1993

Medical Futility: Has Ending Life Support Become the Next Pro-Choice/Right to Life Debate

Daniel Robert Mordarski

MEDICAL FUTILITY: HAS ENDING LIFE SUPPORT BECOME THE NEXT "PRO-CHOICE/RIGHT TO LIFE" DEBATE?[1]

I. INTRODUCTION

In the 1970's, a movement was initiated by the family of Karen Ann Quinlan to recognize that patients and families have a right to decide whether treatments may be legally and ethically withheld from a person in a permanent vegetative state.[2] This family's legal struggle spawned a new "right," based on the doctrines of patient autonomy and personal privacy, which has become known as the "right to die."[3] In the early right to die cases, the state[4] or

---

[1]The author gained much of his knowledge and experience in medical futility while working in the law department of University Hospitals of Cleveland. The author would like to express his deepest gratitude to James J. McMonagle and the other talented attorneys in the law department for the invaluable instruction, guidance and opportunities they granted.

[2]*In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, Granger v. New Jersey, 429 U.S. 922 (1976).

[3]*See generally* Gray v. Romeo, 697 F. Supp. 588 (D.R.I. 1988); Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986); Bartling v. Glendale Adventist Medical Center, 229 Cal. Rptr. 360 (Ct. App. 1986); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re* Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978), *overruled by In re* Spring, 399 N.E.2d 493 (Mass. App. Ct. 1979); Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978); *In re* Jobes, 529 A.2d 434 (N.J. 1987); *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976); *In re* Storar, 420 N.E.2d 64 (N.Y.), *cert. denied*, Storar v. Storar, 454 U.S.

physician/medical facility[5] zealously asserted that the withdrawal of life support systems or the withdrawal of food and hydration from a patient would be legally, ethically and medically inappropriate.[6] However, when the judiciary addressed this delicate matter, it examined the important interest in protecting life and keeping patients alive, and it determined that the right of each person to control his or her own destiny could override the state's or the physician's interest in maintaining the external life support mechanisms.[7]

Two decades later, the pendulum has swung the other way. Physicians have acceded to, and now advocate, the withholding or withdrawing of external life support or food and hydration from patients who are in a prolonged vegetative state.[8] The justification for this advocacy is that these therapies are futile, and that the prolonging of the patient's life is nothing more than a prolongation of the biological organism and not the prolongation of a "life."[9] This position is analogous to the position put forward in *Quinlan*[10] and while ethically and morally sound, it becomes murky and enigmatic when it is the *physician* who wants to terminate the life support and it is the *family* who wants the life support to be continued.[11] Herein lies the genesis of what has come to be known as medical futility.

The concept of medical futility presents two major ethical[12] issues that have tremendous legal ramifications: first, whether a physician may ethically and legally determine that a certain therapy or intervention is medically futile, and second, whether the physician may unilaterally or against the wishes of the patient or family decide to withhold, withdraw or not offer that therapy or intervention.

---

858 (1981).

[4] *Gray*, 697 F. Supp. 588 (state hospital); *Saikewicz*, 370 N.E.2d 417 (state facility for mentally ill); *Quinlan*, 355 A.2d 647 (cross appeal from declaratory judgment by Attorney General).

[5] *Bouvia*, 225 Cal. Rptr. 297; Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d 626 (Mass. 1986); Dinnerstein, 380 N.E.2d 134; *Lane*, 376 N.E.2d 1232; *Jobes*, 529 A.2d 434 (nursing home); *Conroy*, 486 A.2d 1209 (nursing home); *Storar*, 420 N.E.2d 64.

[6] *See* cases cited *supra* note 5.

[7] *See* cases cited *supra* note 5.

[8] American Thoracic Soc'y, *Withholding and Withdrawing Life-Sustaining Therapy*, 115 ANNALS INTERNAL MED. 478 (1991) [hereinafter American Thoracic Soc'y].

[9] *Id.*

[10] *Quinlan*, 355 A.2d 647.

[11] *In re* Helga Wanglie, No. PX-91-283 (Hennepin County, Minn., 4th Dist. Ct., P. Ct. Div. July 1, 1991) (unreported opinion).

[12] While the issue of medical futility envelops a wide array of issues (including economic issues of who will pay for futile treatments) this note will focus on the ethical issues of health care providers unilaterally deciding that certain treatments are futile.

These ethical/legal quandaries are best exemplified by two paradigms of medical futility.[13] The first is a situation in which a physician wishes to withdraw a therapy that the physician believes is futile, but her wish goes against the desires of the family.[14] The second situation arises when a physician determines that cardiopulmonary resuscitation (CPR) would be futile and wishes to write a do-not-resuscitate (DNR) order without obtaining the consent of or even notifying the family[15] or surrogate decisionmaker.[16] In each case, the physician is disregarding the doctrines of patient autonomy and self determination and is assuming the role of the decisionmaker. However, this

---

[13]The concept of medical futility has been analyzed in depth with regard to whether physicians must treat genetically handicapped infants when the treatment will be more harmful than beneficial or when the infant will die soon, regardless of the treatment. *See* Abigail L. Kuzma, *The Legislative Response to Infant Doe*, 59 IND. L. J. 377 (1983); John M. Maciejczyk, *Withholding Treatment from Defective Infants: "Infant Doe" Postmortem*, 59 NOTRE DAME L. REV. 224 (1983). Some authors have also suggested that the issue of medical futility may be expanded by the technology used for organ transplants. Robert D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560 (1992). "Extracorporeal membrane oxygenation can replace heart and lung function for up to several weeks. Physicians now use this intervention when they expect organ systems eventually to recover or while they await organs for transplantation. However, it could prolong the life of almost anyone with cardiorespiratory failure, reversible or not. Care givers do not now offer this therapy to terminally ill patients, presumably because it would be futile. This judgment has gone largely unchallenged . . . ." *Id.* at 1561.

[14]This type of medical futility issue is exemplified by the case of Helga Wanglie. *In re* Helga Wanglie, No. PX-91-283. Mrs. Wanglie was placed on a respirator and, after an extended period of time, the medical staff at Hennepin County Medical Center declared that the respirator was a futile therapy. *See* Ronald E. Cranford, *Helga Wanglie's Ventilator*, HASTINGS CENTER REP., July-Aug. 1991, at 23. The medical center then informed the family that they wanted to terminate the respirator, but the family vehemently refused. *Id.*

[15]Throughout this note, the word family shall be interchanged with the term "surrogate" or "decisionmaker." This use of the word family is not a judgment that only families can serve as surrogate decisionmakers, but rather, it is used merely out of convenience since most surrogate decisionmakers tend to be family members of the incompetent patient. For the issues of the validity of surrogate decisionmaking and who should serve as a surrogate decisionmaker, see generally Michelle Yuen, Comment, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581 (1992).

[16]When a physician believes that cardiopulmonary resuscitation (CPR) should not be used on a certain patient (because of the age of the patient or the advanced stage of a terminal disease), the physician may write a do-not-resuscitate (DNR) order which indicates to the medical staff that CPR and other life saving procedures should not be initiated when the patient expires. *See* AMERICAN MED. ASS'N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders*, 265 JAMA 1868 (1991) [hereinafter AMA]. It is generally agreed that family should participate in decisions regarding the use of resuscitation or the issuance of a DNR order. *Id.* However, some physicians have advocated that, as experts in the field of medical science, physicians can unilaterally determine that CPR is futile and consequently, physicians need not even offer or discuss CPR as an option to the patient or family. *See* Leslie J. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281 (1987).

usurping of the family's decisionmaking ability is precisely what the courts prohibited in previous right to die cases.[17] If a family has the right to make the decision to end a loved one's life support, a family should have the same right to make the decision of whether to continue life support.

This note will provide an analysis of the issue of medical futility and propose "solutions" to the issue. Part II considers the definition of "medical futility" and different ways to view the concept. In Part III, the position is forwarded that medical futility is not actually a medical question, but rather, a question of values which the medical profession is not necessarily more qualified than a layperson to answer. In Part IV, medical futility will be examined in the context of existing law. The *Wanglie*[18] case, which has generated a great deal of attention to the issue of medical futility, is discussed. This section also addresses the potential tort liability of a health care provider who unilaterally takes certain actions based on the concept of medical futility, as well as the potential constitutional challenges that may be advanced by a patient or her family. This section also suggests that the courts should recognize a common law right to self-determination which would permit patients to continue on life support.

Finally, Part V presents "solutions" to the conundrum of medical futility. Because of the intricate emotional and value laden issues surrounding medical futility, it is concluded that the issue of medical futility can best be addressed and resolved by communication between all the parties involved. Consequently, each solution is focused on requiring open communication from the parties. The first solution to medical futility involves the Patient Self-Determination Act[19] which encourages every person to execute a living will before she becomes incompetent. The second proposed solution mandates that the medical community promote a policy of open communication concerning the futility of certain treatments. This obligation to use open communication should begin in medical school and should extend to the policy and procedure manuals of all medical institutions. If the medical community is unable or unwilling to establish procedures for communication regarding medical futility, the legislature should establish procedures for handling medical futility confrontations. This note recommends a statutory framework to provide the best legislative solution to the issue.

It should be stressed that this note does not encourage the continuation of life support of a patient who is terminally ill or in a persistent vegetative state. Nor does it favor or encourage the administration of CPR on patients who are terminally ill or extremely elderly. This note does, however, support the proposition that decisions concerning life support and the use of CPR should be made by the people who are best able to make these decisions in accordance with the patient's wishes and beliefs: the patient or family.

---

[17] *See* cases cited *supra* note 3.

[18] *In re* Helga Wanglie, PX-91-283.

[19] Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751 (codified in scattered sections of 42 U.S.C., especially §§ 1395, 1396 (West Supp. 1991)).

II. WHAT IS MEDICAL FUTILITY?

"Medical futility refers to a physician's conclusion that a therapy will be of no value to the patient and should not be prescribed."[20] The medical futility issue contains two basic inquiries. The first issue is philosophical: whether physicians, on scientific grounds alone, can determine what treatments are futile.[21] The second issue is ethical: whether physicians, once they determine that a treatment is futile, have an obligation to offer that treatment or can unilaterally withhold or withdraw the treatment.[22] In an attempt to analyze and understand the different facets of medical futility, Dr. Steven Miles suggests that futility can be divided into four clinical usages.[23]

The first clinical usage of medical futility is physiological futility. Physiological futility has been defined as a treatment that "is clearly futile in achieving its physiological objective and so offers no physical benefit to the patient [and consequently] the professional has no obligation to provide it."[24] The most basic example of physiological futility is the use of antibiotics for a viral infection. Since antibiotics destroy only bacteria and do not affect viruses, the use of an antibiotic for such an infection would provide no physiological benefit to the patient.[25] This note argues that because physiologic futility is entirely a scientific, medical question, this is the only category of medical futility that physicians can unilaterally withhold from patients without violating their duty to those patients. This note will focus on those situations which have been classified as medical futility but in reality should not be included under such a label because they are not completely within the expertise of the medical profession.[26]

The second clinical usage of futility concerns those therapies and treatments that are considered non-beneficial.[27] These therapies may provide important physiologic benefits to keep the human organism alive, but the therapy is non-beneficial to the patient as a person.[28] A patient in a permanent vegetative

---

[20]Steven H. Miles, *Medical Futility* 1 (Jan. 11, 1992) (unpublished manuscript, on file with the *Cleveland State Law Review*).

