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THADDEUS MASON POPE*

ABSTRACT

Over the past fifteen years, a majority of states have enacted medical futility statutes that permit a health care provider to refuse a patient's request for life-sustaining medical treatment (LSMT). These statutes typically permit the provider to unilaterally stop LSMT where it would not provide "significant benefit" or would be contrary to "generally accepted health care standards." These safe harbors are vague and imprecise, however. Consequently, providers have been reluctant to utilize these medical futility statutes.

The uncertainty concerning these statutes most likely cannot be reduced. States have been unable to reach a consensus on substantive measures of medical inappropriateness. Only a purely process-based approach like that outlined in the Texas Advance Directives Act (TADA) has proven effective in inducing the conduct that medical futility statutes intended. Therefore, while the specific contours of TADA must be refined, policymakers in other states should look to the TADA as a model.

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INTRODUCTION

Esther Hutchison is a 97-year-old woman with metastasized cancer in her liver, kidneys, and lungs.[1] She will never again be conscious. Her medical treatment includes mechanical ventilation support and artificial nutrition and hydration. Pursuant to an advance directive, Mrs. Hutchison's daughter is her mother's agent for health care decisions. She wants the health care team to "do everything" to save her mother's life.

But, given her situation, Mrs. Hutchison's health care providers are uncomfortable with continuing to provide her with life-sustaining medical treatment (LSMT).[2] They want to switch her to comfort care.[3] Several meetings with the treatment team, ethics committee, social workers, and clergy have failed to change the daughter's treatment request. Now, the treatment team wants to withdraw treatment *without* the daughter's consent. The relevant health care law seems to authorize this unilateral action,[4] but the team and the hospital are unwilling to proceed. They are reluctant to do what they think is right and what the law allows.

During the 1990s, a significant number of professional medical associations and individual health care providers and institutions formally concluded that, under some circumstances, in cases of intractable conflict such as Mrs. Hutchison's, it would be appropriate for health care providers to

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1. This is a fictional case based on the facts of many cases discussed in this Article.

2. LSMT refers to medical interventions that sustain the patient's life, but are not effective in helping the patient recover from a terminal condition or persistent vegetative state. These interventions may include assisted ventilation, artificial nutrition and hydration, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs. Following the statutory convention, this Article refers to LSMT as a category. *See, e.g.*, ALA. CODE § 22-8A-3(8) (LexisNexis 2006); 755 ILL. COMP. STAT. ANN. 40/10 (West 2007). Yet, as Edmund Pellegrino notes, "[e]ach treatment must be evaluated in terms of its end . . . ." Edmund D. Pellegrino, *Decisions at the End of Life—The Abuse of the Concept of Futility*, PRACTICAL BIOETHICS, Summer 2005, at 3, 5.

3. *See infra* notes 79–80 and accompanying text.

4. This Article uses the term "unilateral action" to describe the situation in which the health care provider overrides a patient's or surrogate's request for LSMT. Where the provider acts unilaterally, she acts contrary to the instructions of the legally authorized decision maker. This usage is consistent with most of the literature. *See, e.g.*, Kathryn L. Moseley et al., *Futility in Evolution*, 21 CLINICS GERIATRIC MED. 211, 216 (2005). While the term "unilateral action" is also sometimes used to refer to a situation where the provider stops LSMT when the patient is incompetent and no surrogate is reasonably available, this Article does not cover such cases. In such a situation, there is no overriding authority because the provider typically becomes the authorized decision maker.

unilaterally withhold or withdraw LSMT.[5] But most health care providers were unwilling to act on these policies and guidelines without sufficient legal protection.[6] Many state legislatures responded by enacting statutes that purport to provide this protection and to authorize health care providers to unilaterally withhold or withdraw LSMT.[7]

But, as exemplified in Mrs. Hutchison's case, these unilateral decision statutes have failed to achieve their intended purpose. Today, even with explicit statutory authorization and grants of immunity, health care providers are *still* reluctant to unilaterally withhold or withdraw medically inappropriate LSMT.[8]

Futility disputes are becoming increasingly common.[9] Because providers want adequate legal authority to make unilateral decisions, it is important to diagnose the effects, or lack thereof, of the unilateral decision statutes. This Article reviews the history and effects of the unilateral decision statutes. Certainly, there are ongoing academic and legislative debates concerning whether unilateral decision making is even good public policy. Rather than directly engaging that debate, this Article assesses these statutes on their own terms.

Part One of this Article provides a brief overview of medical futility[10]

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5. *See infra* notes 53, 280-82 and accompanying text.

6. *See infra* notes 276-90 and accompanying text.

7. *See infra* notes 291, 297-310 and accompanying text.

8. *See infra* notes 382-83, 387-403 and accompanying text.

9. *See infra* notes 84–88 and accompanying text. *See generally* Thaddeus Mason Pope & Ellen A. Waldman, *Mediation at the End-of-Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143 (2007) (explaining why mediation has failed as a mechanism for resolving the growing number of futility disputes).

10. This Article uses the term "medical futility" to describe only a type of dispute. *Cf.* Anne L. Flamm, *The Texas "Futility" Procedure: No Such Thing as a Fairy Tale Ending*, 11 LAHEY CLINIC MED. ETHICS J. 11, 11 n.1 (2004) (using "futility" for "sake of brevity" to describe situations where patients or surrogates demand LSMT that the health care provider believes to be un-useful or harmful); John Fletcher, *The Baby K Case: Ethical and Legal Considerations of Disputes about Futility*, 2 BIOLAW: A LEGAL AND ETHICAL REPORTER ON MEDICINE, HEALTH CARE AND BIOENGINEERING S:219, S:231-:233 (1994) (using "futility" to describe a "type of moral dispute"); Edmund D. Pellegrino, *Futility in Medical Decisions: The Word and the Concept*, 17 HEC FORUM 308, 309 (2005) (using "futility" as a clinical concept to describe the point where medical treatment "can no longer serve any recognizable good for the patient"). The term's pervasiveness in the literature justifies this much. Because the term is so troubled; however, this Article abandons "medically futile" in favor of "medically inappropriate" when referring to a type of treatment or intervention. *Cf.* Michael Ardagh, *Futility Has No Utility in Resuscitation Medicine*, 26 J. MED. ETHICS 396, 399 (2000) ("The words futile and futility should be abandoned . . . ."); Jeffrey T. Berger, Letter to the Editor, *Advance Directives, Due Process, and Medical Futility*, 140 ANNALS INTERNAL MED. 402, 403 (2004) (noting concept of medically appropriate, rather than futility, "integrates the society-based authority under which physicians operate with the physicians' fiduciary obligations to patients"); Raanan Gillon, *Futility—Too Ambiguous and Pejorative a Term?*, 23 J. MED. ETHICS 339, 339 (1997) (describing "futility" term as unclear and too complex); Eric M. Levine, *A New*

disputes, including both how they arise and how they are resolved. Part Two summarizes the leading definitions of "medical inappropriateness." These include brain death and physiological futility, where there is literally nothing that medicine can offer the patient. Other definitions of "medical inappropriateness" include concepts that are less scientifically measurable and more value-laden, including quantitative futility, qualitative futility, and generally accepted health care standards.

But definitions are not enough. Taking unilateral action has been and still is fraught with legal risks. Part Three outlines legal constraints on the unilateral withholding and withdrawing of LSMT. In particular, this Part reviews potential civil, criminal, and disciplinary sanctions that could result. Then, Part Four canvasses state legislation that purports to relieve providers from these constraints by authorizing the unilateral limitation of LSMT.

Part Five examines the effects of these unilateral decision statutes. While some evidence suggests that unilateral decision statutes facilitate the informal resolution of disputes, they do not provide a workable solution against intractable disputes. The unilateral decision statutes were meant to permit providers to decline to comply with requests for medically inappropriate treatment. But providers continue to comply with such requests. Not only have most health care institutions never adopted a futility policy, but most of those that have a futility policy have never implemented it. Yet, there is a notable exception in Texas where providers do unilaterally stop LSMT.

Part Six analyzes why the unilateral decision statutes have failed to achieve their intended objective. In particular, this Part contends that despite statutory authorization and grants of immunity, providers are "chilled" from unilaterally stopping treatment because of legal uncertainty. There are three potential sources of this uncertainty: (1) the vagueness of the state statutes, (2) their potential federal preemption, and (3) their potential unconstitutionality. Since Texas providers are subject to the same federal and constitutional restrictions, this Article posits that the relevant "chilling" uncertainty must come from the vagueness of the state statutes.

Finally, Part Seven offers some suggestions on how to eliminate this statutory vagueness. There are two primary options: (1) legislate concrete, measurable, and predictable clinical criteria; or (2) legislate a concrete, measurable, predictable process. No consensus exists on the precise, legislatable measures of medical inappropriateness. Apparently then, only a purely process-based approach, like the one adopted in Texas, can effectively protect the conduct that medical futility statutes were designed to protect. While the current formulation of that process may not be sufficiently fair and

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Predicament for Physicians: The Concept of Medical Futility, the Physician's Obligation to Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care, 9 J. L. & HEALTH 69, 84 n.104 (1994-1995) (avoiding use of terms "futile" and "useless" by replacing them with "medically inappropriate"); Thaddeus Mason Pope, *Is Public Health Paternalism Really Never Justified? A Response to Joel Feinberg*, 30 OKLA. CITY U. L. REV. 121, 202-06 (2005) (discussing the dangers of employing "thick" terms).

rigorous, Texas's pure process approach wizens (if not eliminates) uncertainty and should serve as a model for other states.

I. OVERVIEW OF MEDICAL FUTILITY

A. Dying in America

Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill individuals, without always offering realistic prospects for improvement or cure.[11] "Halfway" technologies such as mechanical ventilation and artificial nutrition and hydration can sustain biological life for practically indefinite periods of time but may not themselves lead to improvement or cure.[12]

As a consequence of the availability of these life-sustaining technologies, most deaths in America occur in an institutional setting such as a hospital.[13] Most of these institutional deaths are the result of an intentional, deliberate decision to stop LSMT and allow death.[14] Nancy Dubler explains that "[d]eath is a negotiated event; it happens by design. . . . 70% of the 1.3 million Americans who die in health care institutions do so after a decision has been made and implemented to forego some or all forms of medical treatment."[15]

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11. *See* Alan Meisel & Bruce Jennings, *Ethics, End-of-Life Care, and the Law: Overview*, *in* LIVING WITH GRIEF: ETHICAL DILEMMAS AT THE END OF LIFE 63, 63 (2005) ("Most of the cases and dilemmas that have shaped the law on end-of-life care have involved patients whose lives could be prolonged by new medical treatments and technologies, but whose health, functioning, quality of life, and even conscious awareness itself could not be restored."). *See generally,* WILLIAM H. COLBY, UNPLUGGED: RECLAIMING OUR RIGHT TO DIE IN AMERICA 57-71 (2006) (discussing the ascent of medical technology in futility cases); JOHN D. LANTOS & WILLIAM MEADOW, NEONATAL BIOETHICS: THE MORAL CHALLENGES OF MEDICAL INNOVATION 18–52 (2006) (describing moral controversies arising from advances in neonatal care).

12. John Lantos, *When Parents Request Seemingly Futile Treatment for their Children*, 73 MOUNT SINAI J. MED. 587, 588 (2006); Gay Moldow et al., *Why Address Medical Futility Now?*, MINN. MED., June 2004, at 38, 38.

13. *See* Thomas Wm. Mayo, *Living and Dying in a Post-Schiavo World*, 38 J. HEALTH L. 587, 587–88 n.3 (2006) (citing S. 570, 109th Cong. § 2(a)(1) (2005)) (stating that eighty percent of deaths in America occur in hospitals).

14. *See* Arthur E. Kopelman, *Understanding, Avoiding, and Resolving End-of-Life Conflicts in the NICU*, 73 MOUNT SINAI J. MED. 580, 580 (2006) ("Eighty percent of the deaths that occur in the neonatal intensive care unit (NICU) are preceded by decisions to limit, withhold, or withdraw life support . . . ."); Pellegrino, *supra* note 2, at 3 ("[T]he majority of patients in modern hospitals today die as a result of a deliberate decision to withhold or withdraw treatment."); Thomas J. Prendergast & John M. Luce, *Increasing Incidence of Withholding and Withdrawal of Life Support from the Critically Ill*, 155 AM. J. RESPIRATORY & CRITICAL CARE MED. 15, 15 (1997) ("[W]ithholding or withdrawal of life support precedes 40 to 65% of deaths in intensive care facilities.").

15. Nancy Dubler, *Limiting Technology in the Process of Negotiating Death*, 1 YALE J.

B. The Right to Die

For some individuals the possibility of extended life is meaningful and beneficial. For others, the artificial prolongation of life may provide nothing beneficial and serve only to extend suffering and prolong the dying process. To accommodate these varying attitudes, the rise of modern life-sustaining medical technologies was accompanied by the rise of patient autonomy.[16]

During the 1970s and 1980s, appellate courts across the country decided numerous cases in which patients and patients' families wanted to withdraw or withhold LSMT but health care providers were reluctant to cede to such requests.[17] These cases firmly established the right of patients to refuse LSMT.[18] These cases also established the right of surrogates to exercise this right for patients who were incompetent and unable to exercise it for themselves.[19]

Today, all states have laws enabling patients and surrogates to refuse medical care.[20] Patients and surrogates decide whether LSMT is beneficial

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HEALTH POL'Y L. & ETHICS 297, 297 (2001) (reviewing MANAGING DEATH IN THE INTENSIVE CARE UNIT: THE TRANSITION FROM CURE TO COMFORT (J. Randall Curtis & Gordon D. Rubenfield eds., 2001) [hereinafter MANAGING DEATH]); *see* Thomas J. Prendergast et al., *A National Survey of End-of-Life Care for Critically Ill Patients*, 158 AM. J. RESPIRATORY & CRITICAL CARE MED. 1163, 1163 (1998). *See generally* COLBY, *supra* note 11, at 95–107 (discussing the correlation between the increasing life expectancy and the rising use of LSMT).

16. *See* Matthew S. Ferguson, *Ethical Postures of Futility and California's Uniform Health Care Decisions Act*, 75 S. CAL. L. REV. 1217, 1230 (2002) ("As we moved into the 1990s, however, patients became consumers of medical technology, often forcing the hands of their doctors by seeking to determine when treatment should be applied.").

17. *See generally* ALAN MEISEL & KATHY CERMINARA, THE RIGHT TO DIE § 2 (3d ed. 2005 & Supp. 2007) [hereinafter THE RIGHT TO DIE] (discussing legal development of end-of-life decision making); CLAIRE C. OBADE, PATIENT CARE DECISION-MAKING: A LEGAL GUIDE FOR PROVIDERS chs. 7-8 (1991 & Supp. 2006) (providing case law guidance for balancing patient rights with medical responsibilities).

18. *See generally* THE RIGHT TO DIE, *supra* note 17, at § 2 (tracing the right to die from its common law roots to Supreme Court jurisprudence); OBADE, *supra* note 17, at chs. 7-8 (discussing exceptions to the general rule requiring treatment and the legal bases for such exceptions).

19. *See generally* THE RIGHT TO DIE, *supra* note 17, at § 4; OBADE, *supra* note 17, at chs. 9, 11. This Article employs the term "surrogate" to refer to all those who are authorized to make health care decisions on behalf of the patient, whether appointed by the patient herself (e.g, agents, surrogates), by a court (e.g., guardians, conservators), or by default legal rules (e.g., surrogates). Most patients are unable to communicate with providers at the time decisions are made about stopping LSMT. *See* MANAGING DEATH, *supra* note 15, at 364; Seth Rivera et al., *Motivating Factors in Futile Clinical Interventions*, 119 CHEST J. 1944, 1945 (2001) ("None of the patients were able to participate in the decision-making process of their own care since they were universally too impaired."). Therefore, these decisions are usually made by surrogates.

20. *See generally* THE RIGHT TO DIE, *supra* note 17, at § 7; OBADE, *supra* note 17, at app. A.

given their own values and particular circumstances.[21] Health care providers must generally comply with decisions to refuse LSMT.[22]

C. *Nature of Medical Futility Disputes*[23]

A medical futility dispute arises when a health care provider seeks to stop LSMT that the patient or surrogate wants continued.[24] A medical futility dispute is sometimes referred to as a "reverse right to die,"[25] a "right to life,"[26] a "duty to die,"[27] or even an "involuntary euthanasia"[28] situation. In a classic right to die situation, the patient or the surrogate wants to limit LSMT but the

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21. *See infra* notes 37-50 and accompanying text.

22. *See, e.g.*, Rodriguez v. Pino, 634 So. 2d 681, 683 (Fla. Dist. Ct. App. 1994) (finding doctor who complied with patient's initial refusal of LSMT could not be held subsequently liable for patient's death); Osgood v. Genesys Reg'l Med. Ctr., No. 94-26731-NH (Genesee County Cir. Ct. Feb. 16, 1996), *noted in* THE RIGHT TO DIE, *supra* note 17, §11.01[A] (Supp. 2005) (awarding $16.6 million verdict where the ICU provided LSMT to a patient in contravention of her agent's demands); Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984) (authorizing battery action for maintaining a PVS patient on a respirator against her previously expressed wishes); *see also* Elena N. Cohen, *Refusing and Forgoing Treatment: Liability Issues*, *in* 3 TREATISE ON HEALTH CARE LAW §§ 18.07[1] & 18.07[2] nn.45-56 (Alexander M. Capron & Irwin M. Birnbaum eds., 2005) (detailing the success of claims for providing unwanted treatment on various legal grounds); *Barriers to End of Life Care—Not in My ER, Not in My Nursing Home*, 11 L. & HEALTH CARE NEWSL., Spring 2004, at 16, 20 [hereinafter *Barriers*] (reporting Maryland state agency fined nursing home for failing to heed resident's advance directive); Amy Lynn Sorrel, *Lawsuit Showcases DNR Liability Twist for Doctors*, AM. MED. NEWS, Feb. 5, 2007, *available at* http://www.ama-assn.org/amednews/2007/02/05/prl20205.htm (noting that courts in Florida increasingly hold providers liable for providing unwanted LSMT).

23. There is an enormous literature on the definition of "medical futility" and the ethical justifiability of unilateral decisions. This Article provides neither a conceptual analysis nor a normative defense of "medical futility." While these issues provide essential context, this Article focuses on the effects of the unilateral decision statutes and on the effectiveness of their safe harbors.

24. *See* Flamm, *supra* note 10, at 11 n.1 (medical futility describes situations where patients or surrogates demand LSMT which the health care provider believes to be un-useful or harmful)

25. *See, e.g.*, Mayo, *supra* note 13, at 602 n.68; *see also* THE RIGHT TO DIE, *supra* note 17, § 13.01[B] at 13-4 (referencing the "reverse end-of-life").

26. *See, e.g.*, Nancy Neveloff Dubler, *Conflict and Consensus at the End of Life*, 35 HASTINGS CTR. REP. (SPECIAL REPORT), Nov.-Dec. 2005, at S19; Leigh B. Middleditch Jr. & Joel H. Trotter, *The Right to Live*, 5 ELDER L.J. 395, 397 (1997); Wesley J. Smith, *Suing for the Right to Live*, THE DAILY STANDARD, Mar. 11, 2004, *available at* http://www.weeklystandard.com/Content/Public/Articles/000/000/003/836zeecs.asp.

27. *See, e.g.*, Smith, *supra* note 26.

28. *See, e.g.*, Mary Ann Roser, *Debate Heats Up on 10-Day Medical Law*, AUSTIN AM.-STATESMAN, Aug. 10, 2006, at B1.

health care provider resists.[29] This is represented as situation (3) in the diagram below. In contrast, in a futility situation, the roles are reversed such that the health care provider wants to limit LSMT and the patient or the surrogate resists.[30] This is represented as situation (2) in the diagram below.

	Provider: "LSMT yes"	Provider: "LSMT no"
Patient/Surrogate: "LSMT yes"	(1) Consensus – no dispute	(2) *Medical futility dispute*
Patient/Surrogate: "LSMT no "	(3) Classic right to die dispute	(4) Consensus – no dispute

In a futility dispute, it is the health care provider, rather than the patient or surrogate, who judges LSMT as unbeneficial.[31] In other words, it is the health care provider who wants to stop the train when the patient or surrogate says, "keep going."[32]

Often the surrogate and the health care provider's disagreement over whether LSMT provides a benefit is caused by a failure in communication; the surrogate and provider perceive the situation differently.[33] In other cases, the disagreement is normative.[34] Whether for factual or normative reasons,

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29. *See, e.g.*, Mayo, *supra* note 13, at 587.

30. For the sake of economy, this Article assumes that there are only two relevant players: the patient and the health care provider. Of course, things are actually often far more complicated. When, as is often the case, the patient is incompetent, it may not always be clear who is the appropriate decision maker or there may be intra-family disagreement as to the proper action. *See, e.g.*, *In re* Doe, 418 S.E.2d 3, 7 (Ga. 1992) (finding hospital could not enter DNR order where mother agreed to DNR order for daughter but father did not); Lebreton v. Rabito, 650 So. 2d 1245, 1246-47 (La. Ct. App. 1995) (allowing daughter's lawsuit against physicians for withdrawing LSMT from father because withdrawal was authorized by wife/mother but strongly suggesting that her claim had no merit); NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS 10 (2004); Troyen A. Brennan, *Ethics Committees and Decisions to Limit Care*, 260 JAMA 803, 806 (1988) (remarking that health care provider's recommendation of DNR order for an incompetent patient is controversial where there was no family present to make decision or family was divided over choice). Similarly, on the provider side there may be disagreement among residents, nurses, or attending physicians. *See* Warthen v. Toms River Cmty. Mem'l Hosp., 488 A.2d 229, 230 (N.J. Super. Ct. App. Div. 1985) (reviewing termination of nurse's employmet for refusing to administer dialysis to terminally ill patient); Arthur U. Rivin, *Futile Care Policy: Lessons Learned from Three Years' Experience in a Community Hospital*, 166 W. J. MED. 389, 390 (1997).

31. *See* K. Francis Lee, *Postoperative Futile Care: Stopping the Train When the Family Says "Keep Going"*, 15 THORACIC SURGERY CLINICS 481, 481 (2005).

32. *Id.*

33. *See* JOSEPH J. FINS, A PALLIATIVE ETHIC OF CARE: CLINICAL WISDOM AT LIFE'S END 82–86 (2006); *see also infra* notes 70-72, 89-92 and accompanying text.

34. *Cf.* FINS, *supra* note 33, at 82-86 (describing how most, but not all, disagreements between patients and surrogates or providers are caused by miscommunication).

however, the provider and surrogate disagree because they have different goals.[35] The patient's goals might include cure, amelioration of disability, palliation of symptoms, reversal of disease processes, or prolongation of life. The provider, on the other hand, might judge these goals to be impossible, virtually impossible, or otherwise inappropriate under the circumstances.[36]

1. Patient and Surrogate Reasons for Insisting on Treatment

Surrogates are often inclined to request that "everything [be] done."[37] There are many reasons that surrogates insist on continuing treatment that their health care provider considers medically inappropriate. Surrogates might think that the health care provider's prognosis is wrong, perhaps distrusting that the patient is receiving proper care either because of their race or socioeconomic status[38] or because of their provider's financial incentives.[39] A significant volume of scientific literature demonstrates that patients from racial and ethnic minorities more frequently and more adamantly demand LSMT.[40]

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35. *Cf.* Thomas Wm. Mayo, *Health Care Law*, 53 SMU L. REV. 1101, 1109-10 n.78 (2000) ("[T]he disagreement is over what constitutes a 'benefit' to the patient . . . ."). The Supreme Court observed that when questioning the benefit of LSMT, the relevant question to ask is "effective at doing what?" LSMT for Nancy Cruzan, after all, was "100 percent effective at sustaining life." Transcript of Oral Argument at *28, Cruzan v. Dir., Mo. Dept. Health, 497 U.S. 261 (1989) (No. 88-1503).

36. *See infra* Part III (providing definitions of medical inappropriateness).

37. *See, e.g.*, LAWRENCE J. SCHNEIDERMAN & NANCY S. JECKER, WRONG MEDICINE: DOCTORS, PATIENTS, AND FUTILE TREATMENT 22-34 (1995) [hereinafter WRONG MEDICINE]; John Ellement, *Woman Suing MGH Tells Court of Distress*, BOSTON GLOBE, Apr. 8, 1995, at B18; Donalee Moulton, *Death, Denial and the Law*, 40 MED. POST (Toronto), May 4, 2004, at 29 ("[T]his is the recommendation of a doctor or health-care team not to do anything further, to stop treatment of not proceed with a treatment. It is a recommendation patients and families often refuse to accept").

38. *See, e.g.*, FINS, *supra* note 33, at 78 ("An especially difficult dynamic can arise when the family believes that the patient's dire condition was precipitated by a medical error or if they are suspicious that substandard care is being provided because the patient is from a traditionally marginalized population."); Lee, *supra* note 31, at 483; Moseley, *supra* note 4, at 212-13; Mary Ellen Wojtasiewicz, *Damage Compounded: Disparities, Distrust, and Disparate Impact in End-of-Life Conflict Resolution Policies*, 6 AM. J. BIOETHICS, Sept.-Oct. 2006, at 8-12; Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES, Mar. 27, 2005, at A1 (reporting that some "patients and families . . . are skeptical of doctors' interpretations or intentions").

39. *See* Pope & Waldman, *supra* note 9, at 164-65.

40. *See, e.g.*, William Bayer et al., *Attitudes Toward Life-Sustaining Interventions Among Ambulatory Black and White Patients*, 16 ETHNICITY & DISEASE 914 (2006); Ursula K. Braun et al., *Decreasing Use of Percutaneous Endoscopic Gastronomy Tube Feeding for Veterans with Dementia—Racial Differences Remain*, 53 J. AM. GERIATRIC SOC'Y 242 (2005); Marion Danis, *Improving End-of-Life Care in the ICU: What's to be Learned from the Outcomes Research*, 6 NEW HORIZONS 110 (1998); Michael N. Diringer et al., *Factors Associated with Withdrawal of Mechanical Ventilation in a Neurology/Neurosurgery Intensive Care Unit*, 29 CRITICAL CARE

Even if not distrustful of health care providers, surrogates might be in denial or under a "therapeutic illusion" that the patient can recover or that a new therapy will come along.[41] Access to online medical information makes surrogates more confident in opposing providers' recommendations.[42] Even in the face of clear and dire medical facts, family members often hold out hope that the patient will "beat the odds."[43]

Even when surrogates appreciate that the odds are exceedingly slim, they may believe that those odds are still worth pursuing. They might believe that God will perform a miracle.[44] They might otherwise be compelled by religious or cultural traditions.[45]

MED. 1792 (2001); Kevin Fiscella, *Socioeconomic Status in Healthcare Outcomes: Selection Bias or Biased Treatment,* 42 MED. CARE 939 (2004); Joanne Mills Garrett et al., *Life-Sustaining Treatments During Terminal Illness: Who Wants What?*, 8 J. GEN. INTERNAL MED. 361 (1993); Faith P. Hopp & Sonia A. Duffy, *Racial Variations in End-of-Life Care*, 48 J. AM. GERIATRIC SOC'Y 658 (2000); Hilary Waldman, *End-of-Life Care, Viewed in Stark Black and White*, L.A. TIMES, Feb. 6, 2006, at F5. *But see* Amber E. Barnato et al., *Racial Variation in End-of-Life Intensive Care Use: A Race or Hospital Effect?*, 41 HEALTH SERVICES RES. 2219, 2219 (2006) (arguing that differences were attributable to the use of hospitals with higher ICU use rather than to racial differences).

41. *See* Middleditch & Trotter, *supra* note 26, at 402-03 (discussing modern "culture's persistent denial of death's reality"); Stacey A. Tovino & William J. Winslade, *A Primer on the Law and Ethics of Treatment, Research, and Public Policy in the Context of Severe Traumatic Brain Injury*, 14 ANNALS HEALTH L. 1, 2 n.5, 26 n.153 (2005) (discussing "therapeutic illusions" where patients have "false hopes despite the lack of future benefit").

42. Julie Sneider, *Medical Ethics Experts See Shift in Care Disputes*, MILWAUKEE BUS. J., Apr. 22, 2005, *available at* http://www.bizjournals.com/milwaukee/stories/2005/04/25/focus2.html.

43. *See* Clare Dyer, *Doctors Need not Ventilate Baby to Prolong His Life*, 329 BMJ 995, 995 (2004) (reporting that two mothers of terminally ill infants rejected medical advice because their babies were "'fighters'. . . [and] had lived longer than doctors had predicted . . . ."); Todd Ackerman, *Hospital Rules to Unplug Baby Girl: Leukemia Patient's Parents Scramble to Find New Care Facility*, HOUSTON CHRON., Apr. 30, 2005, at B1 (reporting that the mother of Knya Dismuke-Howard, a six-month old girl with leukemia in her brain, multiple organ failure, and a life-threatening antibiotic-resistant infection stated, "I think she can beat the odds . . . . She's a fighter."); Belluck, *supra* note 38, at A1 ("Extraordinary medical advances have stoked the hopes of families."); Bill Murphy, *Life and Death Matter Goes to Court: Comatose Man's Relatives Fighting State Law, Hospital to Keep Him Alive*, HOUSTON CHRON., Mar. 18, 2001, at A37 (reporting that relatives opposed to removing life support did not "share the conclusion that [patient's] condition [was] hopeless"). *Cf. In re* Guardianship of Schiavo, 851 So. 2d 182, 186 (Fla. Dist. Ct. App. 2003) ("[W]e understand why a parent . . . would hold out hope . . . . If Mrs. Schiavo were our own daughter, we could not but hold to such a faith.").

44. *See, e.g.*, *In re* Baby K, 832 F. Supp. 1022, 1026 (E.D. Va. 1993) ("The mother opposes the discontinuation of ventilator treatment . . . because she believes that all human life has value . . . . [and] that God will work a miracle if it is his will."); Lee, *supra* note 31, at 483; Robert Sibbald et al., *Perception of "Futile Care" Among Caregivers in Intensive Care Units*, 177 CANADIAN MED. ASS'N J. 1201, 1204 (2007); *Parents Fear Home Delay May Keep 'Miracle' Baby Charlotte in Hospital*, BIRMINGHAM POST (UK), Jan. 7, 2006, at 3 (reporting that

The surrogates may feel a sense of responsibility or guilt with respect to their relationship to the patient.[46] They might be too grief stricken to stop treatment.[47] Or they might—consistent with the technological imperative in

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parents of Charlotte Wyatt were "committed Christians" who believed that "miracles do happen")Ed Yeates, *Parents Fight to Keep Son on Life Support* (KSL TV5 broadcast Oct. 13, 2004) (transcript on file with Tennessee Law Review) (parents sought an injunction to stop physicians from disconnecting their son from life support even though he was declared dead because "we performed a miracle and I don't see why we can't do that again").

