treatment be provided. But, in futility cases, the patient's physiological concerns are often not primary. Once the patient (or the surrogate acting in her stead) learns that she has virtually no chance of survival, purely physiological concerns might entirely cease to be relevant. The objective of "prolonging death," as it is so often referred to, is not necessarily a physiological objective but might be an emotional one. Under these circumstances, using modern medical analysis to help advance the patient's interests and assess treatment options is akin to using quantum physics to understand Chaucer. Just as quantum physics is not properly matched with the *Canterbury Tales*, so too the normal presumptions of medical practice will not offer useful guidance in the realm of medical futility. In many futility cases, the patient's emotional, spiritual, or personal need to remain alive justifies particular action that prevailing standards of care might not. The physician who desires to help effectuate his patient's objectives would focus his attention at achieving his patient's emotional or spiritual fulfillment, whatever that might entail.

The absence of institutional competence in the medical profession effects quite a bit more than the simple observation that the socialization of physicians has them trying to meet the wrong goals. It is not simply that *individuals* lack the capacity to answer futility questions but rather that the *institution* does so. The medical community's entire normative (and legal) authority is granted to them as a function of its particular role as providers of medical treatment. The role of a hospital and the physicians who work within it is to treat patients—that is, to bring about a physiological or psychological recovery. Perhaps the physicians and hospital personnel in a particular futility case will be properly qualified (through sufficient training in a wide variety of disciplines) to make relevant decisions regarding non-physiological questions. But that individualized training does not give the physicians and hospital authority to deprive a patient of her autonomy; those actors must derive that authority from the role they play within their social institution.²⁷⁵ In other words, if the profession has no normative authority due to a lack of institutional expertise, individuals cannot assume authority even if they are sufficiently individually expert. The hospital's expertise and social function is in medicine, not ethics. It thus has no institutional authority to decide questions of ethics to the extent that those decisions affect the autonomy of its patients (who, by extension, never consented to the authority of the hospital to decide such questions).

275. If my assertion were not true, then a patient with a superior knowledge of law, medicine, and ethics should have normative authority to overrule virtually *any* decision that the hospital makes that affects her personally.

Moreover, even assuming that physicians are sufficiently expert to make the types of ethical decisions that present themselves in futility cases, there is significant reason to fear that internal biases might prevent them from rendering competent decisions. Discrete social groups, such as the community of physicians, exhibit unique patterns of assessing value that may deviate somewhat from those of the general population.²⁷⁶ Within the medical community in particular, this observation takes on new meaning.

An anonymous 1998 survey by psychologist James H. Leuba asked a group of randomly selected American scientists if they believed in “a G[-]d in intellectual and affective communication with man . . . to whom one may pray in expectation of receiving an answer.”²⁷⁷ Just 40% of all responding scientists stated that they believed in G-d as defined.²⁷⁸ Among the members of the highly prestigious, influential, and quasi-governmental National Academy of Science (NAS), just 10% anonymously responded to Leuba’s question affirmatively.²⁷⁹ Among biologists in the NAS, the number falls to an astounding 5%.²⁸⁰ By contrast, the Pew Forum found in 2008 that 81% of Americans²⁸¹ pray at least a few times a month,²⁸² 80% of whom (65% of all respondents) claim that they have in the past received a definite answer to their prayers.²⁸³ Moreover, 92% of Americans believe in G-d or a “universal spirit,”²⁸⁴ 71% are “absolutely certain” in that belief,²⁸⁵ 39% attend religious services at least once a week (54% at least once a month),²⁸⁶ and 82% define religion as “important” in their lives.²⁸⁷

Leuba’s study can be interpreted in two mutually exclusive ways. One can either conclude that close study of science leads an open mind to the conclusion that religion is false (science yields atheism or agnosticism) or, alternatively, that those who do not believe in G-d tend to achieve greater levels of success as scientists (atheism yields science).

276. Veatch & Spicer, *supra* note 247, at 29.

277. Edward J. Larson & Larry Witham, *Scientists and Religion in America*, SCI. AM., Sept. 1999, at 89. The orchestrator of this study chose to define G-d in this way in an effort to conform the definition with his view of Christian theology. *Id.*

278. *Id.* at 90.

279. *Id.*

280. *Id.*

281. Six percent of respondents were non-citizens. PEW SURVEY, *supra* note 271, at 266 (question 61) (2008). These data include those non-citizens that participated in the survey. *Id.*

282. *Id.* at 242 (question 41).

283. *Id.* at 252 (question 43c).

284. *Id.* at 227 (question 30).

285. *Id.* at 228 (question 31).

286. *Id.* at 219 (question 20). Also, 38% pray *several times* each day. *Id.* at 242 (question 41).

287. *Id.* at 220 (question 21). Fifty-six percent say religion is “very important” while 26% say religion is “somewhat important.” *Id.* Together, those groups sum to 82%.

A closer look at the NAS appointment process may suggest the latter. Congress created the NAS and appointed its first members in 1863.²⁸⁸ Since then, members of the academy appoint their successors.²⁸⁹ “Its current membership . . . remains the closest thing to peerage in American science.”²⁹⁰ To the extent that NAS has become largely monolithic on issues of social import, we might conclude that the bias of the existing membership is preventing minority views from gaining a voice in the community’s leadership. Eminent journals, such as *Science*, *Nature*, and the *New England Journal of Medicine*, have similarly been shown in recent years to incorporate a great deal of majoritarian editorial discretion in selecting pieces for peer review (arguably in an effort to control intellectual debate) and in determining the degree of scrutiny to subject each paper to during the peer review process.²⁹¹

Additionally, there is considerable anecdotal evidence suggesting that scientists who dissent on matters of social import are ostracized from their community.²⁹² Some commentators have observed that this has resulted in self-censorship, causing an increasing number of scientists to decline to dissent. “In research universities, the religious people keep their mouths shut . . . [a]nd the irreligious people discriminate. There’s a reward system to being irreligious in the upper echelons [of science].”²⁹³ This phenomenon further inhibits the expression of minority views on important issues.

These observations are buttressed by the absence of evidence suggesting that the over-representation of atheists among the scientific elite is explainable on the grounds that atheists make better scientists. Further, there is no suggestion that careful analysis of scientific evidence necessitates the adoption of an atheist philosophy. Indeed, even the atheists in the scientific elite often do not use science to explain their atheism. While there are notable exceptions, scientists who reject religion tend to do so because they cannot reconcile the existence of G-d with “all this evil in the world” or simply cannot accept “all that supernatural stuff.”²⁹⁴ These views, while certainly providing legitimate basis for a philosophical position, are not scientific.

288. Larson & Witham, *supra* note 277, at 90.

289. *Id.*

290. *Id.*

291. Kevin Shapiro, *Lessons of the Cloning Scandal*, COMMENTARY, Apr. 2006, at 62, 63.

292. See, e.g., Nature Publ’g Grp., *Cast out from Class*, 434 NATURE 1064, 1064 (2005); EXPELLED: NO INTELLIGENCE ALLOWED (Premise Media Corporation 2008).

293. Larson & Witham, *supra* note 277, at 91 (quoting University of Washington sociologist Rodney Stark) (internal quotation marks omitted).

294. *Id.* at 90–91 (citing an informal study by the leading evolutionary biologist and Harvard professor Ernst Mayr, appointed to the NAS in 1954).

Indeed, scientists are often very quick to say that science and religion occupy different spheres of knowledge, neither one being superior to the other. For example, the NAS recently declared that science and religion rest in “different aspects of human experience” such that “[a]ttempts to pit science and religion against each other create controversy where none needs to exist.”²⁹⁵ As a result, it is very difficult to accept the notion that scientists believe that their discipline has somehow proven or disproven any form of religious dogma.²⁹⁶

It seems more plausible that the structure and organization of the scientific community stifles minority views, particularly when they are controversial. If that is correct, it is all the more likely to be so when the ‘fringe’ views come not from within the scientific community but from without. When patients attempt to dictate the course of medical treatment to their physicians in a manner unpopular among the elite in the medical community, we would expect the medical community to react unfavorably. While this hypothesis does not suggest that the community of physicians operates in bad faith and with improper motives, it raises legitimate doubt regarding their institutional objectivity. Accordingly, it would seem that the medical community, as a community, should not have the responsibility of making important social decisions on behalf of the population at large, at least where the questions that underlie the important social decisions are non-medical. Rather, significant moral questions such as those presented in futility cases should belong to the larger society.²⁹⁷

TADA²⁹⁸ and similar popularly enacted statutes²⁹⁹ represent a significant and positive shift away from physician-directed decision making in these areas as the popularly elected legislature has assumed the ability to make futility decisions (by appointing a proxy). Unfortunately, to my knowledge, all such statutes grant decision-making authority back to the community of physicians and hospitals.³⁰⁰ While these statutes implicitly recognize that the questions

295. NAT'L ACAD. OF SCIS. & INST. OF MED., SCIENCE, EVOLUTION, AND CREATIONISM 12 (2008).

296. Compare RICHARD DAWKINS, THE G[-]D DELUSION (2008) (arguing that evolutionary science disproves the existence of G-d) with STEPHEN C. MEYER ET AL., EXPLORE EVOLUTION (2007) (adopting a different approach to understanding the same evidence).

297. Veatch & Spicer, *supra* note 247, at 29, 36.

298. TEX. HEALTH & SAFETY CODE ANN. § 166.001–166.166 (West 2010).

299. See ME. REV. STAT. ANN. tit. 18-A, § 5-807 (1998); MD. CODE ANN., HEALTH–GEN. § 5-611 (West 2009); MASS. GEN. LAWS ANN. ch. 201D, §§ 14–15 (West 2004); N.Y. PUB. HEALTH LAW § 2984 (McKinney 2007); TENN. CODE ANN. § 68-11-1808 (West, Westlaw through 2010 First Ex. Sess. and 2010 Reg. Sess.); VA. CODE ANN. § 54.1-2990 (West, Westlaw through 2010 Reg. Sess. 2010); WASH. REV. CODE ANN. § 70.122.060 (West 2002); See also MD. CODE ANN., HEALTH–GEN. § 5-613 (West 2009) (pertaining to patient transfer).

300. See, e.g., N.Y. PUB. HEALTH LAW § 2984 (McKinney 2007).

that underlie futility cases are social and moral questions, and thus ought to be decided by society, they grant decision-making authority back to a professional community that lacks sufficient institutional competence and might be subject to intolerable bias. While that delegation of power is presumably legitimate as a matter of constitutional law, such a delegation of legal authority is not necessarily coextensive with normative authority. And, for the reasons that I have presented throughout this section, the medical community lacks normative authority in futility cases.