[21]Daniel Callahan, *Medical Futility, Medical Necessity: The-Problem-Without-a-Name*, HASTINGS CENTER REP., July-Aug. 1991, at 30, 31.

[22]*Id.*

[23]*See generally* Miles, *supra* note 20.

[24]Truog *supra* note 13, at 1560, 1561.

[25]*See* ERNEST JAWETZ ET AL., REVIEW OF MEDICAL MICROBIOLOGY 157 (1987).

[26]Throughout this note the term "medical futility" will carry a legal definition which refers to a situation in which a health care professional wishes to make a unilateral health care decision without the consent or against the wishes of the patient or the patient's surrogate decisionmaker.

[27]*See* Miles, *supra* note 20, at 2.

[28]*See* AMA, *supra* note 16.

state (PVS) who has renal failure will receive physiological benefit from dialysis treatments.[29] However, these dialysis treatments will be non-beneficial to the patient as a person since the treatment will serve only to keep the biological organism alive and not ameliorate the cause of the PVS, nor enable him to regain consciousness.[30] Included under this argument are therapies that provide a physiological benefit to the living organism, but cause "vastly disproportionate iatrogenic harms."[31] An example of such a therapy is the rigorous and aggressive treatment of babies who are in constant pain and are terminally ill.[32] In this situation, the treatment itself causes more pain and suffering than benefit.[33]

The third proposed clinical category for medical futility is unlikely therapy. These "are therapies which are very unlikely to produce a desired physiologic or personal benefit."[34] Unlikely therapies are based on probabilities, and when the probability of success of the therapy falls below a certain point, physicians often deem the use of the therapy as futile.[35] An example of such a therapy is the use of a brain scan to rule out the minuscule chance of brain cancer for a patient who suffers from tension headaches which subside with rest and stress management.[36] While unlikely therapies are based on probabilities, Dr. Steven H. Miles argues that a uniformly accepted "low probability may be objectively determined," and therefore the decision not to use unlikely therapies is not based on the whim of each physician.[37]

The final proposed clinical category of medical futility is non-validated, but plausible therapy. Dr. Miles provides an example of an insurer who refused to pay for a bone marrow transplant to treat a patient who had breast cancer which had metastasized to the patient's eyes and liver.[38] The insurer considered the operation non-validated even though a clinician estimated that it might give the patient a 20% chance for years of survival.[39] This non-validating category of medical futility is based primarily on the financial considerations of medical futility. If the third-party payor believes that a certain

---

[29] *See generally* RUTH MEMMLER ET AL., THE HUMAN BODY IN HEALTH & DISEASE 317 (1992); Phyllis S. Dunetz, *If Your Med/Surg Patient is on Dialysis*, 55 RN 46 (1992).

[30] *See* American Thoracic Soc'y, *supra* note 8.

[31] *See* Miles, *supra* note 20, at 2.

[32] *See generally* Kuzma and Maciejczyk, *supra* note 13.

[33] *See* Kuzma and Maciejczyk, *supra* note 13.

[34] *See* Miles, *supra* note 20, at 2.

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.*

therapy is futile or "non-valid," the insurance company will not pay for the procedure. In this sense, the procedure is not rendered futile by the medical community, but by the financial community who has decided not to pay for a procedure with a very low success rate.[40]

In the four clinical usages of medical futility, there are three categories that should not be classified as medical futility: non-beneficial, unlikely and non-validating therapies. The decision to withhold these types of therapies is a value judgment relating to cost, rather than a physician's value judgment on the scientific possibility of achieving the patient's goals. Non-beneficial therapies do provide physiologic benefit to the patient, but these therapies are too costly or the resources used are too rare to be used in the given situation.[41]

Unlikely therapies are not medically futile because the therapy may actually achieve its desired effect (i.e., rule out the possibility that the patient's headaches are caused by brain cancer).[42] As a medical community and as a society, we have made a value decision to make certain resource allocations.[43] One value decision that the medical community has made is that it is not worth the time, expense and inconvenience to order a brain scan for every patient who has a tiny chance of having brain cancer and whose ailment subsides with other treatment.

In addition, therapies that are considered medically futile because they are non-validated are, by their nature, nothing more than economic value judgments made by the party paying the medical bills.[44] These three types of decisions are not a decisions that fall within the expertise of medical science, but rather, are cost/benefit value judgments that are being made for purely financial reasons. While these types of decisions are probably prudent and economically wise value judgments, they should not be disguised under the over-reaching umbrella of medical futility.[45]

Physiological futility is the only category that may truly be called medically futile and is the only uniformly agreed upon, value-free understanding of the concept.[46] Physiological futility is the only category that contains decisions that are completely within the realm of special knowledge held by medical professionals. This form of futility does not consider the financial burdens

---

[40]The issue of who pays for medical futility is an important issue but one that is much too expansive and complex to adequately address in this note. For a brief discussion on who will pay for medical futility, see Michael A. Rie, *The Limits of a Wish*, HASTINGS CENTER REP., July-Aug. 1991, at 24, 26.

[41]*See* Miles, *supra* note 20.

[42]*Id.*

[43]*See* Truog, *supra* note 13, at 1562.

[44]*See* Rie, *supra* note 40.

[45]Felicia Ackerman, *The Significance of a Wish*, HASTINGS CENTER REP., July-Aug. 1991, at 28.

[46]*See* Truog, *supra* note 13, at 1561.

imposed by or the difficulties of administering the therapy, but rather, physiological futility rests on the scientific determination that a certain therapy will be physiologically ineffective. Therapies that are withheld on the grounds that they are non-beneficial, unlikely or non-validating should not be withheld under the guise of medical futility; they should be withheld for the proper reason.[47] Such "assertions of futility may camouflage judgments of comparative worth that are implicit in debates about the allocations of resources."[48] It should be openly stated that the therapy is being withheld because of the economic values of society, the medical community, third party payers or the wishes of the family or patient.

In an attempt to put concrete labels on extremely difficult issues, some authors have divided medical futility into neat and organized packages that can easily be placed in a metaphysically 'proper' place on a shelf.[49] However, these labels and categories do little more than wedge the volatile issues of medical futility into a Procrustean bed.[50] The over-definition of these terms does not make this problem any easier to address; it only makes the problem more difficult by obfuscating and camouflaging the issue.[51] More emphasis needs to be placed on addressing the underlying issue and fostering communication between the doctor and patient, rather than affixing well-intentioned, but meaningless labels on the issue.

III. Is Medical Futility a Medical Question?

The dilemma of medical futility often raises more questions of values rather than technical, medical questions. When parties dispute the decision to maintain a permanently unconscious patient on a respirator, they do not dispute whether the respirator will prolong the patient's life; they dispute whether the life is worth prolonging.[52] Such a dispute is not about medical technology, where doctors can be presumed to have more knowledge than a layperson. It is about the values of each person individually and the values of society as a whole.[53] For example, one rationale for declaring that the

---

[47] *See* Ackerman, *supra* note 45.

[48] *See* Truog, *supra* note 13, at 1563.

[49] *See* Miles, *supra* note 20. *But see* Callahan, *supra* note 21, at 30 (discouraging the use of labels for the issue of medical futility).

[50] Procrustes was a mythical Greek giant who forced his captives to lie down on one of his two beds. OXFORD CLASSICAL DICTIONARY 881 (5th ed. 1970). If the captive was too tall for the bed, Procrustes chopped off part of the captive until he fit in the bed. *Id.* If the captive was too short for the bed, Procrustes stretched the captive until he fit in the bed. *Id.* Ironically, Procrustes was killed in the same manner by Theseus, one of the great heroes of Greek mythology. *Id.*

[51] *See* Truog, *supra* note 13.

[52] *See* Ackerman, *supra* note 45, at 28.

[53] *Id.*

prolonging of life in an unconscious state is futile is that even if the patient does recover consciousness, the patient will most likely be severely disabled.[54] Such an argument is a blatant value judgment about the quality of life.[55] While it is within the realm of a physician's expertise to predict that a patient who recovers from a prolonged unconscious state will be paralyzed or blind, it is not within the physician's expertise to say scientifically that such an existence is not worth pursuing.[56] Thousands of blind, deaf and paralyzed people find their lives to be fulfilling and worth living.[57] "It is . . . presumptuous and ethically inappropriate for doctors to suppose that their professional expertise qualifies them to know what kind of life is worth prolonging . . . ."[58] There is "a sharp distinction . . . between scientific knowledge on the one hand, and moral and political judgments on the other; no social 'ought' can be drawn from a scientific 'is.'"[59]

This distinction between a doctor making a decision based on scientific knowledge and a doctor making a decision based on her own values is also evident in a situation in which a physician wishes to write a DNR order without consultation with the patient or the patient's family. In this situation, the effectiveness of CPR is often judged on the basis of whether the patient would survive long enough to be discharged from the healthcare facility.[60] Using her individualized definition of futility, a physician may decide to write a DNR order for a patient who she thinks will never be discharged.[61] "Patients and families may value additional hours of life differently however."[62] For some patients, surviving in a hospital bed for an additional week, in excruciating pain, may be tolerable and quite worth the fight.[63] This additional week may give some patients the opportunity to resolve personal conflicts, to partake in religious ceremonies, to arrange financial dealings, to say good-byes to family

---

54 *Id.* (citing PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIOR RESEARCH, DECIDING TO FORGO LIFE-SUSTAINING TREATMENT (1983)).

55 *Id.*

56 *Id.*

57 *Id.*

58 *See* Ackerman, *supra* note 45.

59 *See* Callahan, *supra* note 21, at 31.

60 J. Chris Hacker & F. Charles Hiller, *Family Consent to Orders Not to Resuscitate: Reconsidering Hospital Policy*, 264 JAMA 1281 (1990).

61 *Id.*

62 *See* Truog, *supra* note 13, at 1561.

63 *See* Stuart J. Youngner, *Who Defines Futility?*, 260 JAMA 2095 (1988).

and friends,[64] to wait for the arrival of a loved one from another city,[65] to see the birth of a new grandchild,[66] or even cast their vote for the president of the United States.[67] In this instance, only the patient can decide whether CPR is futile or whether surviving in a hospital bed, in tremendous pain for a few more days, would be worth the resuscitation efforts.

Not only are physicians outside the scope of their expertise in determining if a life is worth prolonging, a physician should also be dissuaded from making unilateral health care decisions for her patients because physicians have been proven to be generally poor predictors of the success of therapeutic interventions.[68] The medical community has been amazed by miraculous recoveries from "irreversible" vegetative conditions.[69] While it is conceeded that these recoveries are miracles and statistically insignificant, it does raise a question of how heavily society should rely on statistical cut-offs. While one physician may determine that a certain treatment is futile if the patient has only a three percent chance of survival, another practitioner may believe that the same treatment is futile if the patient has a five percent chance of survival.[70] In such a hypothetical, a patient with a four percent chance of success is in a precarious position. If she chooses the second physician, the treatment will be deemed futile and will not be offered, but if she chooses the first physician, the treatment will not be considered futile and may be offered.[71] To protect against such an anomaly, some physicians suggest that a "treatment should be

---

[64] *Id.*

[65] *Id.*

[66] *Id.*

[67] A 74 year old, hospitalized patient told his wife that he wanted to be kept alive until he could cast his absentee ballot for Bill Clinton in the 1992 presidential election. Vic Gideon, *A Candidate to Die For.* (WENZ FM 107.9 radio broadcast, Oct. 21, 1992, Cleveland, Ohio) (transcript on file with the *Cleveland State Law Review*).