45. *See, e.g.*, Rideout v. Hershey Med. Ctr., 30 Pa. D. & C.4th 57, 62 (Dauphin County Ct. C.P. Dec. 29, 1995) (No. 872S1995), 1995 WL 924561 (parents opposed to removing ventilator from daughter because of "religious belief that all human life has value and should be protected"); 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, 841 (1994) ("I cannot make that decision to terminate life. God did not give me that power." (quoting Brief of Appellant, *In re* Achtabowski, No. 93-1247-AV, at 39 (Mich. Cir. Ct. Aug. 12, 1993) (No. 170251))); Lee, *supra* note 31, at 483; John Carvel, *Muslim Family Lose Right-to-Life Appeal*, GUARDIAN, Sept. 2, 2005, *available at* http://www.guardian.co.uk/print/0,,5276201-103690,00.html (noting the "family's religious conviction"); Bill Murphy, *Comatose Man Dies After Battle Over Life Support: Family Cited Spiritual Beliefs*, HOUSTON CHRON., Mar. 23, 2001, at A29 (reporting that for spiritual and cultural reasons, the family of Joseph Ndiyob sought an injunction preventing Memorial Hermann Hospital from removing Ndiyob's life support); Emily Ramshaw, *Children Fight to Save Mom: Carrollton Hospital Seeks to End Care of Woman with Brain Injury*, DALLAS MORNING NEWS, Aug. 18, 2006, at B1 (injured woman's children believed that their mother, "Ruthie Webster, [was] deeply religious and believe[d] only God should give and take life"); Kevin Rollason, *Jewish Kin Say Pulling Plug Would Be a Sin*, WINNIPEG FREE PRESS, Dec. 11, 2007, at A4 (family of Samuel Golubchuk sought injunction against removing LSMT since Orthodox Jews believe life must be extended as long as possible); Benjamin Weiser, *The Case of Baby Rena: Who Decides When Care is Futile?—A Question of Letting Go: A Child's Trauma Drives Doctors to Reexamine Ethical Role*, WASH. POST, July 14, 1991, at A1 (discussing the religious views of Baby Rena's foster parents).

46. Lee, *supra* note 31, at 483 ("Many [surrogates] believe it is morally wrong to end a patient's life intentionally or to allow a patient's life to end without available interventions."); John J. Paris et al., *Has the Emphasis on Autonomy Gone Too Far? Insights from Dostoevsky on Parental Decisionmaking in the NICU*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 147, 147 (2006); Jan Hoffman, *The Last Word on the Last Breath*, N.Y. TIMES, Oct. 10, 2006, at F1 ("Families often believe that consenting to a D.N.R. order implies they are giving up on their loved one, signing a death warrant . . . ."); Ann Wlazelek, *Pendulum Swings in Life-Saving Efforts; Hospitals' Policies on Doing All They Can to Keep Patients Alive Have Changed*, THE ALLENTOWN MORNING CALL, June 13, 2004, at A1 ("'It's dangerous to give the family the last word since guilt and a desire to do everything for pop makes it emotionally impossible to stop treatment.'" (quoting Arthur Caplan)).

47. *See, e.g.*, Alexander Morgan Capron, *Abandoning a Waning Life*, 25 HASTINGS CTR. REP., July–Aug. 1995, at 24 (reporting that Massachusetts General Hospital wrote a unilateral DNR because "the family's unpreparedness for their mother's death did 'not justify mistreating the patient.'"); Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis*, 267 JAMA 2067, 2067–68 (1992) (discussing that many family members find that they cannot let the patient go).

American medicine[48]—simply believe that the patient is entitled to everything.[49] Whatever the reason, more and more surrogates want their health care providers to "do everything to save [the patient's] life."[50]

2. Provider Reasons for Resisting Treatment

In some circumstances, health care providers resist surrogate requests that "everything be done." Such resistance stems from a significant consensus that some requests for treatment are inappropriate and that health care providers should not comply with them.[51] While no consensus exists on the specific

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48. This is the mindset that because doctors *can* use a given technology, they *should* use that technology. *See* Kathy Cerminara, *Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even When the Answer Is "No")*, 15 HEALTH MATRIX: J. L.-MED. 285, 296 (2005) (commenting that this "technological imperative" has subordinated the general availability of health care services to the pursuit of medical research); Robert L. Fine, *The History of Institutional Ethics at Baylor University Medical Center*, 17 BAYLOR U. MED. CTR. PROC. 73, 81-82 (2004) (explaining how medical innovation causes "moral tension" in regards to "distributive justice and fairness"). *See generally* VICTOR R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE (1974) (describing the limitations that economics places on how health care resources are allocated in terms of both equity and efficiency).

49. *See, e.g.*, Kopelman, *supra* note 14, at 582–85; Alan Meisel, *The Role of Litigation in End of Life Care: A Reappraisal*, 35 HASTINGS CTR. REP. (SPECIAL REPORT), Nov.–Dec. 2005, at S49 ("A vocal proportion of the population . . . believes that life per se is a pearl beyond price and must be preserved at all costs . . . . This set of beliefs [is] known as 'vitalism' . . . ."); Rivin, *supra* note 30, at 392; James W. Walter, *Medical Futility—An Ethical Issue for Clinicians and Patients*, PRACTICAL BIOETHICS, Summer 2005, at 1, 1, 6. Particularly where LSMT is covered by insurance, it is financially easy for surrogates to insist on continued treatment. All the economic and social costs are external. The insurer pays through other policyholders. Health care providers, particularly nurses, bear the emotional burden of treating the patient. *See* Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 ISSUES L. & MED. 3, 9 (1995) (comparing the benefit to family and friends for prolonging the patient's life and the burden subsequently carried by the medical professionals and insurance companies); *see also* Todd Ackerman, *St. Luke's Postpones Removal of Life Support: Man's Family Has Until 3 p.m. to Explore Any Possible Appeals,* HOUSTON CHRON., Mar. 12, 2005, at B1 ("[T]he family understands there is no hope . . . [but] 'the decision when life support is removed should be [the family's], not a corporation's.'").

50. *See* News Release, Pew Res. Ctr. for the People and the Press, *More Americans Discussing— and Planning—End-of-Life Treatment: Strong Public Support for Right to Die* 24 (Jan. 5, 2006), *available at* http://people_press.org/reports/pdf/266.pdf (reporting that between 1990 and 2005, the percentage of Americans who want a doctor to "do everything to save life" increased from 15% to 22%); *see also* Sneider, *supra* note 42 ("[M]ore families are challenging doctors who believe additional medical treatment of a critically ill patient is unwarranted.").

51. For this reason, this Article starts with the controversial presumption that the law should facilitate health care providers' ability to unilaterally terminate LSMT. However, some physicians do not resist patient requests for inappropriate LSMT for several reasons. First, some treating physicians judge that the conflict is not worth the trouble, especially when they

criteria and conditions under which providers may decline to comply with requests for LSMT, the appropriateness of unilateral refusals has long been accepted.[52] In fact, a plethora of professional medical associations have issued policy statements supporting the unilateral withholding and withdrawal of inappropriate LSMT.[53]

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will soon shift off rounds for that patient. *See, e.g.*, Capron, *supra* note 47, at 24 (reporting Catherine Gilgunn's original attending physician eventually deferred to the surrogate's request to continue LSMT, but a month later, the new attending physician did not); Susan Carhart, *Process Approach to End-of-Life Care Fails to Eliminate Ethical, Political Issues*, 11 BNA HEALTH L. REP. 1755, 1756 (2002) ("'[I]t's not worth the hassle . . . .'" (quoting Stephen Streat)). Second, some physicians accede to requests for inappropriate LSMT because they do not want to admit defeat. *See, e.g.*, WRONG MEDICINE, *supra* note 37, at 25–28; ROBERT ZUSSMAN, INTENSIVE CARE: MEDICAL ETHICS AND THE MEDICAL PROFESSION 109 (1992) (noting that doctors are "inclined towards activism"); MANAGING DEATH, *supra* note 15, at 377; Rivin, *supra* note 30, at 392 (discussing the physicians' "attitude that death is the enemy" which leads to a "compulsion to be thorough and to leave no possibility untried"); Tovino & Winslade, *supra* note 41, at 27 (discussing vitalism and the "heroic urge to rescue"). Third, some providers accede because of their own religious or cultural convictions. Rivin, *supra* note 30, at 392 tbl.2. Fourth, some agree with the requests out of a "desire to please the patient's family." *Id.* Fifth, some providers accede because of reimbursement incentives. *See* Tovino & Winslade, *supra* note 41, at 27.

52. *See, e.g.*, 2 HIPPOCRATES, *The Art*, *in* HIPPOCRATES 193 (W.H.S. Jones trans. 1923) (purpose of medicine includes "to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless"); PLATO, THE REPUBLIC 100 (408b) (Richard W. Sterling & William C. Scott trans., 1985) ("But they thought a man constitutionally sickly and intemperate was of no use to himself or anyone else. They believed that the art of medicine ought not to be squandered on his ilk and that he should not receive treatment even if he were richer than Midas."); Lee, *supra* note 31, at 484 ("According to Hippocrates, 'to attempt futile treatment is to display an ignorance that is allied with madness.'") (citing L. EDELSTEIN, ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN 97-98 (O. Temkin & C.L. Temkin eds., 1967)).

53. *See, e.g.*, AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS §§ 2.035, 2.037 (2006–2007), *available at* http://www.ama-assn.org; AMA Council on Ethical and Judicial Affairs, *Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs*, 281 JAMA 937, 938 (1999) [hereinafter AMA Council]; Am. College of Obstetricians and Gynecologists, *Committee Opinion: Opinion No. 362: Medical Futility*, 109 OBSTETRICS & GYNECOLOGY 791 (Mar. 2007); Am. Thoracic Soc'y, *Withholding and Withdrawing Life-Sustaining Therapy*, 144 AM. REV. RESPIRATORY DISEASE 726, 728 (1991); College of Physicians and Surgeons of Manitoba, *Statement No. 1602: Withholding and Withdrawing Life Sustaining Treatment* (Jan. 30, 2008), *available at* http://www.cpsm.mb.ca/statements/1602.pdf; Soc'y of Critical Care Med. Ethics Comm., *Consensus Statement Regarding Futile and Other Possibly Inadvisable Treatments*, 25 CRITICAL CARE MED. 887, 888 (1997); *2004 House of Delegates Action on Resolutions and Board Reports*, 103 WIS. MED. J. 91, 91 (2004) [hereinafter *House of Delegates Action*] (referencing the Wisconsin Medical Society Resolution 1-2004, which "establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care"). *See generally* BRIT. MED. ASSOC., WITHHOLDING AND WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT (2001) (providing guidance for such action).

The policy statements are primarily motivated by four concerns, the most significant of which is professional integrity. Physicians do not want to be indentured servants,[54] "reflexive automatons,"[55] "vending machines,"[56] "prostitutes,"[57] or "grocers"[58] beholden to provide whatever treatment patients or surrogates want. After all, medicine is not a "consumer commodity like breakfast cereal and toothpaste."[59]

The medical profession is a self-governing one with its own standards of professional practice.[60] The "integrity of the medical profession" is an important societal interest that must be balanced against patient autonomy.[61]

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54. E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, 24 HASTINGS CTR. REP., Jan.-Feb. 1994, at 18 ("The physician-patient relationship is not an irrevocable indentured servitude . . . .").

55. WRONG MEDICINE, *supra* note 37, at 58, 103-04 (stating that physicians are not obligated to do everything a patient wants).

56. WRONG MEDICINE, *supra* note 37, at 9; Lawrence J. Nelson & R.M. Nelson, *Ethics and the Provision of Futile, Harmful, or Burdensome Treatment to Children*, 20 CRITICAL CARE MED. 427, 431 (1992).

57. WRONG MEDICINE, *supra* note 37, at 126. Dr. Schneiderman has more recently further developed this analogy, noting that "there were some things [prostitutes] would not do no matter how much they were paid." LAWRENCE J. SCHNEIDERMAN, EMBRACING OUR MORTALITY: HARD CHOICES IN AN AGE OF MEDICAL MIRACLES 123 (2008).

58. Ellen Goodman, *The Shift from Dr. Partner to Dr. Provider*, BOSTON GLOBE, Oct. 24, 1993, at 85.

59. George J. Annas, *Asking the Courts to Set the Standard of Emergency Care—The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1545 (1994) (arguing for avoidance of the scenario where "physicians will do whatever patients want (as long as they can pay for it), because medicine will be seen as a consumer commodity like breakfast cereal and toothpaste"); *see also* Tom Tomlinson & Diane Czlonka, *Futility and Hospital Policy*, 25 HASTINGS CTR. REP., May-June 1995, at 29 ("[T]he value assumptions made in cases of futility will have to receive their warrant from . . . values for the profession."). *But see* Eric Gampel, *Does Professional Autonomy Protect Medical Futility Judgments?*, 20 BIOETHICS 92, 97 (2006) (arguing that while limits on physician autonomy are set by the norms of the medical community rather than by individual providers, those limits do not extend to the futility context).

60. Gampel, *supra* note 59, at 97 (referencing the "right of the medical profession to be a self-governing body, one which defines its own standards of professional practice").

61. *See generally* Washington v. Glucksberg, 521 U.S. 702, 731 (1997) ("The State also has an interest in protecting the integrity and ethics of the medical profession."); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977) ("The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation."); *In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976) ("[T]he unwritten constitutional right of privacy . . . is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances . . . ."); Ferguson, *supra* note 16, at 1239-43 (noting that the UHCDA attempts to protect the ethical integrity of the medical profession). The legal profession is similar to the medical profession in this respect. While generally the client is in charge, a lawyer can withdraw from representation if "the client insists upon taking action that the lawyer considers repugnant . . . ." ABA MODEL OF RULES PROF'L. CONDUCT R. 1.16(b)(4) (2006). Lawyers also have obligations under Rule 11 of the Federal

Indeed, patient autonomy "has never been construed as requiring a health professional to provide a particular type of treatment."[62] Since the medical profession determines the goals and values of medicine, it can judge certain requests as inconsistent with those goals and values.[63]

In particular, many health care providers do not consider the practice of medicine to include measures aimed solely at maintaining corporeal existence and biologic functioning.[64] Under these circumstances, providers feel that continued LSMT is just "bad medicine . . . medicine being used for the wrong ends."[65] Moreover, health care providers find it gruesome, distressing, and demoralizing to provide treatment that harms patients.[66]

Rules of Civil Procedure—lawyers cannot file frivolous lawsuits even if the client demands it. *See* 2 JAMES WM. MOORE, MOORE'S FEDERAL PRACTICE THIRD EDITION § 11.11[1] (3d ed. 2007).

62. Loane Skene, *Disputes about the Withdrawal of Treatment: The Role of Courts*, 32 J. L. MED. & ETHICS 701, 701 (2004) (citing Schwartz, *infra* note 105, at 32). Nevertheless, other legal principles (e.g., nondiscrimination) have been construed to require providers to provide treatment that they deemed inappropriate. *See infra* Part III.

63. *See* Gampel, *supra* note 59, at 97 (stating that a health care provider "may refuse treatments which the medical profession gauges to be inappropriate, i.e. as being inconsistent with the basic goals and values of medicine").

64. *See, e.g.*, College of Physicians and Surgeons of Manitoba, *supra* note 53, at 15-S4 ("A patient is not just a physical being, but a person with a body, mind and spirit expressed in a human personality of unique worth.").

65. *See* Weiser, *supra* note 45, at A1 (quoting Dr. Murray Pollack).

66. *See* ZUSSMAN, *supra* note 51, at 123–38; Robert A. Burt, *The Medical Futility Debate: Patient Choice, Physician Obligation, and End-of-Life Care*, 5 J. PALLIATIVE MED. 249, 253 (2002); Betty R. Ferrell, *Understanding the Moral Distress of Nurses Witnessing Medically Futile Care*, 33 ONCOLOGY NURSING F. 922 (2006); Terese Hudson, *Are Futile-Care Policies the Answer? Providers Struggle with Decisions for Patients Near the End of Life*, 68 HOSPITALS & HEALTH NETWORKS, Feb. 20, 1994, at 26, 28; Stacey Burling, *Penn Hospital to Limit Its Care in Futile Cases: Severely Brain-Damaged Patients Won't Get Certain Treatments, as a Rule*, PHILA. INQUIRER, Nov. 4, 2002, at A1; Hoffman, *supra* note 46, at F1 ("'[D]oing CPR [to end-stage patients] felt not only pointless, but like I was administering final blows to someone who had already had a hard enough life.'" (quoting Dr. Daniel Sulmasy)); Liz Kowalczyk, *Hospital, Family Spar Over End-of-Life Care*, BOSTON GLOBE, Mar. 11, 2005, at A1 [hereinafter Kowalczyk, *Hospital, Family Spar*] ("Howe's longtime doctors and nurses believe[d] . . . that keeping her alive [was] tantamount to torture."); Liz Kowalczyk, *Mortal Differences Divide Hospital and Patient's Family*, BOSTON GLOBE, Sept. 28, 2003, at A1 [hereinafter Kowalczyk, *Mortal Differences*] (reporting physician and nurse refused to participate in continued aggressive treatment of Barbara Howe); Elisabeth Rosenthal, *Rules on Reviving the Dying Bring Undue Suffering, Doctors Contend*, N.Y TIMES, Oct. 4, 1990, at A1 ("Doctors and nurses . . . describe anger and anguish at being forced by a patient or family to inflict pain on the dying, knowing that it is to no avail."); Gregory Scott Loeben, Medical Futility and the Goals of Medicine 98 (1999) (unpublished Ph.D. dissertation, University of Arizona) (on file with Tennessee Law Review) ("If such judgments are meant to benefit anyone, it makes more sense to say that it is the physician . . . uncomfortable with the role [he is] being asked to play . . . ."). *Cf.* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 38 (5th ed.

Second, in addition to professional integrity, providers resist inappropriate treatment requests out of concern for the patient. Continued interventions can be inhumane, invasive, pointless, intrusive, cruel, burdensome, abusive, degrading, obscene, violent, or grotesque.[67] For example, CPR can be painful, causing rib or sternal fractures in a majority of cases.[68] Health care providers want to shorten and ease patient suffering; they do not want to cause or prolong it.[69]

A third reason that providers resist requests for inappropriate treatment is that they do not want to offer false hope. If they acted as though a medically inappropriate option were "available," this would create a psychological burden on surrogates to elect that option regardless of their prior wishes.[70] Naturally, families want to at least take all reasonable measures. Yet, it is unfair and

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2001) (defending the physician's right to autonomy and "conscientious objection" where the patient's request for something is "morally objectionable").

67. *See, e.g.*, *In re* Doe, 418 S.E.2d 3, 4 (Ga. 1992) (failing to reach hospital's allegation that continued treatment of a patient with degenerative neurological disease would constitute "medical abuse"); Wendland v. Sparks, 574 N.W.2d 327, 328-29 (Iowa 1998) (ignoring testimony that doctor's unilateral decision not to attempt CPR was "an act of mercy" because the patient's prospects for quality of life were "not good"); *In re* Dinnerstein, 380 N.E.2d 134, 137 (Mass. App. Ct. 1978) (characterizing LSMT as "pointless, even cruel, prolongation of the act of dying"); Brief of Appellants at 3, *In re* Baby "K," 16 F.3d 590 (4th Cir. 1994) (No. 93-1899), 1993 WL 13123742 ("This tragic case involves a parent's attempt to require physicians to provide to a dying infant treatment that is medically unreasonable, invasive, burdensome, inhumane, and inappropriate."); John Altomare & Mark Bolde, Note, *Nguyen v. Sacred Heart Medical Center*, 11 ISSUES L. & MED. 199, 200 (1995) (observing hospital alleged continued treatment was "cruel and inhumane"); Martha Kessler, *Court Orders Hospital to Comply with Decisions Made Under Health Proxy*, 13 BNA HEALTH L. REP. 527, 527 (2004) (reporting Massachusetts General Hospital successfully argued to a Boston court that CPR for Barbara Howe would be "severe, invasive and harmful"); Kowalczyk, *Hospital, Family Spar*, *supra* note 66, at A1 ("'[T]his inhumane travesty has gone far enough . . . . This is the Massachusetts General Hospital, not Auschwitz.'" (quoting Dr. Edwin Cassem)).

68. *See generally* WRONG MEDICINE, *supra* note 37, at 94 ("[A]ttempted cardiopulmonary resuscitation could involve forceful, even violent, efforts at compressing the chest cage to the point of fracturing ribs . . . ."); Paul C. Sorum, *Limiting Cardiopulmonary Resuscitation*, 57 ALB. L. REV. 617, 617 (1994) ("The patient will usually receive the following interventions: manual compressions of the chest . . . ; one or more jolts of electricity to the chest . . .; and intravenous medications and fluids.").

69. *See* WRONG MEDICINE, *supra* note 37, at 100–01 ("[P]hysicians . . . should be *encouraged* or *required* to refrain from using futile treatments."); Capron, *supra* note 47, at 24 (unilateral termination can sometimes avoid "mistreating the patient").

70. *See, e.g.*, Annas, *supra* note 59, at 1543 (calling the provision of mechanical ventilation to Baby K after birth a "medical misjudgment" that gave the mother a false impression); Allan S. Brett, *Futility Revisited: Reflections on the Perspectives of Families, Physicians, and Institutions*, 17 HEC FORUM 276, 281-82 (2005) (discussing the "psychologically difficult conundrum for families" in futility cases). *But cf.* Fletcher, *supra* note 10, at S:224 (suggesting that the court documents in *Baby K* showed the physicians had certain reasons to support intubation).

deceptive to offer an option where none actually exists.[71] If health care providers offered ineffective treatment, they would risk losing public confidence.[72]

Lastly, providers resist inappropriate treatment requests in an effort to maximize the utility of scarce resources.[73] Providers want to be good "steward[s]"[74] of both "hard" resources like ICU beds and "soft" resources like health care dollars.[75] While costs have seldom been a consideration in defining when treatment is inappropriate,[76] there is little doubt that costs have been a major impetus for increasing attention on medical futility.[77] Thus, the issue of

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71. *See* Howard Brody, *The Physician's Role in Determining Futility*, 42 J. AM. GERIATRICS SOC'Y 875, 876-77 (1994) (unethical to mislead patients by falsely raising hopes); Hudson, *supra* note 66, at 28 (quoting Dr. John Popovich's argument that "physicians who offer futile, meaningless care are charlatans"); Paris, *supra* note 46, at 150 (discussing how offering futile options gives false hope and unrealistic expectations to family members ultimately leading to "demands for more and more interventions and the risk of further complications"); Tomlinson & Czlonka, *supra* note 59, at 28, 30 (offering futile care is "a bogus choice, and the offer of it is a deception"; rather, providers should seek "acceptance" of a plan for a futility judgment rather than "consent").

72. *See* Brody, *supra* note 71, at 876-77 (discussing the importance of maintaining the medical profession's integrity).

73. *See* Rosenthal, *supra* note 66, at A1 ("Doctors and nurses . . . question whether futile resuscitations, which can costs thousands of dollars and tie up precious intensive care beds, make sense in an era of rising health costs."). *Cf.* WRONG MEDICINE, *supra* note 37, at 42 (treating 14,000 to 25,000 patients in a permanent vegetative state has estimated cost between $1 billion and $7 billion per year); Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1611 (1992) (estimating that Missouri spent nearly $1 million to keep Nancy Cruzan in a persistent vegetative state for eight years).

74. S.H. Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 514 (1991).

75. *See infra* notes 188-97 and accompanying text.

76. *See infra* notes 188-97 and accompanying text. *But see* Murphy, *supra* note 43, at A37 (while Joseph Ndiyob's lack of health insurance and costs approaching $500,000 did not influence his attending physician's recommendation to stop treatment, the hospital's "medical futility review committee" did consider "whether the hospital should expend resources on a terminal patient rather than one who may recover").

77. *See* Rideout v. Hershey Med. Ctr., 30 Pa. D. & C.4th 57, 62 (Dauphin County Ct. C.P. Dec. 29, 1995) (No. 872S1995), 1995 WL 924561 (noting that a day after learning that patient's private health insurance was almost exhausted, hospital entered DNR order for patient); Nat'l Conference of Comm'rs on Uniform State Laws, Proceedings in Comm. of the Whole, Uniform Health-Care Decisions Act, Aug. 2, 1993, at 269-70 (statement of Comm'r King Hill) (noting that "medically ineffective" refers to costs). Mr. Hill explained:

> "This says to the physician that you don't have to institute some new radical $200,000 procedure if it's only going to keep the patient alive for two or three months, even though there may be many articles in the journals that say that's an accepted health-care standard for a [twenty-two] year old."

Nat'l Conference of Comm'rs on Uniform State Laws, Proceedings in Comm. of the Whole,

medically futile treatment is likely to increase in the future as concerns about costs for such treatment grows.[78]

Uniform Health-Care Decisions Act, Aug. 2, 1993, at 269-70 (statement of Comm'r King Hill); *see also* J.K. MASON & G.T. LAURIE, *Medical Futility*, *in* MASON AND MCCALL SMITH'S LAW AND MEDICAL ETHICS 539, 571-74 (7th ed. 2006) ("[T]he law clearly accepts that resource allocation forms a proper part of medical decision making."); Hudson, *supra* note 66, at 26 (noting that "economic losses for the hospital" motivated the futility of care policy at Santa Monica Hospital); Lantos, *supra* note 12, at 588-89 (discussing the "fundamental economic element" involved in futility determinations); Middleditch & Trotter, *supra* note 26, at 404 ("[T]he right to live may have less to do with societal conceptions of death or the legal doctrine of patient autonomy and more to do with money."); Rivin, *supra* note 30, at 389 (describing how the futile care policy developed directly from a review of the medical center's "financial losers"); Taylor & Lantos, *supra* note 49, at 7 ("We believe that the futility debate was more immediately motivated by changes in the way doctors and hospitals are paid."); Benjamin Weiser, *The Case of Baby Rena: Who Decides When Care is Futile?—Who Should Decide When Treatment is Futile? In Many Cases, Physicians Are Asking Whether Patient Autonomy Has Gone Too Far*, WASH. POST, July 14, 1991, at A19 ("It is not a coincidence that futility emerged as an issue in the mid-1980s only after the government limited hospital reimbursement for many patients."). Costs were similarly a motivation for moving from cardiopulmonary to neurological criteria for death. *See, e.g.*, Henry K. Beecher et al., *A Definition of Irreversible Coma, Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 205 JAMA 337, 337 (1968) ("Our primary purpose is to define irreversible coma as a new criterion for death").

78. *See* MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS 3 (6th ed. 2003) ("[T]he Baby K situation may become more typical as a result of greater pressure on physicians to limit medical costs."); JOAN M. KRAUSKOPF ET AL., ELDERLAW: ADVOCACY FOR THE AGING § 13:26, at 500-01 (2d ed. 1993); THE RIGHT TO DIE, *supra* note 17, § 13.01[C] at 13-5, § 13.09 at 13-43; Donald J. Murphy, *The Economics of Futile Interventions*, *in* MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS 123, 133 (Marjorie B. Zucker & Howard D. Zucker eds., 1997) (arguing that the "economics of futile interventions deserves more study"); Ronald Bailey, *Pulling the Plug on Unwilling Patients: Should the High Cost of Living Affect Your Chances of Dying?*, REASON, Feb. 10, 2006, *available at* http://www.reason.com/news/printer/35016.html ("[I]t is clear that in the real world of limited medical resources that the 'authorities,' whether private or governmental, will unavoidably be making similar life and death decisions in the future."); Miran Epstein, *Legitimizing the Shameful: End-of-Life Ethics and the Political Economy of Death*, 21 BIOETHICS 23 (2007); Gampel, *supra* note 59, at 98 (predicting "managerial pressures on [health care providers] to use and extend the category of futility . . . ."); Kowalczyk, *Mortal Differences*, *supra* note 66, at A1 ("[H]ospitals will go to court more often to remove patients from life support, 'as health care becomes more of a scarce commodity . . . .'" (quoting law professor Charles Baron)); Wlazelek, *supra* note 46 ("'[B]ecause of the rising cost of health care, someone like the government or insurers will dictate that if you have X, Y, or Z you will not get the care.'" (quoting Joseph Vincent)); *cf.* CONGRESSIONAL BUDGET OFFICE, TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING (Jan. 2008) (urging less and more cost-effective use of medical technology).

3. Limits on Resisting Treatment

Whatever might be their motivations for stopping LSMT, health care providers generally recognize two important limits on the extent to which they will resist a surrogate's request for LSMT: (1) comfort care and (2) accommodation. First, even when LSMT is stopped, providers will continue to administer comfort care.[79] They will continue to ensure the patient's comfort by providing services that include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, positioning, warmth, appropriate lighting, and other measures aimed at relieving pain and suffering or respecting the patient's dignity and humanity.[80] In short, stopping treatment does not mean stopping care.

Second, even when they consider continued LSMT to be inappropriate, providers will generally make a short-term accommodation of the surrogate's wishes.[81] Providers will respect patient treatment goals such as providing time to resolve personal matters, grieving, and allowing time to say goodbye.[82] Brain dead patients are oftentimes maintained on life support for several hours or days as a matter of sensitivity to religious, cultural, or moral values.[83]

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79. *See, e.g.*, CONN. GEN. STAT. § 19a-573(a) (1993) ("Notwithstanding the [unilateral decision] provisions . . . , comfort care and pain alleviation shall be provided in all cases."); MINN. STAT. § 145B.13(1) (1991) (upon withdrawal of LSMT, there should be a "a continuation of appropriate care to maintain the patient's comfort, hygiene, and human dignity and to alleviate pain"); N.J. STAT. ANN. § 26:2H-67(b) (1991) (decision to forego LSMT does not impair care and comfort obligations); OR. REV. STAT. § 127.642 (2005) (care to provide comfort and cleanliness should be administered after withdrawal of LSMT); Pellegrino, *supra* note 10, at 309 ("Care [and] comfort . . . are never futile.").

80. *See, e.g.*, MINN. STAT. § 145B.13(1); OR. REV. STAT. § 127.642.

81. *See, e.g.*, Erich H. Loewy & Richard A. Carlson, *Futility and Its Wider Implications: A Concept in Need of Further Examination*, 153 ARCHIVES INTERNAL MED. 429, 429-30 (1993) (defending extending treatment for a reasonable time to allow family to come to terms with the situation, because while medically inappropriate, treatment may have social value).

82. *See* THE RIGHT TO DIE, *supra* note 17, § 13.08[A] at 13-40 ("[T]reatment might be rendered despite its certain or probable lack of medical benefit occurs when the patient or family has personal, 'non-medical' reasons for wanting the treatment . . . ."); WRONG MEDICINE, *supra* note 37, at 166; Carhart, *supra* note 51, at 1755 ("'[W]hy not just leave the machines on for two weeks?'" (quoting health law attorney Shirley Paine)); Fletcher, *supra* note 10, at S:236 (arguing that physicians should be permitted to discontinue treatment "after a grace period of adjustment"); Pellegrino, *supra* note 10, at 315-16 (urging a "permissive" rather than an "overly rigorous" application of futility because the family needs "time to adjust" and a patient might like to see "a grandchild born, or have a last meeting with family or friends"); Skene, *supra* note 62, at 701 (arguing for the "broader aspect of patients' 'best interests'"); Tomlinson & Czlonka, *supra* note 59, at 29 (providers must consider "nonbiomedical goals"); David M. Zientek, *The Texas Advance Directives Act of 1999: An Exercise in Futility?*, 17 HEC FORUM 245, 253 (2005) (urging certain goals to be respected, such as "support[ing] life until a child overseas in the military can return home for a last visit" or "continu[ing] life support to allow for spiritual preparation for death").

83. *See* Dority v. Superior Court of San Bernardino County, 193 Cal. Rptr. 288, 289 (Cal.