This discussion on bias and institutional incompetence is not merely theoretical; it is demonstratively relevant in actual cases. While a full exploration of the way bias and institutional incompetence express themselves is beyond the scope of this Article, a brief look at one example is in order. The medical community debates how to approach infant care. There are many parties that have an interest in the care of the infant and the question is whose interests should the physician seek to actualize when there is a conflict: those of the parents, the medical community, society at large, or those of the infant. Many medical ethicists, although certainly not all, believe that the interests of the infant are of paramount importance and must prevail over all other interests.³⁰¹ The question is obvious: how are doctors to discern the best interest of the infant? The best interests of the infant are complex and certainly involve questions that are non-physiological. Someone trying to assess the best interest of any child who cannot communicate would have to consider the residual effects of any decision on the family and how those will impact on the child, the psychological implications of either decision on the child, the ability of the family to finance medical treatment or care for their child in the absence of medical treatment, spiritual or religious considerations, and a host of other considerations that do not relate directly to the efficacy of a particular treatment. And if a “best interests” test simply means ruling out certain procedures because they are clearly not “beneficial” to a child, the implementation of such a test will require consensus among reasonable well-meaning and disinterested people about what constitutes unacceptable treatment. There is no such consensus.³⁰²

Employing best interests to justify non-initiation of rescue treatment in this context necessarily means accepting the parents’ and/or physician’s normative assessment of the future value of a likely seriously disabled life, and accepting their moral motivations for disregarding such a compromised state of human

301. For example, ethicist John Paris indicated that there is “strong consensus in the medical, legal, and ethical literature that it is the best interests of the infant—not the desires of parents or the determination of the physician—that must prevail in the care of newborns.” Sayeed, *supra* note 211, at 605 (quoting John J. Paris et al., *Ethical and Legal Issues*, in *ASSISTED VENTILATION OF THE NEWBORN* 81 (J. P. Goldsmith & E. H. Karotkin, eds., 4th ed. 2003)).

302. *Id.*

existence. . . . One set of parents may view a particular disability as ‘worse than death,’ while another set of parents would not.³⁰³

So what, precisely, are medical providers to do in light of this problem? There are no purely medical answers. But medical providers cannot develop a treatment plan without adequate answers. Indeed, their patients *require* an answer. Out of necessity, they will answer the question, presumably in good faith, the best way they know how. They will rely on their education, the pearls of wisdom they glean from other doctors, their own presumptions, and their personal moral code. The conclusions derived from these sources are likely to differ significantly from the preferences of society at large or those of the particular patient whom they represent. It follows that the public interest would be better served by asking a different institution to answer the difficult questions that arise in futility cases.

C. Non-Materialist Considerations

While hardly dispositive of the broader question of how to resolve futility disputes, understanding how spiritual and religious doctrines might address the question of futility is informative. This section seeks to explore how Western spiritual and religious doctrines generally approach futility cases and to illustrate how vastly those doctrines differ from the conclusions embraced by the medical community. I proceed on the assumption that many of those in scientific community who are vocal on social questions have adopted a (non-scientific) philosophy known as “materialism,”³⁰⁴ which argues that nothing exists in the universe but physical matter (and, presumably, energy).³⁰⁵ This assumption is not without basis. “Many atheists con-

303. *Id.* at 606–07 (quoting *Montalvo v. Borkovec*, 2002 WI App 147, ¶27, 256 Wis. 2d 472, 489, 647 N.W.2d 413, 421).

304. DINESH D’SOUZA, *LIFE AFTER DEATH: THE EVIDENCE* 10–11 (2009). “[M]aterialism . . . refers to the philosophical position that material reality is the only reality. Materialists hold that there is only one kind of stuff that exists—material stuff. . . . Even human beings and other living creatures are ultimately collections of atoms and molecules.” *Id.* at 10.

305. *Id.*; see also *Materialism—What Matters?*, ALL ABOUT PHILOSOPHY, <http://www.allaboutphilosophy.org/materialism.htm> (last visited Feb. 25, 2011) (discussing the basic principles of materialism). Not all scientists are philosophical materialists. Certainly, science itself does not mandate an acceptance of materialism; materialism is a philosophy and exists outside the realm of science. But it seems that materialism has occupied much of science’s bandwidth for a good while and, accordingly, it is fair to talk about modern science as having adopted materialism. See STEPHEN JAY GOULD, *EVER SINCE DARWIN: REFLECTIONS IN NATURAL HISTORY* 12 (1992) (describing Darwinian evolution as built upon “radical philosophical content” that amount to a “challenge to a set of entrenched Western attitudes,” among them being Darwin’s “consistent” application of a “philosophy of materialism”); D’SOUZA, *supra* note 304, at 11. See generally GEORGE NOVACK, *THE ORIGINS OF MATERIALISM: THE EVOLUTION OF A SCIENTIFIC VIEW OF THE WORLD* (1979).

sider . . . materialism to be synonymous with reason and science”³⁰⁶ The influence that materialist thought has had on public debates about scientific and medical issues is unmistakable.³⁰⁷ But it is, nevertheless, not widely held by society nor is it part of our national culture.

The Declaration of Independence memorialized the belief held by many of those highly influential men who founded our country that G-d grants “unalienable Rights” which may not be denied by government, and that the right to life rests among those rights.³⁰⁸ Thus, part of the foundation of the United States, or at least part of the theory that inspired its creation, was an acceptance of natural law (which includes, as understood at the Founding, a natural right to life) and the natural limitations therein restricting government from interjecting into certain arenas.³⁰⁹ While not without limitation, the notion that individuals retain a right to life remains part of our fabric. And even where society recognizes an exception to the individual right to life—most notably in the form of capital punishment—it does so with a degree of trepidation as evidenced by extensive procedural limitations that it places upon government.³¹⁰

In the context of medical futility, there should similarly be a presumption that the right to life ought not to be circumscribed or denied.³¹¹ The utility of a “futile” (that is, low probability) treatment option must be weighed (according to its probability) against its expected benefits. A low-probability venture that offers the potential of vast rewards is a venture worthy of at least some investment. If we accept, by hypothesis, the notion that life is of intrinsic value, a diminished quality of life following treatment and recovery does not negate that value. It might diminish the value, but does not negate it. And if we start with the assumption that life is supremely valuable, perhaps even a significant diminishment of that value would nevertheless not render the expected value of the “futile” treatment to be less than its costs. Similarly, if we adopt other philosophical non-materialist approaches to the question of medical futility, the likelihood of physiological success is but one of the factors that enters into the patient’s analysis. The patient or surrogate claiming a non-materialist interest to continued aggressive treatment views the treatment as being helpful to achieving some other (perhaps religious or spiritual) end.

306. D’SOUZA, *supra* note 304, at 11.

307. *See supra* note 305. For example, philosopher-scientist Richard Dawkins, an avowed materialist, dominates the position of the scientific community in the Intelligent Design debates. Largely thanks to him, the lay audience has come to associate evolution with materialism.

308. DECLARATION OF INDEPENDENCE para.2 (U.S. 1776) (emphasis added).

309. Smith, *supra* note 272, at 47–48.

310. *See supra* note 1.

311. *See generally* Smith, *supra* note 272.

Some ethicists have noted that it is unwise to apply a materialist framework to a patient who believes in a religious theory. They counsel that permitting futile treatment to go on a few extra hours or days (assuming that the patient is expected to die within that time) “is a small price to pay to prevent emotional and spiritual devastation in a survivor.”³¹² They further recognize that “[t]here are sincerely observant people whose religion teaches that preventable death must not be allowed to happen” and are therefore obligated, as part of their religious teachings, to oppose efforts to discontinue treatment.³¹³ But note just how far this argument goes. It is a pragmatic argument, recognizing that the emotional costs associated with ending “futile” care are, in some cases, not worth their institutional or financial benefits. However, when “futile” care would significantly prolong a patient’s life by, say, two years (recall that Sonya Causey’s physician denied her access to care that was likely to extend her life by two years),³¹⁴ this pragmatic argument would counsel for a different result, recognizing that two years of additional care are too much for the medical profession to concede in exchange for the emotional satisfaction of the patient’s family. The pragmatic approach is quite problematic, as I will explain.

Some published court decisions suggest that the families³¹⁵ of these terminal patients view the withdrawal of life-sustaining medicine as murder.³¹⁶ The position that (generally well-meaning) health care providers who turn off life-sustaining devices are “murderers” is quite unpopular. Almost without exception, the words “murder” and “murderer” do not appear in scholarly works (in both the medical and legal fields) on medical futility. This suggests that proponents of medical futility are unconcerned about the possibility that, as a matter of theology or moral philosophy, they might be considered murderers and their patients murder victims. Assuming *arguendo* that at least some theologies or moral philosophies view as murder the termination of a critically ill patient for whom further medical care is deemed “futile,” the futility movement should have to explain why (1) as a matter of religious law, murder in this context is acceptable, (2) religious law, so articulated, is wrong; permitting a patient to die in the context of futility is not rightly viewed as murder, (3) in this lim-

312. See Joseph M. Foley, *Letter to the Editor*, 330 NEW ENG. J. MED. 81, 145 (1994).

313. *Id.*; see also *supra* notes 9–27 and accompanying text.

314. Causey v. St. Francis Med. Ctr., 30732-CA, p. 2 (La. App. 2 Cir. 8/26/98), 719 So.2d 1072, 1073 (La. App. 1998); *supra* note 228 and accompanying text. .

315. Typically, futility patients are unable to express their views. I will explain below, *infra* notes 334, 352–55 and accompanying text, why the positions of surrogates, particularly where the surrogate is a family member, are relevant.

316. *E.g.*, Rideout v. Hershey Med. Ctr., 30 Pa. D. & C.4th 57, 63 (Pa. Com. Pl. 1995) (“The Rideouts heard the announcement and immediately rushed . . . hysterically crying and screaming that their child had been *murdered*.” (emphasis added)).

ited context, the murder of the critically ill is necessary for furthering the public good, regardless of the general positions of religious law, or (4) the positions of the medical community should generally be adopted over the objections of religious dissenters (i.e., even if the act is murder under a given theology, that theology is irrelevant as a matter of law and policy). If we are to allow the proponents of medical futility to force a theory upon society that is seen by many as immoral, it should be required to respond in some fashion, such as by adopting one of the four arguments set forth above. But if the proponents of medical futility are unable to provide cogent support for at least one of the above propositions, it is unclear why a largely moral society permits continued violation of the theology and philosophy of at least some of its members.

More significantly, it is unclear why the proponents of medical futility should be permitted to impose their philosophical views upon individual patients who do not subscribe to those views. The patient in a terminal futility case is made to pay the highest imaginable price simply because the physician disagrees with him. If the physician is able to transfer the patient to another willing physician, without harming the interests of the patient in the process, he should be entitled to do so. But if he cannot, and the patient's interests are squarely at odds with the physician's interests, it is at best unclear why the physician should win that battle when it means the death of the patient.³¹⁷

Perhaps physicians who provide non-emergent care will counter that their patients have entered into a voluntary relationship with their physicians and, as a result, the physician cannot be expected to divorce his personal belief system from his treatment of his patients. This argument would have considerable merit, limiting my objections to emergency care only, if physicians disclosed their beliefs to prospective patients before initiating treatment. For example, if intake forms stated in bold letters in a conspicuous manner that the physician does not provide futile medical care, and assuming that the patient had the ability to either negotiate the terms of the contract or to find a suitable alternative physician, the physician can rightly decline to respond to his patient's religious objections in the course of treatment. But where the patient did not know and had no reason to know the physician's beliefs and preferences, or had no ability to work around those preferences *ex ante*, the physician who has accepted care of this patient must be accountable, at minimum, to answer the patient's theological objections.