[68] Physicians are often highly unreliable in estimating the success of certain therapies and treatments. *See, e.g.*, Arthur S. Elstein, *Clinical Judgment: Psychological Research and Medical Practice*, 194 SCIENCE 696 (1976); Amos Tversky & Daniel Kahneman, *Judgment Under Certainty: Heuristics and Biases*, 185 SCIENCE 1124 (1974); Roy M. Poses et al., *The Answer to "What Are My Chances Doctor?" Depends on Whom is Asked: Prognostic Disagreement and Inaccuracy for Critically Ill Patients*, 17 CRITICAL CARE MED. 827 (1989).

[69] *See* Carol DeMare, *"Hopeless" Hospital Patient, 86, Comes out of Coma*, ALBANY TIMES UNION, April 12, 1989 at A-1. (After the family received a court order to remove the feeding tubes from a patient who was in a purportedly "irreversible vegetative state" for five and a half months, the 86 year old patient regained consciousness.); W.F.M. Arts et al., *Unexpected Improvements After Prolonged Posttraumatic Vegetative State*, 48 J. NEUROLOGY, NEUROSURGERY & PSYCHIATRY 1300 (1985) (Doctors were amazed by the recovery of a patient who was in a vegetative state for over two and a half years.).

[70] *See* Youngner, *supra* note 63.

[71] *Id.*

considered futile when 100 consecutive patients do not respond to it."[72] The flaw with this proposal is that it is also necessary to determine how similar the patients are in age, disease, progression of disease and other types of complicating medical ailments.[73]

While this note advocates that the ultimate decision on a question of futility should be left to the patient, the volatile issue arises of whether society can force a physician to provide or continue a therapy that the physician believes to be morally and ethically repugnant.[74] "[P]hysicians and other care givers have a legitimate interest in seeing that their knowledge and skill are used wisely and effectively."[75] It would be an anathema to modern society to propose that we could somehow pressure or force a surgeon to perform operations that the surgeon believes inappropriate. Not only would such a suggestion border on involuntary servitude,[76] but the medical community "would certainly suffer a loss of dignity and a sense of purpose."[77] If society attempted to force a physician to perform CPR on a patient when the physician believed CPR was inappropriate or harmful, the health care system would be converted from a healing and therapeutic system to a battle of rebuffed professionals looking for respect rather than looking to help and heal society.

In this respect, the courts have held that the right to refuse medical treatment is not absolute when it impinges on the ethical rights of the medical community.[78] The solution for protecting the ethical rights of the medical community was to permit the patient to be transferred to another provider who would follow the patient or family's wishes.[79] In the right to die cases, this was a viable solution because many health care providers were available who would follow the dictates of the family and terminate the life support.[80] In the case of medical futility, however, it may be more difficult to find a provider

---

[72] *See* Truog, *supra* note 13, at 1561 (citing Lawrence J. Schneiderman, *Medical Futility: Its Meaning and Ethical Implications*, 112 ANN. INTERNAL MED. 949, 949-954 (1990)).

[73] *Id.*

[74] The cornerstone case which protects the ethical rights of physicians is Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986). The court held that a hospital could refuse to remove a G-tube that provided the food and hydration for a patient in a persistent vegetative state because it violated the ethical and moral principles of the medical staff. *Id.* However, the court held that the family could transfer the patient to another provider who would accede to the family's wishes and the hospital could not impede that move. *Id.*

[75] *See* Truog, *supra* note 13, at 1562.

[76] U.S. CONST. amend. XIII.

[77] *See* Truog, *supra* note 13, at 1562.

[78] *Brophy*, 497 N.E.2d at 625.

[79] *Id.*

[80] *Id.*

willing to accept a patient.[81] There is a great difference in finding a practitioner to terminate life support and consequently terminate the physician-patient relationship, and finding a practitioner who is willing to accept a patient with a poor prognosis who will take a bed away from another, healthier patient. Because it may not be possible to find a practitioner who is willing to accept such a patient, the solution of transferring the patient to another provider is not the panacea that it was for the right to die cases.

If the patient cannot be transferred, and the physician and the family have diametrically opposite positions on the treatment decisions, the question of who should prevail becomes critical. While the ethical integrity of the medical community is an important interest, this interest should not override the interest in patient autonomy and self-determination.[82] The courts have held that while the family is looking for a new practitioner to accept the patient, the existing practitioner must comply with the family's wishes.[83] If no other physician can be found to accept the patient, one court has held that the physician must ultimately comply with the wishes of the family.[84] Consequently, when the physician and the family have completely opposite views on extending treatment, the courts have held that, "as unsettling as it must be to them, health care professionals must acknowledge [a patient's] right of self-determination."[85]

IV. LEGAL AUTHORITY SURROUNDING MEDICAL FUTILITY

A. The Helga Wanglie Story

In the judicial decisions that have dealt with the withdrawal of life support, no American court has ever specifically decided whether a physician may unilaterally decide that a certain treatment is futile. The issue of medical futility is "still in its infancy."[86] Although many courts have dealt with the right to die,[87] no court has dealt with this unique right to life issue until it was thrust to the forefront of the medical and legal community's interest in 1990 at a hospital in Minnesota.[88]

---

[81] The Wanglie Family could not find another health care provider to take Mrs. Wanglie. *See* Cranford, *supra* note 14, at 24.

[82] *In re* Jobes, 529 A.2d 434, 450 (N.J. 1987).

[83] *Id.* at 451.

[84] Gray v. Romeo, 697 F.Supp. 588, 590-91 (D.R.I. 1988).

[85] *Id.* at 591.

[86] *See* Callahan, *supra* note 21, at 34.

[87] *See* cases cited *supra* note 3.

[88] *In re* Helga Wanglie, No. PX-91-283 (Hennepin County, Minn., 4th Dist. Ct., P. Ct. Div. July 1, 1991) (unreported opinion).

In December of 1989, an eighty-six year old woman named Helga Wanglie broke her hip.[89] After she was successfully treated at Hennepin County Medical Center (HCMC) she was discharged to a nursing home.[90] Approximately one month later, Mrs. Wanglie was readmitted to HCMC when she developed respiratory failure.[91] At this time she was placed on a respirator and over the next five months, attempts to wean her from the respirator failed.[92] During this time she was conscious and aware of her surroundings.[93]

In May of 1990, she was transferred to another facility that specialized in the care of respirator dependent patients.[94] While at this facility, she had a cardiopulmonary arrest, was resuscitated, and was transferred to an acute care hospital in St. Paul.[95] At this institution, the medical staff discussed the possibility of limiting further life support treatment, but the family resisted the suggestion and transferred her back to HCMC where they felt she received excellent care.[96]

After being readmitted to HCMC, she was evaluated and the medical staff suggested the removal of the respirator but the family again rejected the idea.[97] Mr. Wanglie understood the medical diagnosis and the medical staff's opinion that his wife would never regain consciousness. When confronted with the poor prognosis of his wife, Mr. Wanglie replied, "That may be true, but we hope for the best."[98] The family's reluctance to withdraw the life support system was based on personal and religious grounds. They believed that only God could take a life and that if the medical staff removed the respirator from Mrs. Wanglie, the doctors would be playing God.[99]

As this dispute began to develop, a HCMC ethics committee addressed the issue. The initial advisory opinion of the ethics committee was that the hospital staff should err initially on the side of continuing treatment and follow the

---

89 *See* Cranford, *supra* note 14, at 23.

90 Since no opinion was authored in the Wanglie case, the only facts that are available come from reports from those who were involved in the situation. The essential foundation of facts are illustrated by Ronald E. Cranford of the department of neurology at Hennepin County Medical Center. *See id.*

91 *See* Cranford, *supra* note 14, at 23.

92 *Id.*

93 *Id.*

94 *Id.*

95 *Id.*

96 *See* Cranford, *supra* note 14, at 23.

97 *Id.*

98 *Id.*

99 *Id.*

wishes of the family.[100] At the same time, the staff should make every reasonable attempt to resolve conflicts between the family's wishes and the views of the hospital staff.[101] Also during this time, extensive efforts were made by HCMC and the Wanglie family to find another physician or health care facility that would be willing to take Mrs. Wanglie. However, no other facility could be found.[102]

Finally, the hospital turned to the courts and asked for answers to two interdependent questions.[103] First, they asked for the appointment of an independent conservator to decide whether the respirator was beneficial to Mrs. Wanglie, and second, if the conservator found that the respirator was not beneficial, whether the hospital had a duty to continue to provide the respirator.[104] Mr. Wanglie cross-filed, requesting to be appointed the conservator of his wife.[105] After a hearing in the Hennepin County Probate Court, the judge appointed Mr. Wanglie the conservator of his wife.[106] Three days after Mr. Wanglie was appointed as conservator, Mrs. Wanglie died of multisystem organ failure.[107]

While the tragic story of Mrs. Wanglie brought medical futility to the attention of the medical community,[108] it did not provide much substantive law or direction on how to legally address the issue of medical futility. The fact that the *Wanglie* decision has no written opinion and did not reach the appellate court level also makes any precedential value gleaned from the case very weak.[109] Therefore, when addressing the legal issues surrounding medical futility, we must apply existing law to the difficult and unique aspects of this issue.

---

[100] *Id.*

[101] *Id.*

[102] *Id.*

[103] The preceding information concerning the impetus of the legal battle between the Wanglie family and the Hennepin County Medical Center is provided by the head of the Medical Center, Steven H. Miles. *See* Steven H. Miles, *Informed Demand for "Non-Beneficial Treatment"*, 325 NEW ENG. J. MED. 512 (1991). [hereinafter *Informed Demand*].

[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] *Id.*

[108] *See, e.g.*, Ackerman, *supra* note 45; Callahan, *supra* note 21; Cranford, *supra* note 14; *Informed Demand*, *supra* note 104; Rie, *supra* note 40; Schneiderman, *supra* note 72; Truog, *supra* note 13.

[109] *In re* Helga Wanglie, No. PX-91-283 (Hennepin County, Minn., 4th Dist. Ct., P. Ct. Div. July 1, 1991) (unreported opinion).

B. Common Law Tort Liability

Although no legal authority exists on the specific issue of medical futility, a variety of common law torts could impose liability on a physician who unilaterally decides a course of treatment or removes a life support system against the wishes of the patient or family.[110] The focus of this analysis will be on medical negligence (malpractice), battery, and the intentional infliction of emotional distress.