D. The Resolution of Futility Disputes

The disagreement between surrogates and providers regarding continued LSMT produces a significant number of futility disputes each year.[84] Fortunately, the vast majority of these disputes are resolved internally and informally through good communication and mediation practices.[85] The standard dispute resolution process consists of six roughly chronological stages.[86] Most futility disputes are resolved within the first five stages.[87]

Ct. App. 1983) (describing hospital policy of keeping brain dead children on life support "until the parents were emotionally able to realize what the medical opinion was"); Lorry R. Frankel & Chester J. Randle Jr., *Complexities in the Management of a Brain-Dead Child*, *in* ETHICAL DILEMMAS IN PEDIATRICS: CASES AND COMMENTARIES 135, 137 (Lorry R. Frankel et al. eds., 2005) ("On rare occasions, life support will be continued for a few more hours, pending arrival of other family members."); Myra J. Edens et al., *Neonatal Ethics: Development of a Consultative Group*, 86 PEDIATRICS 944, 947 (1990) ("[T]reatment is continued for a period of time to allow the parents to come to terms with the hopelessness of [the] . . . condition."); Rasa Gustaitis, *Right to Refuse Life-Sustaining Treatment*, 81 PEDIATRICS 317, 319 (1988) ("[C]hildren have not infrequently been kept alive on life-support equipment for the sake of others . . . ."); George J. Annas, *When Death Is Not the End*, N.Y. TIMES, Mar. 2, 1996, at 19 ("Maintaining a corpse in an intensive care unit for a few days may be reasonable as a matter of sensitivity to religious or moral beliefs . . . ."); Yeates, *supra* note 44 (reporting that parents tried to maintain the life support of their six-year old boy after he was declared dead by the doctors). In some jurisdictions this is required by statute or regulation. *See, e.g.*, N.J. STAT. ANN. § 26:6A-5 (1991) (exemption to accommodate patient or family's religious beliefs); N.Y. COMP. CODES R. & REGS. tit. 10, § 400.16(e)(3) (1987) (allows for accommodations for an "individual's religious or moral objection" to determinations of death).

84. One study found 974 futility disputes in sixteen hospitals over an average four-year period. *See* Emily Ramshaw, *Bills Challenge Care Limits for Terminal Patients: Some Say 10 Days to Transfer Isn't Enough Before Treatment Ends*, DALLAS MORNING NEWS, Feb. 15, 2007. According to the American Hospital Association, there are 5,700 hospitals in the United States. American Hospital Association, Fast Facts on US Hospitals, at 1 (2007), http://www.aha.org/aha/content/2007/pdf/fastfacts2007.pdf. If the study's sample is representative, then that rate of fifteen futility disputes per hospital per year means that there are tens of thousands of futility disputes nationwide. However, there is reason to think that this sample is not representative. One reason is that the sample is from Texas, a state where physicians became more willing to resist inappropriate treatment requests after enactment of an effective statutory safe harbor. *See* Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743, 745 (2003) [hereinafter Fine & Mayo] (upon passage of the statutory safe harbors, futility consultations increased 67%); *see also infra* Parts V.C, VII.B (discussing the Texas Advance Directives Act).

85. *See infra* notes 89-95 and accompanying text.

86. These stages track the process recommended by the AMA and endorsed by most regional and facility policies. *See* AMA Council, *supra* note 53, at 939 (discussing the steps of fair process in futility cases).

87. *See infra* note 110 and accompanying text (discussing that few cases ever reach the final stage of the process and thus, are presumably resolved in one of the previous stages).

Nevertheless, a small but significant number of cases do proceed to the sixth and final stage, where the provider must unilaterally decide whether to stop treatment.[88]

Stage One: Ensure Good Communication by the Health Care Team. It is best to avoid a futility dispute in the first place through careful communication—clarifying the goals of treatment, its possible outcomes, and the patient's values and wishes.[89] Many commentators argue that much more can and should be done in this respect.[90] Nevertheless, through education and persuasion, the surrogate and the provider usually reach agreement.[91] Most disputes are avoided or resolved at this stage.[92]

Stage Two: Bring in a Consultant. If the health care team is unable to convince the surrogate to end LSMT, then the team typically employs an individual consultant or mediator to negotiate an agreement between the physician and patient.[93] Professor Nancy Dubler explains that a bioethics mediator "facilitates a discussion between and among the parties to the

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88. *See infra* notes 111-14 and accompanying text.

89. *See* Chad Bowman, *Disputes Over End-of-Life Care Treated Increasingly with Mediation*, 9 BNA HEALTH L. REP. 1527, 1527 (2000) ("'If you communicate well enough, often enough, and clearly enough, you will not have futility issues.'" (quoting attorney Shirley J. Paine)); Ursula Braun et al., *Defining Limits in Care of Terminally Ill Patients*, 334 BMJ 239, 239 (2007) ("Doctors should make clear that good medical care does not always mean doing everything that is technically possible . . . ."); Fine & Mayo, *supra* note 84, at 745 ("Most end-of-life consultations ease the transition from curative to a palliative model of care and occur in the absence of any particular conflict between parties."); Stanley A. Nasraway, *Unilateral Withdrawal of Life-Sustaining Therapy: Is It Time? Are We Ready?*, 29 CRITICAL CARE MED. 215, 217 (2001) (recommending "preemptive actions" to prevent conflicts from taking place).

90. For example, some commentators recommend that health care providers should not offer non-indicated options because the family will feel guilty if they do not do everything. *See supra* notes 46-50, 70-71 and accompanying text. Alternatively, providers should offer inappropriate options only as a time-limited trial to be stopped if unsuccessful. *See, e.g.*, Tovino & Winslade, *supra* note 41, at 52-53.

91. Lantos, *supra* note 12, at 589 ("Generally, in such situations, doctors explain [the situation] to the patients or their surrogates, the latter understand and accept the situation, and treatment is withheld or withdrawn."). Of course, some disputes may be resolved not only though persuasion but also through manipulation and coercion. *Cf.* THE RIGHT TO DIE, *supra* note 17, § 13.09 at 13-41 ("Some (perhaps most) futility cases can be resolved at the bedside, without the necessity of litigation, by acquiescence of one of the parties to the view of the other . . . .").

92. *See* Robert L. Fine, *The Texas Advance Directives Act of 1999: Politics and Reality*, 13 HEC FORUM 59, 71-72 (2001) (reporting that "within a day or two of learning of the [dispute resolution] process," families often agree to substitute comfort care in place of LSMT); Giles R. Scofield, *Medical Futility: Can We Talk?*, 18 GENERATIONS 66, 67 (1994) (reporting evidence that 94% of patients agree with their physician's recommendation to not attempt LSMT); Tomlinson & Czlonka, *supra* note 59, at 34 ("[A]lmost all cases are resolved at this [first] stage.").

93. *See generally* Pope & Waldman, *supra* note 9, at 155-58 (reviewing the relevant literature on mediation in futility disputes).

conflict[,]" helping the parties "to identify their goals and priorities and to generate, explore, and exchange information and options."[94] For many futility disputes, "mediation can provide a process to assist in the formation of a care plan that meets the needs of the patient and family and respects professional commitments."[95]

Stage Three: Go to the Hospital Ethics Committee. If the provider and surrogate still disagree about the appropriate treatment for the patient, the provider will typically ask the institutional ethics committee to intervene.[96] The committee usually, though not always, agrees with the treating physician's recommendation to stop LSMT.[97]

Upon receiving the committee's decision, the surrogate may agree to terminate care.[98] This acquiescence might stem from the passage of additional time and the opportunity for more careful deliberation, making the surrogate feel more secure about such a decision.[99] Moreover, if the ethics committee indicates that it will authorize the unilateral withdrawal of treatment, the surrogate may likely feel relieved from the burden of that decision.[100]

Stage Four: Change the Decision Maker. In some cases, the health care provider may doubt that the surrogate's decision reflects the patient's actual

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94. Dubler, *supra* note 26, at S24-S25.

95. *Id.* at S25.

96. *See* Hudson, *supra* note 66, at 26 ("The bioethics committee gets involved in about 2 percent of cases . . . because by the time an ethics committee conference is scheduled, the issue has often been resolved . . . or the patient dies before the conference is held.").

97. *See, e.g.*, Fine & Mayo, *supra* note 84, at 745 tbl.3 (reporting that one hospital's ethics committee agreed with the attending physician 90% of the time).

98. Zientek, *supra* note 82, at 250. Doctor Zientek reported that "[o]f the 43 cases deemed futile, in 37 cases the family agreed to withdrawal of treatment, while in six cases they refused to accept withdrawal. Of these six cases, the families of three agreed to shifting to comforting measures a 'few days' after receiving the committee's formal report." *Id.*; *see* Fine & Mayo, *supra* note 84, at 745 (reporting that family decision makers accepted the committee's judgment 86% of the time); Belluck, *supra* note 38, at A1 ("Ethics committees resolve most cases, often through repeated family discussions over weeks or months.").

99. *See* Robert D. Truog & Christine Mitchell, *Futility—From Hospital Policies to State Laws*, 6 AM. J. BIOETHICS 19, 20 (2006).

100. *See* Robert L. Fine et al., *Medical Futility in the Neonatal Intensive Care Unit: Hope for a Resolution*, 116 PEDIATRICS 1219, 1221 (2005) ("[T]he family was relieved because they had 'put up the good fight' . . . but now the decision was out of their hands."); Fine & Mayo, *supra* note 84, at 745 ("'If you are asking us to agree with the recommendation to remove life support from our loved one, we cannot. However, . . . if the law says it is OK to stop life support, then that is what should happen.'"); Lantos, *supra* note 12, at 589 ("The concept of futility . . . has a moral role in helping absolve patients or surrogates of the moral obligation to continue treatment."); Hoffman, *supra* note 46, at F1 ("Families often believe that consenting to a D.N.R. order implies they are giving up on their loved one, signing a death warrant, turning their backs on hope."); Wlazelek, *supra* note 46 ("'It's dangerous to give the family the last word since guilt and a desire to do everything for pop makes it emotionally impossible to stop treatment.'" (quoting Arthur Caplan)).

preferences or best interests.[101] Under these circumstances, providers may try to switch the legally authorized decision maker to one that will agree with their recommendation to cease LSMT.[102] One strategy providers sometimes employ to make the switch is to argue that LSMT constitutes abuse or neglect where it primarily imposes burdens such as pain.[103] That is a difficult task because the provider is usually not questioning whether the surrogate's decisions truly reflect the patient's preferences or whether the surrogate is acting in the patient's best interests.[104] Rather, the provider is just disagreeing with the decision maker's determination.[105]

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101. *See infra* notes 102-05 and accompanying text.

102. *See In re* Baby K, 832 F. Supp. 1022, 1031 (E.D. Va. 1993) (remarking that mother's treatment decision need not be respected if it "would constitute abuse or neglect"); Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1076 n.3 (La. Ct. App. 1998). The *Causey* court noted that if a surrogate insists on inappropriate treatment, "the usual procedure . . . is to transfer the patient or go to court to replace the surrogate or override his decision. The argument would be that the guardian or surrogate is guilty of abuse by insisting on care which is inhumane [or that the surrogate is not fulfilling their statutorily provided role]." *Causey*, 719 So. 2d at 1076 n.3.

103. *See, e.g.*, *Baby K*, 832 F. Supp. at 1031 (discussing whether continuing LSMT constituted abuse); *In re* Doe, 418 S.E.2d 3, 6-7 (Ga. 1992) (discussing but declining to decide whether LSMT constituted "medical abuse"); *see also* Gustaitis, *supra* note 83, at 318-19 (suggesting use of child abuse laws to override parental requests for inappropriate treatment).

104. *See, e.g.*, *In re* Howe, No. 03 P 1255, 2004 WL 1446057, at *3, *21 (Mass. Prob. & Fam. Ct. Dept. Mar. 22, 2004) (refusing Massachusetts General Hospital's request to replace Barbara Howe's daughter as her proxy); *State of Minnesota District Court –Probate Court Division County of Hennepin Fourth Judicial District*, 7 Issues L. & Med. 369, 372 (1991) (discussing *In re Wanglie*, where the court denied the hospital's request for conservator because the patient's husband was the appropriate person to articulate her wishes); Weiser, *supra* note 45, at A18 (reporting how the district court rejected the hospital's attempt to replace a mother who was demanding LSMT with a court-appointed guardian); *cf. In re* Guardianship of Schiavo, No. 90-2908GD-003, 2000 WL 34546715, at *7 (Fla. Cir. Ct. Feb. 11, 2000) (denying Theresa Schiavo's parents' motions to transfer guardianship from her husband). *But see In re* Guardianship of Mason, 669 N.E.2d 1081, 1085-87 (Mass. App. 1996) (affirming probate court's entry of DNR order and overriding patient's son's decision because he was in "denial about the deterioration [of] his mother"); Bopp & Coleson, *supra* note 45, at 825-26 ("Baby Terry's parents had 'specific incompetence' to choose Baby Terry's medical treatment.") (citing Brief of Appellant at 5, *In re* Achtabowski, No. 93-1247-AV (Mich. Cir. Ct. Aug. 12, 1993) (No. 170251)). Judicial hostility to surrogate shopping in these cases does seem to be waning. *See* Thaddeus Mason Pope, *Reassessing the Judicial Treatment of Futility Cases*, 9 MARQ. ELDER'S ADVISOR (forthcoming 2008), *available at* http://ssrn.com/abstract=1078983.

105. *See* Robert L. Schwartz, *Autonomy, Futility, and the Limits of Medicine*, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 159, 161 (1992) (arguing that whether Mr. Wanglie was his wife's best substitute decision maker was the wrong question). Professor Schwartz posits that "[t]he real question . . . [should have been] whether the continuation of ventilator support and gastrostomy feeding were among the reasonable medical alternatives that should have been available to Mrs. Wanglie or her surrogate decision maker, whoever that might be." *Id.* at 161-62.

Frequently, surrogate decision makers are often replaced in child abuse cases where the parent is the alleged abuser.[106] In such cases, it is naturally assumed that the parent would *not* be acting in the best interest of the child by insisting on continued LSMT. This assumption arises particularly where the child's death could result in murder charges against the parent. There is no such clarity in the typical futility case.

Stage Five: Attempt Transfer. If the surrogate cannot be replaced and the provider and surrogate still do not agree, then the health care provider should do one of the following: (1) find a new provider or (2) attempt to transfer the patient to another institution willing to comply with the surrogate's treatment requests.[107] While this is rarely successful, it does sometimes resolve a few additional disputes.[108]

Stage Six: Implement the Unilateral Decision to Stop Treatment. Only after diligently making all of the foregoing attempts to resolve the conflict should a provider take unilateral action to stop LSMT against the wishes of the patient or surrogate.[109]

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106. *See, e.g.*, Tabatha R. v. Ronda R., 564 N.W.2d 598, 602, 605 (Neb. 1997). In that case, the Department of Social Services took temporary custody of an infant in a persistent vegetative state and requested withdrawal of LSMT over parents' objections; consequently, the court ruled that parental rights must first be terminated since this would result in the death of the child. *Id.*; Pam Belluck, *Custody and Abuse Cases Swirl Around a Troubled Girl on Life Support*, N.Y. TIMES, Dec. 6, 2005, at A18 (reporting Massachusetts juvenile court granted DSS request to remove life support from child in their custody against the wishes of child's adoptive parents); *Clackamas County Judge to Rule on Brain-Damaged Baby*, COLUMBIAN, Apr. 24, 2004, at C8 (reporting state advocate for brain damaged baby took custody of child and requested juvenile court to grant a DNR order); *see also* Child & Family Servs. of Cent. Manitoba v. R.L., 123 Man. R. (2d) 135, 154 D.L.R. (4th) 409 (Man. App. 1997) (allowing the providers to enter a DNR at the direction of Child & Family Services over the parents' objections).

107. Most institutional and professional association model futility policies provide for transfer. *See* sources cited *supra* note 53. This is consistent with the law of tortuous abandonment, which requires that physicians assist their patients in finding a new provider before terminating a treatment relationship. *See, e.g.*, Payton v. Weaver, 182 Cal. Rptr. 225, 227 (Cal. Ct. App. 1982) (dealing with the problem of a disruptive dialysis patient and the lack of accepting institutions); Stella L. Smetanka, *Who Will Protect the 'Disruptive' Dialysis Patient?*, 32 AM. J.L. & MED. 53, 71-79 (2006) (discussion of cases and "no duty to treat"). Transfer is also required by most state health care decision making statutes. *See* sources cited *infra* note 369.

108. *See infra* notes 339-52, 369 and accompanying text.

109. *See* MICHAEL D. CANTOR ET AL., NATIONAL CENTER FOR ETHICS IN HEALTH CARE, DO-NOT-RESUSCITATE ORDERS AND MEDICAL FUTILITY: A REPORT BY THE NATIONAL ETHICS COMMITTEE OF THE VETERANS HEALTH ADMINISTRATION 1, 8 (2000) [hereinafter VHA-NEC REPORT] (arguing that unilateral decisions "should be reserved for exceptionally rare and extreme circumstances after thorough attempts" to resolve disagreements have failed); THE RIGHT TO DIE, *supra* note 17, § 13.04[B] at 13-22 ("[S]ometimes only litigation can break the impasse between demanding families and resistant health care professionals."); Timothy Bowen & Andrew Saxton, *New Developments in the Law—Withholding and Withdrawal of Medical*

While most cases will never reach this stage,[110] a significant percentage will.[111] One recent five-year study of sixteen hospitals found that in approximately sixty-five cases, the hospitals decided to unilaterally stop LSMT.[112] Another study of nine hospitals found that they decided to unilaterally stop LSMT in 2% of 2,842 cases.[113] Furthermore, there are strong reasons to suspect that the rate of intractability and unilateral hospital action will rise.[114]

II. LEADING DEFINITIONS OF "MEDICAL INAPPROPRIATENESS"

"Medical inappropriateness" is a term with a contentious history because commentators argue it has different meanings in different contexts. While there is a consensus that LSMT is inappropriate where the patient is brain dead or where the requested treatment simply will not work (i.e., physiological futility), these definitions cover only a tiny fraction of the relevant cases.[115] In most disputes, providers employ a notion of quantitative or qualitative futility, considering either the likelihood that the treatment will succeed or the quality of life that it can provide the patient.[116] These definitions of medical inappropriateness, however, are value-laden determinations, lacking consensus support from the medical community, the bioethical community, and the public.[117]

Treatment, 14 AUSTL. HEALTH L. BULL. 57, 60 (2006).

110. *See* Brennan, *supra* note 30, at 807 ("In all cases [where unilateral DNR orders were entered], the families either ultimately accepted this reasoning or ceased insisting that invasive procedures be used.").

111. *See* Pope & Waldman, *supra* note 9, at 158-61; *see also* Fine, *supra* note 48, at 79 (noting that five of twenty-nine cases went through the whole process, although two died and three agreed to withdraw before treatment was unilaterally stopped); Daniel Garros et al., *Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit*, 112 PEDIATRICS 1171, 1173 (2003) (in 1 out of 68 cases, no complete agreement could be reached between the surrogates and providers).

112. Ramshaw, *supra* note 84. About half of the patients in the study died or were transferred to other facilities before treatment was actually stopped. *Id.*

113. Tex. H.R. Comm. on Pub. Health, 80th Leg., *Interim Report*, at 36 (2006) [hereinafter Interim Report] (citing written testimony of Greg Hooser).

114. The reasons for surrogate insistence are becoming more prevalent. *See supra* notes 37-50 and accompanying text. At the same, provider resistance may increase with changes in reimbursement and an increased focus on palliative care.

115. *See infra* notes 118-56 and accompanying text.

116. *See infra* notes 157-66, 175-77 and accompanying text.

117. *See infra* notes 167-73, 178-211 and accompanying text.

A. Brain Death

Perhaps the clearest case of medically inappropriate care is LSMT requested for a brain dead patient.[118] Since the 1950s, health care providers have been able to artificially maintain respiration and circulation even for a patient whose brain had completely and irreversibly ceased to function.[119] In light of this possibility to maintain breathing and a heart beat with technology, the previously accepted standard for determining death—the cessation of cardiopulmonary function—was too limited.[120] Consequently, every state soon adopted the cessation of all brain function as an alternative method for determining death.[121]

There is a consensus that it is ethically, legally, and medically appropriate to stop LSMT for a brain dead patient.[122] The adoption of the Uniform Determination of Death Act has "alleviate[d] concern among medical practitioners that legal liability might be imposed" for stopping LSMT for a brain dead patient.[123] Indeed, defining a patient as dead provides such legal clarity that many have argued for broadening the statutory standards for the determination of death.[124]

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118. *See* David C. Blake, *Bioethics and the Law: The Case of Helga Wanglie: A Clash at the Bedside—Medically Futile Treatment v. Patient Autonomy*, 14 WHITTIER L. REV. 117, 126 (1993).

119. *See* James L. Bernat, *The Whole-Brain Concept of Death Remains Optimum Public Policy*, 34 J.L. MED. & ETHICS 35, 35 (2006).

120. *See id.*

121. *Id.* at 36; Kirsten Rabe Smolensky, *Defining Life from the Perspective of Death: An Introduction to the Forced Symmetry Approach*, 2006 U. CHI. LEGAL F. 39, 43-48 (2006).

122. *See, e.g.*, Gallups v. Cotter, 534 So. 2d 585, 589 (Ala. 1988) (affirming summary judgment for defendants on outrage claim); Dority v. Superior Court of San Bernardino County, 193 Cal. Rptr. 288, 290-91 (Cal. Ct. App. 1983); Cavagnaro v. Hanover Ins. Co., 565 A.2d 728, 731 (N.J. Super. Ct. Law Div. 1989) (finding insurer need not pay medical and hospital expenses after brain death because not incurred for treatment); *In re* Long Island Jewish Med. Ctr., 641 N.Y.S.2d 989, 992 (N.Y. Sup. Ct. 1996) (holding that hospital can withdraw LSMT from brain dead child over parent's objections); Alvarado v. N.Y. City Health & Hosps. Corp., 547 N.Y.S.2d 190 (N.Y. Sup. Ct. 1989), *vacated by* 550 N.Y.S.2d 353, 354 (N.Y. App. Div. 1990) (finding condition of infant did not constitute brain death as defined by statute); Marshall B. Kapp, *Legal Liability Anxieties in the ICU*, *in* MANAGING DEATH, *supra* note 15, at 234.

123. *In re* Bowman, 617 P.2d 731, 738 (Wash. 1980) (citing Uniform Brain Death Act § 1, 12 U.L.A. (Supp 1980)).

124. Some have proposed extending the definition to include patients in a permanent vegetative state and anencephalic infants. *See, e.g.*, E. Haavi Morreim, *Futilitarianism, Exoticare, and Coerced Altruism*, 25 SETON HALL L. REV. 883, 886 n.11, 888 n.22 (1995). *But see* Alexander Morgan Capron, *Anencephalic Donors: Separate the Dead from the Dying*, 17 HASTINGS CTR. REP., Feb. 1987, at 5 ("It would be unwise to amend the Uniform Determination of Death Act to classify anancephalics as 'dead.'"); David T. McDowell, Note, *Death of an Idea: The Anencephalic as an Organ Donor*, 72 TEX. L. REV. 893, 930 (1993) (arguing that society would be "worse off" if the legal definition of death were extended to include the

B. Physiological Futility

Apart from brain death, the narrowest and perhaps most clearly defined definition of medically inappropriate care is referred to as "physiological futility."[125] Physiologically futile interventions are inappropriate because they do not produce a measurable effect on the patient.[126] In essence, the requested treatment has a zero percent chance of being effective.[127]

Physiological futility is true to the etymological origins of the term "futility."[128] The Latin word *futilis* refers to "actions or instruments which were inherently leaky and therefore ill-suited for achieving [their] desired ends."[129] The classic illustration of *futilis* comes from Greek mythology; the daughters of King Danaus were condemned to Hades and forced to draw water in leaky containers.[130] Because of the leaks, the daughters could not achieve the goals of their actions.[131]

Commentators have offered a multitude of colorful examples of physiological futility, including the following:[132] (1) prescribing laetrile or

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anencephalic). As Roger Dworkin notes, "Definition is dangerous because it allows us to avoid analysis and do bad things to persons without concern by defining them out of existence." ROGER B. DWORKIN, LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISION MAKING 112 (1996).

125. *See, e.g.*, Fletcher, *supra* note 10, at S:232 (discussing the narrow meaning of treatment that is "physiologically ineffective"); Dale L. Moore, *Challenging Parental Decisions to Overtreat Children*, 5 HEALTH MATRIX: J. L.-MED. 311, 315-16 (1995) (briefly explaining the concept of physiologically futile treatment).

126. Moore, *supra* note 125, at 315-16. Sometimes this can be known *ex ante* as a matter of science. Other times, physiological futility cannot be determined until after one or more failed attempts with a specific patient.

127. *Id.* at 316 ("[A] clear example of treatment that is 'futile' in the 'physiologically futile' sense: it simply did not (and was not destined to) work.")

128. *See* SUSAN RUBIN, WHEN DOCTORS SAY NO: THE BATTLEGROUND OF MEDICAL FUTILITY 42 (1998).

129. *Id.*

130. *See* PLATO, *supra* note 52, at 59 ("These they bury in the mud of Hades; some are also compelled to fetch water in a sieve.")

131. *See id.* This assumes that the leaks were so substantial that all the water drained out between the river Styx and the destination. If the leaks were slower such that not all of the water was drained, then the daughters could have achieved their goal, at least to some degree. This situation would be analogous to qualitative futility. *See infra* Part II.D.

132. *See, e.g.*, Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1074 (La. Ct. App. 1998). The court argued that "[t]he problem is not with care that the physician believes is harmful or literally has no effect. For example, radiation treatment for Mrs. Causey's condition would not have been appropriate. This is arguably based on medical science." *Id.*; FINS, *supra* note 33, at 79-80 (offering examples such as "infus[ing] septic patients with fluids and pressors to hold a blood pressure[,] . . . . intubation in a patient with an obstructing tracheal mass[, or] . . . . 'call[ing] the code' . . . [i]f one can not get a rhythm or bring the pH up to normal range"); Moore, *supra* note 125, at 315-16 (CPR on patient with renal failure who had not had dialysis); Morreim, *supra* note 124, at 894, 896 (offering examples where disability would render the

pasque-flower tea for cancer,[133] (2) prescribing antibiotics for a viral illness,[134] (3) performing a heart transplant for a patient dying of liver failure,[135] (4) performing CPR in the presence of cardiac rupture or severe outflow obstruction,[136] (5) offering chemotherapy for an ulcer,[137] (6) giving a penicillin shot for a head cold,[138] (7) performing an appendectomy to calm a patient's fears that they may have appendicitis,[139] and (8) treating the dead with mechanical ventilators and pressors.[140]

With physiological futility, the provider does not make any assessment that the effect is unlikely, too small, or not worthwhile.[141] The provider does not characterize whether the effect is a "benefit" or not.[142] Instead, health care providers can readily ascertain physiological futility based solely upon their clinical knowledge.[143] Thus, there is no room for normative disagreement.[144]

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treatment "utterly pointless").

133. Fletcher, *supra* note 10, at S:232; Schwartz, *supra* note 105, at 160.

134. Levine, *supra* note 10, at 74; *see also* Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J. L. & MED. 15, 18 (1992) (prescribing antibiotics for the common cold).

135. Taylor & Lantos, *supra* note 49, at 4.

136. Fletcher, *supra* note 10, at S:232. A similar example entails a blood transfusion where the recipient is hemorrhaging at a rate that exceeds the maximum rate of transfusion. Levine, *supra* note 10, at 74; *see also* American Heart Association, *2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care—Part 2: Ethical Issue*, 112 CIRCULATION IV-6, IV-7 (2005), *available at* http://circ.ahajournals.org/cgi/content/full/112/24_supp/IV-6 ("[A]ll patients in cardiac arrest should receive resuscitation unless . . . "[n]o physiological benefit can be expected because vital functions have deteriorated despite maximal therapy (e.g., progressive septic or cardiogenic shock)."); Veatch & Spicer, *supra* note 134, at 18 (CPR is physiologically futile where performed on a patient who last breathed three hours prior to administering the care).

137. Wesley J. Smith, *Death by Ethics Committee: Refusing to Treat Lives Deemed Unworthy of Living*, NAT'L REV., Apr. 27, 2006, *available at* http://www.nationalreview.com/smithw/smith200604271406.asp.

138. Marcia Angell, *The Case of Helga Wanglie: A New Kind of "Right to Die" Case*, 325 NEW ENG. J. MED. 511, 512 (1991).

139. THE RIGHT TO DIE, *supra* note 17, § 13.07[B] at 13-38; *see also* WRONG MEDICINE, *supra* note 37, at 157 ("Nor is a surgeon obligated to perform a prophylactic appendectomy to assuage a patient's fears that her recurrent abdominal pains are due to appendicitis.").

140. FINS, *supra* note 33, at 79-80 (offering examples such as "infus[ing] septic patients with fluids and pressors to hold a blood pressure").

141. *See* Gampel, *supra* note 59, at 96 (contrasting refusals to provide physiologically futile treatment with refusals because the treatment is "inappropriate . . . [and] the risks outweigh the potential benefits, or because the patient's request is irrational or ill-considered given the low odds or limited benefit involved").

142. *See id.*

143. *See* Levine, *supra* note 10, at 79 ("Characterizing a treatment as 'useless' based on the extremely low chance that a physiological effect will occur requires an opinion that this low probability is not worth pursuing, *not a scientific determination* that the physiological effect sought is scientifically impossible.") (emphasis added).

The basis for refusing treatment is an empirical one: the treatment simply will not work.[145] Even the biggest opponents of unilateral decision making concede that "[r]efusals of requests for such 'physiologically futile care' would be proper and professional."[146]

However, this objectivity comes at a steep price because physiological futility has a very limited applicability.[147] First, the vast majority of cases are not as clear-cut as those described in the previous four paragraphs. Decisions on withholding and withdrawing treatment are usually based on mere probabilities as opposed to certainties.[148] Most providers find it difficult to be certain that there is a 100% probability that any given intervention will have zero effect.[149]

Second, physiological futility has limited applicability because it is too demanding, requiring the absence of an "effect" on any part of the patient's anatomy, physiology, or chemistry.[150] Because technology permits many "effects," such as keeping a heart beating, obtaining true physiological futility rarely occurs.[151] One must be careful to distinguish between physiological

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144. Because physiological futility is so much more easily justified, hospitals often attempt to characterize (or mask) the care that they seek to unilaterally withdraw as physiologically futile. *Cf.* Gampel, *supra* note 59, at 96. For example, Baylor Hospital argued that mechanical ventilation for Tirhas Habtegiris was "medically inappropriate, on scientific grounds alone." Yet, Baylor conceded that it would "keep [the] suffering patient alive." Baylor Health Care System, Tirhas Habtegiris Case: Baylor Response, http://www.baylorhealth.com/articles/habtegiris/response.htm (last visited Oct. 15, 2007) [hereinafter Baylor Response]. More convincingly, Massachusetts General Hospital argued this theory of medical inappropriateness to the jury in the *Gilgunn* case. Capron, *supra* note 47, at 26 (noting the defendants argued that "CPR 'could not produce the desired physiological change' . . . [and] would not only be ineffective but would be harmful").

145. *See* Moore, *supra* note 125, at 315-16.

146. *See, e.g.*, Smith, *supra* note 137.

147. *See* FINS, *supra* note 33, at 80-81 ("[T]he narrowness of the physiologic definition is also its greatest weakness . . . ."); Bowman, *supra* note 89, at 1527 ("'With the exception of a small number of cases, it's not possible to say with certainty that care will provide no benefits.'" (quoting Dr. Gregg Bloche)); Brett, *supra* note 70, at 293 ("[T]he vast majority of contentious cases do not involve physiologic futility."); Gampel, *supra* note 59, at 94 ("[I]f clinical certainty of a zero chance of success were required, there would be little if any room for the use of the concept of futility in medical practice."); Levine, *supra* note 10, at 82 n.92 ("Treatment is strictly physiologically futile only when it is *certain* that the physiological effect sought from the treatment cannot be achieved").