Before continuing, I must state that this is not a proper forum for discussing and attempting to develop any particular theology. Rather,

317. For further elaboration on this point, see *infra* section V.B.

I will assume that the religious arguments that I will mention below exist, are strongly held by some members of the population, and need to be addressed by ethicists. Great care must be taken to ensure that religious positions, whatever they may be, are respected and not dismissed by the medical community absent a truly compelling justification. “People who have lived their whole lives in accordance with a religious tradition should be accorded the courtesy—dare I say respect—of living their last hours and days in accordance with that tradition.”³¹⁸

In weighing the value of human life, ethicists typically take two approaches. They state either that life has intrinsic value or that it does not. Those who say that human life has no intrinsic value must consider whether human life has any value at all and, if it does, they must define the basis of that value. In other words, they must explain what gives life its value if it has no intrinsic value. One author articulated this problem with refreshing clarity: “If the hospital is on fire[,] what justifies our decision to rescue the patients before the hospital cat and the animals in the laboratories?”³¹⁹

Bioethicists often take the position that the subjective *quality* of a given life is what defines its value,³²⁰ notwithstanding the highly controversial implications of that position.³²¹ Life’s value is thus not intrinsic, but depends on something external to it: the ability to enjoy one’s surroundings. Using this approach, if a life is without quality, either because it is wrought with pain or is limited by extreme cognitive deficiency, the life is one without value.³²²

One variation of the quality-of-life approach to valuation, currently in common practice in the United Kingdom, is known as “quality adjusted life years” (QALY).³²³ “The thrust of the QALY approach is to apply numerical data to medical decision-making so as to allocate resources to those procedures that maximize not just life-years, but those life-years that are most ‘livable,’ most ‘human,’ or most ‘enjoyable.’ Those magical numbers are then used to set central limits on [health care] consumption”³²⁴ Devising a robust QALY scheme preliminarily requires that the standard-setters answer a breathtakingly large number of normative questions. As a result, QALY is effectively nothing more than an arbitrary means of answering

318. Marc D. Stern, “*And You Shall Choose Life*”—*Futility and the Religious Duty to Preserve Life*, 25 SETON HALL L. REV. 997, 1008 (1995).

319. John Harris, *The Concept of the Person and the Value of Life*, 9 KENNEDY INST. ETHICS J. 293, 295 (1999).

320. See Smith, *supra* note 272, at 49–51.

321. See *supra* notes 228–62 and accompanying text.

322. See Smith, *supra* note 272, at 49–51.

323. See Meir Katz, *Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals*, 36 AM. J.L. & MED. 78, 100 (2010).

324. *Id.*

unanswerable questions using seemingly neutral language. (I have analyzed the QALY approach at length elsewhere and incorporate that discussion by reference.³²⁵)

Nevertheless, it seems to be intuitive to many that saving a life of little quality is a low-value endeavor. The persistence of this argument illustrates the pervasiveness of materialist thought in the end-of-life arena. But if, as I have argued, QALY and other similar vehicles to value life on the basis of its perceived quality are internally incoherent (because they rest on countless preliminary normative judgments), the proponents of medical futility must find an external logical basis to support their theory if it is to continue to resolve difficult questions of social import.

Similarly, if one rejects the materialist view and accepts that life has intrinsic value, even if not infinite value, efforts to define or quantify that value are elusive. This is so because attempts to value life implicitly presume that life can be commodified. But the notion that life itself is a commodity is intuitively false. Indeed, commentators have great difficulty dealing with the commodification of human body parts, even if parted with consensually and in a manner that does not undermine health.³²⁶ If so, coherency in medical futility is likewise elusive. Without some basis with which to assess the value of life, it is virtually impossible to determine when efforts to save, preserve, or extend that life are essentially valueless.

It is only when one subscribes to philosophical materialism, or some variation thereof, and starts from the presumption that life has *no* value, can the conclusions of the futility movement follow logically without further external support. But if life has no value, it is unclear why we should ever expend effort or expense to preserve it. Nearly everyone believes that life has at least some value, whether intrinsic or external. But if external, what defines it? And if intrinsic, how is it to be assessed?

Many believe that life has infinite or nearly infinite value, defined by some transcendental ideal or force. When one starts from this presumption, the flaws inherent in the presumptions of medical futility become more apparent. If life has infinite or nearly infinite value, heroic measures to preserve it are not only appropriate, but expected.

325. *See id.* at 100–02, 104–07.

326. *See, e.g.,* Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 *GEO. MASON L. REV.* 69 (2004); Linda C. Fentiman, *Marketing Mothers' Milk: The Commodification of Breastfeeding and the New Markets for Breast Milk and Infant Formula*, 10 *NEV. L.J.* 29 (2009); Pamela Foohey, *Paying Women for Their Eggs for use in Stem Cell Research*, 30 *PAGE L. REV.* 900 (2010); Peter Halewood, *On Commodification and Self-Ownership*, 20 *YALE J.L. & HUMAN.* 131 (2008); Margaret Jane Radin, *Market-Inalienability*, 100 *HARV. L. REV.* 1849 (1987).

The philosophical belief that life has infinite or nearly infinite intrinsic value is hardly a periphery or fringe position. I count among the adherents of this view—that there exists a “higher law” or moral philosophy that ought to inform our actions and legal standards—Professors Prosser and Keeton:

[T]he 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 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. Such decisions are revolting to any moral sense.³²⁷

It is important to point out that natural law and natural rights theory—which provide the theoretical basis for the infinite value thesis—are not theology. They are rooted in philosophy and are widely held.³²⁸

Indeed, [references to G-d as a source of Natural Law or natural rights theory] have been [made] by Bracton, Coke, Blackstone, Washington, Hamilton, Madison, Jefferson, Lincoln], some of whom were deists or perhaps not religious at all,] . . . to recognize that the rights of every person are rooted in a source outside of, and prior to, the State. The [deity] they referred to was the Philosophers’ G[-]d—the G[-]d that Aristotle, Avicenna, . . . Leibniz and others derived from the structure of human reason itself.³²⁹

-
327. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 56 at 375–76 (5th ed., 1988) (footnote omitted).
328. See *Newdow v. Rio Linda Union Sch. Dist.*, 597 F.3d 1007, 1025–28 (9th Cir. 2010) (holding that the 2002 Congress viewed the phrase “one Nation under G[-]d” as representative of “the *political philosophy* of the Founding Fathers that G[-]d granted certain inalienable rights to the people which the government cannot take away.”) (emphasis added).
329. Reply Memorandum in Support of Motion To Dismiss of Defendant-Intervenors Muriel Cyrus, *et al.* at 5, *Freedom From Religion Found. v. Hanover Sch. Dist.*, 665 F. Supp. 2d 58 (D.N.H. 2009) (No. 07-cv-356-SM), 2008 WL 7296496 (citations omitted) [hereinafter Muriel Cyrus Memo]; see also THE DECLARATION OF INDEPENDENCE, *supra* note 2 (stating all men are “endowed by their Creator with certain unalienable Rights”); James Madison et al., *Address to the States by the United States in Congress Assembled* (Apr. 26, 1783), reprinted in 1 DEBATES ON THE ADOPTION OF THE FEDERAL CONSTITUTION 96, 100 (Jonathan Elliot ed., 2d ed. 1836) (“[I]t has ever been the pride and boast of America, that the rights for which she contended were the rights of human nature.”); ARISTOTLE, METAPHYSICS bk. XIII, ch.7 at 1072, reprinted in INTRODUCTION TO ARISTOTLE 277, 318–20 (Richard McKeon, ed., 2d. ed. 1973) (“The first mover, then, exists of necessity; and in so far as it exists by necessity, its mode of being is good, and it is in this sense a first principle.”); 1 WILLIAM BLACKSTONE, COMMENTARIES *38, *41 (stating the law of nature “is binding over all the globe in all countries, and at all times: no human laws are of any validity, if contrary to [it]”); 2 BRACTON ON THE LAWS AND CUSTOMS OF ENGLAND 33 (George E. Woodbine ed., Samuel E. Thorne ed. & trans., Harvard Univ. Press 1968) (“The king must not be under man but under G[-]d and under the law, because law makes the king.”); RON CHERNOW, ALEXANDER HAMILTON 60 (The New Penguin Press 2004) (“The sacred rights of mankind are not to be rummaged for among old parchments or musty records. They are written, as with a sunbeam, in the whole *volume* of human nature by the hand of the divinity itself and can never be erased or obscured by mortal

These philosophies define themselves by appeal to a power that is higher than the state.³³⁰ That higher power might be G-d but it just as plausibly might be derived through reason and logic. Philosophy is accessible to people regardless of religious belief. The view that life has intrinsic value is held by an overwhelmingly large percentage of the population³³¹ and ought not to be discounted.

Objections to medical futility seem even more pronounced for those who subscribe to variations of theology or moral philosophy that describe the interaction between body and soul. If the human soul is what makes a human being different from the hospital's cat,³³² allowing a person to die in the name of medical futility may be no less acceptable than permitting a healthy person to drown. In both instances, the observer is permitting the soul, which, by hypothesis, grants this person his uniqueness, to depart from his body. The fact that the former was already sick and the latter not should not affect that analysis. If we assume, as many religious people seem to, that the soul remains present and "aware" even in the bodies of those who appear unresponsive (such as those in a persistent vegetative state), the departure of the soul from the body is not a less significant or less painful event. Further, for various theological reasons, this interaction between body and soul may be valuable, even if the body is to remain forever unresponsive. By ending this person's life, a physician

power." (quoting ALEXANDER HAMILTON, *The Farmer Refuted* (1775), reprinted in 1 THE PAPERS OF ALEXANDER HAMILTON 86 (Harold C. Syrett et al. eds., 1961-1987)); 12 EDWARD COKE, COKE'S REPORTS *63, *64-65 (differentiating between the positive law of man and the universally endowed law of natural reason); THOMAS JEFFERSON, *Notes on Virginia*, in 2 THE WRITINGS OF THOMAS JEFFERSON 225, 227 (Andrew A. Lipscomb & Albert Ellery Bergh eds., 1903) ("[C]an the liberties of a nation be thought secure when we have removed their only firm basis, a conviction in the minds of the people that these liberties are of the gift of G[-]d?"); JOEL L. KRAEMER, PHILOSOPHY IN THE RENAISSANCE OF ISLAM 288-89 & n.47 (Itamar Rabinovich et al. eds., 1986) ("[T]here exists some mover that does not move in any respect."); Abraham Lincoln, *Address Delivered at the Dedication of the Cemetery of Gettysburg, Final Text*, reprinted in 7 THE COLLECTED WORKS OF ABRAHAM LINCOLN 22, 23 (Roy P. Basler ed., 1953) ("[T]his nation, under G[-]d, shall have a new birth of freedom—and that government of the people, by the people, for the people, shall not perish from the earth."); George Washington, *First Inaugural Address*, reprinted in DAVIS NEWTON LOTT, THE PRESIDENTS SPEAK: THE INAUGURAL ADDRESSES OF THE AMERICAN PRESIDENTS, FROM GEORGE WASHINGTON TO GEORGE W. BUSH 3, 4 (M. Hunter & H. Hunter eds., Olive Grove Publ'g, 4th ed. 2002) ("[I]t would be peculiarly improper to omit in this first official act my fervent supplications to [G-d].").

330. See Muriel Cyrus Memo, *supra* note 329 (arguing that the phrase "under G[-]d" in the Pledge of Allegiance is a political philosophy rather than a theological statement).

331. The vast majority of Americans are religious. See *supra* notes 270-287 and accompanying text. It stands to reason that a good number of those who are not religious subscribe to a moral philosophy that governs the present analysis.

332. My reference to the hospital cat is taken from Harris, *supra* note 319.

is depriving this person of a potentially positive spiritual experience. For that reason alone, physicians and ethicists should think twice before declaring that medical treatment has no “benefit,” is “futile,” or must be discontinued for some other reason.