The well-known elements of negligence include the existence of a legal duty to the person harmed and a breach of that duty by the defendant which causes damages to the person harmed.[111] In a case in which a patient is dependent on a life support system, the physician would have a duty to act as a reasonable physician would act when dealing with that patient.[112] If the physician were to terminate the life support system against the wishes of the family, the family would have to convince a jury that a reasonable physician, in the same circumstances, would not have terminated the life support.[113]

It is quite possible that a plaintiff could convince a jury that a reasonable physician would not disconnect the life support system of a patient when the family vehemently objected to such action. If a plaintiff could show that a reasonable physician would not disconnect the life support of a person under similar circumstances, the plaintiff would be able to show that the physician breached his duty to the patient to act with due care, and that breach was the proximate cause of the patient's death. Furthermore, since the physician knowingly and willfully terminated the life support, the family could show that the physician acted recklessly rather than merely negligently.[114] If the family proved recklessness, the physician might be liable for punitive damages as well as compensatory damages for wrongful death.[115]

---

[110] While this section on tort liability is an integral component of the medical futility issue, it has been included with great caution and consternation. Our society has unfortunately become outrageously litigious, and this section of the paper only adds more fuel to the mighty litigation conflagration that has consumed the American public and lined the pockets of the contingency fee attorneys. The major premise behind this section of the paper is to persuade health care providers to communicate and include patients and families in the decision-making process of health care, not to contribute to the already overloaded dockets of America's courts. It is hoped that the threat of a tort suit may persuade the medical community to move away from making unilateral decisions and move towards discussing procedures with the families and obtaining informed consent.

[111] *See* W. PAGE KEETON ET. AL, PROSSER AND KEETON ON THE LAW OF TORTS 164 (5th ed. 1984).

[112] *Id.* at 185.

[113] *Id.*

[114] *Id.*

[115] *Id.*

In medical malpractice, the jury must determine whether the physician acted with the same skill, knowledge and intelligence as a reasonable physician in similar circumstances.[116] The standard of care question in malpractice involves a minimum standard of care, below which an individual is not permitted to fall.[117] To show that a physician breached the standard of care, the family would have to prove that the standard of care in the specific situation would dictate that life support be continued. Because the question of the standard of care involves explicitly technical, medical information which is beyond the competence of a normal jury, expert witnesses are usually used to explain what the standard of care is in a certain situation.[118] The family bringing the action would have to find physicians to testify that the life support system should have been continued because of the possibility of the patient regaining consciousness. On the other hand, the physician who terminated the system would have to produce experts to show that the therapy was futile and the standard of care did not require a physician to provide futile treatment. With the recent push in the medical community to terminate futile treatments,[119] and the prevalence of "futility policies" in many medical centers, it might be possible for a physician to show that the standard of care would be to terminate life support when it is deemed futile by the physician.

Along with the standard of care, another sub-issue under the rubric of medical malpractice is the issue of informed consent. "The informed consent doctrine is based on principles of individual autonomy, and specifically on the premise that every person has the right to determine what shall be done to his own body."[120] The right to determine what is done to one's body does not concern whether the decision is prudent, however. "The law protects a person's right to make his own decision to accept or reject treatment, whether that decision is wise or unwise."[121] The doctrine of informed consent has placed an affirmative duty on a physician or surgeon to disclose the material risks of a certain medical or surgical treatment.[122] This has been regarded as a professional duty, and the failure of a practitioner to obtain the informed consent of a patient is considered a negligent act and medical malpractice.[123]

---

[116] *Id.* at 185.

[117] *Id.* at 170.

[118] *See* CHARLES KRAMER & DANIEL KRAMER, MEDICAL MALPRACTICE 100 (5th ed. 1983).

[119] *See* AMA, *supra* note 16; American Thoracic Soc'y, *supra* note 8; Blackhall, *supra* note 16; Rie, *supra* note 40; *Informed Demand*, *supra* note 104.

[120] *See* KEETON, *supra* note 111, at 190.

[121] Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 633 (Mass. 1986) (quoting Lane v. Candura, 376 N.E.2d 1232, 1231 (Mass. App. Ct. 1978)).

[122] *See* FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE (2d ed. 1990).

[123] *Id.*

Regardless of what standard is used,[124] the duty of the practitioner is to disclose all material facts surrounding the procedure.[125]

The issue of informed consent would arise if a physician unilaterally wrote a DNR order.[126] This type of unilateral decisionmaking by the physician would violate the principles of informed consent because the patient would not have been informed of all the medical alternatives and would not have consented to the order to not be resuscitated.[127] Even if a majority of the doctors believed that CPR should not be used in the certain situation, a doctor who did not inform the patient or family of the issuance of a DNR order could still be held liable for malpractice.[128] In some jurisdictions, the doctor has a duty to disclose the risks and benefits of any medical alternatives, "even though the medical community is divided over the relative benefits."[129] "The patient cannot exercise her fundamental right of physical self determination when she is kept in the dark about a medical alternative favored by a significant number of physicians."[130] If a physician unilaterally decided that CPR were futile, the failure to obtain informed consent for a DNR order could be a breach of her professional duty and an invitation to a medical malpractice claim.

In some jurisdictions, in order to prevail on a claim for lack of informed consent the patient must prove three elements: nondisclosure, causation and injury.[131] In the context in which a doctor unilaterally wrote a DNR order, the family could show that the doctor had not disclosed the issuance of the DNR order and that the patient had suffered an injury (death). However, proving the causation element could present a certain dilemma. In this situation, the patient would not have undergone a procedure, but rather would have had opportunity for a potentially lifesaving procedure foreclosed. To satisfy the causation element, the patient's estate might have to prove that the patient would have survived if the DNR order had not been written.[132] Such a position

---

[124] Although there are no hard and fast rules on what type of information must be disclosed, two general standards have been developed. *See* ROZOVSKY, *supra* note 122, at 59. The first standard is the medical community standard which dictates that a physician must disclose to the patient whatever a reasonable practitioner would disclose under the same circumstances. *Id.* The second standard is the patient need standard which is usually phrased in terms of what a reasonable person in the patient's position would want to know in order to make an informed decision. *Id.* at 60.

[125] *Id.*

[126] *See* Blackhall, *supra* note 16.

[127] *See* Rozovsky, *supra* note 122.

[128] Wachter v. United States, 877 F.2d 257 (4th Cir. 1989) (Murnaghan, J., concurring in part and dissenting in part).

[129] *Id.* at 263.

[130] *Id.*

[131] Creech v. Roberts, 908 F.2d 75, 82 (6th Cir. 1990) (applying Oklahoma law).

[132] *Id.*

might be difficult or impossible to prove since these types of patients are usually in fragile or unstable medical conditions, and, furthermore, the success rate of CPR is not very high.[133] Consequently, it might be impossible to prove that the patient would have lived if CPR had been administered. This technical/legal roadblock is a harsh obstacle for the family to overcome, and may be a sinister and even macabre shield behind which doctors may hide.

If the causation element of informed consent or the "battle of the experts" prevents the family from prevailing in a claim for malpractice, the family might be able to prevail in battery. In a situation where a physician unilaterally determined that a life support device was futile and she removed that device without the consent of the patient or family, the act could be considered a battery. "[A] patient can sustain a successful claim [for battery] without having to show that if adequately informed of the risks which led to his injuries, he would not have consented to the treatment."[134]

As with the informed consent issue, a cause of action for battery would also present a problem. First, the tort of battery is defined as an intentional infliction of a harmful or offensive touching.[135] In the case of a unilateral DNR order, the patient would have suffered because the physician did *not* touch the patient (i.e., did not perform CPR). Similarly, in the case of a unilateral termination of life support, the physician might not actually touch the patient. The harm might be caused by flipping a switch, rather than by actually touching the patient. However, a battery may be committed by "unpermitted and intentional contacts with anything . . . intimately connected with one's body as to be universally regarded as part of the person."[136] Under this context, since the life support machine is the only thing allowing the patient to live, it could be said that it is so intimately connected with the patient's body as to be regarded as part of the patient.[137] Using this reasoning, a physician could be liable for battery for unilaterally terminating a life support system. However, it may be more difficult to allege a battery for the failure to administer CPR.

The second difficulty with alleging battery in this situation is that battery is said to be a personal tort, or one of personal integrity, and presumably the cause of action may only be brought by the person who was battered.[138] In the context of medical futility, the patient who was battered by the doctor would most likely be killed as a result of the battery. Under the common law tort of battery, the surviving family would not have a cause of action in battery against the

---

[133] *See* Blackhall, *supra* note 16.

[134] MacDonald v. United States, 767 F. Supp. 1295, 1312 (M.D. Pa. 1991).

[135] *See* RESTATEMENT (SECOND) OF TORTS §§ 13, 18 (1989).

[136] *Id.* at § 18, cmt. p; *see also* Fisher v. Carrousel Motor Hotel, Inc., 424 S.W.2d 627 (Tex. 1967) (plate snatched from a person's hand).

[137] *See* RESTATEMENT (SECOND) OF TORTS § 18.

[138] *Id.* at § 900 (1)(a).

doctor, because it was actually their loved one who was battered and the cause of action died with the patient.[139]

The harsh result of precluding families from pursuing tort claims of their deceased family member has been abrogated by state legislatures which have promulgated survival statutes.[140] These statutes generally give the decedent's estate the cause of action that the decedent would have had if the decedent were still alive.[141] Along with the development of survivorship statutes, many legislature have enacted wrongful death statutes.[142] "The basic distinction between a wrongful death statute and a survival statute is that the former creates a new cause of action for the decedent's death, while the latter merely saves the decedent's cause of action for injuries."[143] In the medical futility context, both survival statutes and wrongful death statutes may extend the liability for a tort, such as battery, to the family after the patient has died.

When applied to medical futility, even the use of a survivorship statute presents some problems. Under a survival statute, the decedent's family may collect damages for the pain that the decedent suffered before dying as a result of the tort.[144] In the futility context, where a doctor removed the life support from a patient, the patient may actually survive for a period before expiring, and the family may be able to collect damages for the suffering that the patient experienced before passing away.[145] A difficulty would arise, however, if the patient had been in a physical state in which she could not actually feel pain. If the patient had been in such a state, the physician could have a strong argument that the family could not maintain a survival action for pain and suffering of the patient because the patient could not feel any pain. Such an argument by the physician would depend on the specific situation and would require expert testimony to determine whether the patient could feel pain or actually suffered at all before passing away.

Under a wrongful death statute, however, the family would be more successful in collecting damages from the physician. Generally, with a wrongful death action, the family may collect for any losses that have pecuniary value.[146] Therefore, in the futility context, the family would merely need to show what items the decedent provided for the family which they are

---

139*Id.*

140*See* 1 AM. JUR. 2d *Abatement, Survival and Revival* §§ 51, 113 (1964).

141*Id.*

142*See* James O. Pearson, Jr., *Annotation, Recovery, In Action for Benefit of Decedent's Estate in Jurisdiction Which Has Both Wrongful Death and Survival Statutes, of Value of Earnings Decedent Would Have Made After Death*, 76 A.L.R. 3d 125 (1977) (for a general discussion of jurisdictions with both a survival and wrongful death statute).

143*Id.* at 129 (citing 22 AM. JUR. 2d *Death* § 92 (1964)).

144*See* KEETON, *supra* note 111, at 942.

145*Id.*

146*Id.* at 951.

now deprived of receiving as the result of the physician's removal of the life support system.[147] Some interests that have been considered to have pecuniary value are loss of society, comfort, intercourse, protection and other incidents of family association.[148] With such a broad range of compensable interests, it is quite possible that a physician could be held liable under various wrongful death statutes.