148. *See* WRONG MEDICINE, *supra* note 37, at 14, 97, 136 (discussing the inaccuracies of assessing "quantitative probabilities" in health care); Bowen & Saxton, *supra* note 109, at 59 (noting that published guidelines for the withdrawal of LSMT contemplate probabilities).

149. *See* WRONG MEDICINE, *supra* note 37, at 14 ("[O]ne can never be absolutely certain of the outcome.").

150. *See* FINS, *supra* note 33, at 80 ("[T]he physiologic definition is the narrowest definition of medical futility. It is a clinical determination based on narrow physiologic parameters.").

151. *See id.* ("A physiologic definition simply asks whether the infection could be resolved

futility, where there is no effect, and the more typical situation of qualitative futility, where there is some effect, albeit one judged to offer no meaningful "benefit."[152] Therefore, physiological futility is a narrow category covering few cases.[153]

While many states explicitly permit the unilateral termination of physiologically futile interventions, no state with a unilateral decision statute relies *solely* on a physiological futility standard of medical appropriateness.[154] New York's standard most closely resembles this idea, articulating that "'[m]edically futile' means that cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short time period before death occurs."[155] Yet, even the language of this statute recognizes that the CPR might work, just not for a sufficient time to be considered worthwhile.[156]

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with antibiotics. If so, the treatment is not physiologically futile, even though the "restoration" of health will be a pre-morbid state of severe cognitive impairment.").

152. *Cf. id.* at 80-81 ("[P]atients are more than their physiology.").

153. *See, e.g.*, Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1074 (La. Ct. App. 1998) ("Strictly speaking, if a physician can keep the patient alive, such care is not medically or physiologically 'futile;' however, it may be 'futile' on philosophical, religious, or practical grounds.").

154. For example, Maryland allows providers to refuse "medically ineffective treatment." MD. CODE ANN., HEALTH–GEN. § 5-611(b)(1) (West 2007). But even Maryland makes clear that this is not limited to physiological futility but also includes medical procedures that, to a reasonable degree of medical certainty, will not do the following: "(1) Prevent or reduce the deterioration of the health of an individual; or (2) Prevent the impending death of an individual." MD. CODE ANN., HEALTH–GEN. § 5-601(n) (West 2007); *see also* GA. CODE ANN. § 31-39-2(4) (2006) ("'Candidate for nonresuscitation' means a patient who . . . (C) Is a person for whom cardiopulmonary resuscitation would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time . . . ."); OKLA. STAT. ANN. tit. 63, § 3131.4(C)(2) (West 1999) (providing that CPR is not required where it would not prevent imminent death); OR. REV. STAT. ANN. § 127.580(b) (West 2005) ("Administration of such nutrition and hydration is not medically feasible or would itself cause severe, intractable or long-lasting pain."); OR. REV. STAT. ANN. § 127.635(c) (West 2005) (LSMT is not required where it would not benefit the patient or only cause them pain); S.D. CODIFIED LAWS § 59-7-2.7 (2004) (artificial nutrition or hydration may be withheld or withdrawn if "the attending physician reasonably believes that the principal's death will occur within approximately one week" or that the nutrition or hydration "cannot be physically assimilated by the principal").

155. N.Y. PUB. HEALTH LAW § 2961(12) (McKinney 1993). This statute permits unilateral decisions only in the absence of a contrary decision. *See infra* notes 376-77 and accompanying text.

156. Therefore, this statute employs a standard of "imminent demise futility," not physiological futility because the "patient will die shortly regardless of the intervention." Amir Halevy et al., *The Low Frequency of Futility in an Adult Intensive Care Unit Setting*, 156 ARCHIVES INTERNAL MED. 100, 101 (1996); *see* Amir Halevy & Baruch A. Brody, *A Multi-Institution Collaborative Policy on Medical Futility*, 276 JAMA 571, 571 (1996).

C. Quantitative Futility

While a physiological standard of medical inappropriateness is objective, a quantitative standard is subjective.[157] Though it seemingly possesses the precision of mathematics, a quantitative standard cannot be determined by reference to science alone; a quantitative standard can only be set through "reasonable consensus."[158] It is "not so much a realistic, factual or scientific concept as it is a pragmatic or useful one."[159]

Some evidence suggests that a quantitative standard of medical inappropriateness is practically implementable.[160] Proponents note that clinical studies and scoring systems can provide enough information about their likelihood to provide an empirical basis for establishing some percentage thresholds.[161] Indeed, percentages have been developed for certain patient populations.[162]

Furthermore, proponents of a quantitative standard of medical inappropriateness contend that the standard is not only workable but also ethically justified.[163] By employing such a standard, the provider is only determining whether the requested treatment can achieve the patient's goals. This determination would not necessarily challenge those goals.[164]

In fact, this is a well-established role for health care providers because they already interpret conditions specified in patients' advance directives.[165] If the advance directive states, "Treat me as long as *x*," then health care providers must determine when or whether *x* is obtainable.[166] For example, if the goal

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157. *See* WRONG MEDICINE, *supra* note 37, at 162 ("This proposal is not an 'objective' . . . definition.").

158. *See id.*

159. Lisa Anderson-Shaw et al., *The Fiction of Futility: What to Do with Policy?*, 17 HEC FORUM 294, 295 (2005).

160. *See* WRONG MEDICINE, *supra* note 37, at 148 (discussing the use of clinical studies and scoring systems to determine overall probabilities of a treatment's effectiveness).

161. *Id.*

162. *See, e.g.*, L. Esserman et al., *Potentially Ineffective Care—A New Outcome to Assess the Limits of Critical Care*, 274 JAMA 1544, 1544-51 (1995); A. Rauss et al., *Prognosis for Recovery from Multiple Organ System Failure: The Accuracy of Objective Estimates of Chances for Survival*, 10 MED. DECISION MAKING 155-62 (1990).

163. *See, e.g.*, Nancy S. Jecker, *Medical Futility: A Paradigm Analysis*, 19 HEC FORUM 13, 25-29 (2007).

164. *See, e.g.*, AMA Council, *supra* note 53, at 937; Anderson-Shaw, *supra* note 159, at 301; Rivin, *supra* note 30, at 389 (defining "futile care" where "further treatment . . . cannot, within a reasonable possibility, cure, ameliorate, improve, or restore a quality of life that would be satisfactory *to the patient*") (emphasis added); Tomlinson & Czlonka, *supra* note 59, at 33 (criticizing the precise formulation of Rivin's policy).

165. *See infra* note 166.

166. The New Jersey advance directive statute, for example, permits patients to indicate that they want LSMT withheld or withdrawn where it "is *likely* to be ineffective or futile in prolonging life, or is *likely* to merely prolong an imminent dying process." N.J. STAT. ANN. §

for a patient in a persistent vegetative state were full recovery, a provider could determine that continued treatment would be quantitatively futile. In contrast, if the goal were family contact before death, continued treatment might not be quantitatively futile.

However, a quantitative standard of medical inappropriateness suffers from two serious problems. First, where should legislatures set the threshold percentage for quantitative futility? One percent? One-tenth of a percent? Any level is likely to be controversial and arbitrary. Second, even if lawmakers are able to settle upon a threshold percentage, then how exactly do doctors ascertain whether that threshold standard is satisfied with respect to a particular patient? Any quantitative threshold would be impossible to apply with precision across a wide variety of patients and cases.

Where, if at all, should the threshold percentage be set? The most prominent proponent of quantitative futility, Lawrence Schneiderman, argues that "a treatment should be regarded as medically futile if it has not worked in the last 100 cases . . . ."[167] Tomlinson and Czlonka argue that "[a]ttempted resuscitation is futile when it provides no meaningful possibility of extended life or other benefit for the patient."[168] But what possibility is "meaningful"? Certain scholars believe that a provider must offer even a chance of "'1 in a million.'"[169] Setting a threshold of probability not worth pursuing is a value judgment.[170] Moreover, it is a value judgment about which there is considerable variability.[171]

26:2H-67(a)(1) (West 2007) (emphasis added). The "likeliness" of these conditions occurring is determined by the health care provider.

167. WRONG MEDICINE, *supra* note 37, at 97; *cf.* Morgan County Dep't Human Servs. v. Yeager, 93 P.3d 589, 591 (Colo. Ct. App. 2004) (commenting on physician's testimony that "the likelihood of resuscitating [the patient] would be approximately one out of a hundred" and thus justified DNR order).

168. Tomlinson & Czlonka, *supra* note 59, at 33. Setting the percentage threshold also requires determining what constitutes a benefit. In *Causey,* the defendant physician "agreed that with dialysis and a ventilator Mrs. Causey could live for another two years . . . [but] that she would have only a slight (1% to 5%) chance of regaining consciousness." Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1073 (La. Ct. App. 1998).

169. GREGORY E. PENCE, CLASSIC CASES IN MEDICAL ETHICS: ACCOUNTS OF CASES THAT HAVE SHAPED MEDICAL ETHICS, WITH PHILOSOPHICAL, LEGAL, AND HISTORICAL BACKGROUNDS 11 (2d ed. 1995).

170. *See, e.g.*, Wendland v. Sparks, 574 N.W.2d 327, 332 (Iowa 1998) (refusing to dismiss medical malpractice and lost chance action based on physician's unilateral DNR order, explaining "even a small chance of survival is worth *something*"); *Causey*, 719 So. 2d at 1074 ("Placement of statistical cut-off points for futile treatment involves subjective value judgments. The difference in opinion as to whether a 2% or 9% probability of success is the critical point for determining futility can be explained in terms of personal values, not in terms of medical science."); Ferguson, *supra* note 16, at 1229 ("It appears to be a technical assessment of the limits of our technology, but these limits often become confused with the moral propriety of applying a particular technology."); *id.* at 1234 ("Simply because a treatment *is* only of marginal success does not mean that it *ought* not be pursued. Such reasoning belies a moral decision

Furthermore, even if policymakers could settle on a percentage threshold definition of medical inappropriateness, it would be difficult to employ with sufficient precision because "[p]rognostication is difficult on a case-by-case basis."[172] Thus, as applied to any particular patient, available measures from scholarly studies are very imprecise.[173]

D. Qualitative Futility

When applying either a physiological futility or a quantitative futility standard of medical inappropriateness, the provider starts with the patient's own goals and determines whether those goals are sufficiently achievable.[174] However, when applying a qualitative futility standard of medical inappropriateness, the provider questions whether the patient's goals themselves are worthwhile.[175] For example, LSMT for a patient in a persistent vegetative state can sometimes sustain the patient's life for a very long time.[176]

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being made about the value of percentages and scientific assessments of success . . . ."); *cf.* Bouvia v. Superior Court, 225 Cal. Rptr. 297, 305 (Cal. App. 1986) ("Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days . . . ?").

171. *See* Lee, *supra* note 31, at 482; Karen Trotochaud, *"Medically Futile" Treatments Require More than Going to Court*, CASE MANAGER, May–June 2006, at 60, 61 ("Although most physicians believed a roughly 5% chance of survival equated to futility, the range was from 0% to 60% . . . ."). Of course, the likelihood for a specific patient can be clarified through a time-limited trial.

172. Lee, *supra* note 31, at 482; *see* James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice "Safe Harbors" As a New Role for QIOs?*, 59 VAND. L. REV. 1017, 1027 (2006) (discussing the "widespread existence of clinical uncertainty").

173. *See* Arato v. Avedon, 858 P.2d 598, 601 (Cal. 1993) (observing that "statistical life expectancy data had little predictive value when applied to a particular patient with individualized symptoms, medical history, character traits and other variables"); Gampel, *supra* note 59, at 94 ("It is rare in clinical practice to have reliable numbers based on scholarly studies."); Tomlinson & Czlonka, *supra* note 59, at 31 (arguing that quantitative futility creates "the illusion of specificity" because it fails to consider "individual clinical circumstances"); Trotochaud, *supra* note 171, at 61 ("Although [scoring] systems can be helpful in predicting outcomes of populations of patients, they fail to be specific enough to be of significant help in predicting outcomes for an individual patient."); *see also* BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 75-76 (2d ed. 2000) (noting the likelihood of successful CPR is often mistaken); Louise Swig et al., *Physician Responses to a Hospital Policy Allowing Them to Not Offer Cardiopulmonary Resuscitation*, 44 J. AM. GERIATRICS SOC'Y 1215, 1217 (1996) (reporting 58% of those patients considered by their physicians to be unlikely to benefit from CPR were later discharged); Robert D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560, 1561 (1992) ("[P]hysicians are often highly unreliable in estimating the likelihood of success of a therapeutic intervention.").

174. *See supra* notes 141-46, 157-66 and accompanying text.

175. *See* WRONG MEDICINE, *supra* note 37, at 9 (questioning whether a patient's request coincides with the goal of medicine).

176. *See, e.g.*, Bush v. Schiavo, 885 So. 2d 321, 324 (Fla. 2004) (noting Theresa Schiavo

Assuming that life itself is the goal, LSMT is neither physiologically nor quantitatively futile for a patient in a persistent vegetative state because providing LSMT really will achieve this goal. In contrast, LSMT for a patient in a persistent vegetative state might be qualitatively futile because the life sustained is not "worth" sustaining.[177]

Qualitative futility has three distinct forms: (1) LSMT is inappropriate when its prospective benefits are outweighed by its associated burdens to the patient, (2) LSMT is inappropriate when its prospective benefits are not worth the required health care resources, or (3) LSMT is inappropriate when it simply cannot provide the patient a quality of life worth living.

1. Burdens Outweigh the Benefits

The first form of qualitative futility asserts that LSMT is medically inappropriate where the prospective benefits of treatment are outweighed by their associated burdens.[178] For example, for a patient that is unable to derive any pleasure, emotional enjoyment, or other satisfaction from life, the benefits of prolonged life may be outweighed by pain and suffering.[179]

Since this standard has enormous intuitive appeal, providers employ it with some regularity.[180] For example, Seattle providers were unwilling to provide

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was in a persistent vegetative state for nearly fifteen years).

177. *See In re* Finn, 625 N.Y.S.2d 809, 812–13 (N.Y. Sup. Ct. 1995) (noting doctor unilaterally entered DNR order for a patient on grounds that CPR would be medically futile because the patient was "profoundly retarded and would likely be more severely retarded after the administration of CPR" and therefore that patient's life would not be "worth living").

178. *See* Pellegrino, *supra* note 2, at 3 ("[W]hen the capabilities of medicine to cure, ameliorate, or reverse a disease process have been exhausted[,] . . . continuance of treatment under those circumstances may impose further suffering and other burdens on the patient—physical, emotional, and fiscal."); Linda B. Siegel, *When Staff and Parents Disagree: Decision Making for a Baby with Trisomy 13*, 73 MOUNT SINAI J. MED. 590, 591 (2006) (describing baby who "was suffering significantly" and "did not appear to get any pleasure from life"); Tomlinson & Czlonka, *supra* note 59, at 33 (defining attempted resuscitation as "harmful" where "harm inflicted on the patient is grossly disproportionate to any possibility of benefit"); *see also* Morreim, *supra* note 124, at 898. Under the circumstances, a compelling case can be made that a surrogate demanding such continued aggressive treatment should be stripped of decision making authority. *See supra* notes 101-06.

179. Some have referred to this qualitative standard as the "unbearable situation." ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH, WITHHOLDING OR WITHDRAWING LIFE SUSTAINING TREATMENT IN CHILDREN: A FRAMEWORK FOR PRACTICE 29 (2d ed. 2004). Others have defined the treatment to be "inhumane." 45 C.F.R. § 1340.15(b)(2)(iii) (1990).

180. An "objective" or "best interests" standard is well-established for proxy decision makers in circumstances where they have little or no evidence of the patient's preferences. *See, e.g.*, OR. REV. STAT. § 127.580(1)(b) (West 2005) (providing an exception to the administration of nutrition or hydration if it causes "severe, intractable or long-lasting pain"); *id.* § 127.635(1)(c) (allowing withdrawal of LSMT if it creates no benefit to patient's condition or causes "permanent and severe pain"); S.D. CODIFIED LAWS § 59-7-2.7 (2004) (allowing

long-term dialysis to Ryan Nguyen, "since it would prolong agony with 'no likelihood of a good outcome.'"[181] Baylor Regional Medical Center at Plano withdrew LSMT from Tirhas Habtegiris because the care was "disproportionately burdensome"[182] and was only "increasing her suffering."[183] Similarly, D.C. Children's Hospital wanted to withdraw LSMT from Baby Rena because she had no prospect for recovery or positive interaction with her environment and had to be "constantly sedated" to soothe her continuous pain.[184]

In one of the earliest reported futility cases, providers argued that further intervention for "Baby L" would be inhumane and that continued LSMT "would only add to her pain, without helping."[185] Because Baby L was blind, deaf, quadriplegic, and could not otherwise interact with her environment, maintaining her on a respirator provided no opportunity for improvement or cure, but only more seizures, infections, and cardiac arrests.[186] Baby L "could experience nothing but pain."[187]

2. Resources Outweigh the Benefits

The second form of qualitative futility also weighs the prospective benefits of treatment. Yet, unlike the first form, which balances the benefits against the burdens of treatment for the patient, the second form balances the benefits against the health care resources used to provide the treatment.[188] Under this theory, LSMT is medically inappropriate where it is not worth the requisite resources that are better spent elsewhere.[189]

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withdrawal or withholding of artificial nutrition or hydration if "the burden of providing [it]. . . outweighs its benefit, provided that the determination of burden refers to the provision of artificial nutrition or hydration itself and not to the quality of the continued life of the principal"). As a standard, qualitative futility has been employed not only to patients without subjective preferences but also to patients who have exercised preferences for continued LSMT.

181. Alexander M. Capron, *Baby Ryan and Virtual Futility*, 25 HASTINGS CTR. REP., Mar.-Apr. 1995, at 20.

182. Baylor Response, *supra* note 144.

183. Baylor Health Care System, Tirhas Habtegiris Case: Medical History, http://www.baylorhealth.com/articles/habtegiris/history.htm (last visited Oct. 15, 2007).

184. Weiser, *supra* note 45, at A1.

185. Joan Beck, *Use Medical Technology to Save Every Damaged Baby?*, ORLANDO SENTINEL, May 18, 1990, at A13; *see also* John J. Paris et al., *Physicians' Refusal of Requested Treatment: The Case of Baby L*, 322 NEW ENG. J. MED. 1012, 1013 (1990) (reporting conclusion of ethics committee meeting that because Baby L "could experience only pain[,]" further LSMT was "not in the best interest of the patient").

186. Beck, *supra* note 185, at A13.

187. *Id.*

188. *See* AMA Council, *supra* note 53, at 938 ("Another context in which futility questions come up is resource allocation. Some commentators argue that elimination of futile care is good for both patients and allocation of resources.").

189. *See* Tomlinson & Czlonka, *supra* note 59, at 32 ("Many interventions are not

Commentators have articulated both a modest and a robust version of resource-focused qualitative futility. The modest version focuses on hard resources like ICU beds.[190] When these resources are needed by other patients with better prospects, then it is inappropriate to give those resources to the patient with the poorer prospects.[191] This modest version of resource-focused qualitative futility is similar to the concept of "triage" where emergency room providers do "not work on a first come, first serve basis," but serve the most urgent or severe yet treatable injuries and illnesses first "to avoid [any] delay in treatment."[192] The modest version of resource-focused qualitative futility is employed in a few states.[193]

While the modest version of resource-based qualitative futility is well-grounded, the robust version of resource-focused qualitative futility is more controversial. Rather than looking to the allocation of hard resources, the robust version examines the allocation of soft resources like health care dollars.[194] In many cases, families allege that providers make unilateral

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costworthy because they consume too many resources *relative* to their benefit, not because they offer no benefits at all."). Some commentators have referred to this as "[t]herapeutic extravagance . . . mean[ing] the provision of high-cost treatments that offer little or no benefit." Tovino & Winslade, *supra* note 41, at 2-3 n.5.

190. *See, e.g.*, Amy Iggulden, *Premature Babies Are Blocking Beds, Says Royal Medical College*, TELEGRAPH, Mar. 27, 2006, *available at* http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/03/27/nprem27.xml (reporting that the Royal College of Obstetrics and Gynaecology felt that very premature babies were "'bed blocking'" by "taking up intensive care space that could be used by healthier babies"); Roy Lilley, *A Bad Time to Be Very Young or Old*, TELEGRAPH, Mar. 28, 2006, *available at* http://www.telegraph.co.uk/opinion/main.jhtml?xml=/opinion/2006/03/28/do2802.xml ("[T]he Royal College of Obstetricians and Gynaecologists . . .[suggests that] [b]abies born at 25 weeks . . . should be left to die . . . [because] more weight [should] be given to 'economic considerations.'").

191. *See* sources cited *supra* note 190.

192. *See* STEVEN E. PEGALIS, AMERICAN LAW OF MEDICAL MALPRACTICE § 6.18 (3d ed. 2006) (describing the process of "triage"); JOINT COMM'N ON THE ACCREDITATION HEALTHCARE ORGANIZATIONS, MANAGING PATIENT FLOW: STRATEGIES AND SOLUTIONS FOR ADDRESSING HOSPITAL OVERCROWDING 120–29 (2004).

193. *See, e.g.*, OKLA. STAT. ANN. tit. 63, § 3101.9 (West 1998) ("Nothing in this section shall require the provision of treatment if the physician or other health care provider is physically or legally unable to provide or is physically or legally unable to provide without thereby denying the same treatment to another patient."); VA. CODE ANN. § 54.1-2990(C) (1992) ("Nothing in this section shall require the provision of treatment that the physician is physically or legally unable to provide, or treatment that the physician is physically or legally unable to provide without thereby denying the same treatment to another patient.").

194. *See, e.g.*, Mary Ann Roser, *Austin Doctors Want to Withdraw Care from Vegetative Patient (Terri Schiavo Type Situation)—Family Objects and Says Woman Is Still Aware; Seeking Transfer to Another Facility in Texas*, AUSTIN AM.-STATESMAN, Apr. 28, 2006, *available at* http://www.freerepublic.com/focus/f-chat/1623122/posts (reporting in the case of Lang Yen Thi Vo that the patient's daughter "sees a financial reason behind the decision [to withdraw care] . . . . Her mother will soon exhaust her Medicare and Medicaid benefits.").

withdrawal decisions based on financial reasons.[195] Providers, on the other hand, almost always deny that money is a relevant factor.[196]

Whether or not providers determine LSMT to be inappropriate based in whole or in part on its cost, most commentators agree that neither resource consumption nor rationing is a legitimate ground for making life-and-death decisions for individual patients.[197] For example, a treatment that has a 2%

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195. *See, e.g., id.*

196. *See, e.g., In re* Baby K, 832 F. Supp. 1022, 1026 (E.D. Va. 1993) ("The Hospital has stipulated that it is not proposing to deny ventilator treatment to Baby K because of any lack of adequate resources or any inability of Ms. H to pay for the treatment."); Burke v. Gen. Med. Council [2004] EWHC 1879 (Admin), 2 W.L.R. 431, 444–45 (2005) (explaining that the case was not "about the prioritisation [sic] or allocation of resources" or concern over "significant cost implications"); WRONG MEDICINE, *supra* note 37, at 53 (noting that Wanglie's providers "avoided seeking court permission to withdraw treatment on another patient who happened to be in the hospital at the same time in a similar condition—but who happened to be on welfare"); Schwartz, *supra* note 105, at 161 ("[Helga Wanglie's] hospitalization cost nearly 1 million dollars, which was paid by Medicare and her private medigap insurance carrier. Neither objected to the care for financial or cost-benefit reasons, and the cost properly did not enter into the judicial analysis of the case."); Frank Bruni, *Care vs. Cost: Suit Against Pa. Hospital on Life Support Raises Questions*, PITTSBURGH POST-GAZETTE, Mar. 10, 1996, at A1 (reporting that the CEO of Hershey Medical Center denied that the financial cost of caring for Brianna [Rideout] or the fact that her insurance was running out influenced the decision to remove her ventilator); Kowalczyk, *Mortal Differences*, *supra* note 66 (reporting Massachusetts General Hospital executives denied that they were motivated to stop Barbara Howe's LSMT because Blue Cross stopped paying); Roser, *supra* note 194 (reporting in the case of Lang Yen Thi Vo that the hospital "had no idea of Vo's financial status and that it was not a factor"); Baylor Response, *supra* note 144 ("The hospital did not stop treatment because of economic considerations. . . . The same course of action followed in this case has in the past been followed with privately insured patients . . . ."). While costs may not be the basis of the unilateral decision, they may be the reason other institutions refuse to accept transfer of the patient. *See, e.g.*, Murphy, *supra* note 43, at A37 (reporting that while the family of Joseph Ndiyob eventually found a Los Angeles hospital willing to accept him, the hospital "recanted when it learned he lacked health insurance"); Smith, *supra* note 26 ("[P]atients who would be refused care under futility protocols would usually be the most expensive to care for and thus, given the economics of managed care, probably unwelcome in another institution."). For some, it is unnecessary to even consider the legitimacy of cost-based inappropriateness, because other more acceptable standards are available. *See* Hudson, *supra* note 66, at 32 ("Some treatments—such as keeping a patient in a persistent vegetative state alive, even if it costs only 10 cents a day—are not what medicine is about." (quoting Lawrence Schneiderman)).

197. AMA Council, *supra* note 53, at 938 ("Efforts to understand futility should not make use of resource-saving criteria, and rationing needs should not motivate declarations of futility."); Dubler, *supra* note 26, at 297 ("[F]inancial disincentives . . . must not be permitted to contaminate decisions about death."); S.Y. Tan et al., *Creating a Medical Futility Policy*, HEALTH PROGRESS, July–Aug. 2003, *available at* http://findarticles.com/p/articles/mi_qa3859/is_200307/ai_n9263834/pg_1 ("Resource consumption, inability to pay, or rationing are not legitimate criteria to be used in defining medical futility."); Tomlinson & Czlonka, *supra* note 59, at 32 (relying on costs to define, rather than just to prompt consideration of medical inappropriateness, will poison communication, credibility, and trust).

chance of extending a patient's life ten days at a cost of $1 million may be too expensive. However, the consideration of cost, alone, would not make the treatment medically inappropriate.

3. Treatment Cannot Provide a Worthwhile Quality of Life

The third form of qualitative futility does not weigh the prospective benefits of treatment against either the prospective burdens or the required resources.[198] Instead, providers determine that the expected outcome of the requested treatment is of no value, without regard to either burdens or resources.[199] The provider judges the expected outcome to be of no value because of the patient's extremely poor condition or prognosis.[200]

The most notable situations, in which providers consider continued LSMT to be qualitatively inappropriate, exist when a patient is permanently unconscious, totally dependent on intensive medical care, or both.[201] Permanent unconsciousness means a condition that, to a high degree of medical certainty, will last permanently without improvement. In this condition, patients have no thought, sensation, purposeful action, social interaction, awareness of self, or awareness of their environment.[202]

But cf. HALL ET AL., *supra* note 78, at 600 (suggesting that futility may be a mask for rationing and driven by the concern about scarce health care resources); Lantos, *supra* note 12, at 589 ("[T]he only downside to trying a treatment that is unlikely to work is economic. It will be a wasted expenditure. To the extent that this is the case, futility determinations collapse into rationing decisions."); Mildred Z. Solomon, *How Physicians Talk about Futility: Making Words Mean Too Many Things,* 21 J. L. MED. & ETHICS 231, 232-33 (1993) (explaining that medical futility denotes "both efficacy *and* evaluative judgments about the wisdom of pursuing further treatment").

198. *See* AMA Council, *supra* note 53, at 937 (without considering benefits or resources, the physician simply "sees dying as inevitable and wishes to pursue the goal of comfort care").

199. *See id.* at 938 (examining the qualitative approach of the "worth-the-effort quality of life" standard).

200. *See id.* at 937 (providers may decline intervention as futile if the intent is only to prolong dying).

201. *See, e.g.*, GA. CODE ANN. § 31-39-2(4)(B) (Supp. 2007) ("'Candidate for nonresuscitation' means a patient . . . in a noncognitive state with no reasonable possibility of regaining cognitive functions."); N.C. GEN. STAT. § 90-322(a) to (b) (2006) (permitting providers, in the absence of a contrary patient or surrogate request, to unilaterally stop LSMT for a patient who is in a persistent vegetative state or terminal, incurable and comatose or mentally incapacitated); OR. REV. STAT. § 127.580 (2005). This provision similarly permits providers, in the absence of a contrary request from the patient or surrogate, to unilaterally stop LSMT for a patient who is "permanently unconscious" or who "has a progressive illness that will be fatal and is in an advanced stage," if the patient "is consistently and permanently unable to communicate by any means, swallow food and water safely, care for the person's self and recognize the person's family and other people, and it is very unlikely that the person's condition will substantially improve." *Id.*

202. *See, e.g.*, OR. REV. STAT. § 127.505(18) (2005) ("'Permanently unconscious' means completely lacking an awareness of self and external environment, with no reasonable

Withholding LSMT as medically inappropriate based on a quality of life assessment is a heavily criticized standard.[203] While some accept that an individual may make a personal choice to forgo LSMT, it is highly controversial for a health care provider to make this decision on the patient's behalf.[204] The controversy arises because health care providers can be poor predictors of a patient's quality of life.[205] The point at which life becomes "worthless" is not known to the patient's health care provider "any better than [it is] known to nine people picked at random from the Kansas City telephone directory."[206] A health care provider may judge the patient's quality of life to be far less than the patient would.[207] Nonetheless, "people with physical, sensory, and cognitive impairments can and do obtain many satisfactions and rewards in their lives."[208] For this reason, Professor Felicia Ackerman rejects quality of life determinations:

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possibility of a return to a conscious state, and that condition has been medically confirmed by a neurological specialist who is an expert in the examination of unresponsive individuals.")

203. *Cf.* Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 432 (Mass. 1977) ("To the extent that this formulation equates the value of life with any measure of the quality of life, we firmly reject it.").

204. *See* Adrienne Asch, *Recognizing Death While Affirming Life: Can End of Life Reform Uphold a Disabled Person's Interest in Continued Life?*, 35 HASTINGS CTR. REP. (SPECIAL REPORT), Nov.–Dec. 2005, at S31. Dr. Asch questions the autonomy of the patient's choice and argues that "clinicians and policymakers [should be prompted] to question how truly autonomous is anyone's wish to die when living with changed, feared, and uncertain physical impairments . . . ." *Id.* at S33; *see also* ROBERT L. BURGDORF JR., NATIONAL COUNCIL ON DISABILITY, ASSISTED SUICIDE: A DISABILITY PERSPECTIVE 48 (1997) ("The pressures upon people with disabilities to choose to end their lives . . . are already way too common in our society. These pressures are increasing and will continue to grow . . . .").

205. *See* Susan Dorr Goold et al., *Conflicts Regarding Decisions to Limit Treatment: A Differential Diagnosis*, 283 JAMA 909, 912 (2000) (noting the uncertainty of prognostications made by doctors).

206. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

207. *See* Asch, *supra* note 204, at S35 (questioning the basis of a provider's decision to end LSMT contrary to the patient's and the patient's family's wishes because the provider felt that continued treatment was "inhumane").