Given that (a) it is difficult to reconcile supernatural and non-materialist approaches of thought with medical futility, (b) giving normative preference to materialist approaches over non-materialist ones is beyond the competence of medical science, (c) those who reject such theories likely constitute a small minority of the population (even if a majority within the medical community), and (d) the proponents of medical futility often have no means of assessing or accessing the various philosophical or theological positions that might motivate their patients and/or surrogates, we should be slow to impose medical futility on those who reject it. Indeed, physicians who wish to impose medical futility on a patient who has a well-developed moral, religious, ethical, emotional, or other subjective but well-considered preferences that do not tolerate the termination of treatment should take pause and consider the social implications of his proposed counter-majoritarian imposition.

For those patients who do not have a comprehensive theory regarding the end of life and relationship between body and soul, a discussion on the likely success of various medical treatments is very much in order. Physicians should inform patients about the knowledge they have as a function of their expertise: the likelihood of success, the likely benefits, and the likely burdens of different forms of medical treatment. Patients should know not just what their options are, but which options have merit as a matter of medical science and which ones represent little more than a hope or a wish. But that does not yield the strong argument of medical futility: that physicians have the unilateral right (given certain prerequisites)³³³ to withhold or terminate “futile” medical treatment.

Rather, the patient’s interests should be routinely preferred in futility cases over the objections of his physician. In the case of a surrogate, when it is plausible that a surrogate’s requests represent the moral, religious, ethical, emotional, or other subjective positions of the patient (and they often do because the surrogate is often a close family member and likely knows the patient well), the surrogate stands in place of the patient to articulate the patient’s position on moral and ethical questions.³³⁴ Those wishes should likewise be honored.

333. For a discussion on the positive law surrounding medical futility, see *supra* Part III.

334. Both the Supreme Court’s majority opinion and Justice Brennan’s dissent in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), argued that the true preferences of a patient can potentially be ascertained by listening to the surrogate and that those preferences should be actualized. The opinions

When the surrogate's ability to accurately represent the patient is highly doubtful, physicians may have some normative basis to interject their beliefs and preferences. But this is a rare exception, not the rule.³³⁵

Of course, physicians do have a substantial and indispensable role to play in guiding their patients. They assess their patient's physiological state and make recommendations regarding various treatment options. By virtue of their proximity to their patient and as a result of their role as the bearer of bad news in futility and terminal cases, they also should be expected to provide emotional support to patients and their families and counsel them on how to deal with their difficult circumstances. They might also make recommendations regarding further treatment. Nothing in this Article is meant to suggest that physicians should abandon their role as counsel to their patients.

only disagree about whether a state may (1) impose particular "safeguards" to ensure accuracy and (2) assert that the default presumption for those in persistent vegetative state for patients in a persistent vegetative state is to sustain life rather than to end it. *Compare id.* at 279–80 ("[W]e assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition. . . . Such a 'right' must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient . . . but it has established a procedural safeguard to assure that the action of the surrogate *conforms as best it may to the wishes expressed by the patient while competent.*" (emphasis added)), *with id.* at 312–16 (Brennan, J., dissenting) ("Whatever a State's possible interest in mandating life-support treatment under other circumstances, there is no good to be obtained here by Missouri's insistence that Nancy Cruzan remain on life-support systems *if it is indeed her wish not to do so.* . . . [I]f and when it is determined that Nancy Cruzan would want to continue treatment, the State may legitimately assert an interest in providing that treatment. . . . *Accuracy, therefore, must be our touchstone.*" (emphasis added)). For some reason, this point seems to give people some trouble. I do not understand why. If the family member is trustworthy and has sufficient basis to articulate the patient's positions, why is the family member less qualified to state those positions than the patient herself? And if the family member is not trustworthy or does not have a sufficient basis to articulate the patient's position, the family member is not a good surrogate and it should be obvious that we ought not do as the family member requests. In either case, the question is purely factual, not normative. For further elaboration, see *infra* notes 352–55 and accompanying text. The matter is less clear when the patient was never physically able to articulate any particular position (such as with infants and mentally handicapped patients). There too, however, I see no reason not to listen to the surrogate at least where the surrogate is a parent or legal guardian. Parents and legal guardians have legal and moral authority to make decisions for their children. That authority extends to decisions that relate the moral philosophy, the meaning of life, and spiritual or religious obligations (to the extent that they exist). Why, then, should that same parent or guardian not be able to articulate the "interests" of the patient in the context of medical futility?

335. See the discussion regarding *In re Wanglie*, *supra* notes 51–58 and accompanying text.

But patients must be aware that their physician’s recommendations are “overflowing with normative judgment.”³³⁶ A physician that recommends only palliative care, in light of the “futility” of further aggressive treatment is taking a moral position, does so “from a position of remarkable influence, and *despite having no legitimate moral expertise in this regard.*”³³⁷ Patients and surrogates must be made aware that their physicians are making normative arguments, that there are implicit value judgments associated with those arguments, that they are not obligated or expected to adopt those value judgments, that they are encouraged to seek counsel from religious or spiritual leaders where appropriate, and that they ought not simply trust their physician when deciding whether to terminate medical treatment.

V. REBUTTAL AND RESPONSE

Proponents of the medical futility movement are likely to respond to my arguments by stating that while medical futility may not be perfect, is not without internal bias, and may discount the interests of certain religious people, it is a necessity nonetheless. The necessity of a doctrine of medical futility is derived, they might say, from its ability to solve significant social problems. The three most persuasive arguments that I have identified in the literature on medical futility follows: (1) By pursuing aggressive medical care, rather than focusing on palliative treatment, we are putting our patients through unnecessary physical and emotional pain, and that pain amounts to torture.³³⁸ As the argument goes, even if the patients tell us that they want aggressive treatment, it is not the job of a doctor to torture his patients. (2) By forcing physicians to act in accord with the will of their patients, the physician is rendered a “medical vending machine” and essentially puts the patient in the practice of medicine.³³⁹ The advocates of the medical futility movement claim that a physician must be returned to his position as an independent and moral agent of the medical profession and that adhering to a doctrine of medical futility moves the physician in that direction.³⁴⁰ (3) The exhaustion of medical resources on patients who have no statistical chance of recovering is wasteful.³⁴¹ And, given that society suffers from a shortage of medical resources, it is affirmatively harmful to other, more deserving, patients.³⁴² Rather

336. Sayeed, *supra* note 211, at 608.

337. *Id.* (emphasis added).

338. *See, e.g., In re Howe*, No. 03 P 1255, 2004 WL 1446057, *5, *20 (Mass. Prob. & Fam. Ct. Mar. 22, 2004).

339. *See Daar, supra* note 50, at 1245.

340. *See id.*

341. *See Veatch & Spicer, supra* note 247, at 17, 28–29.

342. *See id.* at 17.

than capitulate to the desires of a particular patient or family, it is far more efficient, as well as humane, to preserve these resources for future patients who have the opportunity to fully recover.³⁴³ I will develop and respond to each of these criticisms in turn. In short, all of these criticisms revolve around the false presumptions and value judgments discussed in Part IV that govern the medical futility movement. By exposing the presumptions and value judgments hidden in each of these criticisms, I will demonstrate the failure of these arguments and the propriety of allowing individual patients and surrogates to decide whether to receive life-sustaining medical care.

A. Human Suffering for a Purpose and with Consent Is Not Torture

I came across a very powerful narrative arguing for the furtherance of the futility movement by attaching a human face and a story to the argument. The narrative endeavors to convince readers that human compassion can tolerate only one choice for patients in extreme pain: palliative care (that is, supplying pain relieving medication that offers no curative benefit).³⁴⁴ What makes this narrative particularly interesting for me is that it starts several years prior to the cases that I discuss in this Article. In the narrative, Mr. Smith is still healthy and stands at the ultimate crossroads of his life.³⁴⁵ He is facing terminal cancer and must decide whether to treat his cancer with the hope of extending his life or to opt for palliative care.³⁴⁶ What should he do?

If Mr. Smith chooses aggressive treatment, he will continue to undergo chemotherapy that will cause vomiting, diarrhea, loss of hair, and permanent hospitalization. His liver will stop working and he will suffer dementia, jaundice, kidney failure, a diminished immune system, rapid gastrointestinal bleeding, an inability to breakdown proteins, and a loss of clotting factors. To combat these illnesses, Mr. Smith will be treated with dialysis, artificial nutrition, blood transfusions, antibiotics, biopsies to test the advancement of the cancer, and constant blood tests to monitor his blood levels. Eventually Mr. Smith may need intubation to help him breathe and restraints because of his dementia. He will probably develop bed sores from being bed-bound that will bleed uncontrollably and may become infected, despite the regular doses of antibiotics. His condition will continue to deteriorate until he wastes away and dies alone in a hospital intensive care unit (ICU), or with two family members, as limited by ICU rules. Mr. Smith's other option is palliative treatment. This therapy will focus on easing his pain, and will allow Mr. Smith to say goodbye to his loved ones and die at home, surrounded by family. Under this alternative, Mr. Smith will be treated primarily with pain prevention and will die

343. *See id.*

344. Jon D. Feldhammer, Note, *Medical Torture: End of Life Decision-Making in the United Kingdom and United States*, 14 *CARDOZO J. INT'L & COMP. L.* 511, 511–13 (2006).

345. *Id.* at 511.

346. *Id.*

comfortably before most of the symptoms described above have progressed. . . . Keeping someone with a terminal prognosis alive by extraordinary medical means is tantamount to torture and degrades that person’s dignity.³⁴⁷

Certainly, the argument in favor of palliative treatment is a strong one. Extreme pain accompanied with little chance of benefit seems an unconscionable combination. But there lies the rub. In order to establish that the pain is excessive in light of its potential gains, we must first establish what those potential gains are. Simply stating that there is little to no chance of *physiological* recovery does not suggest that there is little to no chance of benefit. As discussed above,³⁴⁸ the patient may obtain certain other benefits by prolonging her life. Those benefits might not be cognizable by physicians, but that fact does not make them any less objectively significant or subjectively valuable. Additionally, there are benefits to family members that are cognizable, such as the knowledge that they have done the “right” thing, as per their subjective definitions, on behalf of their family member.³⁴⁹

To the extent that the patient or surrogate sees benefit in the requested medical treatment, it makes little sense for a physician to impose his judgment on the patient. That the physician deems treatment to be “torture” is not grounds to withdraw treatment when the physician retains little or no expertise enabling him to opine on the nature or value of the perceived benefit.³⁵⁰

Of course, if the physician feels that his patient is making a cognitive error, he should advise the patient and give her any data and other information that might help her make a more informed decision. But his assessment that she is making an uninformed—even a foolish—decision does not make further treatment torture. For even in cases of unspeakable pain, if the patient honestly wants³⁵¹ that pain, given her belief that it is good for her, it cannot be labeled torture.

347. *Id.* (citations omitted).

348. *See supra* sections IV.B–C.

349. *See supra* notes 312–14 and accompanying text.

350. Note the limits of this argument. I am saying only that the physician’s definitions do not provide grounds to cease treatment. I am *not* saying that the physician therefore has an affirmative obligation to treat. If the physician has the capacity to transfer his patient to another physician who wants to provide treatment, I see no objection to permitting the physician to insist upon such a transfer (even over the protests of the patient). If, however, the physician is not able to facilitate a transfer (perhaps because no other physician is willing to provide treatment), I believe the physician would be obligated to provide treatment (perhaps unless the physician presents a true conscientious objection). *See infra* section V.B.