Along with exposing herself to liability under a wrongful death action, a practitioner who removed life support against the wishes of the family might also be exposed to liability for the intentional or negligent infliction of emotional distress. For the family to prevail in an action for emotional distress, they would have to prove that the conduct of the doctor was outrageous and that it caused them severe emotional distress.[149] The RESTATEMENT (SECOND) OF TORTS indicates that "[l]iability has been found only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community."[150] In a situation in which a doctor knew that the family wanted their loved one to be kept alive but nevertheless terminated the life support, a strong argument could be advanced that this conduct was beyond the bounds of decency and the actions were atrocious and utterly intolerable.[151] In many cases, a family's request to sustain the life of the patient is based on the religious belief that only God can take human life.[152] While religious beliefs are not always logical, scientific or rational, these beliefs must be respected and, as a society, we must be careful not to allow the medical community to callously violate the sanctity of the beliefs of the patients and families whom they treat.

It should also be noted that emotional distress is a developing tort that has not yet established its boundaries.[153] Although the courts have been leery and cautious of fictitious or trivial claims,[154] the termination of a person's life support system, against the explicit wishes of the family, is a situation which should support a cause of action for emotional distress. The law has routinely provided relief for the negligent mishandling of a corpse without an overt

---

147*Id.*

148*Id.* at 952.

149*See* RESTATEMENT (SECOND) OF TORTS § 46.

150*Id.* at § 46 cmt. d.

151*Id.*

152*See* Cranford, *supra* note 14. (The Wanglie family believed that only God could take a life and if the doctors at the Hennepin County Medical Center removed the life support from Mrs. Wanglie, the family believed that the physicians would be playing God.)

153*See* RESTATEMENT (SECOND) OF TORTS § 46 cmt. b.

154*Id.*

showing of any proof of emotional distress.[155] It is only a natural extension of that policy that families should be able to collect for intentional mishandling, and killing, of a fragile individual. The likelihood of the family suffering from emotional distress is not any less when their loved one's body is "mishandled" by turning off the life support than when a loved one has passed on and the corpse is mishandled. If the law will provide emotional damages for the negligent mishandling of a corpse, the law should provide emotional damages for the intentional mishandling of a live, but frail person. The possibility of liability for the intentional infliction of emotional distress is real, and one that should force doctors to be cautious before making decisions that contradict the wishes of the family.

The existing tort system can grant damages to a family who is injured by a physician's actions, but it cannot bring the patient back and it cannot necessarily prevent the doctor from continuing the policy of making unilateral decisions for their patients. While existing common law torts, especially intentional infliction of emotional distress, may impose liability on unilateral decisions made by the medical profession, the current tort system is inadequate to resolve the issues that arise from medical futility. Although the family may be financially compensated, the family of the patient cannot truly be adequately compensated for the manner in which their loved one died. Furthermore, the task of trying to calculate damages in such a situation presents a troublesome problem. Therefore, the law must find other ways to handle the issues that are generated from the problem of medical futility.

C. Constitutional Challenges

While common law tort remedies may not provide an adequate remedy to the issue of medical futility, the use of constitutional law is much more effective in preventing physicians from making unilateral health care decisions. The Supreme Court has found that the right to make medical decisions about one's own body is analogous to a right to control one's own body, and rises to the level of a fundamental, constitutional right.[156] This recognition of a fundamental right to self-determination and patient autonomy is not a recent development in the law. In fact, a little over a century ago, the Supreme Court indicated that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and

---

[155] *See* KEETON, *supra* note 111, at 63; *see also* Lott v. State, 225 N.Y.S.2d 434 (Ct. Cl. 1962); *cf.* Corso v. Crawford Dog & Cat Hosp., 415 N.Y.S.2d 182 (Civ. Ct. 1976) (Owner of a pet poodle who had arranged an elaborate funeral for her dog and was shocked when she opened the casket and found the remains of a cat, was awarded damages for mental distress.)

[156] Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) (citing Roe v. Wade, 410 U.S. 113 (1973); Griwsold v. Connecticut, 381 U.S. 479 (1965)).

control of his own person, free from all restraint or interference of others...."[157] The Court has continually affirmed this principle of self-determination and the right of an individual to decide what should happen to her own body.[158] Families and surrogates may use the Court's long tradition of supporting the right of self-determination, the constitutional right to privacy, and the right to patient autonomy to prevent health care professionals from making unilateral health care decisions.

In order to assert a constitutional right however, the party bringing the action must assert that the party depriving them of the right is a state actor.[159] In past right to die cases, plaintiffs have been able to use constitutional doctrines because the state has been involved in the issue. Many of these cases involved state hospitals;[160] in some the government became involved as an adverse party to the case;[161] in others a guardian was appointed by the court;[162] and in others the courts were asked for a declaratory judgment.[163] In these cases it was clear that constitutional doctrines were able to be used because the state was involved in the proceedings. However, the issue arises whether a patient may assert a constitutional challenge to the unilateral acts of a physician in a private hospital where the state is not otherwise involved in the case.

Since public hospitals are not governed directly by the state or federal government, these hospitals are not automatically state actors. Therefore the plaintiff would have to show some other reason why the hospital should be treated as a state actor.[164] A private entity may be treated as a state actor if it is so heavily regulated by the state that "there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself."[165] A plaintiff could

---

[157]Union Pac. R.R. v. Botsford, 141 U.S. 250, 251 (1891).

[158]Winston v. Lee, 470 U.S. 753 (1985) (holding that a criminal defendant could not be compelled to submit to surgery); Eisenstadt v. Baird, 405 U.S. 438 (1972) (recognizing an unmarried couple's right of privacy in decisions concerning contraception); Roe v. Wade, 410 U.S. 113 (1973) (recognizing a woman's fundamental right to choose to have an abortion).

[159]Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974).

[160]Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); *Saikewicz*, 370 N.E.2d 417; *In re* Storar, 420 N.E.2d 64 (N.Y. App. Ct. 1981).

[161]Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261 (1990).

[162]Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1987); *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, Granger v. New Jersey, 429 U.S. 922 (1976).

[163]Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986); *In re* Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978), *overruled by In re* Spring, 399 N.E.2d 493 (Mass. App. Ct. 1979); *In re* Jobes, 529 A.2d 434 (N.J. Sup. Ct. 1987).

[164]Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974).

[165]*Id.* at 351.

argue that, because the health care industry is so heavily regulated by state[166] and federal laws,[167] most major medical centers should be treated as state actors. Some courts have already accepted the combination of state and federal regulatory requirements as providing the required nexus between the State and a medical facility in order to treat the medical facility as a state actor.[168]

Once it was established that a hospital could be treated as a state actor, the family or surrogate of a patient could assert certain constitutional rights to prohibit a physician from terminating life support.[169] Among the constitutional rights that might be violated by such a unilateral act is the patient's right of due process. The Fifth and Fourteenth Amendments to the Constitution indicate that no person shall be deprived of life, liberty or property without due process of law.[170] The surrogate or family could argue that before the physician could terminate the life support and deprive the patient her life, there would have to be some due process in the form of a hearing. While it is not certain what type of hearing would satisfy the due process standards of the Constitution, it could be argued that nothing less than a full, adverse hearing would be appropriate when the interest at stake is a human life.[171] Until this hearing were arranged, the judiciary would be able to temporarily enjoin any unilateral decision of the physician to terminate the life support.

---

[166]In every state, physicians and nurses must be certified and licensed by the state to practice medicine. The state is also involved when courts become guardians for incompetent patients or when a patient becomes a ward of the state. Also, many states require medical facilities to obtain a certificate of need before that facility may make any addition or expansion to their facility.

[167]Health care institutions are heavily regulated by federal Medicare laws. *See generally* Social Security Act of 1964 (codified as amended in scattered sections in 42 U.S.C.).

[168]*See* Downs v. Sawtelle, 574 F.2d 1 (1st Cir.), *cert. denied*, 439 U.S. 910 (1978); Ross v. Hilltop Rehabilitation Hosp., 676 F. Supp. 1528 (D. Col. 1987); Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); *cf.* Carnes v. Parker, 922 F.2d 1506 (10th Cir. 1991) (termination of an employee from a Baptist hospital constituted state action).

[169]While it could be argued that a private hospital may be considered a state actor in some circumstances, it is conceded that it may be more difficult to treat a physician as a state actor, since most physicians are independant contractors and not employed by hospitals. However, when dealing with the constitutional rights of a patient, the courts may be willing to treat physicians as ostensible agents of the hospital in order to protect the constitutional rights of the patient. *See* Uhr v. Lutheran Gen. Hosp., 589 N.E.2d 723 (Ill. App.) (holding that the apparent agency doctrine may be applied for medical malpractice cases), *appeal granted*, 596 N.E.2d 638 (Ill. 1992), *vacated and appeal dismissed*, 614 N.E.2d 319 (Ill. App. 1993).

[170]U.S. CONST. amends. V & XIV.

[171]The Court held in Goldberg v. Kelly, 397 U.S. 254 (1970), that before benefits are terminated, a welfare recipient is entitled to a full adverse hearing with an opportunity to present evidence, cross examine witnesses, obtain legal counsel and have an impartial decisionmaker state the reasons for the decision. If an individual is entitled to a full hearing before welfare benefits are terminated, an individual should be entitled to at least the same due process before a human life may be terminated.

Along with protecting the patient's constitutional right of due process, the court must protect the patient's constitutionally protected right of privacy. Since 1965, when the Supreme Court found that a right to privacy exists in the penumbras of the Bill of Rights,[172] American courts have consistently protected an individuals' right to self-determination and personal autonomy.[173] In *Griswold v. Connecticut*,[174] the Court held that there are certain decisions that are in the "realm of family life which the state cannot enter without substantial justification."[175] No decision is more sacrosanct and private than the decision to terminate a life, and therefore physicians as state actors should not constitutionally be permitted to make unilateral value judgments on whether life support should be terminated or whether CPR should be performed. If the Supreme Court will protect the right of privacy in seeking contraceptive advice,[176] obtaining an abortion[177] and maintaining the integrity of the family,[178] the Court should uphold the privacy right of a family to decide whether their family member should remain on a life support system. Many of the right to die cases rested on the premise that the individual's right to terminate life support is rooted in the individual's right to privacy.[179] If the right to terminate one's life support can be encompassed under the right to privacy, the converse should also be true: the right to privacy should also permit an individual the choice to remain on life support in an attempt to recover from the vegetative state.

---

172 *See* Griswold v. Connecticut, 381 U.S. 479 (1965).

173 *See* Zablocki v. Redhail, 434 U.S. 374 (1978) (stating that the right to marriage is fundamental and falls within the right of privacy); Carey v. Population Serv. Int'l, 431 U.S. 678 (1977) (invalidating a New York law prohibiting any person but a licensed pharmacist to distribute contraceptives); Moore v. City of East Cleveland, 431 U.S. 494 (1977) (holding that the traditional concept of "family" is within the right of privacy and therefore the government cannot define what makes up a family.); Roe v. Wade, 410 U.S. 113 (1973) (stating that a woman's right to chose to have an abortion is within her constitutionally protected right of privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (protecting the privacy of unmarried persons in seeking information concerning contraception).

174 381 U.S. 479 (1965).

175 *Id.* at 502 (White, J., concurring).

176 *See Eisenstadt*, 405 U.S. 438; *Griswold*, 381 U.S. 479.

177 *Roe*, 410 U.S. 113.