208. *Id.* at S32; *see also In re* Finn, 625 N.Y.S.2d 809, 813 (N.Y. Sup. Ct. 1995) ("Although Leonard's life as a developmentally disabled person may seem a small possession from the perspective of some, it remains his possession and 'no person or court should substitute its judgment as to what would be an acceptable quality of life for another.'" (quoting *In re* Westchester County Med. Ctr. *ex rel* O'Connor, 531 N.E.2d 607, 613 (N.Y. 1988))); A Nat'l Health Serv. Trust v. D, [2000] EWHC FD 00P10551 (Fam), [2000] 2 FLR 677, 687 (Eng.) (describing child with terminal illness who "has a delightful smile and can indicate pleasure and displeasure"); Lewis Smith, *Victory for Dying Boy's Family*, THE TIMES, Mar. 16, 2006, at 4 (reporting High Court in London refused application to withdraw ventilator from a 18-month old baby with spinal muscular atrophy because even though the baby was paralyzed, he could still experience pleasure from sight, touch, and sound).

> It is as presumptuous and ethically inappropriate for doctors to suppose that their professional expertise qualifies them to know what kind of life is worth prolonging as it would be for meteorologists to suppose their professional expertise qualifies them to know what kind of destination is worth a long drive in the rain.[209]

Some commentators refer to this as the problem of "therapeutic illusion" because providers may not recognize possible benefits of treatment.[210] Furthermore, a qualitative standard of inappropriateness, unmoored from any demonstrable weighing of benefits and burdens, is obviously subject to abuse.[211]

E. Summary of Definitions of "Medically Inappropriate"

Despite an exhaustive debate over the past fifteen years, only brain death and physiological futility are fully supported by a consensus in the medical, legal, and bioethical communities as acceptable definitions of medical inappropriateness.[212] However, these are not the relevant conditions in the vast majority of futility disputes. The typical case involves a living patient for whom LSMT can produce *some* effect.[213]

In order to define a treatment as medically inappropriate, a health care provider typically must question whether the expected effect on the patient is beneficial and worthwhile. There is no consensus about this.[214] Many

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209. Felicia Ackerman, *The Significance of a Wish*, 21 HASTINGS CTR. REP., July-Aug. 1991, at 27, 28 (emphasis omitted). But while people may find satisfaction despite severe physical or mental handicaps, this is not possible where they are irreversibly unconscious. *See* WRONG MEDICINE, *supra* note 37, at 18.

210. Tovino & Winslade, *supra* note 41, at 2 n.5.

211. *Cf.* ROBERT JAY LIFTON, THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE 45 (1986) (describing the Nazi Germany program whereby the disabled, labeled as "life unworthy of life," were euthanized).

212. *Cf.* Robert S. Chabon, *The Case of Baby K*, 311 NEW ENG. J. MED. 1383, 1383 (1994) ("Within the medical profession itself there appear to be disputes about whether physicians must provide medically inappropriate interventions on a patient's or surrogate's request."); Fletcher, *supra* note 10, at S:232 (comparing the narrow, objective definition of futility as physiologically ineffective with the broad, subjective definition of "nonbeneficial"); William Prip & Anna Moretti, *Medical Futility: A Legal Perspective*, *in* MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS 136, 137 n.2 (Marjorie B. Zucker & Howard D. Zucker eds., 1997) (examining roots of notion that brain death defines actual death).

213. *Cf.* Prip & Moretti, *supra* note 212, at 137 (describing the progression from patients demanding assisted suicide to patients challenging the physician's decision to stop LSMT).

214. *See* Jeffrey P. Burns & Robert D. Truog, *Futility: A Concept in Evolution*, 132 CHEST 1987, 1988-89 (2007) (reviewing "problems inherent to definitional approaches to futility"); Bryan Rowland, *Communicating Past the Conflict: Solving the Medical Futility Controversy with Process-Based Approaches*, 14 U. MIAMI INT'L & COMP. L. REV. 271, 284 (2006) ("Even those who accept the concepts of quantitative and qualitative futility disagree on how to draw the dividing line between futile and non-futile care.").

providers are unable to reduce medical inappropriateness to an algorithm "contained within the four corners of a formula."[215] Consequently, medical inappropriateness can only be identified the way beauty is perceived, "in the eye of the beholder,"[216] or the way pornography is identified—we know it when we see it.[217]

III. LEGAL CONSTRAINTS ON THE UNILATERAL TERMINATION OF LSMT

Employing these ad hoc definitions of medical inappropriateness, providers often want to stop LSMT unilaterally when they are unable to secure surrogate consent; however, the unilateral withholding and withdrawing of LSMT is remarkable in three important respects.[218] First, it typically results in the patient's death.[219] Second, it is rare and unusual.[220] Third, and most significantly, it devalues patient autonomy.[221]

Before the 1970's, this devaluation of patient autonomy did not seem so remarkable.[222] Historically, it did not matter so much what the patient wanted because health care providers just provided the treatment that they thought was right.[223] But today, providers generally must comply with treatment requests made by or on behalf of their patients.[224] Autonomy has become the touchstone.

This nonconsensual aspect of unilateral termination is the most distinctive.[225] Both without patient or surrogate consent and typically even over

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215. Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 444 (Cal. 1963).

216. *Cf.* Fla. Power & Light Co. v. Lorion, 470 U.S. 729, 737 (1985) (discussing the subjectivity of the "plain meaning" of a statute granting judicial review of a lower court's decision).

217. *Cf.* Jeffrey Burns, *Does Anyone Actually Invoke Their Hospital Futility Policy?*, 12 LAHEY CLINIC MED. ETHICS J. 3, 3 (2005) (comparing futility to Potter Stewart's remark of pornography: "I know it when I see it" (quoting Jacobellis v. Ohio, 378 U.S. 184, 197 (1964) (Stewart, J., concurring))).

218. *See* Diane E. Hoffmann & Jack Schwartz, *Who Decides Whether a Patient Lives or Dies?*, TRIAL, Oct. 2006, at 30, 32 (revealing these three aspects through the last days of a two-year-old patient).

219. *See id.* at 32, 34.

220. *See id.* at 32.

221. *See id.*

222. *See* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 76-101 (1986).

223. *See id.*

224. *See, e.g.*, CAL. PROB. CODE § 4650(a) (West Supp. 2007) ("[T]he law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care . . . ."); *id.* § 4733 (stating that health care providers are required to comply with the requests of their patients or surrogates); Ferguson, *supra* note 16, at 1237 ("[T]wenty-five years of patients' rights development indicate that unilateral actions are *not* the standard. The unilateral withdrawal of care . . . violates our sense of patient autonomy . . . .").

225. MASON & LAURIE, *supra* note 77, at 601 ("An act of involuntary euthanasia involves

vehement opposition, the provider causes the patient's death.[226] Consequently, taking unilateral action can expose the health care provider to civil, criminal, and disciplinary sanctions.[227]

A. Civil Sanctions

Health care providers who make unilateral decisions to stop LSMT may be subject to a wide array of civil sanctions. Reported cases show claims for patient neglect and abuse,[228] infliction of emotional distress,[229] and breach of contract.[230] However, the causes of action most often utilized in response to unilateral decisions are the following: (1) lack of informed consent, (2) medical malpractice, and (3) wrongful death.[231]

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ending the patient's life in the absence of either a personal or proxy invitation to do so."); Brenda Fastabend, *Virginia's Involuntary Euthanasia Problem*, VSHL LIFESAVER, Aug. 1999, *available at* http://www.vshl.org/education/euthanasia/5_4/5_4_4_Virginia_Involuntary_Euthanasia_Problem.shtml (referring to "medical futility" as "involuntary [passive] euthanasia"). Where patients decline LSMT through contemporaneous decisions, advance directives, or surrogates, this is known as "voluntary passive euthanasia." Medical futility is characterized as "passive" where providers withhold or withdraw LSMT, but take no affirmative action such as a lethal injection. Medical futility becomes "involuntary" when LSMT is stopped *without* the patient's or surrogate's consent.

226. *See* Hoffman & Schwartz, *supra* note 218, at 32.

227. *See infra* notes 228-75 and accompanying text. The following discussion is qualified in three respects. First, this Article does not distinguish the liability of the individual provider from that of the institutional provider. Second, while the Article assumes that the provider has already implemented the unilateral decision, in addition to these *ex post* sanctions, the patient or surrogate may seek injunctive relief. Third, the Article focuses here on state law. For discussion of federal law constraints, see *infra* notes 439 to 464 and accompanying text. For a thorough analysis of futility disputes in court, see Pope, *supra* note 104.

228. *See, e.g.*, *In re* Estate of Greenspan, 558 N.E.2d 1194, 1200 (Ill. 1990).

229. *See, e.g.*, Manning v. Twin Falls Clinic & Hosp., 830 P.2d 1185, 1187 (Idaho 1992); Morgan v. Olds, 417 N.W.2d 232, 236 (Iowa Ct. App. 1987); Rideout v. Hershey Med. Ctr., 30 Pa. D. & C.4th 57, 62 (Dauphin County Ct. C.P. Dec. 29, 1995) (No. 872S1995), 1995 WL 924561; Strickland v. Deaconess Hosp., 735 P.2d 74, 75 (Wash. Ct. App. 1987); Capron, *supra* note 47, at 28 (discussing *Gilgunn v. Massachusetts Gen. Hosp.*, No. CIV.A.92-4820 (Suffolk Super. Ct. Apr. 21, 1995)); Hoffman & Schwartz, *supra* note 218, at 30, 32 (citing Bland v. Cigna Healthplan of Tex., No. 93-52630 (Harris Cty., Tex. Dist. Ct. Apr. 25, 1995)).

230. *See, e.g.*, Gamble v. Perra, No. E2006-00229-COA-R3-CV, slip. op. at 2 (Tenn. Ct. App. Feb. 22, 2007). There is also potential exposure for providers under state disability laws. *See, e.g.*, ALASKA STAT. § 13.52.135 (2006) ("When determining the best interest of a patient under this chapter, health care treatment may not be denied to a patient because the patient has a disability or is expected to have a disability.").

231. *See infra* notes 232–54 and accompanying text. At least one court has suggested that unilateral decisions to terminate would constitute tortuous abandonment. Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996) ("Such reprehensible disregard for one's patient . . . would . . . constitute . . . the well established tort of abandonment."). However, abandonment claims are weak for two reasons. First, it is unlikely that the physician-

1. Lack of Informed Consent

Patients and surrogates have brought informed consent actions against health care providers that implemented unilateral decisions to stop LSMT.[232] For example, in *Rideout v. Hershey Medical Center,* the hospital withdrew a ventilator from a two-year-old girl, not only without her parent's consent, but also "against their vehement and desperate opposition."[233] The court overruled the hospital's motion to dismiss the parent's informed consent cause of action.[234] The case subsequently settled for an undisclosed sum.[235]

The doctrine of informed consent requires health care providers to obtain consent to discontinue a patient's treatment.[236] In a typical futility dispute, the

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patient relationship would be terminated completely and unilaterally. *See* THE RIGHT TO DIE, *supra* note 17, at § 11.03[d]; Prip & Moretti, *supra* note 212, at 142. While a provider may decline to continue LSMT, the provider must continue comfort care. *See* sources cited *supra* note 79 and accompanying text. Second, if treatment were medically inappropriate, then the treatment relationship would have already ended because the provider's services were no longer necessary. *See* Levine, *supra* note 10, at 88 (arguing that if the treatment is medically inappropriate, then physician's services were no longer necessary).

232. *See, e.g.*, *Morgan*, 417 N.W.2d at 235 (DNR order without patient's consent); Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1075-76 (La. Ct. App. 1998) (discussing that while the physician explained the situation to the patient's family, he withdrew the treatment "despite the lack of any consent"); *Strickland,* 735 P.2d at 75 (patient removed from respirator without consent); Preston v. Meriter Hosp., Inc., 678 N.W.2d 347, 352 (Wis. Ct. App. 2004) (dismissing informed consent claim against hospital because it had no independent duty to obtain consent; only doctors are required to obtain informed consent), *rev'd on other grounds*, 700 N.W. 2d 158 (Wis. 2005); Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 838 (W. Va. 1992) (remanding case for trial on whether doctors should have sought parental consent for DNR order from a patient just a few weeks shy of 18).

233. *Rideout,* 30 Pa. D. & C.4th at 69-70.

234. *Id.* at 73.

235. *See* Email from Thomas W. Hall to Thaddeus M. Pope (May 4, 2007) (on file with the Tennessee Law Review).

236. Informed consent also requires health care providers to disclose information about the treatment and its alternatives. However, providers probably have no duty to advise the patient or surrogate of the option to continue treatment that the provider considers inappropriate. Physicians need not disclose information about unreasonable options. They need not disclose information about procedures and interventions that are not within the medical standard of care. *See* FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE § 1.02 (4th ed. 2007) (describing the characteristics of a "valid consent" and what disclosure is required by the provider); *see also* Peter D. Jacobson & C. John Rosenquist, *The Introduction of Low-Osmolar Agents in Radiology: Medical, Economic, Legal, and Public Policy Issues*, 260 JAMA 1586, 1588-89 (1988) (discussing the requirements of informed consent for radiologists implementing a new contrast media); Paris, *supra* note 185, at 1013 ("[A] physician who merely spreads an array of vendibles in front of the patient [or family] and then says, 'Go ahead and choose, it's your life,' is guilty of shirking his duty, if not of malpractice." (quoting F.J. Ingelfinger, *Arrogance*, 303 NEW ENG. J. MED. 1507 (1980))). Furthermore, in a futility conflict, the patient's surrogates are typically already aware of the treatment options that the health care

surrogate demands the continuation of treatment in opposition to the provider's wishes.[237] Therefore, the provider who unilaterally discontinues treatment fails to obtain consent *and* overrides the surrogate's explicit opposition.[238]

2. Medical Malpractice and Negligence

In addition to causes of action for lack of informed consent, patients and surrogates have brought medical malpractice and negligence actions against health care providers that made unilateral decisions to stop LSMT.[239] For example, in *Causey v. St. Francis Medical Center,* a physician and hospital withheld LSMT from a 31-year-old quadriplegic, comatose patient with kidney failure over the strongly expressed objections of her family.[240] While the family members pleaded an intentional tort cause of action, the court allowed the case to proceed as a medical malpractice case.[241]

The heart of a medical malpractice claim is that the provider failed to administer the care and skill ordinarily exercised by members of their profession practicing in the same or similar location under similar circumstances.[242] Therefore, providers should not be exposed to malpractice liability if stopping LSMT really is the standard of care.[243] Because the medical

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provider judges medically inappropriate. *See, e.g., In re* Baby K, 16 F.3d 590, 592 (4th Cir. 1994); *Causey*, 719 So. 2d at 1075-76.

237. *See, e.g., Baby K*, 16 F.3d at 593; *Causey*, 719 So. 2d at 1075-76.

238. *See, e.g., Baby K*, 16 F.3d at 593; *Causey*, 719 So. 2d at 1075-76.

239. *See, e.g.*, Wendland v. Sparks, 574 N.W.2d 327, 328 (Iowa 1998) (allowing husband to proceed with malpractice action against physician and hospital that unilaterally decided not to attempt CPR on his wife); *Causey*, 719 So. 2d at 1072; Kelly v. St. Peter's Hospice, 553 N.Y.S.2d 906, 907 (N.Y. App. Div. 1990) (reviewing plaintiff's medical malpractice claim alleging that physician and facility failed to provide "sufficiently aggressive" treatment to patient with metastatic breast cancer); Strickland v. Deaconess Hosp., 735 P.2d 74, 75 (Wash. Ct. App. 1987); Preston v. Meriter Hosp., Inc., 678 N.W.2d 347, 351 (Wis. Ct. App. 2004) (dismissing medical malpractice against hospital that intentionally refused to treat premature infant because plaintiff failed to identify an expert); *see also* Litz v. Robinson, 955 P.2d 113, 114 (Idaho Ct. App. 1998) (hearing "alleg[ation] that the defendants breached their duties as physicians by wrongfully withholding life sustaining procedures"); King v. Crowell Mem'l Home, 622 N.W.2d 588, 591-92 (Neb. 2001) (hearing medical malpractice action alleging that the defendant nursing home classified the decedent as a DNR patient even though their instructions were to use "'any and all medical measures'"); Gamble v. Perra, No. E2006-00229-COA-R3-CV, slip op. at 2 (Tenn. Ct. App. 2007) (wife "alleged that her husband could have lived longer, but for his lack of treatment by defendants").

240. *Causey*, 714 So. 2d at 1073.

241. *Id.* The trial court found that, as a medical malpractice action, the claim must first be presented to a medical review panel. *Id.* As a result, the court dismissed the plaintiff's action as premature. *Id.*

242. BARRY R. FURROW ET AL., HEALTH LAW § 6-2, at 264–65 (2d ed. 2000).

243. *See id.* § 6-2 at 269 (describing how guidelines establish the standard of care and therefore provide a shield against liability); *see also id.* § 16-77 at 905 ("[H]ealth care providers must offer patients only that range of treatments that is medically indicated under the

standard of care is custom-based, malpractice liability would not seem to present an obstacle to unilaterally stopping LSMT.[244] Although providers do in fact collectively set the standard, three implementation realities dispel this notion.[245]

First, "the practical difficulties of proving just what is the prevailing medical custom break down this protective theory in the real world."[246] Second, to the extent the standard of care is ascertainable, unilaterally stopping LSMT is not now the standard of care.[247] As Justice Brennan observed, "[c]urrent medical practice recommends use of heroic measures if there is a scintilla of a chance that the patient will recover . . . ."[248] Third, by continuing to give such care, providers are creating and perpetuating the very standard with which they do not want to comply.[249]

3. Wrongful Death

In addition to informed consent and medical malpractice actions, patients and surrogates have brought wrongful death suits against health care providers that made unilateral decisions to stop LSMT.[250] In *Velez v. Bethune,* the physician unilaterally terminated the life support of a severely impaired infant.[251] The court held that the parents had a valid claim for wrongful death.[252] The court stated that "Dr. Velez had no right to decide, unilaterally, to discontinue medical treatment even if, as the record in this case reflects, the child was terminally ill and in the process of dying. That decision must be

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circumstances."); Laurence J. Schneiderman & Alexander Morgan Capron, *How Can Hospital Futility Policies Contribute to Establishing Standards of Practice?*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 524, 529 (2000) (arguing that any one of various standards is sufficient if a "'respectable minority'" of physicians would stop LSMT); *cf. Kelly*, 533 N.Y.S.2d at 907-08 (patient's husband failed to present evidence that treatment departed from acceptable medical practice).

244. FURROW, *supra* note 242, § 6-2 at 265, § 16-77 at 905.

245. *Id.* § 6-2 at 265.

246. Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119, 127 (1991).

247. FURROW, *supra* note 242, § 16-77 at 906.

248. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 314 (1940) (Brennan, J., dissenting); *see also* Middleditch & Trotter, *supra* note 26, at 399-400 (finding that use of mechanical feeding and breathing devices for patients in a persistent vegetative state as the new custom).

249. *See* FURROW, *supra* note 242, at § 6-2 at 269.

250. *See, e.g.*, Kranson v. Valley Crest Nursing Home, 755 F.2d 46, 48 (3d Cir. 1985); Velez v. Bethune, 466 S.E.2d 627, 628 (Ga. Ct. App. 1995); Manning v. Twin Falls Clinic & Hosp., Inc., 830 P.2d 1185, 1187 (Idaho 1992) (affirming award of compensatory and punitive damages); Wendland v. Sparks, 574 N.W.2d 327, 328-29 (Iowa 1998); Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 830 (W. Va. 1992).

251. *Velez*, 466 S.E.2d at 628.

252. *Id.*

made *with* the consent of the parents."[253] While both the imminence and inevitability of the infant's death may have been relevant to the amount of damages, neither properly factor into whether the physician had committed an intentional tort.[254]

B. Criminal and Regulatory Sanctions

In addition to civil sanctions, health care providers that make unilateral decisions to stop LSMT may be subject to an array of criminal and regulatory sanctions, including charges for patient neglect,[255] adverse peer review,[256] and even murder.[257]

1. Murder

For health care providers, withholding or withdrawing LSMT, even with consent, and thereby facilitating death, was once considered a serious crime.[258] A health care provider's omission to continue treatment fits the literal definition of murder: an intentional act done with the knowledge that the patient would die.[259] However, that concept was eventually rejected in both cases and statutes.[260]

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253. *Id.* at 629 (emphasis added).

254. *Id.*; *see also Wendland*, 574 N.W.2d at 331 ("That a terminally ill victim would have died on Tuesday, the next day, does not prevent the defendant's conduct from being a cause of his death on Monday, but would obviously be quite relevant to the question of damages.").

255. *See., e.g.*, Preston v. Meriter Hosp., Inc., 700 N.W.2d 158, 163 (Wis. 2005) (citing WIS. STAT. § 940.295(1)(J) (1997-1998)).

256. *See, e.g.*, Warthen v. Toms River Comty. Mem'l Hosp., 488 A.2d 229, 230 (N.J. Super. Ct. App. Div. 1985) (reviewing termination of nurse's employment for refusing to administer dialysis to terminally ill patient); Irene Hurst, *The Legal Landscape at the Threshold of Viability for Extremely Premature Infants: A Nursing Perspective, Part I*, 19 J. PERINATAL & NEONATAL NURSING 155, 162 (2005) ("Hospital administrators warned Dr. Jacob that he should reconsider his recommendation [not to resuscitate, contrary to hospital policy] or lose his privileges at the Hospital and be subject to a peer review."); Arthur E. Kopelman et al., *The Benefits of a North Carolina Policy for Determining Inappropriate or Futile Medical Care*, 66 N.C. MED. J. 392, 394 (2005) ("[T]he legislation . . . [gives] assurance that they are not making a decision that will be questioned by their colleagues or other healthcare peers."); Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 19 (1993) (describing health care providers' "fear of sanction from peer review boards").

257. DWORKIN, *supra* note 124, at 112; *see* Barber v. Super. Ct., 195 Cal. Rptr. 484, 486 (Cal. Ct. App. 1983).

258. *See* DWORKIN, *supra* note 124, at 112.

259. WAYNE R. LAFAVE, 1 SUBSTANTIVE CRIMINAL LAW, § 6.2 at 435-36 (2d ed. 2003); WAYNE R. LAFAVE, 2 SUBSTANTIVE CRIMINAL LAW, § 14.2 at 428 (2d ed. 2003).

260. *See, e.g.*, UNIFORM HEALTH-CARE DECISIONS ACT (UHCDA) § 13(b) (1993) ("Death resulting from the withholding or withdrawal of health care in accordance with this [Act] does

In *Barber v. Superior Court,* for example, physicians withdrew LSMT, at the family's request, from a patient in a vegetative state likely to be permanent.[261] The Los Angeles District Attorney prosecuted the physicians for murder, but the appellate court rejected the charges because the physicians stopped LSMT *with* the consent of the authorized decision maker.[262]

Cases like *Barber* differ from the futility context in two material respects. First, physicians do not have patient or surrogate consent to cease LSMT.[263] The *Barber* court's holding—that the providers were under no duty to continue ineffective treatment—meant only that the authorized decision maker was under no duty to request such treatment.[264] The court's ruling did not mean that the health care provider had no duty to provide LSMT when requested.[265] Second, in contrast to the *Barber* situation where the surrogates and providers were in agreement, somebody will always be angry enough to complain to the authorities in a futility case.[266]

Unilateral decisions to stop LSMT have thus led to homicide charges[267] and at least one conviction.[268] Admittedly, health care providers are rarely convicted.[269] Yet, they must still expend considerable time and resources in the investigation and litigation process.[270]

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not for any purpose constitute a suicide or homicide . . . ."); *Barber*, 195 Cal. Rptr. at 493.

261. *Barber*, 195 Cal Rptr. at 486.

262. *Id.* at 486, 493.

263. *See supra* notes 225-26 and accompanying text.

264. *See Barber*, 195 Cal. Rptr. at 486, 493.

265. *Cf.* Marcia Angell, *The Supreme Court and Physician-Assisted Suicide—The Ultimate Right*, 336 NEW ENG. J. MED. 50, 51 (1997) ("[S]witching off the ventilator of a patient dependent on it . . . would be considered homicide if done without the consent of the patient or a proxy.").

266. *See* Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J. L. MED. & ETHICS 308, 311, 320 (1998) (noting how state authorities typically react only in response to complaints).

267. MASON & LAURIE, *supra* note 77, at 545-47, 582; Fletcher, *supra* note 10, at S:229 (noting one unilateral decision in Virginia led to a charge of homicide and an investigation by the State Board of Medicine).

268. *See* State v. Naramore, 965 P.2d 211, 213, 224 (Kan. Ct. App. 1998) (reversing convictions of murder for failing to resuscitate Mr. Wilt and of attempted murder for over-prescribing pain medication for Ms. Leach). At least one district attorney in Milwaukee, Wisconsin has announced that he will investigate and prosecute deaths caused by the unilateral withdrawal of LSMT. Telephone interview with Dr. Michael Katzoff, Medical Director, Sleep Disorder Center, St. Luke's Medical Center.

269. Joseph P. Pestaner, *End-of-Life Care: Forensic Medicine v. Palliative Medicine*, 31 J.L. MED. & ETHICS. 365, 366 (2003) ("[T]o criminally convict a palliative care provider of a homicidal act essentially requires in admission of guilt.").

270. *See* MARSHA GARRISON & CARL E. SCHNEIDER, THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION (TEACHER'S MANUAL) 112-19 (2003). Dr. Naramore, for example, got his conviction reversed on appeal. *Id.* at 118-19. Nevertheless, he suffered a host of adversities, including: (1) losing his staff privileges, (2) losing his medical license, (3) losing his reputation, (4) incarceration pending trial, and (5) difficulty getting another job. *Id.* at 115-

2. Statutory Damages

Statutory damages are far less serious than murder charges, but they are nevertheless significant. State health care decision statutes normally require compliance with a patient's or surrogate's decision.[271] Many states allow for statutory damages and attorney's fees when intentional statutory violations occur.[272]

If a unilateral decision to stop LSMT is intentionally made to interfere with the patient's autonomy in making health care decisions, then that unilateral decision can constitute a statutory violation resulting in fines,[273] disciplinary action, or both.[274] In one case, the patient's estate brought a $2.5 million civil action based on violation of the state Health Care Decisions Act when the University of Virginia Hospital entered a unilateral DNR order.[275]

C. The Chilling Effect of Legal Constraints

While these legal sanctions may not be very probable, they exert a substantial chilling effect on extremely risk averse health providers.[276] As put

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16, 119.

271. *See, e.g.*, TENN. CODE ANN. § 68-11-1808(b) (2006).

272. *See, e.g.*, HAW. REV. STAT. § 327E-10(a) (Supp. 2005); ME. REV. STAT. ANN. tit. 18-A, § 5-810(a) (1995); MISS. CODE ANN. § 41-41-221(1) (2005); N.J. STAT. ANN. § 26:2H-78(b) (West 1992); N.M. STAT. § 24-7A-10(A) (2006); WYO. STAT. ANN. § 35-22-411(a) (2007); UNIFORM HEALTH-CARE DECISIONS ACT §10 (1993).

273. *See* Marah Stith, *The Semblance of Autonomy: Treatment of Persons with Disabilities under the Uniform Health-Care Decisions Act*, 22 ISSUES L. & MED. 39, 71 (2006) (stating that the civil penalties imposed are "extremely low").

274. *See, e.g.*, IND. CODE ANN. § 16-36-4-21 (LexisNexis 1993) ("A physician who knowingly violates this chapter is subject to disciplinary sanctions . . . as if the physician had knowingly violated a rule adopted by the medical licensing board . . . ."); KAN. STAT. ANN. § 65-28,107(a) (1992); N.J. STAT. ANN. § 26:2H-78(a) (West 1992); Fletcher, *supra* note 10, at S:229 (reporting one unilateral decision led to a an investigation by the State Board of Medicine). On the other hand, some have suggested that if providers follow a process and are in accord with professional guidelines, it is unlikely they will be found to have committed a disciplinary offense. *See* WRONG MEDICINE, *supra* note 37, at 89–94 (suggesting that it is a legal myth that providers will always be subject to legal liability for stopping LSMT).

275. Amended Motion for Judgment at 1-3, Bryan v. Rectors & Visitors of the Univ. of Va., No. CL95-060 (Fauquier County, Va. Cir. Ct. Nov. 27, 1995).

276. *See* Pope & Waldman, *supra* note 9, at 170-85; *see also* GARRISON & SCHNEIDER, *supra* note 270, at 70 ("Doctors egregiously over-estimate the risks of being sued by their patients."); SCHNEIDERMAN, *supra* note 57, at 126-28; ZUSSMAN, *supra* note 51, at 181 ("[U]nfortunately, because of a fear of being sued at a later date, most physicians really are willing to provide every available technology to a patient . . . ."); Kapp, *supra* note 122, at 232 ("[L]aw-related anxieties . . . are palpable, powerful influences on . . . medical care . . . ."); Rowland, *supra* note 214, at 307 ("Legal considerations are of paramount concern when discussing the discontinuation of care."); Carl E. Schneider, *Regulating Doctors*, 29 HASTINGS CENTER REP., July-Aug. 1999, at 21; Connie Zuckerman, Milbank Memorial Fund, *End-of-Life*

by Professors Robert Weir and Larry Gostin, "Because the professional responsibility of hospital attorneys is to protect the hospital's legal and financial interests, they are frequently inclined to give advice on cases that is unduly conservative . . . ."[277] This ultra-cautious approach is no less true in the context of futility disputes.[278] In 1993, the National Center for State Courts observed that there was "no consensus . . . on the legal ramifications associated with [futility]."[279] Before statutory authorization for unilateral decision making in the mid-1990s,[280] legal uncertainty was rampant and the fear of liability discouraged most institutions from adopting futility policies.[281]

Nonetheless, by the early 1990s, a few hospitals had formally adopted futility policies.[282] Yet even these hospitals never fully implemented the

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Care and Hospital Legal Counsel: Current Involvement and Opportunities for the Future 3 (1999), *available at* http://www.milbank.org/end.html ("Legal considerations . . . strongly influence how clinicians think about end-of-life care.").

277. Robert F. Weir & Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients: Ethical Standards and Legal Liability for Physicians After* Cruzan, 264 JAMA 1846, 1846 (1990); *see also* Alan J. Weisbard, *Defensive Law: A New Perspective on Informed Consent*, 146 ARCHIVES INTERN. MED. 860, 860 (1986) ("[T]he lawyer's . . . advice is likely to become ultracautious and may tend to conflict with the responsible practice of medicine . . . .").

278. *See* COORDINATING COUNCIL ON LIFE-SUSTAINING MEDICAL TREATMENT DECISION MAKING BY THE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 147 (2d ed. 1993).

279. *Id.*

280. *See infra* Part IV.

281. *See, e.g.*, WRONG MEDICINE, *supra* note 37, at 32 ("Physicians often . . . fear the legal consequences of forgoing treatment . . . ."); Fletcher, *supra* note 10, at S:229. Professor Fletcher recalls, "On coming to the University of Virginia in 1987, I observed many clinicians overtreating hopelessly ill patients primarily due to fears of legal liability. Also, clinicians were acutely aware of the lack of legal backing if they refused to acquiesce . . . ." *Id.*; *see* Moldow, *supra* note 12, at 3 ("Fear of legal action has previously discouraged many institutions from adopting policies in the area of medical futility . . . ."); Sibbald et al., *supra* note 44, at 1203 (reporting from a survey of ICUs: "When participants were asked why they followed the instructions of families or substitute decision makers instead of doing what they feel is appropriate, almost all cited a lack of legal support."); Weiser, *supra* note 45, at A1 (describing how physicians' wanted to unilaterally withdraw LSMT from severely ill infant, but were prevented by hospital's rules); *see also* ZUSSMAN, *supra* note 51, at 178 ("'I wish,' she concluded, 'the family didn't have the final say. But in 1987 they do . . . .'"). Marshall Kapp argues that the legal risks in the early 1990s were not serious, yet concedes that physicians had "overblown anxiety." Kapp, *supra* note 122, at 175; *see also* Hall, *supra* note 246, at 119 ("[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophecy . . . .").