351. This argument only works to the extent that the sanity of the patient is not legitimately in question. Where there are reasons to believe that the patient does not have the capacity to make decisions for herself, the arguments in this paragraph are not applicable. I should note that religious motivations and other motivating factors that are not purely rational in the mode of, say, Richard Dawkins, see

If a surrogate, rather than the patient herself, is demanding painful treatment, the question appears far more difficult. But as noted above,³⁵² the difficulty is not normative or theoretical but purely factual. If the surrogate is accurately stating the positions of the patient, then the surrogate's request for additional treatment must be accepted as the patient's claims. And where there are serious doubts³⁵³ that the surrogate is accurately expressing the will of the patient, then the surrogate's demands must either be rejected or partially discounted. Where the surrogate is a family member and is expressing the strongly held beliefs of the patient (as the patient articulated them while she had the capacity to do so), it is hard to imagine a case in which the ability of the surrogate to speak for the patient is honestly in doubt.³⁵⁴ And where the patient never had the capacity to articulate her beliefs (perhaps because she is an infant or mentally handicapped), the parent or legal guardian who has legal and moral authority to decide all types of philosophical and moral questions for the patient should have no less authority to do so here.³⁵⁵ Accordingly, in the vast majority of cases, where a surrogate demands treatment that the physician deems to be "torture," the physician would not be permitted to withdraw treatment on that basis alone.

Notwithstanding my arguments above, or perhaps without considering them, many physicians have adopted the "torture" argument. I believe that it is useful to explore two real cases to understand how the argument is applied and appreciate how the subtle value judgments that underlie this argument make a material difference in the lives of some patients.

As set forth in *Nguyen v. Sacred Heart Medical Center*,³⁵⁶ Baby Ryan was born with medical abnormalities so severe that his doctors decided to discontinue aggressive medical treatment. Over the objections of Ryan's parents, the doctors unilaterally removed him from his

DAWKINS, *supra* note 296, are not a mark of insanity, as some might suggest. The suggestion is both insulting and hostilely dismissive. Any attempt to label a patient insane because she is requesting benefits not cognizable by medical science must be promptly rejected.

352. *Supra* note 334 and accompanying text.

353. The fact that the physician disagrees with the surrogate does not create reasonable doubt as to the surrogate's ability to speak for the patient.

354. See the discussion above regarding *In re Wanglie*, *supra* notes 51-58 and accompanying text. If the surrogate has a financial incentive to keep the patient alive, that might create a reasonable doubt as to the surrogate's credibility. But that too would be a highly factual question depending upon all the relevant circumstances. Note that keeping the patient alive is typically to the surrogate's financial detriment.

355. See *supra* note 334 (discussing *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990)).

356. 987 P.2d 634 (Wash. Ct. App. 1999).

dialysis machine, which he vitally required for survival.³⁵⁷ He remained detached from the dialysis machine for eleven days, which, according to his parents, caused his condition to deteriorate significantly.³⁵⁸ Ryan’s parents obtained an injunction compelling dialysis, ending the eleven-day period.³⁵⁹ They claimed that he never fully recovered from the trauma he suffered over those eleven days, which ultimately lead to his death some four years later.³⁶⁰ Later, the hospital sued Ryan’s parents for inhumane treatment of their young child.³⁶¹ They claimed that the insistence of Ryan’s parents to continue dialysis was akin to child abuse by prolonging Ryan’s “undue pain and suffering” and that the state needed to step in to prevent continued abuse.³⁶² The “abusive” treatments that the parents insisted upon extended Ryan’s life by over four years, during which time he was able to go home and lead a relatively normal life.³⁶³ Presumably, the hospital did not anticipate that result. The hospital’s primary error was not its failure to accurately assess Ryan’s ability to recover from his condition—perhaps their conclusion was statistically correct and conforming with prevailing standards and conventions—but in undervaluing (relative to the position of Ryan’s parents) the *possibility* of recovery. They presumably undervalued the possibility of Ryan’s recovery because they valued another year (or four years) of Ryan’s life dramatically differently than did Ryan’s parents.³⁶⁴ Who was right? I don’t know that it matters. The dispositive question here is whether the hospital, a provider of medical services, should even have a seat at that table. The proper valuation of another year of Ryan’s life is not a physiological question; nor is it a question that the hospital has the normative authority to answer.

In some cases, the argument that a patient is being “tortured” by her family is ultimately more understandable. For example, consider the tragic case of Barbara Howe. Barbara’s health care agent, who was also her daughter, insisted on continued treatment despite Barbara’s need to have one eye removed and the other taped shut most of the day.³⁶⁵ Barbara also suffered rib and arm bone fractures which

357. *Id.* at 635.

358. *Id.*

359. *Id.* at 635.

360. *See id.* The parents brought claims against the hospital for lack of informed consent and negligent prenatal, labor, and delivery care, but lost on summary judgment and were denied the opportunity to amend their complaint to add a claim for outrage. *Id.* at 638.

361. Ostrom, *supra* note 194.

362. *Id.*

363. *Id.*

364. *See* Veatch & Spicer, *supra* note 247, at 18–19.

365. *In re Howe*, No. 03 P 1255, 2004 WL 1446057, *11–12 (Mass. Prob. & Fam. Ct. Dept. Mar. 22, 2004); *see also infra* notes 386–403 and accompanying text (discussing *In re Howe* in the context of physician autonomy).

“occurred in the course of usual care, such as turning her on her side or moving her up in the bed.”³⁶⁶ The hospital issued a statement in response to Barbara’s daughter’s requests: “It is not our goal to end Mrs. Howe’s life, but rather to cease care that is inappropriate and harmful, indeed inhumane . . . [and that continuing care is] inconsistent with the first tenet of our Hippocratic Oath, ‘Do no harm.’”³⁶⁷

Even in extreme circumstances such as these, the question of whether Barbara’s medical care qualifies as “torture,” “inappropriate,” “harmful,” or “inhumane,” rather than a terrible condition of being human known as “human suffering,” depends nearly exclusively on the answer to the following question: Was prolonging the life of Barbara Howe sufficiently valuable in its own right? If it was, the pain that she needed to suffer to get there provided her physicians no basis to deny her that opportunity. Just as in the case of Baby Ryan, Barbara’s hospital had no capacity to answer or evaluate the underlying and dispositive question regarding the nature and extent of value rendered to her via medical treatment.³⁶⁸ The question is a deeply personal one. In the present case, Barbara’s daughter, in an attempt (presumably in good faith)³⁶⁹ to actualize Barbara’s wishes, chose life.³⁷⁰ She said following Barbara’s death that it was important to Barbara that she remain alive until the point at which “G[-]d was ready to take her.”³⁷¹ She continued, “my family and I are pleased that her medical wishes were respected in life, as well as in death.”³⁷² Others likely would have chosen a different path. That personal decision must be left to them.

B. ‘Physician Autonomy’ Does Not Define the Scope of a Physician’s Legal Responsibilities

Barring a compelling need, medical providers should not be required to render medical care that they subjectively believe to be torture, or object to on other grounds. Physicians are not machines; they have positions of their own. And while their profession does not grant them the authority to opine on questions regarding moral, religious,

366. *In re Howe*, 2004 WL 1446057 at *13.

367. Liz Kowalczyk, *Plan to Take Woman off Life Support is Halted*, THE BOSTON GLOBE, Feb. 23, 2005, at B1, B5.

368. *See supra* Part III. This argument does not imply that individual doctors are therefore compelled to provide treatment. I address that question *infra* in section V.B.

369. For a discussion on the reasonableness of Barbara’s daughter’s actions, see *infra* notes 387–96 and accompanying text.

370. *See In re Howe*, 2004 WL 1446057.

371. Liz Kowalczyk, *Woman Dies at MGH After Battle over Care: Daughter Fought for Life Support*, THE BOSTON GLOBE, June 8, 2005, at A1.

372. *Id.*

ethical, or emotional convictions,³⁷³ they have their own similar preferences and it is not obvious that they should be required to sacrifice those in favor of the preferences of their patients.

Accordingly, where a physician objects to treatment, the physician should be permitted to transfer his patient to a willing competent physician even over the patient's objections. But where there is no competent physician who is willing to accept this patient, what is the treating physician to do? Ideally, these problems can be resolved contractually, *ex ante*. Physicians could put into their contracts, in a conspicuous manner, what they intend to do should continued aggressive treatment of the patient become extremely unlikely to provide any additional physical benefit.³⁷⁴ Provided that these contracts do not become unenforceable contracts of adhesion in violation of public policy,³⁷⁵ they would likely be useful in defining the obligations of the physician in light of his personal objections. Perhaps law can facilitate this by requiring physicians to negotiate *ex ante* and at arms-length with prospective patients regarding the possibility of future “futile” treatment. Currently, to my knowledge, the law does not require such negotiation and, in any event, contracting is not possible in the case of emergency care. What should the rule be in the absence of a valid and enforceable contract?

A rule respecting physician autonomy has much merit. First, as I discussed immediately above, physicians have moral and personal positions that ought to be respected no less than the moral and personal positions of their patients. Second, patients, as well as policy-makers,

373. *See supra* Part IV.

374. For any such agreement to be enforceable, the physician will have to take a great deal of care in defining his terms. The words “futile” and “unhelpful” are subject to broad interpretation. As I have argued, *see supra* Part IV, very little requested medical treatment is actually “futile.” Also, any appeal to empirical data needs to provide clear definitions. What is statistically a null set from the perspective of the physician might be very good odds in the eyes of the patient.

375. In truth, most such contracts probably would be contracts of adhesion and would violate public policy if the patient has no reasonable means of bargaining with the physician or finding an alternative physician who will agree to the patient's terms. *See* 17 C.J.S. *Contracts* § 12 (1999) (stating that the “factors to be considered in determining whether a contract of adhesion is unconscionable include whether the coerced party was on notice of the offending provision, whether the coercing party achieved agreement by fraud or overreaching, whether any alternatives existed for the coerced party, the subject matter of the contract, the degree of economic compulsion motivating the adhering party, and the public interests affected by the contract.” (citations omitted)). Physician's contracts are generally written by lawyers specifically hired by the physician for that purpose. The contracts are generally not subject to negotiation and a patient who declines to assent to one item on the contract will not receive treatment. If patients are not able to find out which qualified physicians are willing to meet their terms but need prompt medical treatment, they will effectively have no choice but to accept the contract in their hands. As a matter of public policy, a contract signed on those terms cannot be enforced. *See id.*

must understand that “it is difficult for a health care team to work for no positive end.”³⁷⁶ Medical providers presumably enter their profession for the purpose of helping people; when they are required to work long hours and with great diligence for the purpose of harming another (as they have subjectively defined their actions), we can expect that they will become less effective, fatigued, and possibly imprudent over time.³⁷⁷ Third, it may be unwise to undermine the judgment of physicians because they are seen by the public and within their own professional community as moral agents.³⁷⁸ Undermining their judgment may challenge public perception and the manner in which the physician sees himself, both of which could have deleterious consequences. Indeed, “[n]o rational patient would want unnecessarily to have a physician providing care who feels that his or her moral conscience is being violated.”³⁷⁹ Once the moral relationship between patient and physician is eroded, the physician is little more than a purveyor of medical goods in which professional discretion is non-existent and the patient, rather than the physician she hired, is placed in the position of practicing medicine.³⁸⁰ Finally, it is necessary to preserve the professional integrity of the medical profession. A rule that permits a patient or surrogate to force a physician to provide treatment over his objections has rather broad consequences.³⁸¹ If the patient or surrogate is successful, she compels a physician to affirmatively act against his medical judgment and what he believes are the best interests of the patient.³⁸² Accordingly, a denial of treatment over the objections of the patient is viewed as upholding “the obligation of physicians, as articulated in the Hippocratic Oath, . . . to

376. *E.g.*, Kolata, *supra* note 32, at A1.