178 *See Zablocki*, 434 U.S. 374; *Moore*, 431 U.S. 494; Stanley v. Illinois, 405 U.S. 645 (1972).

179 *See generally* Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re* Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978), *overruled by In re* Srping, 399 N.E.2d 493 (Mass. App. Ct. 1979); Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978); *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Jobes, 529 A.2d 434 (N.J. Super Ct. 1987); *In re* Quinlan, 355 A.2d 647; *In re* Storar, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981).

D. Common Law Right of Self-Determination

While a patient has a fundamental right to patient autonomy and self-determination, courts have held that this right is not absolute.[180] The traditional formula in the right-to-die cases has been to balance the rights of the self-determination and patient autonomy against four compelling governmental interests. These interest are: the preservation of life, the prevention of suicide, the protection of innocent third parties and the integrity of medical ethics.[181] In a medical futility dispute, the first two state interests fall on the side of the patient. After all, it is the family that is fighting for the preservation of the life of the patient, which is the greatest of the four government interests.[182] Since the patient's family is fighting to keep the patient alive, the second state interest of preventing suicide is not applicable to the medical futility issue. The third state interest, the protection of innocent third parties, also falls on the side of the family. The interest of protecting innocent third parties "is generally limited to situations in which the interests of the patient's dependent may be adversely affected."[183] In a medical futility dispute, it is the patient's dependents who wish to keep the patient alive. If the health care provider were to terminate the patient's life support system, the state interest in protecting innocent third parties would once again fall on the side of the family who, as innocent third parties, would be emotionally devastated by such a unilateral decision.

When balancing the four state interests involved in the termination of life, the first three state interests clearly fall on the side of a family who wishes to keep the patient alive. It is debatable however, on which side of the line the interest in protecting the medical ethics should fall. At first examination, it could be argued that the interest of protecting the integrity and ethics of the medical profession falls on the side of the medical community. The health care profession may argue that there is no ethical duty to provide futile treatment, and by being forced to provide such treatment, the medical profession is being undermined and the integrity of health care professionals is being injured.[184] However, a more in depth analysis of the situation reveals that the ethics and integrity of the medical profession are actually injured by a unilateral decision made by a physician. After all, "medical ethics incorporates the principle that the patient, not the healthcare provider, determines what the course of care should be."[185] To permit a physician to make a unilateral health care decision

---

[180]Gray v. Romeo, 697 F.Supp. 580 (D.R.I. 1988).

[181]*Id.* at 588.

[182]*Id.* at 588; *see also Saikewicz*, 370 N.E.2d at 425.

[183]*Gray*, 697 F. Supp. at 589 (quoting Tune v. Walter Reed Army Medical Hosp., 602 F.Supp. 1452, 1455 (D.D.C. 1985)).

[184]*See* AMA, *supra* note 16; American Thoracic Soc'y, *supra* note 8; Rie, *supra* note 40; Truog, *supra* note 13.

[185]*See Gray*, 697 F. Supp. at 589.

without consulting the patient or family, or to permit her to make a decision against their wishes would be self-destructive to the ethics of modern medicine and a dangerous regression to policy of medical paternalism. The injury to medical ethics and integrity would be compounded if each individual practitioner were able to unilaterally act on her own definition of futility. The fourth state interest in protecting the integrity and ethics of the medical profession is best protected by letting each patient or surrogate decisionmaker decide on the course of treatment for the patient.

Even if the courts were to find that the integrity of the medical community might be injured, this single interest should be overruled by the other three state interests that fall on the side of patient autonomy and self determination. The courts have held that the "doctrines of informed consent and the right to privacy have as their foundations the right to bodily integrity and control of one's own fate [and] those rights are superior to the [medical] institution'[s] considerations."[186] The courts have recognized that the right of patient autonomy and self-determination may be "unsettling"[187] or even "burdensome,"[188] for health care workers, but these rights take precedence over the wishes of the medical community. When the judiciary is faced with the issue of medical futility, the analysis of the four compelling state interests overwhelmingly point in the favor of patient autonomy and self-determination.

When a case of medical futility is brought before the court, the court should continue to protect a person's right of self determination and protect the right of patient autonomy. In order to respond to the situation, the court should recognize the common law right of self-determination. Because of the previous judicial precedent of protecting the right of self-determination and the right of patient autonomy,[189] the courts should recognize that a patient or her surrogate decisionmaker has a right, under common law, to make the ultimate decision concerning what treatments should or should not be used. The relief granted by the court could be injunctive in nature and require the medical community

---

186 *Saikewicz*, 370 N.E.2d at 426.

187 *Gray*, 697 F. Supp. at 591

188 *In re* Jobes, 529 A.2d 434, 450 (N.J. 1987).

189 *See generally* Winston v. Lee, 470 U.S. 753 (1985); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965); Union Pac. R.R. v. Botsford, 141 U.S. 250 (1891); Gray v. Romeo, 697 F.Supp. 580 (D.R.I. 1988); Tune v. Walter Reed Army Medical Hosp., 602 F. Supp. 1452 (D.D.C. 1985); Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986); *In re* Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978), *overruled by In re* Spring, 399 N.E.2d 493 (Mass. App. Ct. 1979); Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978); *Saikewicz*, 370 N.E.2d 417; *Jobes*, 529 A.2d 434; *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, Granger v. New Jersey, 429 U.S. 922 (1976); *In re* Storar, 420 N.E.2d 64 (N.Y. App. Ct. 1981).

to continue life support systems, or mandate that patients be included in all decisions made by the medical staff.[190]

V. SOLUTIONS TO MEDICAL FUTILITY

A. Patient Self-Determination Act

The conundrum of medical futility cannot easily be resolved by using the common law tort system, and constitutional doctrines may not be a satisfactory solution because of the question of whether a plaintiff can establish state action.[191] Furthermore, the inefficient and laborious court system may not resolve the issue quickly, placing both the family and the medical center in a tedious game of wait-and-see. Therefore, the best solution to medical futility is to have every person, before she becomes incompetent, execute an advanced directive which outlines her choices regarding life sustaining treatment.[192]

Advanced directives may become more prevalent now that the Patient Self-Determination Act has gone into effect.[193] This statute is the first federal statute to focus on advanced directives, and it encourages adults to make decisions about life sustaining treatment.[194] The statute requires medical institutions[195] to provide written information to each individual concerning an

---

[190]Naturally, this right would not be absolute, and patients could not assert a right to physiologically futile treatment. Where a medical determination is completely and unequivocally within the scientific expertise of the medical profession, the physician may make a unilateral medical decision. However, if the decision involves value judgments or, for some other reason, the decision is not completely within the realm of medical expertise, this common law right of self-determination should be upheld by the courts.

The right of self-determination is an equitable right and may be limited by a court. If a patient or surrogate attempts to unconscionably stretch the boundaries of the right of self-determination in a way that justice and equity would not permit, the court should not permit such an expansion. Because each case of medical futility is different, it would be impossible to concretely define the boundaries of the right to self determination. Therefore, it is up to the wise discretion of the judiciary to determine the boundaries of the right in each specific situation so that equity, justice and fairness are achieved.

[191]*See* cases cited *supra* note 189.

[192]The term "advanced directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State) and relating to the provisions of such care when the individual is incapacitated. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206 (codified in scattered sections of 42 U.S.C.).

[193]*See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751 (codified in scattered sections of 42 U.S.C., especially §§ 1395, 1396 (West Supp. 1991)).

[194]*See* Susan M. Wolf et al., *Sources of Concern About the Patient Self-Determination Act*, 325 NEW ENG. J. MED. 1666 (1991).

[195]The statute requires compliance by Medicare certified hospitals, skilled nursing facilities, home health agencies and hospice programs. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206.

individual's rights under state law to make decisions concerning medical care, her rights to accept or reject medical care, and her right to formulate advanced directives.[196] Every state and the District of Columbia now have legislation regarding a patient's right to accept or reject life sustaining treatment and how to establish a surrogate decisionmaker.[197]

---

[196]Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206.

[197]ALA. CODE §§ 22-8A-1- 22-8A-10 (1990); ALASKA STAT. §§ 18.12.010-.100 (Supp. 1990); ALASKA STAT. §§ 13.26.332-353 (Supp. 1990); ARIZ. REV. STAT. ANN. §§ 36-3201-3210 (1986); ARIZ. REV. STAT. ANN. §§ 14-5501-5502 (Supp. 1989); ARK. CODE ANN. §§ 20-17-201,-20-17-218 (Michie Supp. 1989); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1989); CAL. CIV. CODE §§ 2430-2444 (West Supp. 1990); COL. REV. STAT. §§ 15-18-101- 15-18-113 (1987 & Supp. 1990); COL. REV. STAT. §§ 15-14-501-15-14-502 (1987); CONN. GEN. STAT. §§ 19a-570- 19a-575 (Supp. 1989); DEL. CODE ANN. tit. 16, §§ 2501-2509 (19xx); D.C. CODE ANN. §§ 6-2421-2430 (Supp. 1989); D.C. CODE ANN. §§ 21-2201-2213 (1989); FLA. STAT. ANN. §§ 765.01-15 (West 1986); FLA. STAT. ANN. §§ 745.41-.51 (West Supp. 1990); GA. CODE ANN. §§ 31-32-1- 31-32-12 (Michie 1985 & Supp. 1989); GA. CODE ANN. §§ 31-36-1 31-36-13 (Michie Supp. 1990); HAW. REV. STAT. §§ 327D-1 -27 (Supp. 1988); HAW. REV. STAT. § 237D-2 (Supp. 1988); IDAHO CODE §§ 39-4501-4509 (1985 & Supp. 1989); ILL. ANN. STAT. ch. 110 1/2, para. 701 (Smith-Hurd Supp. 1989); ILL. ANN. STAT. ch. 110 1/2, para. 804 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 -16-8-11-22 (Burns Supp. 1989); IOWA CODE ANN. §§ 144A.1 -11 (West 1989); KAN. STAT. ANN. §§ 65-28.101 -28.109 (1985); KAN. STAT. ANN. §§ 58-625 -632 (Supp. 1990); KY. REV. STAT. ANN. §§ 311.622 -642 (Michie/Bobbs-Merrill Supp. 1990); KY. REV. STAT. ANN. §§ 311.970 -.986 (Michie/Bobbs-Merrill Supp. 1990); LA. REV. STAT. ANN. §§ 40:1299.58.1 -.10 (West Supp. 1989); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 -714 (West 1990), ME. REV. STAT. ANN. tit. 18-A, § 5-501 (West Supp. 1989); MD. HEALTH-GEN. CODE ANN. §§ 5-601 -614 (Supp. 1988); MD. EST. & TRUSTS CODE ANN. §§ 13-601 -603 (1974); MASS. GEN. L. ch. 201D, § (1990); MICH. COMP LAWS §§ 496.1 -.23 (1990); MINN. STAT. ANN. §§ 145 B.01; 145 C.01 (West Supp. 1994); MISS. CODE ANN. §§ 41-41-101 -121 (Supp. 1988); MISS. CODE ANN. §§ 41-41-151 -183 (Supp. 1990); MO. ANN. STAT. §§ 459.010 -.055 (Vernon 1990); MONT. ANN. STAT. §§ 50-9-101 -104, -111, 201, -206 (1987); NEB. REV. STAT. §§ 30-34.01 (Supp. 1993), 20-401 (Supp. 1993); NEB. REV. STAT. §§ 449.540 -.690 (Michie 1986 & Supp. 1988); NEB. REV. STAT. §§ 449.800 -.860 (Michie Supp. 1989); N.H. REV. STAT. ANN. §§ 137-H:1 -H:16 (Supp. 1988); N.J. STAT. ANN. § 46:2B-8 (West Supp. 1989); N.M. STAT. ANN. §§ 24-7-1 -11 (Michie 1986); N.M. STAT. ANN. §§ 45-5-501 -502 (Michie Supp. 1989); N.Y. PUB. HEALTH LAW §§ 2980-2994 (McKinney 1990); N.C. GEN. STAT. §§ 90-320 -322 (1989), N.C. GEN. STAT. §§ 32A-8 -14 (1987); N.D. CENT. CODE §§ 23-06.4-01 -14 (Supp. 1989); OHIO REV. CODE ANN. §§ 1337.11 -.17 (Anderson 1989); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West 1991); OKLA. STAT. ANN. tit. 63, §§ 3080.1-.4 (West 1991); OR. REV. STAT. §§ 127.605 -.650 (1990), OR. REV. STAT. §§ 127.505-.585 (1990); PA. STAT. ANN. tit. 20, §§ 5604-5607 (Supp. 1989); R.I. GEN. LAWS §§ 23-4.10 -2 (1989); S.C. CODE ANN. §§ 44-77 -160 (Law. Co-op. 1988); S.C. CODE ANN. §§ 62-5-501 -502 (Law. Co-op. Supp. 1990); S.D. 59-7-2.5 (Michie 1993); S.D. 34-12D-3 (Michie 1993); TENN. CODE ANN. §§ 32-11-101 -110 (Supp. 1988), TENN. CODE ANN. §§ 34-6-101 -214 (Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 672 (West Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 459oh-1 (West Supp. 1990); UTAH CODE ANN. §§ 75-2-1101 -1118 (Supp. 1990); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VT. STAT. ANN. tit. 14, §§ 3451-3467 (Supp. 1988); VA. CODE ANN. §§ 54.1-2981 -2992 (Michie Supp. 1989); VA. CODE ANN. §§ 11-9.1 -9.4 (Michie Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010 -.905 (West Supp. 1990); WASH. REV. CODE ANN. § 11.94.010 (West Supp. 1989); W.VA. CODE §§ 16-30-1 -10 (1985); W.VA. CODE §§ 16-30a-1 -20 (Supp. 1990); WISC. STAT. ANN. §§ 154.01 -.15 (West 1989); WYO. STAT. §§ 35-22-101 -109 (1990); WYO. STAT. §§ 3-5-201 -214 (1991).