282. *See, e.g.*, Fine, *supra* note 92, at 62 (noting early futility policies); Fletcher, *supra* note 10, at S:228 ("Massachusetts General Hospital (MGH) was the first to experiment with an approach to futility disputes . . . that gave institutional backing to physicians to write a DNR order over the objections of a surrogate . . . ."); Hudson, *supra* note 66, at 26 (noting Santa Monica adopted a policy in 1991); Schneiderman & Capron, *supra* note 243, at 526

policies by actually taking unilateral action to stop LSMT requested by a patient or surrogate.[283] Providers understood that an institutional policy did little to alleviate uncertainty about the legal implications of unilaterally stopping LSMT.[284]

(referencing meeting in 1998 to discuss futility policies of twenty-six hospitals).

283. Fine et al., *supra* note 100, at 1221 (describing that before the Texas statute, "[i]n ~80% of such [futility] cases, the ethics consultants were able to persuade families . . . . However, in the other 20% of cases, families insisted on continued [LSMT], and physicians complied, being unwilling to subject themselves to legal jeopardy by overruling the family/surrogate"); Fine & Mayo, *supra* note 84, at 744 ("It is unclear how effective such guidelines could be in the face of legal uncertainty. Even when ethics committees agreed that treatment was futile, treating physicians were generally unwilling to withdraw life-sustaining treatment . . . ."); Amir Halevy & Amy L. McGuire, *The History, Successes and Controversies of the Texas "Futility" Policy*, HOUSTON LAW., May-June 2006, at 38, *available at* http://www.thehoustonlawyer.com/aa_may06/page38.htm ("In spite of its adoption as hospital policy . . . no cases went through the entire process . . . . The most likely explanation is that residual legal uncertainty regarding the policy still lingered."); Hudson, *supra* note 66, at 26 (noting that the hospital had "never reached the last two steps in the [futility] process"); Rivin, *supra* note 30, at 390 ("Despite the recommendations of the physicians and the ethics committee, the [Santa Monica] hospital refused to discontinue life support for fear of lawsuit."); Anna V. Schlotzhauer & Bryan A. Liang, *Definitions of Death*, *in* HEALTH LAW AND POLICY: A SURVIVAL GUIDE TO MEDICOLEGAL ISSUES FOR PRACTITIONERS 287, 291 (2000) ("[N]othing can be done in cases where families of PVS patients seek to continue treatment indefinitely . . . ."); Swig et al., *supra* note 173, at 1218 ("[D]espite a policy that allowed them to do otherwise, . . . physicians at San Francisco General Hospital usually offered CPR to patients who they thought were unlikely to benefit.").

284. *See generally* Cerminara, *supra* note 48, at 327 ("[G]ood process . . . will not insulate a decision maker from being overturned in court . . . ."); Fine, *supra* note 92, at 63 ("Guidelines in the face of legal uncertainty, however, were not particularly effective. . . . [F]ew physicians were willing to limit such treatment in the face of potential lawsuits from families who disagreed."); Fine, *supra* note 100, at 1221 (noting when families insisted on continued LSMT "physicians complied, being unwilling to subject themselves to legal jeopardy by overruling the family/surrogate"); Flamm, *supra* note 10, at 4 ("[T]he previous ambiguity of legal consequences often prevented clinicians from fulfilling ethical obligations against providing medically inappropriate care."); Halevy & McGuire, *supra* note 283, at 38 ("[R]esidual legal uncertainty regarding the policy still lingered."); Kopelman et al., *supra* note 256, at 393 ("Uncertainty about the legal implications of acting against the patient's or surrogate's wishes often prevents physicians from taking that [unilateral] step, despite agreement among all or almost all clinicians."); Rivin, *supra* note 30, at 393 (noting that even when physicians thought a case was futile, they were unwilling to invoke the futile care policy for "fear of a lawsuit"); Solomon et al., *supra* note 256, at 19 (reporting physician uncertainty about legal standards for withdrawing treatment); Swig et al., *supra* note 173, at 1218 (citing "legal considerations" as a possible explanation for why physicians did not utilize their hospital's futility policy); Belluck, *supra* note 38, at 22 ("In the absence of laws like Texas's, hospitals often accede to a family's wishes because they fear being sued."); Burling, *supra* note 66, at A1 ("The weak point of virtually all policies is that hospital leaders fear they would lose a lawsuit if they denied care demanded by a family."); *cf.* COMM. ON PALLIATIVE AND END-OF-LIFE CARE FOR CHILDREN AND THEIR FAMILIES, BD. ON HEALTH SCI. POL'Y, WHEN CHILDREN DIE: IMPROVING PALLIATIVE AND

To alleviate this uncertainty, some hospitals sought judicial permission to implement their futility policies.[285] Declaratory judgments were designed to address such cases of uncertainty.[286] But this judicial approach suffered from two serious drawbacks. First, given the time and resources required, it was perceived as generally unworkable.[287] Second, even if hospitals were willing to invest the time and resources, courts have consistently declined to authorize providers to implement their futility policies.[288]

Consequently, providers complied with requests for treatment that they considered inappropriate, because they recognized that surrogates had a veto authority over their judgment.[289] In light of all the legal constraints and risks, providers wanted legal protection before taking any unilateral action.[290]

END-OF-LIFE CARE FOR CHILDREN AND THEIR FAMILIES 322 (Marilyn J. Field & Richard E. Behrman, eds., 2003) [hereinafter WHEN CHILDREN DIE] ("[T]he findings of an ethics committee have no legal standing and cannot be used alone as the basis for termination of life support."); Brett, *supra* note 70, at 289 (noting the "pragmatic problem with policies that confer no legal protection"); Schneiderman & Capron, *supra* note 243, at 525 ("[T]he *Baby K* decision . . . had a chilling effect on hospitals' willingness to implement futility policies.").

285. *See, e.g.*, *In re* Farrell, 529 A.2d 404, 406-07 (N.J. 1987); *In re* Quinlan, 355 A.2d 647, 669 (N.J. 1976).

286. JAMES WM. MOORE, 12 MOORE'S FEDERAL PRACTICE § 57 (3d ed. 2007).

287. *Cf. Farrell*, 529 A.2d at 415 (resolving end-of-life disputes through a judicial process will "take too long"); *Quinlan*, 355 A.2d at 669 ("[A] practice of applying to a court to confirm such decisions would generally be inappropriate . . . because that would be a gratuitous encroachment on the medical profession's field of competence . . . [and] impossibly cumbersome.").

288. *See, e.g.*, *In re* Baby K, 16 F.3d 590, 592 (4th Cir. 1994) (denying motion by Fairfax Hospital seeking declaratory judgment to withdraw treatment from anencephalic infant); *Judge Affirms Husband's Right to Continue Wife's Treatment*, 53 BIOLAW §12-6, at U:2161 (Aug.-Sept. 1991) (noting that "a county court judge . . . refused the doctors' request to appoint an independent conservator to decide the patient's fate"); Frank Bruni, *A Fight over Baby's Dignity and Death: Parents Sue Hospital Over Shutdown of Life Support Equipment*, N.Y. TIMES, Mar. 9, 1996, at A6 ("[W]hen hospitals go to court for permission to terminate treatment of a patient over the objections of family, courts seldom give consent."); *cf.* Hoffman & Schwartz, *supra* note 218, at 37 (noting that some court have decided that futility issues "should be addressed by the legislative rather than the judiciary").

289. *See* sources cited *supra* note 284.

290. *See* Fletcher, *supra* note 10, at S:231 ("The framers of such futility guidelines would also be well-advised to seek amendments to existing health care legislation that strengthen the authority of clinicians and health care organizations to resolve such disputes."); *id.* at S:229 ("[A]ction was necessary in the Virginia legislature to assure physicians of legal backing if they refused, in certain circumstances, to acquiesce to demands for overtreatment."); Carol Isackson, *Futile Treatment: The Need for Legislation and Uniform Policies*, 9 HEALTH CARE L. MONTHLY, 7, 10 (Oct. 1994) ("In order to protect providers from arbitrary decisions . . . legislation should be enacted . . . ."); Halevy & McGuire, *supra* note 283, at 38 ("Many institutions were interested in pursuing policies that would allow physicians to refuse . . . [but] the legal and ethical uncertainties . . . discouraged institutions from proceeding alone."); Susan Jacoby, *The Schiavo Factor: Now the States Are Rushing to Decide Who Decides*, AARP BULLETIN, May

IV. UNILATERAL DECISION STATUTES

Providers soon got the legal protection for unilateral decision making that they were seeking. Beginning in the early 1990s, a significant number of states began enacting legislation permitting health care providers to unilaterally refuse to provide LSMT that they considered to be medically inappropriate.[291]

A. The Uniform Health-Care Decisions Act

Most notable among the unilateral decision statutes is the Uniform Health-Care Decisions Act (UHCDA).[292] The UHCDA is notable for three reasons. First, it has a significant and growing prevalence.[293] It has now been adopted in ten states, more than any other unilateral decision statute.[294] Second, the

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2005, *available at* http://www.aarp.org/bulletin/yourhealth/the_schiavo_factor.html ("In states without such [futile care] laws, doctors frequently comply with the family's wishes for fear of being sued . . . ."); Weiser, *supra* note 45, at A1 (reporting how a doctor in the Baby Rena case "felt the time had come to change the rules" to give doctors the authority they need in futile cases).

291. *See infra* notes 298-307; *see also* Maggie Datiles, *The Rising Role of Advance Directives in Protecting the Sanctity of Human Life, in* AMERICANS UNITED FOR LIFE, DEFENDING LIFE 2008: A STATE-BY-STATE LEGAL GUIDE TO ABORTION, BIOETHICS AND THE END OF LIFE 511, 512 (2008) ("The majority of states provide that physicians and healthcare facilities may decline to comply [with requests for LSMT]"); Patrick Moore, *An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment that Physicians are Unwilling to Provide,* 48 B.C. L. REV. 433 (2007); Monica Sethi, *A Patient's Right to Direct Own Health Care vs. a Physician's Right to Decline to Provide Treatment*, 29 BIFOCAL, Dec. 2007, at 21 (examining "provisions from all 50 states regarding the various reasons for which a health care provider may refuse to comply with a patient's demand for treatment").

292. *Uniform Health-Care Decisions Act: National Conference of Commissioners on Uniform State Laws*, 22 ISSUES L. & MED. 83, 83-97 (2006) [hereinafter *Uniform Act*].

293. *Id.* at 83.

294. The National Conference of Commissioners on Uniform State Laws' (NCCUSL) website identifies only eight states as having adopted the UHCDA. A Few Facts About the Uniform Health-Care Decisions Act, http://www.nccusl.org/nccusl/uniformact_factsheets/uniformacts-fs-uhcda.asp (last visited Oct. 21, 2007) [hereinafter NCCUSL]. However, the legislative history of both the California and Tennessee statutes confirms that they were largely derived from the UHCDA as well. *See Health Care Decisions for Adults Without Decisionmaking Capacity, Bill Analysis of A.B. 891 Before the Assem. Comm. on the Judiciary*, at 5 (Apr. 15, 1999) (noting that the bill is "[d]rawing heavily on the [UHCDA]."); *Health Care Decisions: Durable Power of Attorney, Bill Analysis of A.B. 891 Before the S. Comm. on the Judiciary*, at 2 (July 13, 1999) ("The provisions of the proposed Health Care Decisions Law (HCDL) are drawn heavily from the Uniform Health Care Decisions Act (1993), and implement major parts of the Commission's recommendation[s]."); Charles M. Key & Gary D. Miller, *The Tennessee Health Care Decisions Act A Major Advance in the Law of Critical Care Decision Making*, 40 TENN. B.J. 25, 28 (2004).

UHCDA has provisions specifically designed to handle futility disputes.[295] Third, the UHCDA is a reasonably comprehensive statute, broadly authorizing health care providers to take unilateral action in all types of futility disputes.[296]

1. Prevalence of the UHCDA

The National Conference of Commissioners on Uniform State Laws completed drafting the UHCDA in 1993.[297] Over the next twelve years, it was adopted in the following ten states: New Mexico (1995),[298] Maine (1995),[299] Delaware (1996),[300] Alabama (1997),[301] Mississippi (1998),[302] California (1999),[303] Hawaii (1999),[304] Tennessee (2004),[305] Alaska (2004),[306] and Wyoming (2005).[307] Together, these ten states comprise about one-fifth of the U.S. population.[308]

Several other states have recently considered adopting the UHCDA, including its unilateral decisions provisions.[309] It is likely that the UHCDA will continue to be adopted or will otherwise influence health care decision making law in other states.[310]

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295. *See Uniform Act*, *supra* note 292, at 84.

296. *Id.*

297. *Id.* at 83.

298. N.M. STAT. §§ 24-7A-1 to -18 (2000).

299. ME. REV. STAT. ANN. tit. 18-A, §§ 5-801 to -817 (1995).

300. DEL. CODE ANN. tit. 16, §§ 2501–2518 (2003).

301. ALA. CODE §§ 22-8A-1 to -14 (LexisNexis 2006).

302. MISS. CODE ANN. §§ 41-41-201 to -229 (2005).

303. CAL. PROB. CODE §§ 4600-4806 (West Supp. 2007).

304. HAW. REV. STAT. §§ 327E-1 to -16 (Supp. 2005).

305. TENN. CODE ANN. §§ 68-11-1801 to -1815 (2006).

306. ALASKA STAT. §§ 13.52.010 to .395 (2006).

307. WYO. STAT. ANN. §§ 35-22-401 to -416 (2007).

308. U.S. Census Bureau, http://factfinder.census.gov (last visited Oct. 21, 2007) (extrapolating total population from 2006 estimates for each of the ten states).

309. *See, e.g.*, Utah S.B. 75 (effective Jan. 1, 2008) (to be codified at UTAH CODE ANN. §§ 75-2a-1103(6)(b) & 75-2a-1114) (based on the UHCDA); *Uniform Health Care Decisions Act: Hearing on S.B. 229 Before the S. Comm. on the Judiciary*, 60th Legis. (Mont. 2007). Unfortunately, the Montana bill died in standing committee on April 27, 2007. *See* http://laws.leg.mt.gov/pls/laws07/law0203w$.startup (search "Bill Type and Number" for "S.B. 229").

310. *See, e.g.*, REP. TO VERMONT ATTORNEY GENERAL WILLIAM H. SORRELL FROM THE COMMS. OF THE ATTORNEY GENERAL'S INITIATIVE ON END OF LIFE CARE 15 (2005) (recording recommendations of committees reached by reviewing UHCDA); ADVANCE DIRECTIVES IN NEW HAMPSHIRE: A STATUTORY REVIEW & SURVEY OF CURRENT ISSUES 1 (2000) (considering advance care planning); *see also* David M. English & Alan Meisel, *Uniform Health-Care Decisions Act Gives New Guidance*, 21 EST. PLAN. 355, 357 (1994) ("It is likely that the Act will serve as an influential model for many years to come.").

2. Purpose of the UHCDA

Some have suggested that the UHCDA's unilateral decision provisions were not written in contemplation of futility disputes, but rather exclusively "in contemplation of the opposite situation" in which the family wants to reject treatment but the health care provider wants to continue.[311] Indeed, the UHCDA does focus on patient autonomy and the empowerment of patients and surrogates.[312]

Nevertheless, the legislative history of the Uniform Act clearly shows this charge to be untrue.[313] The UHCDA commissioners specifically contemplated and sought to relieve health care providers of any obligation to provide inappropriate treatment.[314] Moreover, the very logic of the UHCDA compels an interpretation that authorizes providers to unilaterally terminate LSMT.[315]

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311. *See, e.g.*, ROBERT POWELL CENTER FOR MEDICAL ETHICS, NATIONAL RIGHT TO LIFE COMMITTEE, WILL YOUR ADVANCE DIRECTIVE BE FOLLOWED?, at 8 n.* (Apr. 15, 2005), *available at* http://www.nrlc.org/euthanasia/AdvancedDirectives/ReportRevised2007.pdf. Indeed, some laws do allow only unilateral decisions to *provide* treatment. For example, until this year, Pennsylvania provided immunity only for *provision* of treatment contrary to a patient's living will. *Compare* 20 PA. STAT. ANN. § 5409(c) ("[T]he provision of life-sustaining treatment to a declarant shall not subject a health care provider to criminal or civil liability or administrative sanction for failure to carry out the provisions of a declaration."), *with* 20 PA. STAT. ANN. § 5431(a)(6) (stating that providers will not be subject to criminal or civil liability, or administrative sanctions for "[r]efusing to comply with a direction or decision of an individual [if] based on a good faith belief that compliance with the direction or decision would be unethical" or would result in baseless medical treatment); *see also* MINN. STAT. ANN. § 145C.11(2) (West 1998) (addressing specifically the provision of treatment, but not addressing a provider's refusal of treatment contrary to decision of the agent).

312. *See Uniform Act*, *supra* note 292, at 83.

313. *See, e.g.*, Nat'l Conference of Comm'rs on Uniform State Laws, Proceedings in Comm. of the Whole, Uniform Health-Care Decisions Act, July 30, 1993, at 33 (statement of Comm'r David M. English) ("[T]hey are not obligated to provide me with the type of state-of-the-art, all-out care . . . [because] if a competent patient couldn't ask for it, then an agent couldn't ask for it either."); *id.* at 183 (statement of Comm'r M. King Hill) ("We do not want to impose upon physicians or other health-care providers . . . the obligation to provide treatment that will not be effective."); Nat'l Conference of Comm'rs on Uniform State Laws, Proceedings in Comm. of the Whole, Uniform Health-Care Decisions Act, Aug. 2, 1993, at 268–69 (statement of Comm'r Richard V. Wellman) ("[Provision to decline treatment] is here as a . . . needed qualification of duties imposed on health-care providers to follow instructions and directions by surrogates and others."); *id.* at 269-70 (statement of Comm'r M. King Hill) ("medically ineffective" refers to costs—"This says to the physician that you don't have to institute some new radical $200,000 procedure if it's only going to keep the patient alive for two or three months, even though there may be many articles in the journals that say that's an accepted health-care standard for a [twenty-two] year old.").

314. *See* sources cited *supra* note 313.

315. *See* Stith, *supra* note 273, at 62 (arguing that the UHCDA gives physicians the right to "ignore desired but 'medically ineffective' treatment" and also contains "normative aspects that cause it to favor death-hastening physician judgments: Only continuance of care can be

3. Comprehensiveness of the UHCDA

The UHCDA requires that health care providers generally comply with patient and surrogate health care decisions.[316] But it also makes clear that a health care provider's obligation to comply with a treatment request "is not absolute."[317] A health care provider or health care institution may decline to comply with an individual instruction that requires "medically ineffective health care" or "health care contrary to generally accepted health-care standards."[318] A health care provider may also decline to comply for "reasons of conscience."[319]

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ineffective."); *id.* at 63 ("The UHCDA's preference for the ability to discontinue care could not be clearer.").

316. UNIFORM HEALTH-CARE DECISIONS ACT § 7(d) (1993).

317. *Id.* at Prefatory Note ("The obligation to comply is not absolute, however. A health-care provider or institution may decline to honor an instruction or decision for reasons of conscience or if the instruction or decision requires the provision of medically ineffective care or care contrary to applicable health-care standards."); *id.* at § 4 cmt. ("[H]ealth-care instructions . . . are binding . . . subject to exceptions specified in Section 7(e)–(f), on the individual's health-care providers."); *id.* § 7 cmt. ("Not all instructions or decisions must be honored, however.").

318. *Id.* §§ 7(f), 13(d); *accord* ALA. CODE § 22-8A-8(a) (LexisNexis 2006); ALASKA STAT. § 13.52.060(f) (2006); CAL. PROB. CODE §§ 4654, 4735 (West Supp. 2007); DEL. CODE ANN. tit. 16, § 2508(f) (2003); HAW. REV. STAT. § 327E-7(f) (Supp. 2005); ME. REV. STAT. ANN. tit. 18-A, § 5-807(f) (1995); MISS. CODE ANN. § 41-41-215(6) (2005); N.M. STAT. §§ 24-7A-7(F), 24-7A-13(D) (2000); TENN. CODE ANN. § 68-11-1808(e) (2006); WYO. STAT. ANN. §§ 35-22-408(f), 35-22-414(d) (2007).

319. *See* UNIFORM HEALTH-CARE DECISIONS ACT § 7(e); *accord* CAL. PROB. CODE § 4734(a) (West Supp. 2007) ("A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience."). The conscience exception is well established in the reverse situation, permitting providers to refuse to comply with patient or surrogate requests to stop treatment. *See, e.g.*, Morrison v. Abramovice, 253 Cal. Rptr. 530, 534 (Cal. Ct. App. 1988) ("The prevailing viewpoint among medical ethicists appears to be that a physician has the right to refuse on personal moral grounds to follow a conservator's direction to withhold life-sustaining treatment . . . ."); Brophy v. New Eng. Sinai Hosp., 497 N.E.2d 626, 639 (Mass. 1986) (stating providers should not feel compelled "to take active measures which are contrary to their view of their ethical duty toward their patients"). *But see* Gray v. Romeo, 697 F. Supp. 580, 591 (D.R.I. 1988) (finding providers must acknowledge a patient's "right of self-determination" despite the provider's own personal objections). The conscience exception applies to both individual and institutional providers, though institutions must give notice. *See, e.g.*, *In re* Jobes, 529 A.2d 434, 450 (N.J. 1987) (stating that nursing home should have given patient's family notice of their policy regarding artificial feeding); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL AND LEGAL ISSUES IN TREATMENT DECISIONS, DECIDING TO FORGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 44 (1983). However, the conscience exception is thought to have limited applicability in the futility context because the provider's values are not the central concern. *See* Gampel, *supra* note 59, at 101 ("[T]he values at stake in that judgment are unlikely to be as central to an individual HCP, or to the medical

The UHCDA's authorization of unilateral decisions is comprehensive in at least four important respects. First, the UHCDA permits the provider to decline to comply with a treatment request concerning *any* type of treatment.[320] While some state statutes only authorize unilateral decisions with respect to CPR,[321] the UHCDA authorizes unilateral decisions with respect to CPR, mechanical ventilation, artificial nutrition and hydration, or any other type of medical intervention.[322]

Second, the UHCDA is comprehensive in that it authorizes unilateral decisions even when the patient or surrogate has made an explicit and affirmative request for treatment or has demonstrated explicit and vehement opposition.[323] On the contrary, some state statutes authorize unilateral decisions only where the patient's preferences are unknown—where the patient has no available advance directive or surrogate.[324]

Third, the UHCDA leaves the provider with substantial discretion to determine the circumstances under which treatment is inappropriate.[325] The UHCDA permits providers to decline to comply with requests for treatment that would be medically ineffective.[326] "Medically ineffective" treatment is defined as treatment that would not provide any "significant benefit."[327] However, the UHCDA allows the health care provider broad discretion to determine whether the benefit achievable by a treatment is "significant."[328]

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profession, as the values that tell against acts such as assisted suicide or abortion."). Since many futility cases are driven by providers' desire to avoid patient suffering, the conscience exception may soon play a greater role. *Cf.* Mark R. Wicclair, *Conscientious Objection in Medicine*, 14 BIOETHICS 205, 216–17 (2000) ("The condition is that an appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine."). This is especially true because of the increasing breadth and use of conscience clauses in medicine. *See, e.g.*, Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779 (2007).

320. *See* UNIFORM HEALTH-CARE DECISIONS ACT §§ 7(e)-(f), 13(d).

321. *See infra* note 374 and accompanying text.

322. *See* UNIFORM HEALTH-CARE DECISIONS ACT § 1(6)(i)-(iii).

323. *See id.* §§ 7(e)-(f), 13(d).

324. *See infra* notes 376–77.

325. *See* UNIFORM HEALTH-CARE DECISIONS ACT §§ 7(f), 13(d).

326. *Id.* § 7(f).

327. *Id.* §7(f) cmt. ("'Medically ineffective health care,' as used in this section, means treatment which would not offer the patient any significant benefit."). As adopted, one UHCDA state defines "medically ineffective treatment" more tightly, as medical procedures which, "to a reasonable degree of medical certainty, . . . will not: (1) Prevent or reduce the deterioration of the health of an individual; or (2) Prevent the impending death of an individual." DEL. CODE ANN. tit. 16, § 2501(m) (2003).

328. *See* Ferguson, *supra* note 16, at 1220–21 ("The UHCDA provides a mere framework . . . giv[ing] only broad platitudes . . . [with] sections [that] seemingly create an open-ended excuse for a physician to withdraw treatment . . . .").

Fourth, as adopted in several states, the UHCDA explicitly confers immunity on providers who exercise the unilateral decision provisions in good faith.[329] California, for example, provides that "[a] health care provider . . . acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider . . . is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division."[330]

4. Operation of the UHCDA

Most end-of-life decision making laws are designed to work extra-judicially.[331] The UHCDA is no exception.[332] Providers need not go to court to make a unilateral decision.[333] They need only comply with the following process outlined in the UHCDA.[334]

If the provider is going to decline to comply with a health care decision under the UHCDA, the provider must first inform the patient or surrogate.[335]

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329. *See* UNIFORM HEALTH-CARE DECISIONS ACT § 9. While UHCDA itself confers immunity for several categories of conduct, it does not confer immunity for complying with the unilateral decision provisions. *See id.*

330. CAL. PROB. CODE § 4740 (West Supp. 2007); *accord* ALA. CODE § 22-8A-8(a) (LexisNexis 2006) ("shall not be liable for such refusal"); DEL. CODE ANN. tit. 16, § 2510(a)(5) (2003); ME. REV. STAT. ANN. tit. 18-A, § 5-809(a)(2) (1995); N.M. STAT. § 24-7A-9(A)(4) (2000); WYO. STAT. ANN. § 35-22-410(a)(v) (2007). Providers in other states may qualify for immunity under related statutes. *See, e.g.*, HAW. REV. STAT. § 663-1.7(b) (Supp. 2005) ("There shall be no civil liability for any member of an . . . ethics committee, or . . . for any acts done in furtherance of the purpose for which the . . . ethics committee . . . was established . . . .").

331. *See generally* CAL. PROB. CODE § 4650(c) (West Supp. 2007) ("In the absence of a controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment."); *In re* Rosebush, 491 N.W.2d 633, 637 (Mich. Ct. App. 1992) ("[T]he decision-making process should generally occur in the clinical setting without resort to the courts . . . ."); *In re* Quinlan, 355 A.2d 647, 669 (N.J. 1976) (suggesting that applying to a court for authority to stop LSMT is generally inappropriate, being both cumbersome and an encroachment on the medical profession); Jesse A. Goldner et al., *Responses to Medical Futility Claims*, *in* HEALTH LAW HANDBOOK 404 (Alice Gosfield ed., 1997) ("The final key background theme is that the courts express a clear preference for limiting judicial involvement in these questions."). *But see* Maureen Kwiecinski, *To Be or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 MARQ. ELDER'S ADVISOR 313, 353-55 (2006) (suggesting that judicial review should be required).

332. *See* UNIFORM HEALTH-CARE DECISIONS ACT, Prefatory Note ("[T]he Act is in general to be effectuated without litigation . . . ."); *id.* § 14 cmt. ("[T]he provisions of the Act are in general to be effectuated without litigation . . . .").

333. *See id.* at Prefatory Note, § 14 cmt.

334. While neither the UHCDA itself nor the statutes that are modeled on it make any reference to ethics committees, institutional policies almost invariably provide a role for an institutional committee. Most providers supplement the process in their state's statute with that outlined by the AMA.

335. UNIFORM HEALTH-CARE DECISIONS ACT § 7(g)(1); *see also id.* § 7(a) ("Before

This is a sensible requirement, since mutual agreement is reached in most cases.[336] Furthermore, notice gives the surrogate an opportunity to either seek review of the decision or transfer the patient to another physician or institution or both.[337] Informing the surrogate addresses the notorious lack of transparency associated with unilateral DNR orders in the 1980s.[338]

After the provider informs the patient or surrogate of their refusal to comply with the treatment request, the provider must then try to transfer the patient to another provider who is willing to comply with the treatment request.[339] The UHCDA states:

> [U]nless the patient or person then authorized to make health-care decisions for the patient refuses assistance, [the provider shall] immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.[340]

Thus, prior to transfer, the provider must comply with the treatment request.[341]

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implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.").

336. *See supra* note 91 and accompanying text.

337. *See* UNIFORM HEALTH-CARE DECISIONS ACT § 7(g).

338. Where providers were unable to write a unilateral DNR order and CPR was considered inappropriate, providers were known to affix color dots to the patient's wristband or write "N.T.B.R." (Not to Be Resuscitated) in pencil on the chart to be erased after the patient died. *See* Hoffman, *supra* note 46, at 6; Kapp, *supra* note 122, at 173. Some providers did a "Hollywood Code" or "Show Code" in which they performed a half-hearted or mock resuscitation. George P. Smith, II, *Euphemistic Codes and Tell-Tale Hearts: Humane Assistance in End-of-Life Cases*, 10 HEALTH MATRIX: J. L.-MED. 175, 184 (2000); Rosenthal, *supra* note 66, at A1. Still other providers performed "Slow Codes" in which they moved very slowly. *See* Smith, *supra*, at 180; Editorial, *Slow Codes, Show Codes and Death*, N.Y. TIMES, Aug. 22, 1987, at A26; *cf. In re* Quinlan, 355 A.2d 647, 657 (N.J. 1976) (discussing the medical practice of "judicious neglect").

339. UNIFORM HEALTH-CARE DECISIONS ACT § 7(g)(2)–(3); *see, e.g.*, CAL. PROB. CODE § 4736(b) (West Supp. 2007). It is unclear whether the care in this interim period can be billed once a formal decision has been made that the care is inappropriate. *Cf.* 42 U.S.C. § 1320c-5(a) (2007). The United States Code uses the following language:

> It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) [by Medicare or Medicaid] under this chapter, to assure, to the extent of his authority that services or items ordered or provided . . . will be provided economically and only when, and to the extent, medically necessary."

Id.

340. UNIFORM HEALTH-CARE DECISIONS ACT § 7(g)(2).

341. *Id.* § 7(g)(2).

Interestingly, however, the UHCDA does not specifically address what happens if transfer is not possible.[342] This is significant because those patients, for whom providers deem LSMT inappropriate, typically cannot be transferred.[343] There is almost never a facility available and willing to take such patients.[344] Even in cases where a facility is available, these patients are often not sufficiently stable to be transferred.[345]

The UHCDA requires only that the provider make "all reasonable efforts" to transfer the patient.[346] If the provider is unable to transfer the patient, then

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342. *See id.* § 7.