377. *Id.* (quoting Massachusetts General Hospital officials, and stating that offering care under these conditions can “become[] disabling for the health care team”).

378. *See Daar, supra* note 50, at 1245.

379. Veatch & Spicer, *supra* note 247, at 24.

380. *See id.* at 17; *see also Daar, supra* note 50, at 1245 (opining that the physician’s only remaining role would be to physically dispense medical treatments).

381. “[W]e must recognize that more is at stake than a contest of values; the autonomy, integrity, and future of the medical profession are inevitably highlighted in such clashes.” Daar, *supra* note 50, at 225.

382. *See Daar, supra* note 50, at 234 (“Hospitals addressing the tension between patients and physicians over the provision of medically ineffective treatment have shown increasing empathy for the plight of physicians asked to compromise their professional conscience by acting against their best medical judgment.”). This argument might seem a bit circular in the context of this Article. I have argued that physicians making a futility declaration are making a claim that is based on the physician’s normative preferences rather than true medical judgment or anything resembling the interests of the patient. But note that I speak now from the perspective of the physician and physicians generally articulate futility claims in these terms. If we take physicians on their word, forcing them to treat their patients would indeed violate their judgment (which they may erroneously believe to be grounded on medical principles) and what they subjectively believe to be in the best interests of their patient.

act for the benefit of the patient according to *their ability and judgment*.”³⁸³

To illustrate how forcing medical professionals to offer care (over the objections outlined above) is disruptive to physician autonomy and the integrity of the medical profession, I return to the case of Barbara Howe.³⁸⁴ Barbara suffered from Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig’s Disease.³⁸⁵ After persisting in the hospital for a year and a half, Barbara’s attending physician opined in 2001 that her condition would not improve, she was not able and would not be able to communicate meaningfully with her family, and, based on *his* prior conversations with Barbara, he believed that she did not want to remain alive.³⁸⁶ Carol, Barbara’s daughter and health care agent, disagreed.³⁸⁷ While she conceded that there might be a point at which Barbara would wish to die, that point had not come.³⁸⁸ She believed that Barbara wanted to remain alive until she was unable to make simple physical responses to her family members, such as opening an eye.³⁸⁹ So Barbara remained alive and continued to receive aggressive medical care.³⁹⁰ While it was clear to Barbara’s medical staff that Barbara still had some cognitive ability in 2001,³⁹¹ by the time of the trial in 2004, they believed that Barbara had no meaningful ability to communicate her thoughts³⁹² and no one knew for certain whether and to what extent Barbara was able to experience pain.³⁹³ Further, it was questionable whether Barbara could communicate using facial signs to show that she was in pain.³⁹⁴ That uncertainty tormented members of Barbara’s medical staff.³⁹⁵ Carol continued to demand that Barbara receive aggressive treatment.³⁹⁶

When continued aggressive care necessitated the removal of Barbara’s right eye,³⁹⁷ at least one of Barbara’s long-time nurses refused

383. John J. Paris et al., *Beyond Autonomy—Physicians’ Refusal to Use Life-Prolonging Extracorporeal Membrane Oxygenation*, 329 NEW ENG. J. MED. 354, 357 (1993) (emphasis added) (footnote omitted).

384. See *In re Howe*, No. 03 P 1255, 2004 WL 1446057 (Mass. Prob. & Fam. Ct. Mar. 22, 2004); see also *supra* notes 338–69 and accompanying text.

385. *Id.* at *1, *3.

386. *Id.* at *5.

387. *Id.*

388. *Id.* at *5, *7.

389. *Id.*

390. *Id.* at *21.

391. *Id.* at *5.

392. *Id.* at *18.

393. *Id.* at *8, *19.

394. *Id.* at *19.

395. *Id.* at *8 (“[T]his issue of whether or not Mrs. Howe is suffering does torment many of her care givers.”).

396. *Id.* at *8, *19.

397. *Id.* at *11.

to participate, claiming that the process was “vile” and a “disgrace.”³⁹⁸ Another nurse described the treatment as “morally and ethically wrong” while yet another expressed that she was “saddened” by the thought that she increased Barbara’s suffering by caring for Barbara in the manner requested.³⁹⁹ All of this came to a head on June 6, 2003 when the chairman of the hospital’s Optimal Care Committee issued the following statement:

There is now 100% unanimous agreement that this inhumane travesty has gone far enough. This is the Massachusetts General Hospital, not Auschwitz. . . . They [the Hospital staff] have lived for two years with the appalling realization that they are under orders to resuscitate [Barbara] and so guarantee that her gallant life will be wiped out by a senseless act of brutality.⁴⁰⁰ The administrative mandate [to resuscitate] demands that the dimension of emotion in their care be shut out, repressed, stamped on, derogated, or just plain pretended away. It is therefore not only delusional but unfair. *It demands that the entire body of caregivers violate their professional oaths, the standards of medical and nursing practice, the standards of the Massachusetts General Hospital, and the standards of ethics, morality, human decency and common sense. . . .* The family has been allowed to dictate medical practice. *The resuscitation orders themselves were written by attorneys and make absolutely no medical sense whatsoever. . . .* Today Mrs. Howe is doomed to inevitable endophthalmitis [sic] which brings with it excruciating pain. . . . This tolerance of deliberately inflicted pain on Mrs. Howe must stop at once.⁴⁰¹

It would be callous not to recognize both the anguish of medical professionals asked to offer treatment under circumstances such as these and the plight of a profession forced to surrender its professional discretion. But it would also be callous not to recognize the plight of a patient or surrogate placed at the whim of her medical staff when that staff decides not to work to preserve the patient’s life.

When patient and physician autonomy come into conflict, the question of which ought to rule is an interesting one, but is ultimately decided by law. Physicians have a contractual and fiduciary⁴⁰² relationship with their patients. When the legal restrictions on the physician are in force, his desire or lack thereof to treat his patient is

398. *Id.* at *14.

399. *Id.*

400. The process of resuscitation, cardiopulmonary resuscitation (CPR) in particular, “is a brutal therapy which causes pain, may fracture ribs, and may lacerate internal organs.” *Id.* at *7.

401. *Id.* at *12 (insertion of “[the Hospital staff]” in original) (emphasis added) (footnote added).

402. “There can be little dispute that a doctor occupies a condition of trust and confidence, a fiduciary relationship with [the] patient.” *Taber v. Riordan*, 403 N.E.2d 1349, 1353 (Ill. App. Ct. 1980); see also Thomas L. Hafemeister & Selina Spinos, *Lean on Me: A Physician’s Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U. L. REV. 1167, 1188 & n.110 (2009) (discussing the fiduciary duties of a physician).

irrelevant.⁴⁰³ It does not matter that he has good reasons for not wanting to provide treatment that he is obligated to provide. Underlying normative arguments certainly inform the legal analysis, but to the extent that the legal questions are resolved, those normative arguments provide the physician no legal defense. Nevertheless, the normative questions are best resolved in favor of the patient, as I explain below.

In futility cases, the principal question is one of scope. If the scope of the physician’s relationship with his patient extends to “futile” care, failure to provide care is a breach of fiduciary duty,⁴⁰⁴ the tort of patient abandonment,⁴⁰⁵ or breach of contract.⁴⁰⁶ If, however, the scope

403. At the end of this section, I entertain the possibility that conscientious objection might provide a basis to permit the unilateral withdrawal of treatment. *See infra* notes 416–21 and accompanying text. In this context, that would mean that a conscientious objector is entitled to an exemption from existing background law. Even if conscientious objection ought to be grounds for such an exemption, general claims about autonomy are not. *See id.*

404. Breach of fiduciary duty in the context of a doctor-patient relationship is generally understood as a tort action on a theory of malpractice. *See* 70 C.J.S. *Physicians, Surgeons, and other Health-Care Providers* § 81 (2005). Because the duty of care is generally defined by custom, *see id.* § 87, and the custom of physicians is not to provide “futile” care, a claim for breach of fiduciary duty would seem to be a dead letter. Indeed, courts have given little attention to breach of fiduciary duty as a cause of action distinct from malpractice. *See id.* § 81 (“Malpractice . . . may be defined as comprising all acts and omissions of a physician or surgeon as . . . to a patient . . . which may make the physician or surgeon either civilly or criminally liable.”). But no court has explored the question in the context of medical futility either and the facts presented by futility cases suggest that a different approach to understanding fiduciary obligations is in order. *See generally* Hafemeister & Spinosa, *supra* note 402, at 1200–10 (articulating the fiduciary duty as theory distinct from malpractice). Fiduciary responsibilities are nowhere more acute than where trust has brought the beneficiary of the relationship into a helpless and dependant position. *See id.* at 1186. When a patient enters a relationship in trust of her physician, she expects that the physician will provide care according to her wishes. *See id.* Where there was no prior discussion about “futile” treatment and the patient had no reason to believe that the physician would not provide “futile” care, the patient might reasonably *expect* that “futile” care will be provided. *See id.* at 1192–93. Fiduciary law seeks to honor those reasonable expectations and not permit the dominant party to abuse the trust granted to him. *See* 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 76. If we accept that the doctor-patient relationship extends to “futile” care, this fiduciary relationship requires the physician to act even against his interests and wishes. *See id.* The physician’s autonomy does not protect him.

405. Patient abandonment is a form of medical malpractice that grows out of the fiduciary relationship between patient and physician. *See* 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 98. Patient abandonment generally has three elements. The physician must (1) unilaterally terminate care (2) without providing sufficient (a rather ambiguous term) notice to the patient at a time when (3) additional care is necessary (another ambiguous term). *See, e.g.,* Granek v. Tex. State Bd. of Med. Exam’rs, 172 S.W.3d 761, 766 n.2 (Tex. Ct. App. 2005). Similar to the analysis regarding fiduciary duty, *see supra* note 404, the tort of patient abandonment protects patients from being abused by their physi-

of that relationship is defined more narrowly, to exclude “futile” care, failure to provide care is completely unactionable, regardless of the merits of the aforementioned normative and moral arguments about physician autonomy. So stated, the relevant legal question is quite simple: does the fiduciary⁴⁰⁷ and contractual⁴⁰⁸ relationship between the patient and physician extend to demands of “futile” care?

The three causes of action of the prior paragraph have one important point in common in the context of “futile” care: The autonomy of the physician plays no role in their analysis because that autonomy

cians while completely helpless. See 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 98. Traditionally, patient abandonment applies where a physician accepts care of a patient and then walks away from the patient during the course of treatment in a context clearly within the scope of their relationship. See *id.* Assuming that “futile” care is within the scope of the relationship, see *infra* note 406, the physician that denies “futile” care and permits his patient’s condition to progress has abandoned the patient even if he continues to provide palliative care or some other limited form of care. The three elements are all met: The physician who terminates life saving care is terminating all meaningful care (defined from the prospective of the patient), he does so without providing *sufficient* notice given that at the time these cases arise the patient is helpless, thus rendering the provision of sufficient notice impossible (transfer to a willing competent physician would provide the only adequate alternative), and the additional requested care is necessary to the patient (again defined from the prospective of the patient).