By following the statutory guidelines of each state, it may be possible for patients to express their wishes with regard to life sustaining treatment. The Patient Self-Determination Act and the corresponding state statutes are geared toward notifying a patient of his rights to refuse life sustaining treatment.[198] However, in a case of medical futility, it is the patient (spoken for by the surrogate or family) who wishes the treatment to continue and the physician who wishes to terminate the treatment.[199] While these statutes were designed to allow patients to refuse medical treatment, they may also be used to request and retain medical treatment.[200] These statutes give patients and their families the right to decide treatment issues, and these rights include the right to have, as well as to refuse, treatment.[201]

The best solution to resolving the medical futility enigma is to do everything possible to prevent any type of problem from arising in the first place. Every competent adult should execute a living will as soon as possible, regardless of whether the person is sick or well. While future incompetence and death may not be easy topics to address, all adults should accept the realities of the future and take control of their lives while they are competent.[202] If an individual absolutely refuses to confront the possibility of future incompetence, then the person should at least execute a durable power of attorney for health care.[203] By selecting a surrogate decisionmaker, the individual will be able to select someone who knows and understands the person, and can make an informed and educated health care decision for that individual. Also, by selecting a surrogate decisionmaker while she is still competent, the individual gives the surrogate time to reflect and contemplate her duty. Such a decision will most likely foster communication between the individual, the surrogate and the physician, and will generate a better understanding of medical science and of each person's values. This type of communication and decisionmaking is the only way to truly solve the issue of medical futility.[204]

---

198 *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206. *See also* state statutes cited *supra* note 197.

199 *See In re* Helga Wanglie, No. PX-91-283 (Hennepin County, Minn., 4th Dist. Ct., P. Ct. Div. July 1, 1991) (unreported opinion).

200 *See* Wolf, *supra* note 194, at 1667.

201 *Id.*

202 *Id.*

203 *See* statutes cited *supra* note 197 for durable power of attorneys for health care.

204 The effectiveness of the living will to solve the issue of medical futility depends on whether health care professionals abide by living wills. One study found that one-third of the physicians surveyed believed that their training, skill and experience gave them greater authority than their patients to decide questions about life sustaining treatment. Kent W. Davidson et al., *Physicians' Attitudes on Advanced Directives*, 262 JAMA 2415 (1980); *see also* Wolf, *supra* note 194.

Other studies showed that physicians were reluctant to follow living wills when they disagreed with those directives. Joel M. Zinberg, *Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives*, 13 VT. L. REV. 445 (1989).

B. Communication by the Medical Community

While the Patient Self-Determination Act may provide a solution to some cases of medical futility, it certainly does not solve all of the potential cases. Many studies have shown that few Americans have executed advanced directives.[205] For those Americans who have not executed a living will or a durable power of attorney for health care, the potential for a dispute over medical futility still exists and a solution is still needed to deal with the issue. However, the solution should protect the doctrines of patient autonomy and self-determination as well as the integrity and ethical values of the health care workers who treat these patients.

Perhaps the best way to balance the interests and values of both the patient and the medical community is to maintain a strong bond of trust between the patient and physician. This bond of trust must be maintained and communication is the single most important adhesive in that bond.

In an attempt to establish this trust, Dr. Donald J. Murphy recently tried an informal assessment of the effects of communication on the issuance of DNR orders.[206] Dr. Murphy stopped discussing the futility of CPR for the elderly in vague and imprecise statements. He found that statements like, "Would you want us to do everything possible to save your life if your heart stops beating?," invariably elicited a response of "Why of course, doctor."[207] Instead of using such vague questions, Dr. Murphy "started talking turkey."[208] He gave patients and family members accurate portrayals of the patient's bleak medical condition and described the harsh realities of dying in a critical care unit of a hospital.[209] The results of these descriptions were surprising and encouraging. Twenty-three out of the twenty-four families who were openly informed, agreed that resuscitation would be futile and consented to the issuance of a DNR order.[210] None of the parties refused to discuss the tough issues because

---

Some physicians believe that living wills show a lack of confidence in physicians. Susanna E. Bedell & Thomas L. DelBanco, *Choices About Cardiopulmonary Resusciation in the Hospital: When do Physicians Talk with Patients?*, 310 NEW ENG. J. MED. 1089 (1984); *see also* Marnie J. Lerner, *State Natural Death Acts: Illusory Protection of Individuals' Lifesustaining Treatment Decisions*, 29 HARV. J. ON LEGIS. 175 (1992).

205 *See* Elizabeth R. Gamble et al., *Knowledge, Attitudes and Behavior of Elderly Persons Regarding Living Wills*, 151 ARCHIVES INTERNAL MED. 277 (1991); Richard A. Knox, *Americans Favor Mercy Killing*, BOSTON GLOBE, Nov. 3, 1991, at 1, 22; John Puma et al., *Advanced Directive on Admission: Clinical Implications and Analysis of the Patient Self Determination Act of 1990*, 266 JAMA 402 (1991).

206 Donald J. Murphy, *Do-Not-Resuscitate Orders: Time for Reappraisal in Long-Term-Care Institutions*, 260 JAMA 2098 (1988).

207 *Id.*

208 *See* Youngner, *supra* note 63, at 2096.

209 *Id.*

210 *Id.*

they felt uncomfortable.[211] Dr. Murphy's quasi-experiment illustrates the importance and the effectiveness of communication in the context of medical futility.[212]

If a treatment or intervention is presumed by the medical staff to be futile, the physician should have a legal and ethical duty to explain to the patient or family why the treatment is considered futile. This is especially true when the intervention, such as CPR, is assumed to be provided if cardiac arrest occurs.[213] This requirement of communication on behalf of the medical profession is not unreasonable. If the treatment is futile, the physician should simply explain why it is futile. In the context of CPR, doctors should explain the realities of CPR. They should explain that CPR was devised to resuscitate an otherwise healthy individual whose heart stopped because of some other tragedy such as a near drowning.[214] They should go on to explain that the effectiveness of CPR is intricately related to the underlying event or illness that brings about the cardiac arrest.[215] Therefore, CPR will be far less effective for patients who have disease or other medical conditions that have deteriorated and weakened the patient's body.[216]

When CPR was first described by W.B. Kouwenhoven as "closed-chest cardiac massage," the reported long-term success rate was 70 percent.[217] However, this tremendous success rate has never been duplicated in the last 30 years.[218] In fact, in the 13 papers published since 1960, the rates of survival of hospitalized patients past discharge ranged from only 5 to 23 percent.[219] Physicians should not be timid or afraid of informing patients and families of these statistics, but should be upfront and honest about the slim advantages CPR offers in some circumstances. Physicians could even prepare a pamphlet, ahead of time, covering the "facts" about CPR, and use this in conjunction with a conversation with the family and patient.

Not only should physicians be honest about the dismal probability of the success of CPR, physicians should also inform the patient or family about the

---

211 *Id.*

212 Ironically, Dr. Murphy has advocated excluding patients and families from the decisionmaking process when issuing DNR orders, even after observing such success with open and honest communication with patients and families. For a criticism of this view, see Youngner, *supra* note 63.

213 Currently, it is standard practice to attempt CPR on any patient in the hospital who has cardiac arrest, regardless of the patient's underlying illness. *See* Blackhall, *supra* note 16.

214 *See* AMA, *supra* note 16.

215 *See* Blackhall, *supra* note 16.

216 *Id.*

217 W.B. Kouwenhoven et al., *Closed Chest Cardiac Massage*, 173 JAMA 1064 (1960).

218 *See* Blackhall, *supra* note 16.

219 *Id.* at 1282.

possible negative consequences of CPR. When CPR is performed on a frail elderly patient, the chest compressions of CPR will certainly inflict severe damage to the patient, including crushing the ribs and sternum as well as puncturing various internal organs. If the patient is successfully resuscitated, the patient will not only have to deal with the pre-existing illness but also with the extreme pain and suffering that can result from the damage of CPR.[220] The medical community should not withhold this information from the patient or family. While it is recognized that such a conversation may be difficult to conduct, we cannot let awkwardness and aversion to difficult situations determine how the medical profession operates.

The harsh scientific realities that surround medical futility may be very difficult to discuss with a patient or family. Along this line, some physicians assert that the doctrine of informed consent permits a therapeutic exception to providing certain information if hearing this information may be detrimental to the patient's health.[221] This excuse, however, should not be used by physicians as a means of avoiding a discussion about the explicit realities of the success rate of a certain intervention. Furthermore, in many medical futility situations, the patient is not the person who is making the decisions; it is the family or some other surrogate decisionmaker who must hear the explicit details. In this case, the medical community cannot assert the therapeutic exception found in the doctrine of informed consent, because the patient will not hear the information and therefore the health of the patient will not be effected.[222] The medical community should not be permitted to shirk its duty to communicate with patients simply because the topic of futile treatments and death are difficult to talk about. Furthermore, physicians should not be permitted to use the therapeutic exception to informed consent as a shield to avoid talking about the difficult issue.