343. *See, e.g.*, *In re* Baby K, 16 F.3d 590, 593 (4th Cir. 1994) (noting no hospitals with a pediatric intensive care unit (PICU) were willing to accept Stephanie Keene from Fairfax Hospital, although she was temporarily transferred to a nursing home); Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1073 (La. Ct. App. 1998) (noting physician sought unsuccessfully to transfer patient); Lee, *supra* note 31, at 487 ("[T]ransfer of care is difficult in a medical futility case . . . ."); Miles, *supra* note 74, at 513 (reporting family of Helga Wanglie unsuccessfully tried to transfer her); Keith Shiner, *Medical Futility: A Futile Concept?*, 53 WASH. & LEE L. REV. 803, 845–46 (1996) (stating that the "transfer option, by itself, is an incomplete solution to the problem of medical futility"); Ackerman, *supra* note 43, at B1 ("Memorial Hermann officials said that other pediatric hospitals they consulted concurred with their treatment plan and decision to discontinue care."); Murphy, *supra* note 43, at 37 (reporting that while the family of Joseph Ndiyob eventually found a Los Angeles hospital willing to accept him, the hospital recanted when it learned he lacked health insurance); Baylor Response, *supra* note 144 ("Ultimately, twelve different health care facilities refused to accept the patient in transfer."); News Release, Memorial Hermann, *Statement to the Media Regarding Kyna Dismuke-Howard*, (May 3, 2005), http://www.memorialhermann.org/newsroom/050305a.htm ("[O]ur physicians contacted premier children's hospitals across the country . . . [but] each one reviewed the facts and refused to accept her transfer."). Texas provides a registry of providers willing to accept patients possibly subject to unilateral decisions. TEX. HEALTH & SAFETY CODE ANN. § 166.053 (Vernon 2006). But the registry currently includes only one provider. Texas Department of State Health Services, Registry of Health Care Providers and Referral Groups, http://www.dshs.state.tx.us/THCIC/Registry.shtm (last updated Sept. 25, 2007).

344. *See* sources cited *supra* note 343. Once in a while, providers are able to transfer patients who request inappropriate treatment. *See, e.g.*, Alexander M. Capron, *Baby Ryan and Virtual Futility*, 25 HASTINGS CTR. REP., Mar.-Apr. 1995, at 20 (reporting that the parents of Ryan Nguyen found a facility willing to provide the requested treatment); Paris, *supra* note 185, at 1013 (reporting parents transferred Baby L's care to a consultant pediatric neurologist); Todd Ackerman, *Hospital to End Life Support: Houston Woman Faces Second Fight in 2 Months Over Husband's Care*, HOUSTON CHRON., Apr. 28, 2005, at B5 (noting report by St. Luke's Hospital in Houston that "more than 30 facilities had rejected Nikolouzos before Avalon Place surprised them and agreed to take [him]"); Beck, *supra* note 185, at A13 (stating the guardian ad litem for Baby L "found a pediatric neurologist from another hospital who was willing to do everything the mother wanted").

345. *See, e.g.*, Brief of Respondent at 3, 21, Duarte v. Chino Comty. Hosp., No. E020473 (Cal. Ct. App. Aug. 19, 1998) (arguing that while a transfer would have resolved a conflict where the provider refused to withdraw treatment at the surrogate's request, the patient "was never stable enough to transfer to the proposed facility").

346. UNIFORM HEALTH-CARE DECISIONS ACT § 7(g)(3).

the provider may decline to comply with the treatment request.[347] California, for example, rejected an ultimatum approach which requires the provider to transfer or comply.[348] Tennessee similarly clarifies that if a transfer cannot be made, then the provider shall not be compelled to comply.[349]

If the patient is transferred, then she will receive the requested treatment.[350] If the patient is not transferred, the inability to transfer should serve as confirming evidence that the requested treatment was outside the standard of care and that the provider's refusal to comply with the request was appropriate.[351] To the extent there is variability among providers' judgments of medical appropriateness, transfer thereby serves as an important safety valve function.[352]

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347. *See id.* § 7(e)-(g).

348. CAL. PROB. CODE § 4736(b)-(c) (West Supp. 2007).

349. TENN. CODE ANN. § 68-11-1808(d) (2006).

350. Schwartz, *supra* note 105, at 162 (stating that "[i]f a patient who desires a particular course of treatment can find a healthcare provider—*any* healthcare provider—who believes that the proposed course of treatment is within the realm of reasonable medical alternatives, that patient will have access to that course of treatment").

351. *See* Anne L. Flamm & Martin L. Smith, Letter to the Editor, *Advance Directives, Due Process, and Medical Futility*, 140 ANNALS INTERNAL MED. 402, 404 (2004) ("The absence of a facility willing to accept transfer may indicate that a community consensus exists on the futility of particular medical interventions for a patient."). On the other hand, the inability to transfer may show nothing about the consensus over medical inappropriateness. First, many facilities do not make a diligent effort to locate potential transferee providers. Second, many providers refuse transfer for purely economic and risk management reasons.

352. AMA Council, *supra* note 53, at 940. The report describes the "fair process approach" as "insist[ing] on full and fair deference to the patient's wishes, placing limits on this patient-centered approach only when the harm to the patient is so unseemly that, even after reasonable attempts to find another institution, a willing provider of the service was not found." *Id.*; *see also* Halevy & McGuire, *supra* note 283, at 38 ("[T]he fact that the registry [of willing transfer providers] is so sparse supports the underlying ethical principle . . . of a professional consensus . . . ."); Lee, *supra* note 31, at 486 ("'Transfer of care' is used as a legal device to ensure the physician's professional rights are balanced against those of the patient-surrogates."); James J. Murphy, Comment, *Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession*, 9 J. CONTEMP. HEALTH L. & POL'Y 451, 483-84 (1993) (stating that where no physician will agree to a transfer, this demonstrates consensus); Schwartz, *supra* note 105, at 163 ("When there is universal agreement among healthcare providers that the patient's request seeks something beyond the limits of medicine, that should constitute very strong evidence that the request is inappropriate."). This assumes that the patient's request for a particular course of treatment is based on medical reasons. Schwartz, *supra* note 105, at 162-63.

B. Other Comprehensive Unilateral Decision Statutes

While the UHCDA may be the most common unilateral decision statute, it is not the only one. Other states have adopted comprehensive unilateral decision statutes similar to those in the ten UHCDA jurisdictions.[353]

Like the UHCDA, these statutes are comprehensive in that they authorize providers to make unilateral decisions concerning any type of requested treatment, including situations where the surrogate has made an affirmative request for treatment.[354] Similar to the UHCDA, many of these statutes not only authorize unilateral decisions but also offer immunity for the providers who make those decisions.[355]

The key difference among the non-UHCDA comprehensive unilateral decision statutes concerns the definition of "medically inappropriate." Some statutes provide no definition or standard, leaving providers with maximum

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353. *See generally* sources cited *infra* note 355 (citing state statutes containing unilateral decision provisions similar to UHCDA). Many of these states' laws were based on earlier NCCUSL uniform acts. *See generally* Thomas J. Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis,* 1 ISSUES L. & MED. 441, 474 (1986) (observing that the Act "gives the physician almost unfettered discretion to decide what will be done"); Leslie B. Oliver, *The Right to Die in North Dakota: The North Dakota Living Will Act,* 66 N.D. L. REV. 495, 525 (1990) ("Allowing physicians discretion to enforce the terms of a declaration may require them to become the ultimate authority as to whether life-prolonging treatment will be provided, withheld or withdrawn.").

354. *See, e.g.*, GA. CODE ANN. § 31-36-7(2) (2006) (stating that a provider may refuse to comply with a surrogate's request, but must aide in seeking transfer for the patient to another provider who will comply with the treatment request).

355. *See, e.g.*, ARK. CODE ANN. § 20-17-208(b) (2005) ("A physician or other health care provider, whose actions under this subchapter are in accord with reasonable medical standards, is not subject to criminal or civil liability or discipline for unprofessional conduct with respect to those actions."); GA. CODE ANN. § 31-32-8(b) (2006) ("No person shall be civilly liable for failing or refusing in good faith to effectuate the living will of the declarant patient."); GA. CODE ANN. § 31-36-8(2) (2006) ("No such provider or person shall be subject to any type of civil or criminal liability or discipline for unprofessional conduct . . . ."); GA. CODE ANN. § 31-36-8(3) (2006); IDAHO CODE ANN. § 39-4513(2) (Supp. 2007); 755 ILL. COMP. STAT. § 45/4-8(b), (c) (West 1993); IOWA CODE ANN. § 144A.9(2) (West 2002); KY. REV. STAT. § 311.633(3)-(4) (no penalties by anyone) (LexisNexis 2007); MD. CODE ANN., HEALTH–GEN. § 5-609(a) (LexisNexis 2005); MINN. STAT. ANN. § 145C.11 (West 1998) (establishing immunity to providers if the provider acts in good faith or acts according to a surrogate's decision); MONT. CODE ANN. § 50-9-204(2) (2005); NEB. REV. STAT. § 20-410(2) (1997); NEV. REV. STAT. § 449.630(2)-(3) (1991); NEV. REV. STAT. § 449.640(2) (1993); N.H. REV. STAT. ANN. § 137-J:8(II) (2005); N.C. GEN. STAT. § 90-322(d) (1993); N.D. CENT. CODE § 23-06.5-12(2) (2002); OHIO REV. CODE ANN. § 2133.11(A)(4) (LexisNexis 2006); OKLA. STAT. ANN. tit. 63, § 3101.10 (West 1995); TEX. HEALTH & SAFETY CODE ANN. §§ 166.044(a), 166.045(d), 166.166 (Vernon 1999); VT. STAT. ANN. tit. 18, § 9713(c)(3) (2006) (giving protection to hospital employees only from adverse employment decision); VA. CODE ANN. § 54.1-2988 (2005); WASH. REV. CODE §§ 70.122.051, .122.060(3) (2006); WIS. STAT. ANN. § 154.07(1)(a)(3) (West 1998); WIS. STAT. ANN. § 155.50(1)(b) (West 2003).

discretion to determine the circumstances under which they will refuse to comply with treatment requests.[356] Virginia, for example, provides that a physician is not required to "render medical treatment to a patient that the physician determines to be medically or ethically inappropriate."[357] Other states' statutes provide a more precise formulation, authorizing providers to decline to comply with treatment requests that would require treatment outside their professional medical judgment.[358] States articulate this standard in different ways, but all the formulations are analogous to the UHCDA's standard of "generally accepted health care standards."[359] The most common formulation of medical appropriateness is one based on "reasonable medical practice,"[360] "reasonable medical standards,"[361] "responsible medical practice,"[362] "medical judgment,"[363] or "usual and customary standards of medical practice."[364] Other statutes refer to "professional reasons,"[365]

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356. *See, e.g.*, GA. CODE ANN. §§ 31-32-8(b), 31-36-7(2) (2006) (mentioning that physicians may refuse to comply with a living will, but not addressing when they may or may not refuse treatment); GA. CODE ANN. § 31-36-8(2), (3) (2006) (requiring that physician's refusal to comply with treatment request must be "substantially in accord with reasonable medical standards"); 755 ILL. COMP. STAT. §§ 35/3(d), 45/4-7(b) (West 1993); IND. CODE ANN. § 16-36-4-13(e) (LexisNexis 1993); IND. CODE ANN. § 30-5-7-4(b) (LexisNexis 2000); IOWA CODE ANN. § 144A.8(1) (West 2002); MINN. STAT. ANN. § 145B.06(1) (West 1991); MINN. STAT. ANN. § 145C.15(b) (West 1998); MO. ANN. STAT. § 459.030(1) (West 1985); MONT. CODE ANN. § 50-9-203 (2005); NEV. REV. STAT. §§ 449.628, 449.640 (1997); OHIO REV. CODE ANN. §§ 1337.16(B), 2133.02(D)(1) (LexisNexis 2006); OKLA. STAT. ANN. tit. 63, § 3101.9 (West 1998); TEX. HEALTH & SAFETY CODE ANN. § 166.046 (Vernon 1999); WIS. STAT. ANN. §§ 154.07(1)(a) (West 1990); WIS. STAT. ANN. § 155.50(1)(b) (West 2003).

357. VA. CODE ANN. § 54.1-2990(A) (2005).

358. Like the UHCDA, the statutes in most states allow providers to refuse to comply with surrogate treatment requests for *moral* reasons. *See, e.g.*, CAL. PROB. CODE § 4734 (West 2007); MD. CODE ANN., HEALTH–GEN. § 5-611(a) (West 2005); VA. CODE ANN. § 54.1-2990 (2005). While these provisions have rarely been used in the context of futility disputes, they are applicable and may soon be invoked more frequently. *See supra* note 319.

359. *See infra* notes 360-69.

360. *See, e.g.*, MINN. STAT. ANN. § 145B.13 (West 1991) ("reasonable medical practice").

361. *See, e.g.*, GA. CODE ANN. § 31-36-8(3) (2006) ("substantially in accord with reasonable medical standards at the time of reference").

362. *See, e.g.*, N.H. REV. STAT. ANN. §§ 137-J:7(I) (2006) (complying "within the bounds of responsible medical practice").

363. *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.58.1(B)(3) (1985) ("It is the intent of the legislature that nothing in this Part shall be construed . . . to require the application of medically inappropriate treatment or life-sustaining procedures to any patient or to interfere with medical judgment with respect to the application of medical treatment or life-sustaining procedures.").

364. *See, e.g.*, CONN. GEN. STAT. ANN. § 19a-571(a) (West 2002) (shielding providers from liability where "the decision to withhold or remove such life support system is based on the best medical judgment of the attending physician in accordance with the usual and customary standards of medical practice"); MO. ANN. STAT. § 459.040 (West 1985).

365. *See, e.g.*, IDAHO CODE ANN. § 39-4513(2) (Supp. 2007) (allowing provider to withhold LSMT if unwilling to provide treatment for "professional reasons").

"professional grounds,"[366] or "professional standards"[367] as means for determining medical inappropriateness. Like the UHCDA, the other comprehensive unilateral decision statutes operate extra-judicially.[368] Additionally, these state statutes require the unwilling provider to attempt to transfer the patient before taking unilateral action.[369]

C. Narrow Unilateral Decision Statutes

While most states with unilateral decision statutes have adopted comprehensive provisions similar to the UHCDA, a few have taken a more "narrow" approach. New York, for example, enacted a narrow unilateral decision statute in 1987.[370] Other states soon enacted statutes similar to New York's, permitting unilateral decisions only in narrowly defined circumstances.[371]

As compared to the UHCDA and other comprehensive unilateral decision statutes, these narrow statutes offer a stricter range of circumstances under which providers can unilaterally stop LSMT.[372] In particular, the statutes are tightly delineated with respect to the following: (1) the type of treatment, (2) the presence of a surrogate request for treatment, and (3) the expected effect of the treatment.[373] First, certain types of medical interventions have been the focus of special attention. Consequently, some statutes limit types of treatment by authorizing unilateral decisions to withhold only CPR,[374] while others

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366. *See, e.g.*, KY. REV. STAT. ANN. § 311.633(3) (LexisNexis 2007) (allowing providers to refuse treatment on "professional grounds").

367. *See, e.g.*, N.J. STAT. ANN. §§ 26:2H-62(d) (1992) ("Nothing in this act shall be construed to require . . . care in a manner contrary to law or accepted professional standards.").

368. *See, e.g.*, N.J. STAT. ANN. §§ 26:2H-66 (1992) (implementing a dispute resolution process to resolve disagreements between patients, patient's surrogates, and doctors); *cf.* sources cited *supra* note 355 (referencing statutes which give providers immunity from civil and criminal liability for treatment or refusal of treatment, implying that the judicial process may not lead to a satisfactory result for the patient or surrogate).

369. *See, e.g.*, 20 PA. CONS. STAT. ANN. § 5424(b) (West Supp. 2007); MD. CODE ANN., HEALTH-GEN. § 5-613(a)(1)(iii) (LexisNexis 2005); VA. CODE ANN. § 54.1-2987 (2005) ("An attending physician who refuses to comply . . . shall make a reasonable effort to transfer the patient . . . .").

370. N.Y. PUB. HEALTH LAW §§ 2961(12), 2966(1) (McKinney 1988).

371. *See, e.g.*, OR. REV. STAT. § 127.635(1) (2005); S.D. CODIFIED LAWS § 59-7-2.7(1) (2004); UTAH CODE ANN. § 75-2-1107(1) (1993); VT. STAT. ANN. tit. 18 § 9708(a) (Supp. 2006); W. VA. CODE ANN. § 16-30C-6(e) (LexisNexis 2006); *see also* VHA-NEC REPORT, *supra* note 109, at 6 ("VA physicians are not permitted to write a DNR order over the objection of the patient or surrogate, but they are permitted to withhold or discontinue CPR based on bedside clinical judgment at the time of cardiopulmonary arrest.").

372. *See* sources cited *supra* note 371.

373. *See* sources cited *supra* note 371.

374. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2966(1) (McKinney 1988); VT. STAT. ANN. tit. 18, § 9708(a) (Supp. 2006); W. VA. CODE ANN. § 16-30C-6(e) (LexisNexis 2006).

authorize unilateral decisions to withhold only artificial nutrition and hydration.[375] Second, the narrow unilateral decision statutes limit not only the type of treatment, but they also limit unilateral decisions to situations where neither the patient nor the patient's surrogate has made a contrary decision.[376] The health care provider can only unilaterally stop LSMT when no other decision maker is available.[377] Third, the narrow unilateral decision statutes authorize a provider to make unilateral decisions only in narrow, verifiable circumstances of medical inappropriateness.[378] Rather than giving providers discretion to determine medical inappropriateness, these narrow statutes authorize unilateral decisions only in cases of brain death, physiological futility, or permanent unconsciousness.[379]

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375. *See, e.g.*, OR. REV. STAT. §§ 127.580(1), 127.635(1) (2005); S.D. CODIFIED LAWS § 59-7-2.7 (2004).

376. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2966(1) (McKinney 1988); OR. REV. STAT. § 127.580 (2005); UTAH CODE ANN. § 75-2-1107(1) (1993); VT. STAT. ANN. tit. 18, § 9708(a) (Supp. 2006); W. VA. CODE ANN. § 16-30C-6(e) (LexisNexis 2006). The New York Department of Health has apparently expanded the exception to permit physicians to write DNR orders even over the objection of a surrogate. *See* Edward F. McArdle, *New York's Do-Not-Resuscitate Law: Groundbreaking Protection of Patient Autonomy or a Physician's Right to Make Medical Futility Determinations?*, 6 DEPAUL J. HEALTH CARE L. 55, 73-74 (2002-2003).

377. *See* sources cited *supra* note 376.

378. *See, e.g.*, OR. REV. STAT. § 127.635(1) (2005). Oregon's unilateral decision statute requires one of four specified conditions:

> Life-sustaining procedures [such as artificial nutrition and hydration] . . . may be withheld or withdrawn . . . if the [patient] has been medically confirmed to be in one of the following conditions: (a) A terminal condition; (b) Permanently unconscious; (c) A condition in which administration of life-sustaining procedures would not benefit the principal's medical condition and would cause permanent and severe pain; or (d) The person has a progressive illness that will be fatal and is in an advanced stage, the person is consistently and permanently unable to communicate by any means, swallow food and water safely, care for the person's self and recognize the person's family and other people, and it is very unlikely that the person's condition will substantially improve.

Id. South Dakota similarly enumerates three circumstances:

> [A]rtificial nutrition or hydration may be withheld or withdrawn if: (1) Artificial nutrition or hydration is not needed for comfort care or the relief of pain and the attending physician reasonably believes that the principal's death will occur within approximately one week; or (2) Artificial nutrition or hydration cannot be physically assimilated by the principal; or (3) The burden of providing artificial nutrition or hydration outweighs its benefit, provided that the determination of burden refers to the provision of artificial nutrition or hydration itself and not to the quality of the continued life of the principal . . . .

S.D. CODIFIED LAWS § 59-7-2.7 (2004).

379. *See* sources cited *supra* note 378.

V. EFFECTS OF THE UNILATERAL DECISION STATUTES

In the early 1990s, health care providers were unwilling to make unilateral decisions to stop LSMT without legal protection.[380] Consequently, over the past eighteen years, state legislatures have promulgated statutes that purport to provide this protection.[381] Now, it is time to assess the effects of these statutes.

While little empirical data exists, there is sufficient evidence to detect four broad trends and identify focused issues for empirical research. The first two trends are reasonably negative, at least from the perspective of statutory effectiveness. First, even in states with comprehensive unilateral decision statutes, many hospitals still do not have futility policies.[382] Second, those few hospitals with futility policies rarely implement them to make a unilateral decision in cases of intractable conflict.[383]

Two additional trends have more positive attributes. First, the unilateral decision statute in one state, Texas, does appear to work.[384] Texas hospitals both have *and* implement futility policies.[385] Second, unilateral decision statutes appear to facilitate the informal resolution of futility disputes, reducing, although not eliminating, the need to resort to unilateral decision making.[386]

A. Hospitals Do Not Have Futility Policies.

Unfortunately, there is a "disturbing lack of information" on the prevalence of hospital futility policies.[387] The two most populated states in the country failed to implement any reporting mechanism as part of their unilateral decision statutes.[388] Consequently, as one distinguished health law scholar concluded, "No data exist on futility policies adopted by [institutions] in California [or Texas], much less across the nation."[389]

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380. *See supra* notes 276-84.

381. *See supra* note 355.

382. *See infra* notes 387-97.

383. *See infra* notes 398-403.

384. *See infra* notes 404-13.

385. *See infra* notes 404-08.

386. *See infra* notes 409-13.

387. Kwiecinski, *supra* note 331, at 329.

388. In 2002, California, a UHCDA state, considered legislation that would "study the extent to which health care providers and institutions are denying patients life-sustaining health care that they desire." *Hearing on S.B. 1344 Before the S. Assembly Comm. on Appropriations* (2002). Unfortunately, that legislation was never enacted. *S.B. 1344 Status Rep.* (2002), http://www.leginfo.ca.gov/pub/01-02/bill/sen/sb_1301-1350/sb_1344_bill_20021130_status.html. Similarly, Texas failed to monitor the use of its unilateral decision statute. *See* Ramshaw, *supra* note 84. A bill introduced in March 2007 proposed to change this, H.B. 3474, 80th Leg. (Tex. 2007), but that bill died with the close of Texas's 80th legislative session. Texas Legislature Online, http://www.capitol.state.tx.us (search by bill number).

389. Schneiderman & Capron, *supra* note 243, at 529; *see also* Kwiecinski, *supra* note 331, at 329 ("At the writing of this essay, no reports surveying the circumstances in which

In fact, a distinguished group of scholars conducted an empirical research study in 1996 on this very issue.[390] They surveyed 1,990 large hospitals in the United States and received 537 responses.[391] Of these, only 29 (about 5%) were "clearly denominated as medical futility policies and . . . reached beyond DNR orders, more traditional life-sustaining treatment decisionmaking, and the determination of death."[392] Moreover, most of these 29 policies "envisioned a primarily consultative, consensus-building approach."[393] Almost none of the hospitals resolved what would happen if neither consensus nor transfer were possible in a case.[394] Additionally, there was no specification or authorization of a mechanism for the unilateral termination of LSMT.[395]

These statistics have not improved over the past decade. Recent evidence indicates that while unilateral decision statutes authorize health care providers to refuse compliance with inappropriate treatment requests, providers in these jurisdictions *reluctantly* continue to comply with such requests. [396] Although a number of health care institutions would like to have futility policies, only a few have adopted such policies.[397]

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institutional futility policies have been invoked have been published.").

390. Sandra H. Johnson et al., *Legal and Institutional Policy Responses to Medical Futility*, 30 J. HEALTH L. 21, 27 (1997).

391. *Id.*

392. *Id.* Within the study, 137 hospitals responded that they had futility policies. Of those, 115 hospitals submitted their policy to the research team, who determined that most of the policies just pertained to traditional LSMT decision making with consent or determining brain death. *Id.*; Goldner, *supra* note 331, at 412.

393. Johnson, *supra* note 390, at 32.

394. *Id.* ("Because these transfer . . . provisions provided for permissible or optional courses of action, many do not resolve what will happen if transfer is not available, is burdensome, or is not desired by the patient/surrogate.").

395. *Id.* ("It was quite frequently the case that a policy . . . failed to specify an ultimate decisionmaker or decisionmaking body if conflict were to persist after all the processes were followed.").

396. *See* Bowman, *supra* note 89, at 1527 ("The reluctance of providers to act unilaterally comes in part . . . from a lack of medical agreement on a workable definition for futility and a lack of legal support for overriding patient choice.").

397. *See id.* at 1528 ("'A lot of people want to have policies, but a lot of people don't [have them].'" (quoting Shirley J. Paine)); Moldow, *supra* note 12, at 39 ("Fear of legal action has previously discouraged many institutions from adopting policies in the area of medical futility . . . ."); Nasraway, *supra* note 89, at 216 ("[I]t is much more common for hospital lawyers to argue in favor of doing the easy thing, i.e., to acquiesce to unreasonable demands . . . ."); Email from Ronald Cranford, Faculty Associate, Univ. of Minn.'s Center for Bioethics, to Thaddeus Pope, Assistant Professor of Law, Univ. of Memphis Cecil C. Humphreys School of Law (July 11, 2004, 07:41 PM) ("Many hospital lawyers, much more concerned about legal liability and adverse publicity for their institutions, have been extremely tentative, if not outright hostile, to ethics committees formulating and implementing futility policies, even though many of us in the field of clinical ethics feel these guidelines are badly needed."); *cf.* Anderson-Shaw, *supra* note 159, at 299 ("Absent state or federal statutes specifically guiding futile care activity, many institutions work under a much more informal approach to futile care.").

B. Hospitals Do Not Enforce Their Futility Policies

While a hospital without a futility policy is unlikely to make a unilateral decision to stop LSMT, the existence of a futility policy hardly means it will be fully utilized. It appears that many institutions that have futility policies either are not implementing them at all or are implementing them only in a very narrow and infrequent manner.[398]

For example, a health care provider in an institution with a futility policy may invoke that policy in an attempt to resolve a dispute.[399] However, if the dispute is intractable, the provider may be reluctant to invoke the unilateral decision provisions of the policy.[400] Instead, the provider will ultimately accede to the surrogate's treatment request.[401] In sum, while futility policies facilitate the informal resolution of disputes, providers defer when the dispute proves intractable.

The unilateral decision statutes in most states seem to have had limited effect. Commentators noted that before the passage of state statutes authorizing unilateral action, hospitals typically deferred to family wishes because they feared being sued.[402] Now, even *with* such laws, hospitals still accede to family wishes for fear of being sued.[403] The statutes have failed to change the behavior of providers.

C. Hospitals in Texas Enforce Their Futility Policies

There is an exception to this general failure in unilateral decision statutes: Texas's statute appears to have had a significant impact since its adoption in

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398. *See, e.g.*, Bowman, *supra* note 89, at 1527 ("While physicians sometimes disagree with patients or their surrogates over end-of-life care, however, they rarely end care in violation of patient wishes. . . . 'If you're still at an impasse, the hospital continues to provide maximum support.'"); Burns, *supra* note 217, at 3 ("[D]espite an increasing number of ethics consults on questions of futility we do not invoke our own futility policy."); Mary Pat Flaherty, *Right to Die Decision Has Little Impact Here*, PITT. POST-GAZETTE, June 27, 1990, at A1 (reviewing policies at Pittsburgh-area hospitals and observing that "[c]are usually continues—full bore—when an incapacitated patient's family or his designated decision-maker cannot agree with recommendations made by doctors that further care would be futile"); Fletcher, *supra* note 10, at S:230 (noting a "moratorium" on the use of UVA's policy after the *Baby K* decision); Wlazelek, *supra* note 46 (reporting reluctance at Lehigh Valley Hospital-Muuhlenberg in Bethlehem to utilize its unilateral decision policy). Reporter Ann Wlazelek remarked that the option to refuse treatment "takes courage on the part of the physician because he or she will most likely be sued. No doctor at LVH has refused to treat a patient but some patients have been transferred to other facilities." *Id.*

399. *See supra* Part I.D.

400. *See supra* note 398.

401. *See supra* note 398.

402. *See supra* notes 276-81.

403. *See infra* notes 415-18.

1999.[404] In one study at Baylor University Medical Center in Dallas, researchers found that the statutory authorization gave physicians "more comfort," thereby increasing ethical consultations regarding futility disputes by 67%.[405] Not only did physicians and hospitals across Texas begin the dispute resolution process but also, in approximately two percent of cases that were proven intractable, the providers gave notice that they were going to unilaterally stop LSMT. [406]

A broader study of sixteen Texas hospitals over a five-year period found that, on average, each hospital made the decision to unilaterally stop treatment at least one time each year.[407] Indeed, Texas hospitals unilaterally stopped or decided to stop LSMT, even in the face of significant controversy and mass media coverage urging otherwise.[408] In short, the Texas statute has truly changed provider conduct.

D. Unilateral Decision Statutes Facilitate the Informal Resolution of Futility Disputes

Even in cases where the unilateral decision statutes do not facilitate unilateral decisions, the statute may still help the informal resolution of futility disputes because most disputes are not intractable.[409] These statutes help ensure that *earlier* steps in the dispute resolution process work better.[410] They facilitate informal resolution by setting "temporal and conceptual boundaries."[411] For example, surrogates might say, "If you are asking us to agree with the recommendation to remove life support from our loved one, we cannot. However, . . . if the law says it is OK to stop life support, then that is what should happen."[412] The existence of a hospital policy and state law helps

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404. Fine & Mayo, *supra* note 84, at 744.

405. *Id.* at 744-45.

406. Ramshaw, *supra* note 84.

407. *Id.*

408. *See, e.g.*, Todd Ackerman, *Transfer Resolves Latest Futile-Care Case: Nursing Home in Lubbock to Take Memorial Hermann Patient*, HOUSTON CHRON., July 31, 2006, at B1; Ackerman, *supra* note 43, at B1; Todd Ackerman, *Relocation of Heart Patient on Life Support Called Off: The Controversy is Not Put to Rest as Midwest Facility Says Her Condition is Too Complicated*, HOUSTON CHRON., Apr. 29, 2006, at B1 [hereinafter Ackerman, *Relocation of Heart Patient*]; Ackerman, *supra* note 344, at B5; Belluck, *supra* note 38, at A1; Robert H. Frank, *Weighing the True Costs and Benefits in a Matter of Life and Death*, N.Y. TIMES, Jan. 19, 2006, at C3; Murphy, *supra* note 45, at A29; Emily Ramshaw, *Judge Gives Family Time to Move Woman*, DALLAS MORNING NEWS, Feb. 16, 2007, B2; Ramshaw, *supra* note 45, at B1; Mary Ann Roser, *Where Doctors See Futility, Family Sees Hope*, AUSTIN AM.-STATESMAN, Apr. 28, 2006, at A1.

409. *See supra* notes 91, 331-36 and accompanying text.

410. *See* Fine & Mayo, *supra* note 84, at 744 (noting statute provides for consultations to address disputes between providers and patients or surrogates concerning treatment options).

411. Fine, *supra* note 92, at 70-71.

412. Fine & Mayo, *supra* note 84, at 745 (internal quotations omitted).

families accept the fact that death cannot be postponed forever and that, eventually, LSMT is inappropriate.[413]

VI. CAUSES OF UNILATERAL DECISION STATUTE DISUSE

Providers in unilateral decision statute jurisdictions, other than Texas, generally do not make unilateral decisions to stop inappropriate treatment. Why is this? Why do providers continue to accede to surrogate requests for treatment that they consider medically inappropriate? Why do the unilateral decision statutes remain unused?[414] Many have suggested that the primary reason unilateral decision statutes are not working is because of legal uncertainty and the fear of litigation.[415] Surely, other factors, such as the fear of

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413. *See, e.g.*, Fine, *supra* note 48, at 80 ("[F]amilies come to understand that there is a finite limit . . . [and] that they are not in total control of the situation."); Fine, *supra* note 92, at 70–71; Fine, *supra* note 100, at 1221 ("[T]he family was relieved because they had 'put up the good fight' . . . but now the decision was out of their hands."); Fine & Mayo, *supra* note 84, at 746 ("[T]he greatest significance of the law is how it changes the nature of conversations . . . about futile-treatment situations by providing conceptual and temporal boundaries."). *But see* Burns, *supra* note 217, at 3 (suggesting that a formal futility policy leads to "confrontation" and "polarization").