406. When a contract, whether written or oral, is silent to particular terms, and there was no prior mutual understanding or mistake as to the meaning of the missing term, the law generally imposes a default rule. See Randy E. Barnett, *The Sound of Silence: Default Rules and Contractual Consent*, 78 VA. L. REV. 821, 822–26 (1992); see also, e.g., U.C.C. § 2-305 (2005) (setting forth default rules defining the price of a sale when the contract fails to specify a price); *Rickersten v. Carskadon*, 172 Neb. 46, 48, 108 N.W.2d 392, 395 (1961). To date, American courts addressing futility cases with living patients have generally compelled continued treatment. See *supra* Part III. While no court has expressly addressed the question, they virtually unanimously demand that the court err on the side of life when there is not time or sufficient information to fully address the underlying questions. See *Cruzan v. Dir.*, Mo. Dept. of Health, 497 U.S. 261, 280–81 (1990) (holding that preserving life and ensuring accuracy in end-of-life decision-making are both compelling governmental interests); *In re President & Dirs. of Georgetown Coll., Inc.*, 331 F.2d 1000, 1009–10 (D.C. Cir. 1964) (“Death could have mooted the cause in a matter of minutes, if action were not taken to preserve the status quo. To refuse to act, only to find later that the law required action, was a risk I was unwilling to accept. I determined to act on the side of life.”) (order by J. Skelly Wright, J.). Arguably, these cases illustrate that a default rule has developed requiring the provision of care, at least until a court ordered cessation. Accordingly, parties contracting for medical care would have to contract around that default rule if they desired a different result.
407. The fiduciary relationship is also the basis for the tort of abandonment. See 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 98.
408. Even where there is no written contract, there is at least an oral or implied contract between any physician and patient. See generally 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 79 (“The relationship of physician or surgeon and patient is one arising out of a contract, express or implied.”).

does not define the scope of the doctor-patient relationship. Indeed, the nature of a fiduciary relationship—a requirement under tort law to affirmatively act (as in the case of patient abandonment)—or a contract is to *diminish*, not expand, the autonomy of the parties. Aside for some brief comments in the footnotes,⁴⁰⁹ I will not discuss here the merits of the aforementioned causes of action as that would occupy too much space and would be beyond the scope of this Article. I mention them only to show that while “physician autonomy” presents some interesting normative arguments, it does not compel any particular conclusion. It is rather an afterthought if one comes to the conclusion that the scope of the doctor-patient relationship does not extend to “futile” care. If there is no relationship that compels the physician to act, his autonomy protects him from acting. But if there is a relationship that compels action, it compels action in spite of his autonomy. The arguments presented throughout Part IV of this Article, in contrast, help to define the scope of the doctor-patient relationship by identifying the valid arguments and theoretical bases from which to approach that question.

Further, there are strong normative and moral arguments against upholding physician autonomy in the context of “futility.” Patients in futility cases that lack a sudden trauma and debilitation⁴¹⁰ enter into a submissive trust relationship. Once the patient’s condition deteriorates to the point that she is no longer able to protect her interests, the physician’s responsibilities as an agent are heightened. The physician is not just performing a job, he is acting on behalf of the patient in an effort to actualize her interests. By withdrawing treatment that the patient reasonably⁴¹¹ expected to receive, the physician is doing more than exercising his autonomy. He is also violating the trust of his helpless patient. If the physician had strong feelings about “futile” care, he should have made those known *ex ante* so that the patient could have found another physician while she was able to do so. She is now stuck—and so is her physician.

And in the context of emergency care, when there is no pre-existing trust relationship, Congress stepped in and imposed affirmative obligations on physicians and hospitals. Congress enacted EMTALA to force hospitals to “stabilize”⁴¹² emergency care patients when the patient has no ability to care for herself.⁴¹³ No exception is made for futility patients and the statute, properly read, is fully applicable in

409. See *supra* notes 404–06. Much more can and must be said about all three causes of action. I will have to save those comments for another day.

410. I discuss emergent cases below.

411. While the expectations might not be reasonable from the physician’s perspective, they are reasonable from the patient’s perspective. And it is her perspective that is relevant to the present analysis.

412. 42 U.S.C. §1395dd(b)(1)(A) (2006).

413. See *supra* sections III.C–D.

futility cases.⁴¹⁴ EMTALA is not pragmatic, it is a moral legislation expressing the sense of society that people in these extremely vulnerable situations demand special protection as a function of their dignity. The specific requirements imposed by this dignity in futility situations are debatable and personal. By demanding stabilization, Congress set the bar very high to account for difference of opinion and to respect the dignity of all emergency care patients, even those who believe that the respect for human life requires heroic and perhaps rather painful efforts in the face of “futility.”

Note that where the physician claims that he is compelled by his conscience not to provide treatment, the analysis might be different. While much of the rhetoric at the beginning of this section referred to violations of conscience, the actual cases never discuss true conscience violations. Accordingly, my analysis thus far pertains to violations of *autonomy*, rather than *conscience*. When “sincere and meaningful” claims that “occup[y] a place in the life of [the physician] parallel to that filled [in the minds of the religious] by the orthodox belief in G[-]ld”⁴¹⁵ categorically forbid the provision of “futile” care, the physician’s autonomy claims become conscience claims. He is a conscientious objector; the proper analysis of his objection changes significantly because the normative force and scope of his argument is different for reasons beyond the scope of this Article.⁴¹⁶ Conscience claims by physicians are very uncommon in futility cases. In every futility case of which I am aware, including that of Barbara Howe,⁴¹⁷ those asserting the right to terminate care have not argued that they would rather go to prison than to provide the requested care. They have not argued that they are compelled by something, whether G-d, religious belief, or a deeply held worldview that *forbids* treatment.⁴¹⁸ Rather, they might argue that they are asked to do something that is “unfair” and

414. See *Moses v. Providence Hosp.*, 561 F.3d 573 (6th Cir. 2009), *cert. denied*, 130 S.Ct. 3499 (2010).

415. See *United States v. Seeger*, 380 U.S. 163, 166 (1965); see also *Welsh v. United States*, 398 U.S. 333, 339 (1970) (discussing the conscientious objector standard of a sincere and meaningful *religious* belief).

416. See Douglas Laycock, *Religious Liberty as Liberty*, 7 J. CONTEMP. LEGAL ISSUES 313, 326–37 (“The nontheist’s belief in transcendent moral obligations—in obligations that transcend his self-interest and his personal preferences and which he experiences as so strong that he has no choice but to comply—is analogous to the transcendent moral obligations that are part of the cluster of theistic beliefs that we recognize as religious.”). See generally, e.g., Kevin J. Hasson, *Religious Liberty and Human Dignity: A Tale of Two Declarations*, 27 HARV. J.L. & PUB. POL’Y 81 (2003) (noting the societal and personal value of sincerely held religious beliefs and the interests of government in protecting them).

417. See *In re Howe*, No. 03 P 1255, 2004 WL 1446057 (Mass. Prob. & Fam. Ct. Mar. 22, 2004).

418. The fact that someone uses the word “conscience” or uses other rhetoric of conscientious objection does not automatically make the objection a conscience claim rather than a general autonomy claim. See, e.g., *Aguayo v. Harvey*, 476 F.3d 971,

“makes absolutely no medical . . . sense whatsoever” in part because it is “inhumane” and “brutal[.]”⁴¹⁹ They might believe that continued treatment is wasteful, inefficient, harmful to the patient, foolish, or something along those lines. While these arguments are significant and perhaps valid in many cases, they do not rise to conscience claims. Because conscience claims by physicians are so uncommon, conscience claims that directly implicate severe injury against third parties are particularly complicated,⁴²⁰ and balancing the conscience of the physicians against the arguments in favor of continued treatment is exceedingly difficult, I will not attempt to so balance.

C. The Allocation of Scarce Medical Resources

My arguments against medical futility would not be complete absent a discussion on rationing. Medical resources are scarce, as are the dollars that finance them.⁴²¹ If patients have unfettered authority to demand that physicians provide care, and policy makers are helpless to deny treatment in the face of those demands, it may prove difficult to allocate medical resources efficiently.⁴²² Similarly “if the benefits of a treatment are so debatable that [many people] consider them not to exist, that is an obvious place to conserve [scarce medical] resources,” thus mitigating the problems of allocation.⁴²³

There is a strong argument, which many have accepted, that the arena of medical futility is a great place to conserve scarce medical resources.⁴²⁴ That is, even if medical futility has no ideological or internal justification (indeed, even if it is entirely incoherent), it is exter-

980–81 (D.C. Cir. 2007) (upholding a finding that an applicant’s objections were not true “conscience” claims).

419. See *In re Howe*, 2004 WL 1446057 at *12.

420. Conscience claims typically arise in the context of military service and abortion. Generally, when an enlisted member of the military says that he cannot serve or a physician says that she is not able to perform an abortion, the impact on third parties is minimal (highly unusual cases excepted). The military’s loss of one soldier generally does not impair the military; this physician’s refusal does not prevent the patient from obtaining an abortion. But regarding futility cases in which transfer is not an option, the physician’s conscience claim implicates severe and permanent physical harm to another person.

421. See Monica Schoch-Spana et al., *Influenza Vaccine Scarcity 2004–05: Implications for Biosecurity and Public Health Preparedness*, 3 *BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI.* 224, 224 (2005) (“Scarcity of life-saving resources is one of the most complex challenges that decision makers may face when managing the impact of a biological attack . . .”).

422. *Id.*

423. Veatch & Spicer, *supra* note 247, at 28.

424. *E.g., id.* at 17, 28–29; Paris et al., *supra* note 384, at 357 (referring to the provision of “futile” medical treatment as a “misallocation of resources and personnel” and declaring that providing resources to a “futile” patient “would impose excessive and unnecessary expense on the community”); RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 68–69 (Addison-Wesley Publ’g

nally justified through efficiency arguments. Thus, economic efficiency provides, in the eyes of some commentators, a robust justification for withdrawing care in "futility" cases.⁴²⁵ This section will explore whether scarcity provides a sufficient external justification for the futility movement.

Notwithstanding the genuine problems relating to the scarcity of medical resources, the AMA has stated that the scarcity of resources is not a defense for the futility movement and that futility must be debated on its own terms out in the public square.⁴²⁶ First, the AMA fears that if scarcity is used to justify futility, the two issues may be confused as part of the same problem.⁴²⁷ Decisions relating to both scarcity and futility are often necessary, says the AMA, but they are different and need to be kept analytically separate.⁴²⁸ Second, the AMA states that even if it would be logically appropriate to conflate scarcity and futility, it is unclear that denying treatment to futility patients would conserve resources at a volume sufficient to justify the futility movement because some estimates suggest that doing so would effect only a "minor" health care savings.⁴²⁹

The propriety of the AMA's recommendations are debatable. According to some commentators, scarcity is not a problem that can be expressly addressed in the public forum because any discussion relating to the conservation of medical resources will necessarily involve weighing and *violating* important social norms.⁴³⁰ It is harmful for society when decision-makers explicitly state that they will allow one person or class of people to die in favor of saving another person or class. Accordingly, many political actors, including the British government in 1992, have argued that, as a matter of social policy, it is better to tell patients who will be denied medical care in order to reserve a scarce resource for another patient, that modern medicine is

Co.1999) (arguing that under the "veil of ignorance" most of us would choose better preventative care over end-of-life and emergent care).