While the initial duty to communicate should be placed on the physician, the actual burden to communicate should be borne by the entire treatment team. This may include getting assistance from social workers, psychiatrists or members of the clergy. Every medical institution should establish a communication policy designed to educate and counsel families who must deal with decisions concerning the termination of life sustaining treatments. These communication sessions could inform and educate the decisionmakers on medical matters,[223] while assisting them to deal with the emotional difficulties

---

[220] *See generally id.* at 1281.

[221] *See* Rozovsky, *supra* note 122, at 59; *see also* Bradford Wixen, *Therapeutic Deception*, 13 J. LEGAL MED. 77 (1992) (advancing the position that misinformation can be in the patient's best interest and actually have beneficial, physiological results).

[222] *See* Rozovsky, *supra* note 122.

[223] The treatment team could explain the harmful consequences of using CPR on the very elderly and those patients who are in the later stages of terminal diseases. This communication meeting could also provide decisionmakers with an informal opportunity to ask questions about patients who are in a vegetative state and find out if the patient can feel pain. The treatment team can dispel myths and misconceptions,

of permitting someone they love, to die and the difficulties involved in making that decision.[224] These communication policy requirements should be enforced by the Joint Commission on Accreditation of Healthcare Organizations[225] to ensure that ethical issues, as well as the patients' rights issues, are dealt with properly.

If, after the treatment team has met with the family and has exhausted all its resources, the family still refuses to withdraw life support, this decision must be respected on the grounds of patient autonomy and self-determination. While there will inevitably be a small portion of families who will insist on treatments that are considered futile by physicians, the medical profession should be able to accept this tiny percentage.[226] If Dr. Murphy's experience is any indication of the response to open communication however, the awkwardness and inconvenience of open communication and the tiny percentage of resources used will be *de minimis* in comparison to the great majority of those families who will make an informed consent to an order not to resuscitate, or make an informed decision to the termination of life support.

C. The Legislative Solution

Although the issue of communication and medical futility is best resolved within the medical community itself, if the medical community does not accept this responsibility, then each state legislature should become involved. Even though every state has some type of statute designed to permit patients to terminate life support,[227] each state legislature can do more. For those people who have executed a living will or have legally designated a surrogate decisionmaker, the current state statutes are sufficient. However, for the

---

and can educate decisionmakers on treatment concepts and theories (e.g., that the removal of food and hydration for a patient in a permanent vegetative state is no different than the removal of a medication). *See* American Thoracic Soc'y, *supra* note 8.

[224]A family member may continue life support treatments because of guilt, fear or unrealistic hopes. *See* Blackhall, *supra* note 16. The treatment team may be able to help families to resolve their guilt or fear and possibly provide them with more information so that their hopes may become more realistic. *Id.*

[225]The Joint Commission on Accreditation of Healthcare Organizations (J.C.A.H.O.) is an independent body that develops standards of quality in collaboration with health care professionals and others and stimulates health care organizations to meet or exceed the standards through accreditation and the teaching of quality improvement concepts. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS (1992).

[226]Although these patients will be occupying intensive care beds which are relatively scarce, it seems unlikely that patients similar to Helga Wanglie will occupy an important percentage of those beds, let alone a significant proportion of the cost of medical care in the United States. *See* Truog, *supra* note 13.

[227]*See* statutes cited *supra* note 197.

majority of the people who have not made these important decisions,[228] some type of statutory guidelines for managing their case are needed.

When formulating such a statutory response to medical futility, it may be helpful to use as a model, a recently enacted statutory compilation from the State of New York.[229] This compilation of statutes begins by establishing the validity of DNR orders when consent is obtained and when a patient's medical condition warrants such an order.[230] This section of the statute codifies the generally accepted notion that physicians may write a DNR order: but more importantly, this section requires that physicians obtain consent before the order may be written.[231] Every state should follow the New York example by codifying the right of patients to consent to DNR orders. State statutes should not stop with DNR orders, however, but should establish a general, qualified right of patients to autonomy and self determination.

Once the right of self determination is established, a presumption in favor of resuscitation or the continuation of life support should be created.[232] While a presumption in favor of resuscitation or the continuation of life support will err on the side of continuing life, the statute should explicitly state that there is not a *preference* towards resuscitation or the continuation of life support. The statute should make clear that the best alternative is for each person to execute a living will or legally establish a surrogate decisionmaker. If a patient failed to execute either document after entering the hospital, this additional state statute would assure that each patient's rights would be protected. If the patient were still competent, she could make her own decisions concerning DNR orders and future life sustaining treatment. However, if the patient were incompetent and had not executed a living will or durable power of attorney for health care, the statute should outline a hierarchy of family and friends who could serve as the surrogate decisionmaker and the order by which these persons will be chosen.[233] This person would use her best efforts to make the health care decisions of the incompetent patient based on the patient's wishes, including the patient's values, religious beliefs and moral beliefs.[234]

The statute should also establish a legal definition of medical futility. The way in which medical futility is defined is the most important part of the statute, because it is the nucleus of any decisions made by the surrogate or the

---

[228] *See* sources cited *supra* note 204.

[229] N.Y. PUB. HEALTH LAW §§ 2960-2979 (McKinney 1992).

[230] *Id.* at § 2960.

[231] *Id.*

[232] *See, e.g.*, § 2962 ("Every person admitted to a hospital shall be presumed to consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest, unless there is a consent to the issuance of an order not to resuscitate ....").

[233] *See, e.g.*, § 2965.

[234] *Id.*

health care professional. A legal definition of medical futility must be as close to physiologic futility as possible.[235] The statute should also define other types of treatments that are not legally futile, but could be terminated by the surrogate. Under this second category, the use of interventions that would impose an extraordinary burden on the patient in the light of the patient's medical condition and the expected outcome of resuscitation for the patient could also be eliminated.[236] A surrogate could terminate treatment under either of these two definitions.

Under this statute, if two health care professionals agreed that the treatment is legally futile and the attending physician wishes to terminate the treatment, the surrogate decisionmaker should be consulted. The statute should be prepared for a Helga Wanglie[237] situation in which the family refuses to terminate treatment but the physicians wish to do so. In such a situation, the facility's treatment team should, in an informal meeting, explain the medical findings and attempt to educate and counsel the surrogate on the patient's medical condition. If these informal meetings are unsuccessful in resolving the conflict, the statute should provide that every facility should establish a dispute mediation system.[238]

This dispute mediation system should be an informal hearing in front of a hospital board made up of medical and non-medical personnel. This hearing would serve the same function that many hospital ethics committees currently serve: to exchange ideas and opinions on a difficult situation. In this hearing, the hospital would not be permitted to have legal counsel address the mediation board, and, while the family could have legal counsel present, their counsel would also be prohibited from formally addressing the board. The purpose of the mediation system would be to resolve the dispute, not to have professional "hired guns" argue each side of the issue.

In the dispute mediation system, the surrogate's decision should stand unless clear and convincing evidence were produced by the physician that the surrogate's decision was not in accordance with the patient's wishes and beliefs, or was clearly not in the best interests of the patient. The purpose of the dispute mediation system is not to question every decision made by a surrogate, but rather, to provide a safeguard for the few extreme and outrageous situations in which the surrogate was clearly not making a decision in the best interest of the patient. By using the standard of clear and convincing evidence, the statute would insure that physicians would only bring the most serious cases before the mediation board. Also, since there would be presumption that the surrogate was the best person to know what the patient's

---

235 *See, e.g.*, § 2961(12) ("'Medically futile' means that cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest . . . before death occurs.")

236 *Id.*

237 *See* Cranford, *supra* note 14.

238 *See, e.g.*, § 2972.

beliefs and wishes are and what was in the best interests of the patient, a physician would have a difficult hurdle in attempting to overrule a surrogate's decision. This difficult hurdle should ensure that surrogate's decisions were only questioned when there was a great likelihood that an improper decision was being made. If the mediation board did overturn the decision of a surrogate, the surrogate could turn to the courts for judicial review of that decision.

This suggested legislation would provide a framework for maintaining the essential principles of patient autonomy and informed consent, while balancing the ethical rights and principles of the medical profession. While the legislative framework suggested may appear to be laborious and time consuming,[239] it must be remembered that the law "recognizes higher values than speed and efficiency."[240] Such a decision should not be entrusted to a quick and efficient procedural process. Perhaps the most important result of this proposed legislation is that it would demand and compel communication by both parties. It is hoped that open and unfettered communication would resolve many of the disputes. It is also hoped that the full procedural process would be infrequently used and that continued communication would bring about a solution to the issue.

VI. CONCLUSION

The problems associated with medical futility cannot be easily solved. The first major difficulty that arises is attempting to define what medical futility means and within what parameters it exists. True medical futility includes only those treatments or interventions that are physiologically futile and provide no physical benefit to the patient. Health care professionals may unilaterally withhold physiologically futile treatments because such a decision is entirely within the realm of medical science. In situations in which a therapy or treatment may have a low probability of success, a health care professional may not unilaterally decide not to offer that treatment, nor can the professional withhold or withdraw the treatment under the banner of medical futility.

In a situation in which a health care professional unilaterally decides to withhold or withdraw a treatment that is not physiologically futile, the professional may be liable in tort for the injury or death of the patient. To prevent such an injury from taking place, the patient or her surrogate may assert various constitutional challenges to the withdrawal of the treatment. The use of constitutional challenges is the preferred option since this type of action

---

[239]In this type of situation, time and efficiency are not the important factors. Since the statute would provide a presumption against futility, the interventions (i.e., CPR or external life support) would continue to be provided by the health care institution. The only party that might be negatively affected by the delay in a determination would be the health care professionals who would have the burden of continuing to provide the interventions until a final determination were made. This burden seems relatively small in comparison to the dramatic consequences of allowing a life to terminate.

[240]Stanley v. Illinois, 405 U.S. 645, 656 (1972).

can be asserted before the patient is injured. Finally, if the issue of medical futility does reach the courts, the judiciary should recognize and defend the common law right to patient autonomy and self determination. These doctrines will not permit a physician to make unilateral health care decisions for a patient.

The best solution for preventing physicians from making decisions for their patients is for every competent person to execute a living will before the person becomes ill. If every competent person executed a living will while still healthy, physicians would not have to guess at what a patient would want, nor would they have to stretch the definition of medical futility to cover situations that do not involve physiological futility. The medical community should also recognize that communication is the only true solution to medical futility. Beginning in medical school and continuing though private practice, the medical community should require its professionals to communicate with patients and families about futile treatments and about treatments that have a very low probability of success. While communication and advanced directives are the ideal solution to the problem of medical futility, studies have indicated that most people have not executed living wills or assigned a surrogate decisionmaker. Consequently, each state legislature should develop a statutory framework to protect the rights of those individuals who have not developed an advance directive. Regardless of what solution is adopted to handle this difficult issue, the doctrines of patient autonomy and self-determination should be preserved for the benefit of both patients and the professionals who treat them.

DANIEL ROBERT MORDARSKI