414. Unfortunately, non-anecdotal, statistical evidence of the prevalence and use of hospital futility policies is unavailable. It is imperative that academics and policymakers engage in more empirical research to uncover the reasons why providers accede to inappropriate requests. This research and analysis will aid in identifying the problems with sufficient precision and in developing appropriately tailored solutions.

415. *See, e.g.*, WHEN CHILDREN DIE, *supra* note 284, at 322 ("[I]t is increasingly clear that before a physician may terminate life support on any patient [where the family objects] . . . she or he should assume that it is necessary to ask a court for an order."); Brett, *supra* note 70, at 283–84 ("[T]he threat of litigation is an important reason, perhaps the major reason, that physicians are reluctant to withhold or withdraw 'futile' life-sustaining treatment unilaterally against the wishes of family members."); Fletcher, *supra* note 10, at S:230 (noting that health care organizations must "wait for clarification of the law . . . on which futile treatments can be withheld or withdrawn" and in the meantime must "treat until the dispute is resolved"); Hall, *supra* note 246, at 119 ("[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophecy . . . ."); Kapp, *supra* note 122, at 242 (recommending that in the absence of "unambiguous legal guidance," providers should accede to surrogate requests); Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 119 (2003) (discussing how a "broad fear of regulatory sanctions for providing too little aggressive LSMT" and the likelihood of civil malpractice actions means that "demand for aggressive LSMT virtually always controls the situation regardless of how inappropriate that demand may be"); Lantos, *supra* note 12, at 587 (explaining that many doctors are unwilling to "take the risk that punishment, rather than forgiveness, may come their way"); Valerie A. Palda et al., *"Futile" Care: Do We Provide It? Why? A Semistructured Canada-Wide Survey of Intensive Care Unit Doctors and Nurses*, 20 J. CRITICAL CARE 207 (2005) (finding that 75% of physicians provided futile care because of legal pressures). Notably, whatever the actual risks, they may be overestimated by providers. *See* McArdle, *supra* note 376, at 71 ("Numerous articles have warned physicians of the serious legal risk in unilaterally writing a DNR order

adverse publicity, also intimidate providers from making unilateral decisions.[416] However, legal factors appear to be the most material cause and, therefore, will be the focus of this Article.

In 1999, when the American Medical Association encouraged hospitals to adopt futility guidelines, it noted that "the legal ramifications of this course of action are uncertain."[417] Now, even with statutory authorization, there is *still* significant legal uncertainty.[418]

There are three potential sources of this uncertainty. First, the unilateral decision statutes are vague, leaving providers and hospital counsel unsure of what standards are required to obtain safe harbor status.[419] Second, there is uncertainty concerning whether and when these state statutes are preempted by conflicting federal law.[420] Third, there is uncertainty concerning the constitutionality of the statutes.[421]

It is impossible to conclude that these sources of uncertainty affect a providers' willingness to use unilateral decision statutes. To definitively answer this question, empirical research must be employed to assesses the motivation for provider behavior. But although no such evidence currently exists, one state presents a case study: Texas. The Texas statute effectively facilitates unilateral decisions, yet it is equally subject to federal preemption and constitutional requirements.[422] Therefore, it seems that the only *material* uncertainty must concern that of the non-Texas unilateral decision statutes themselves.

. . . .").

416. *See, e.g.*, WRONG MEDICINE, *supra* note 37, at 134 ("[I]f the decision to withdraw life-sustaining treatment became known to any of the patient's friends or to the public, the hospital might have to face embarrassing publicity (or, as they put it, 'bad headlines')."); Fletcher, *supra* note 10, at S:226 (observing hospitals can "'engender ill will in their communities'" (quoting Alan Meisel)); Rivin, *supra* note 30, at 391 ("The 'pay or leave' demand is probably too coercive for the hospital or the physician's malpractice carrier or public relations advisor to accept."); Schneiderman & Capron, *supra* note 243, at 525-26 ("[I]n a survey of representatives of all 43 children's hospitals in the country . . . almost all acknowledged [that] their own hospital would probably yield to demands for life-sustaining treatment . . . because of fears of lawsuits and bad headlines."); Ackerman, *Relocation of Heart Patient*, *supra* note 408, at B1 ("St. Luke's was flooded with angry calls about the plan to pull the plug on Clark . . . ."); Andrea Clarke's Struggle for Life, Posting to ProLifeBlogs.com, http://www.prolifeblogs.com/articles/archives/2006/04/andre_clarkes_s.php (Apr. 25, 2006, 01:04 AM) (describing unilateral decision making as a "flagrant act of (passive) euthanasia").

417. AMA Council, *supra* note 53, at 940.

418. *See infra* Part VI.A-C.

419. *See infra* notes 423-68.

420. *See infra* notes 440-51.

421. *See infra* notes 452-64.

422. *See infra* Part VII.B.

A. Uncertainty from Statutory Vagueness

Lawyers, bioethicists, health care providers, and policymakers have had enormous difficulty defining "medically inappropriate."[423] Years of debate have failed to produce any consensus.[424] As a result, policymakers designed an approach with vague standards, thereby giving substantial discretion to the health care providers and institutions.[425] Rather than establishing a clear framework for determining medical inappropriateness, the statutes leave that determination to the judgment and discretion of the individual health care

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423. *See generally* Anderson-Shaw, *supra* note 159, at 303 (noting that all state statutes use similar terms like "medically inappropriate" or "medically ineffective" to define futility, yet the definitions of these terms are left to the discretion of the providers); Tomlinson & Czlonka, *supra* note 59, at 33 (arguing "against any attempt to base a futility policy on some concrete definition of *futility*"); David G. Warren, *The Legislative Role in Defining Medical Futility*, 56 N.C. MED. J. 453, 454 (1995) ("[T]here may be another wave of proposals in state legislatures to address the question of . . . medical futility. Drafting difficulties are obvious . . . .").

424. *See* Moseley, *supra* note 4, at 211 ("[D]espite years of debate in scholarly journals, professional meetings, and popular media, consensus on a precise definition eludes us still."); *see also* Burt, *supra* note 66, at 249-50 ("[W]ithin the medical community no consensus has emerged to give practical content to the futility concept . . . ."); Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. a Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1246 (1993) (viewing this struggle as a "clash at the bedside"); Goldner, *supra* note 331, at 416 (empirical research study "suggests an absence of consensus"); Lee, *supra* note 31, at 482; Mark Strasser, *The Futility of Futility? On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505, 514 (1998) (describing current formulations of the term as either under-inclusive, over-inclusive, or both); Richard L. Wiener et al., *A Preliminary Analysis of Medical Futility Decisionmaking: Law and Professional Attitudes*, 16 BEHAV. SCI. L. 497, 499 (1998); Zientek, *supra* note 82, at 251 ("Because of the difficulty in defining futility . . . the [Texas] statute is vague on a number of central issues."). *But see* Levine, *supra* note 10, at 73 (suggesting that there is a general consensus among health care providers that some types of treatment are medically inappropriate).

425. *See, e.g.*, THE RIGHT TO DIE, *supra* note 17, § 13.02 at 13-6 to 13-7; AMA Council, *supra* note 53, at 939 (rejecting an absolute definition in favor of a process-based approach); Ferguson, *supra* note 16, at 1220 ("[T]he statute provides no clear standard regarding the propriety of such decisions."); *id.* (arguing that the UHCDA does not "provide a clear definition of futility and fails to supply adequate ethical context or constraints to guide difficult decisions"); Keith Shiner, *Medical Futility: A Futile Concept?* 53 WASH. & LEE L. REV. 803, 810 (1996) (stating that the legislative bodies failed to deal with the problem of medical futility, instead creating undefined statutes); *cf.* Johnson, *supra* note 390, at 36 ("Developing clarity in the boundaries of futility is fundamental.").

provider.[426] In this sense, the statutes can be described as "purely enabling legislation."[427]

It is not unusual for policymakers to delegate responsibility when they cannot agree on rules or guidelines.[428] Moreover, this deference is typical with respect to the medical profession.[429] The discretion afforded by the unilateral decision statutes, however, is purchased at the expense of significant uncertainty.[430] Because of the statutory vagueness, providers have difficulty ensuring that they are satisfying the required standards.[431]

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426. The legislature's failure to create a clear framework to determine medial inappropriateness is hardly surprising. The inappropriate treatment question "address[es] issues concerning the meaning that we attach to life, particularly diminished life; self-determination; the nature of the physician-patient relationship; and the just allocation of scarce health care resources." Shiner, *supra* note 425, at 808-09.

427. MASON & LAURIE, *supra* note 77, at 596; *see* Ferguson, *supra* note 16, at 1220 ("The UHCDA provides a mere framework . . . [and] gives only broad platitudes . . . ."); *id.* at 1221 ("These sections seemingly create an open-ended excuse for a physician to withdraw treatment. . . ."); *see also* DWORKIN, *supra* note 124, at 144-45 (arguing that given factual variability of the issues and the lack of public consensus, matters should be left to the medical profession with minimal legal oversight); Elizabeth Day, *Do Not Resuscitate—and Don't Bother Consulting the Family,* SUNDAY TELEGRAPH [UK], Mar. 14, 2004, at 22, *available at* 2004 WL 4176646 ("There is the possibility of legislation, but in a field as controversy-strewn as medical ethics, a blanket law remains an imperfectly blunt tool.").

428. *Cf.* Carl E. Schneider, *Discretion, Rules, and Law: Child Custody and the UMDA's Best-Interest Standard*, 89 MICH. L. REV. 2215, 2244-45 (1991) (discussing the "'rule-building discretion'" which arises from a "direct and deliberate grant of discretionary authority").

429. *Cf.* Carl E. Schneider, *Void for Vagueness*, 37 HASTINGS CTR. REP., Jan.-Feb. 2007, at 10 ("In short, lawmakers have essentially established rules intended to hold medicine to its own standards and then mostly left the system to work unmolested.").

430. *See, e.g.*, HALL ET AL., *supra* note 78, at 451 ("On balance, it is difficult to offer much assurance about the existing legal climate regarding futility policies."); Ferguson, *supra* note 16, at 1243 (noting that the statute fails to provide a "usable, clear standard that protects the physician"); Flamm, *supra* note 10, at 4 ("The promise of immunity, of course, is not guaranteed; patients can challenge a provider's adherence to [the statute] or more generally dispute the reasonableness of actions taken."); Kwiecinski, *supra* note 331, at 349-50 ("When treatment can be or should be described as 'inappropriate' is not defined by the statute. . . . This lack of boundaries and oversight allows the providers far too much discretion."); Meisel & Jennings, *supra* note 11, at 75 ("[T]he law is unclear on what should be done."); Rowland, *supra* note 214, at 297 ("[T]hese statutes provide little guidance in regards to the limiting of the obligation for physicians to provide ongoing care they believe futile."); Schneiderman & Capron, *supra* note 243, at 528 ("For if limits to physicians' obligations are not defined, end-of-life outcomes are likely to be determined less by medical circumstances and justifiable standards and more by individual healthcare providers' tolerance for risk, patients' and families' varying degrees of knowledge and rhetorical skills, and economic considerations."); Tovino & Winslade, *supra* note 41, at 29 (observing that in futility cases "no widely accepted ethical and legal framework exists to govern decision-making"); *cf. In re* Bowman, 617 P.2d 731, 738 (Wash. 1980) (noting, with respect to brain death, that "[a]doption of [a legislative] standard will alleviate concern among medical practitioners that legal liability might be imposed when life support systems are withdrawn . . . ."). *But cf.* Goldner, *supra* note 331, at 409 ("[C]ourts

Indeed, the drafters of the UHCDA recognized this very shortcoming, observing that the statute really "provides no immunity at all . . . [because] virtually every question of reasonable care is a jury question."[432] The lack of immunity was "one of the reasons why [providers] want[ed] to get something in the black letter that talks about acceptable health-care standards."[433]

Some have suggested that the unilateral decisions statutes could have been effective, despite their vagueness, if "the medical profession . . . articulate[d] and thereafter follow[ed] uniform practice standards regarding futile care."[434] For example, recognizing the dynamic advancement in technology, the drafters of the Uniform Determination of Death Act (UDDA) did not specify any exact diagnoses in the statute itself.[435] Providers did, however, develop clinical criteria necessary to implement the UDDA.[436] In contrast, with respect to medical inappropriateness under the UHCDA, providers have neither articulated nor adhered to any clear universal standards of practice.[437]

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are hesitant to penalize physicians who reasonably rely on what they perceive to be professional standards . . . .").

431. *Cf.* Blumstein, *supra* note 172, at 1049 (noting that flexibility is not a desirable objective for a safe harbor); *Final Rule: Medicare and State Health Care Programs: Fraud and Abuse; Safe Harbor for Federally Qualified Health Centers Arrangements Under the Anti-Kickback Statute*, 72 Fed. Reg. 56,632, 56,639 (Oct. 4, 2007). A trade association commented that requiring health care centers to implement and document "reasonable, consistent, and uniform standards" provides "insufficient guidance" as well as "a chilling effect on parties' participation in safe harbored arrangements, as parties would be unsure whether their standards would satisfy the requirements of the safe harbor." *Id.* On the other hand, at least one statute defines the provider's discretion subjectively rather than objectively. *See, e.g.*, N.M. STAT. § 24-7A-7(F) (2006) ("'Medically ineffective health care' means treatment that would not offer the patient any significant benefit, *as determined by a physician*.") (emphasis added).

432. Nat'l Conference of Comm'rs on Uniform State Laws, Proceedings in Comm. of the Whole, Uniform Health-Care Decisions Act, July 30, 1993, at 141-42 (statement of Comm'r Windsor Dean Calkins). Louisiana, for example, had a unilateral decision statute in 1998 exempting providers from care that was "medically inappropriate" and "contrary to medical judgment." Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1076 (La. Ct. App. 1998). Because these terms were not defined, however, an appellate court remanded a malpractice case for further litigation to determine the standard of care. *Id.*

433. Nat'l Conference of Comm'rs on Uniform State Laws, Proceedings in Comm. of the Whole, Uniform Health-Care Decisions Act, July 30, 1993, at 144 (statement of Comm'r Michael Franck).

434. Isackson, *supra* note 290, at 11; *see also* Kapp, *supra* note 122, at 172 (noting the need for "broad consensus within the medical community" and "societal agreement").

435. *See* Bernat, *supra* note 119, at 39 (stating that the "distinction between the brain's clinical functions and brain activities, recordable electronically or through other laboratory means," was not found within the UDDA).

436. *See* Bernat, *supra* note 119, at 40.

437. *See supra* notes 214-17. There are a few narrow exceptions. For example, providing only comfort care for anencephalic infants is a well-settled standard of care. Not even the opposing experts in *Baby K* contracted this. Brief of Appellants at 15-16, *In re* Baby K, No. 93-1899 (4th Cir. 1993), 1993 WL 13123742.

Consequently, the practice of deferring to surrogate demands has become the standard of care.[438]

B. *Uncertainty from Fear of Preemption*[439]

Even if providers could be reasonably certain of compliance with state unilateral decision statutes, this clarity would provide no legal comfort to providers if unilaterally stopping LSMT violated federal law. Preemption outside the futility context remains an obstacle to state efforts to develop more rational allocation systems.[440] Preemption may similarly stand as an obstacle to the effectuation of state unilateral decision laws.

Notably, the Fourth Circuit has held that Virginia's unilateral decision statute was preempted by the Emergency Medical Treatment and Active Labor Act (EMTALA).[441] Some commentators have since suggested that the preemptive scope of EMTALA is "limited" and that the duty imposed by EMTALA "cannot be invoked to require treatment in the vast majority of futility cases."[442] After all, EMTALA does not apply to inpatients.[443] Once the

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438. *Cf.* Peter Albertson, *A 72-Year-Old Man With Localized Prostate Cancer,* 274 JAMA 69, 73 (1995) ("[T]here's an interesting catch-22—the medicolegal standard of care becomes what physicians do. If . . . physicians all [provide inappropriate treatment] . . . for fear of being sued if they don't, then eventually if enough of them do it, they'll create the truth of their fear."); Clark C. Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, 54 L. & CONTEMP. PROBS. 87, 97-98 (1991) ("Customary medical practices have evolved in the United States under systems of paying for medical care that create economic incentives for both physicians and patients to overutilize services, spending more on marginal benefits than they are in any sense worth.")

439. While this Article does not fully develop the preemption analysis under each of these statutes, Part VI.B. examines the scope of potential preemption.

440. *Cf.* Mary A. Crossley, *Medical Futility and Disability Discrimination*, 81 IOWA L. REV. 179, 181 (1995-1996) (discussing the preemption effect of the Americans with Disabilities Act on providers' attempts to ration health care).

441. *In re* Baby K, 16 F.3d 590, 597 (4th Cir. 1994).

442. THE RIGHT TO DIE, *supra* note 17, § 13.06[C] at 13-30.

443. *See* Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349, 353 (4th Cir. 1996). The court acknowledged the "legal reality" that "[o]nce EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient, who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians." *Id.* In the court's analysis, "the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt." *Id.* The court also distinguishing *Baby K* in part because that case did not focus on the temporal duration of obligation. *Id.*; *see also In re* AMB, 640 N.W.2d 262, 289 (Mich. Ct. App. 2001) (holding that there was no EMTALA violation where patient had been admitted to hospital for more than a week before withdrawal of LSMT); Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1075 n.2 (La. Ct. App. 1998) ("Agreeing with *Bryan,* we find that EMTALA provisions are not applicable to the present case.").

hospital has screened and stabilized a patient, it no longer has any obligation under EMTALA to provide medical services.[444]

While EMTALA's preemptive scope is circumscribed, the restrictions that it continues to impose on the scope and applicability of state unilateral decision statutes remain noteworthy. In particular, while the requisite treating period under EMTALA is limited, it is significant under the circumstances in which medically inappropriate care is often requested.[445] Specifically, EMTALA does not apply to inpatients; however, the subjects of many futility disputes were not inpatients. For example, in *Baby K,* by the time Fairfax Hospital sought declaratory relief, Baby K had already been transferred to a nursing home.[446] Yet over the next four months, she returned to the hospital three times due to breathing difficulties.[447] This status is even more common among adult patients, who are transferred from nursing homes to hospitals upon the occurrence of an acute event.[448] Furthermore, in similar circumstances, unilateral decisions to stop LSMT may be preempted by competing obligations under other federal statutes, including the following: (1) the Americans with Disabilities Act,[449] (2) section 504 of the Rehabilitation Act of 1973,[450] and (3) the Child Abuse Prevention and Treatment Act.[451]

C. Uncertainty from Fear of Unconstitutionality

Generally, there is little guidance regarding which state futility statutes violate the U.S. Constitution, because futility disputes are rarely litigated and

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444. 42 C.F.R. § 489.24(d)(2) (2007).

445. *See* Fletcher, *supra* note 10, at S:230 (expressing concerned about patient who spent "seventeen days in intensive care").

446. *Baby K*, 16 F.3d at 593; *In re* Baby K, 832 F. Supp. 1022, 1024-27 (E.D. Va. 1993).

447. *Baby K*, 16 F.3d at 593; *Baby K*, 832 F. Supp. at 1024-25. It is unclear whether Baby K was discharged from the nursing home and presented at the emergency department of the hospital or was transferred from the nursing home to the hospital. Regardless, EMTALA would be triggered in either case. *Baby K*, 16 F.3d at 594-95 n.6 (citing 42 U.S.C. § 1395dd(g)).

448. *See, e.g.*, Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1073 (La. Ct. App. 1998) ("Having suffered cardiorespiratory arrest, Sonya Causey was transferred to St. Francis Medical Center (SFMC) from a nursing home."); *Barriers*, *supra* note 22, at 16 (reporting "an increasing number of terminally ill nursing home patients coming to the emergency department . . . when they experience life threatening symptoms"). Spiro Nikolouzos was transferred from St. Luke's Hospital to Avalon Place, a nursing home, but then back to Southeast Baptist Hospital after he developed pneumonia; Southeast Baptist sought to unilaterally terminate care. Ackerman, *supra* note 344, at B5.

449. *See Baby K*, 832 F. Supp. at 1027-28; Bopp & Coleson, *supra* note 45, at 842-44; Crossley, *supra* note 440, at 202-05.

450. *See Baby K*, 832 F. Supp. at 1026-27; Bopp & Coleson, *supra* note 45, at 842.

451. *See* Montalvo v. Borkovec, 647 N.W.2d 413, 419 (Wis. Ct. App. 2002); Sadath A. Sayeed, *Baby Doe Redux? The Department of Health and Human Services and the Born-Alive Infants Protection Act of 2002: A Cautionary Note on Normative Neonatal Practice*, 116 PEDIATRICS e576, e580-81 (2005).

courts tend to avoid deciding constitutional questions. Nevertheless, limited accounts of judicial treatment and academic legal commentary suggest that there is a reasonable risk of unconstitutionality for some unilateral decision statutes.

Where surrogate insistence on treatment is based on "religious convictions," the unilateral termination of LSMT may implicate the patient's First Amendment rights.[452] Where the patient is a prisoner, unilateral termination of LSMT could implicate the Eighth Amendment prohibition against cruel and unusual punishment.[453] Further, some have argued that unilateral termination is inconsistent with equal protection,[454] the right to life,[455] and the freedom of expression.[456]

Some litigants and commentators have even argued that the unilateral termination of LSMT would effectively constitute a usurpation of the patient's fundamental right to refuse LSMT.[457] However, to the extent that *Cruzan* established such a constitutional right, it is probably only a negative right to be free from unwanted treatment, not an affirmative right to LSMT.[458] Nevertheless, more than one court has held that the Fourteenth Amendment Due Process Clause prohibits unilaterally stopping LSMT.[459]

In any case, there is state action and a constitutionally protected interest in life is at stake.[460] Therefore, the procedures attendant to the deprivation of this

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452. *Baby K*, 832 F. Supp. at 1029; *see also* Darren P. Mareiniss, *A Comparison of* Cruzan *and* Schiavo*: The Burden of Proof, Due Process, and Autonomy in the Persistently Vegetative Patient*, 26 J. LEGAL MED. 233, 252-53 (2005) (presenting the argument that the very concept of futility might offend one's belief in faith healing and the absolute sanctity of life).

453. George P. Smith, II, *Futility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Punishment*, 12 J. CONTEMP. HEALTH L. & POL'Y 1 (1995).

454. Bopp & Coleson, *supra* note 45, at 837-39.

455. *Id.* at 839-40.

456. *Id.* at 841-42.

457. *See, e.g.*, Rideout v. Hershey Med. Ctr., 30 Pa. D. & C.4th 57, 62 (Dauphin County Ct. C.P. Dec. 29, 1995) (No. 872S1995), 1995 WL 924561 (reasoning that hospital had violated the constitution and usurped the patient's interest in her own life when the hospital unilaterally disconnected her life support).

458. *See* Johnson v. Thompson, 971 F.2d 1487, 1495 (10th Cir. 1992) (citing DeShaney v. Winnebago County Dep't Soc. Servs., 489 U.S. 189, 195 (1989)); Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695 (D.C. Cir. 2007), *cert. denied* No. 07-444, 2008 WL 114305 (Jan. 14, 2008); Mareiniss, *supra* note 452, at 251, 258.

459. *See In re* Baby K, 832 F. Supp. 1021, 1030 (E.D. Va. 1993) ("A parent has a constitutionally protected right to 'bring up children' grounded in the Fourteenth Amendment's due process clause. . . . [and] '[w]hen parents do not agree on the issue of termination of life support . . . this Court must yield to the presumption in favor of life.'"); *Rideout*, 30 Pa. D. & C.4th at 83-84 (allowing parents to assert right to life claim on behalf of child because "their privacy-based rights were violated under both state and federal constitutions").

460. Thaddeus Mason Pope, *Hospital Ethics Committees as a Forum of Last Resort under The Texas Advance Directives Act: A Violation of Procedural Due Process* (unpublished

interest must provide sufficient protection from error or abuse.[461] At a minimum, the surrogate must be afforded proper notice, an opportunity for a meaningful hearing, and access to an impartial tribunal.[462] Otherwise, unilateral termination could violate procedural due process.[463]

In sum, unilateral decision making may be constrained by constitutional and federal statutory constraints. Determining the parameters of those constraints merits further legal analysis. Yet, regardless of the nature of those constraints, they are not deterring Texas providers from making unilateral decisions to stop LSMT.[464] Therefore, it seems that somewhere deep in the heart of Texas lies the answer to making other state unilateral decision statutes more effective.

VII. SOLUTIONS: MAKING THE SAFE HARBOR NAVIGABLE

Because the unilateral decision statutes are too vague and open-ended, their purported safe harbors are not navigable. Can we make them more navigable? Can we reduce the uncertainty? There are two alternatives: (1) make the statutory standards concrete and precise or (2) abandon substantive standards altogether and use a purely process-based approach, like that used in Texas.[465]

A. Eliminating Uncertainty with Precise Standards

Consensus on precise, substantive, and legislatable measures of medical inappropriateness has proven unachievable.[466] Perhaps this should not be too surprising. Very few areas of medicine have professional standards that are "sufficiently mandatory and concrete" to operate as a safe harbor.[467] Rarely do providers have what is necessary for immunity: "a precise and plain statement of the acceptable medical practice."[468] Instead, professional standards are typically set "*ex post* by selectively drawn expert witness testimony."[469]

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manuscript) (on file with author).

461. Kwiecinski, *supra* note 331, at 347.

462. *Id.*

463. *See id.* at 345-47.

464. *See supra* note 404-08 and accompanying text.

465. *Cf.* John E. Calfee & Richard Craswell, *Some Effects of Uncertainty on Compliance with Legal Standards*, 70 VA. L. REV. 965, 999-1000 (1984) (proposing that the uncertainty may be reduced by an enhanced fact-finding process, the promulgation of enforcement guidelines, or the implementation of a bright-line test).

466. *See supra* notes 214-17 and 423-37 and accompanying text.

467. *See* Hall, *supra* note 246, at 121, 127-28, 144-45.

468. *Id.* at 134.

469. Blumstein, *supra* note 172, at 1028; *see also* Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1075-76 (La. Ct. App. 1998) (holding that because the statute failed to define "medically inappropriate" and "medical judgment," the case had to be sent to a medical review panel to determine the appropriate standard of care).

If doctors cannot achieve even professional consensus, they are even less likely to achieve the social consensus necessary for legislation.[470] Therefore, it seems that only a pure process-based approach like that adopted in Texas could be effective in inducing the conduct that the futility statutes intended.[471]

B. The Texas Pure Process Approach

In Texas, when a provider refuses to honor a surrogate's request for continued LSMT, the provider must commence a multi-stage review process. LSMT must be provided during this review process.[472] The first stage entails an ethics committee review of the attending physician's determination.[473] The surrogate must be notified of the ethics committee review process at least forty-eight hours before the committee meets.[474] The surrogate is also entitled to attend the meeting and to receive a written explanation of the committee's decision.[475]

If the ethics committee agrees with the treating physician that LSMT is inappropriate, the provider must attempt to transfer the patient to another provider that is willing to comply with the surrogate's treatment request.[476] The provider is obligated to continue providing LSMT for ten days after the surrogate is given the ethics committee's written decision.[477] If the patient has not been transferred or granted an extension, then the provider may unilaterally stop LSMT on the eleventh day.[478]

When the Texas Advance Directives Act (TADA) first went to Governor Bush in 1997, he vetoed the bill because it "eliminate[d] the objective negligence standard for reviewing whether a physician properly discontinued the use of life-sustaining procedures."[479] However, replacing the objective

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470. Perhaps with the growth of palliative care and greater awareness of resource limitations, our culture will become less death-defying and more reluctant to conclude that more is better.

471. *House of Delegates Action*, *supra* note 53, at 91 (referencing the Wisconsin Medical Society Resolution 1-2004, which "support[s] the passage of state legislation which establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care, modeled after the Texas Advance Directives Act of 1999").

472. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a) (Vernon 2003).

473. *Id.*

474. *Id.* § 166.046(b)(2).

475. *Id.* § 166.046(b)(4). The surrogate is also entitled to a copy of a registry with the name of providers willing to accept the patient upon transfer. *Id.* § 166.046(b)(3)(B).

476. *Id.* § 166.046(d).

477. *Id.* § 166.046(e). A court may extend this time period only if "there is a reasonable expectation" that a transfer can be made. *Id.* § 166.046(g).

478. *Id.* § 166.046(e) ("The physician and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after the written decision . . . .").

479. Tex. Legis. J. 4926 (June 20, 1997), *vetoing* Tex. S. Bill 414, 76th Leg. (1997); *see also* Interim Report, *supra* note 113, at 33-34 (referencing Governor Bush's veto proclamation of the first TADA).

standard of negligence with measurable procedures was precisely the point, as reflected in the 1999 legislation that Bush did sign:

> A physician, health care professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person's appropriate licensing board if the person has *complied with the procedures* outlined in Section 166.046.[480]

Unlike the UHCDA and other unilateral decision statutes which specify vague substantive standards such as "significant benefit," the safe harbor of TADA is defined solely in terms of process.[481] Texas providers who follow TADA's prescribed notice and meeting procedures are therefore immune from disciplinary action and civil and criminal liability.[482] Because the statute's requirements are concrete and measurable, there is little, if any, uncertainty of compliance.

The TADA is far from perfect. Ten days may not be a reasonable or sufficient time for surrogates to locate an alternative facility willing to accept the patient.[483] There may be procedural due process implications by placing the ultimate decision in the hands of an institutional ethics committee, which is comprised of physicians and administrators who look to the hospital for their economic livelihood.[484] However, these mechanics of the TADA process can and are being considerably refined.[485] The TADA demonstrates that a pure process approach works and that such an approach now serves,[486] and should continue to serve, as a model for other states.

CONCLUSION

Unilateral decision statutes provide the legal protection that health care providers have long sought for their hospital futility policies. Yet without more

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480. TEX. HEALTH & SAFETY CODE ANN. § 166.045(d) (emphasis added).

481. *See* Iliana L. Peters, *Perspectives on the Texas "Medical Futility Statute," as Amended in 2003*, HEALTH LAW. WKLY., Oct. 22, 2004, *available at* http://www.ahla.org/hlw/issues/041022/041022_a_art_01_Peters.cfm ("Importantly, the statute does not attempt to define 'medical futility.' Any attempt to do so might result in a definition that is either too broad or too narrow.").

482. TEX. HEALTH & SAFETY CODE ANN. § 166.045(d); *see also* Truog & Mitchell, *supra* note 98, at 20 ("Clinicians in Texas may therefore be much more confident and bold in applying the policy, knowing that they are protected by the law.").

483. *Hearing on S.B. 439 Before the S. Comm. on Health and Human Servs.*, 80th Leg. (Tex. 2007).

484. *Id*; *see also Hearings on Advance Directives Before the H. Comm. on Public Health*, 80th Leg. (Tex. 2007); Burns & Truog, *supra* note 214, at 1990-91; Pope, *supra* note 460.

485. *See, e.g.*, S.B. 439, 80th Leg. (Tex. 2007) (amendments relating to advance directives and health care and treatment decisions).

486. State medical societies in Wisconsin and North Carolina have formally considered recommending TADA-type statutes to their state legislatures.

precise formulation, this authority is only illusory. The illusion will remain until there is consensus on (1) the proper ends of medicine, (2) the acceptable criteria for rationing, and (3) the legitimate restrictions on patient autonomy. Such consensus is not imminently forthcoming, however. In the meantime, providers and policymakers should look to Texas's pure process approach as a model, just as California, Vermont, and other states look to Oregon for guidance on physician-assisted suicide legislation.