425. At least one commentator wrote about the case of Baby Ryan (in which Ryan Nguyen's parents insisted on aggressive medical treatment over the objections of Ryan's doctors, see *Nguyen v. Sacred Heart Med. Center*, 987 P.2d 634 (Wash. Ct. App. 1999)), arguing that the effort to keep Ryan alive imposed an economic drain on society that ought not to be readily tolerated. Ostrom, *supra* note 194. It is interesting that she chose this case, considering that Baby Ryan partially recovered and lived four years following his treatment. *See id.* In light of its conclusion, this case provides a remarkably weak efficiency justification.

426. AMA Report, *supra* note 261, at 938.

427. *See id.*

428. *See id.*

429. *See id.* I am accepting the AMA's position as a basis for argument without adopting it as my own. I suspect that the AMA might be overstating its case here, *see, e.g.*, EPSTEIN, *supra* note 424, at 63-65, but I do not adopt an opinion for the purpose of this Article.

430. *See* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 18-21 (W.W. Norton & Co. 1978).

unable to help them; that “nothing more can be done medically.”⁴³¹ Medical futility may thus be an appropriate subterfuge for decision-makers to utilize for the purpose of conserving medical resources without admitting to the public that this is what they are doing. In other words, even if the medical futility movement is not coherent and is not independently justified, it may nonetheless be desirable as a means to a larger end. According to Guido Calabresi and Philip Bobbitt, the use of such a subterfuge is important to insure that the “tragic choices” made by official decision-makers seem “necessary [and] unavoidable, rather than chosen.”⁴³²

Many commentators have criticized Calabresi and Bobbitt’s approach for its lack of candor.⁴³³ I have commented elsewhere about the use of the Calabresi and Bobbitt’s approach in the specific context of bioterror preparedness, arguing that the use of subterfuge is not appropriate wherever the subterfuge itself will be conspicuous to the public, even if the public will not be able to discern what the subterfuge is intended to conceal.⁴³⁴ I think that both of those critiques are applicable here, in the context of medical futility, but wish to add a third critique that renders the use of medical futility wholly inappropriate for use as a subterfuge in any case.

The purpose of subterfuge is to disguise the allocation of medical resources in favor of one human being at the expense of another because doing so would violate the esteem in which we hold human life.⁴³⁵ If society’s chosen subterfuge is not the supposed inability of medical science to provide treatment, such as Great Britain claimed when it denied dialysis to sixty-five percent of medically indicated patients,⁴³⁶ but rather the declaration that the patient who will be denied treatment is less-worthy of that treatment (by virtue of its being “futile”), there is no need for a subterfuge. Indeed, using a subterfuge

431. Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1612 (1992) (stating that Great Britain denied dialysis to those aged over sixty-five—or to those over fifty-five who also had a complicating medical condition—to ensure that dialysis machines would be available for younger patients).

432. CALABRESI & BOBBITT, *supra* note 430, at 21.

433. See, e.g., Fleck, *supra* note 431, at 1612–18; David L. Shapiro, *In Defense of Judicial Candor*, 100 HARV. L. REV. 731, 749 (1987) (suggesting that the value of human life may better be served by a candid discussion about the tension between that value and, for example, the desire not to prolong human suffering).

434. Meir Katz, Note, *Bioterrorism and Public Law: The Ethics of Scarce Medical Resource Allocation in Mass Casualty Situations*, 21 GEO. J. LEGAL ETHICS 795, 818–19 (2008).

435. See Fleck, *supra* note 431, at 1608–09 (stating that when we devote untold resources into the search and rescue effort following a coal mine collapse, “we will have affirmed that human life is priceless . . . though we effectively [priced human life] at the safety allocation level”).

436. *Id.* at 1612.

in that scenario may be more destructive than simply declaring that rules of allocation dictate that one patient will be saved and not the other. To use an extreme example, John, an eighty-five-year-old AIDS patient with diabetes and cardiovascular deficiency and Mike, a healthy twenty-three year-old are brought to the emergency room of a small rural hospital following a car crash. Both need immediate access to the hospital's only respirator. Under traditional principles of medical allocation, the hospital can justify giving the respirator to Mike.⁴³⁷ Those principles are outlined in the footnotes. If the hospital opted instead to conceal its use of explicit allocation by adopting a subterfuge, it would be serving no one by declaring that further care of John, an elderly AIDS patient, is "futile." Although John's medical condition, viewed holistically, may be relevant to the hospital triage

437. See Kenneth V. Iserson & John C. Moskop, *Triage in Medicine, Part I: Concept, History, and Types*, 49 ANNALS OF EMERGENCY MEDICINE 275, 279 (2007). Hospitals use "triage" systems to help them queue patients for treatment. These are generally not rules of exclusion, but rather are rules of priority. They operate generally by placing each patient in one of five groups. *Id.* at 279. Patients placed in the highest priority group are those who need immediate medical treatment and who can be saved by treatment that the hospital has the capacity (both in terms of technology and in terms of supply) to administer. See *id.* Patients who have suffered only psychological trauma are given the lowest priority and in some cases may be asked to seek treatment elsewhere. *Id.* Patients "whose condition exceeds the available therapeutic resources" or whose medical needs are greater than the hospital is able to provide under the circumstances receive no priority; they are "black tagged" and are not treated unless the hospital discovers that the patient was assessed incorrectly, resources unexpectedly become available, or the patient's medical condition improves and shifts into another priority category. See *id.*; WORLD MED. ASS'N, WORLD MEDICAL ASSOCIATION STATEMENT ON MEDICAL ETHICS IN THE EVENT OF DISASTERS (2006), <http://www.wma.net/e/policy/d7.htm>. These triage programs do not generally permit a hospital to deny treatment to a patient whose needs are great and prognosis poor where there is not an immediate or anticipated need for the necessary resources. See *id.* They generally assume two patients, presented before the hospital in close temporal proximity (or where the latter patient is reasonably expected, given statistical data, to soon present himself before the hospital), both of whom are seen to have equal rights to health care and would both be treated under normal circumstances, but have come to the hospital under extraordinary circumstances. If a hospital must choose between devoting its resources to a patient who has a reasonable chance of recovery and one who does not, it is fully justified under traditional systems of triage to devote its resources to that patient who can recover. But where the hospital has the technological capacity and sufficient medical resources to treat both patients, or where it is statistically unlikely (based on prior experience) that a second patient who will need the specific resources exhausted by the treatment of the first patient will present himself to the hospital (prior to the time that the hospital can reasonably expect to obtain more such resources), rules relating to allocation and triage say nothing. See *id.* It is uncontroversial that where a hospital is presented with one patient in need of medical services, and has sufficient resources on hand to treat that patient, the hospital would not be justified, under traditional triage doctrine, to deny treatment out of speculative fear that more "worthy" patients may come later. See *id.*

officer designated the responsibility of deciding who will receive treatment first, neither John's age nor his status as an AIDS patient provides a legitimate basis to deny access to medical care in the absence of significant mitigating factors. Identifying those specific aspects of John's medical history as a basis for denying care by way of subterfuge violates important social values to a much greater extent than would conspicuous and explicit allocation due to the absence of sufficient resources.

Withdrawing aggressive medical care from the “futile” patient can be independently appropriate as a vehicle to achieve efficient allocation only where preliminary decisions regarding the relative value of the “futile” patient's life are established and publicly accepted. We need some other basis to choose between these two patients. And as I have argued in this Article,⁴³⁸ the medical profession does not have the expertise and is not sufficiently free from bias to make those preliminary decisions competently. Accordingly, the argument that the futility movement is justified because it satisfies society's need to allocate medical resources needs significant development and normative authority.

The obvious response is that if we must choose, and we must, the logical choice is to choose the patient who will live. While that knee jerk may be initially intuitive, it needs logical support. The necessity of rationing is documented and commentators and decision-makers approach that necessity in a wide variety of ways. Some have argued that the resources are better allocated to he who arrived first, rather than giving them to the patient who will most benefit from them.⁴³⁹ A similar approach, using the facts in my hypothetical above, would be to give the respirator to the patient closest to it at the time that the respirator must be allocated.⁴⁴⁰ Others have suggested that adopting a lottery provides a better approach.⁴⁴¹ I have dealt with these and other approaches to rationing at length elsewhere⁴⁴² and they are beyond the scope of this Article. My point here is simple and, I think, uncontroversial. Rationing and futility are indeed separate ideas, just as the AMA argued.⁴⁴³ The necessity of rationing exists regardless of the doctrine of medical futility and medical futility is not obviously the best or only vehicle to solve the problem of rationing.⁴⁴⁴ The necessity

438. *Supra* Part IV.

439. *See* Katz, *supra* note 434, at 799–805.

440. *See id.*

441. *See id.*

442. *See id.*

443. *See supra* note 426 and accompanying text. AMA's second argument—that the cost savings from adopting a futility standard is unlikely to result in significant savings—might also be correct but is unnecessary for the development of this argument.

444. Katz, *supra* note 434, at 104.

of rationing thus provides no external logical or normative justification to medical futility.

VI. CONCLUSION

The law that has developed in the United States pertaining to medical futility is confusing. There may be no concise analytical way to describe the state of the law or how courts decide futility cases because the underlying inquiries are often highly fact-intensive. Some have postulated that the "law" provides only that when a patient or surrogate comes to court, the court is very likely to grant an injunction to keep the patient alive but if the family comes after the death of the patient to collect damages, the court is very likely to award none, assuming that the hospital or physician acted in accord with the prevailing standards of care.⁴⁴⁵ The question then becomes how to define those standards of care and if the law ought to place limitations on the medical community's ability to define them.

The doctrine of medical futility makes certain significant underlying and questionable assumptions about human life, the lives of ill patients, and about the medical community's ability to decide important ethical questions, including regarding the value of the lives of individual patients. The value of the continuation of a human life is defined not exclusively physiologically but also according to various personal inquires that are beyond the expertise of the medical community. The life of someone in a persistent vegetative state may be supremely valuable to the patient and her family. And the goals of that patient may be distinctly non-physiological. Modern medicine is thus an inappropriate tool for accessing the patient's needs. The decision, then, to cease the provision of medical care for a given patient solely on the grounds that her life is of low quality and because she has a diminished probability of recovery is incoherent; the "futility" of treatment can play no independent role in medical decision-making.

The medical community asserts its ability to make controversial decisions in moral philosophy by appealing to its neutral position as arbiters of all questions relating to medicine. Society, of course, has not given its imprimatur to the medical community to engage in amateur moral philosophy. That community has no expertise to engage in ethics or philosophy and lacks the normative authority necessary to render decisions in futility cases. Further, we must be concerned that institutional bias within the medical community affects its ability to make important ethical decisions for society. This problem is exacerbated when the society that the medical community seeks to represent and the medical community itself seem to adopt different views re-

445. *See supra* Part III.

garding the moral, religious, ethical, emotional, and personal questions that underlie medical futility cases.

Accordingly, we ought to design our end-of-life treatment policies in a manner that respects the interests of the patient and “tolerate[s] the choices of others, even when we believe they are wrong.”⁴⁴⁶

446. Truog, *supra* note 225, at 3; *see* Katz, *supra* note 323, at 107–14.