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1995]

Essay

WORSHIPPING AT THE ALTAR OF TECHNIQUE: MANIC AGGRESSIVE MEDICINE AND LAW*

CHARLES R. DiSALVO**

"We now act as if we really believe that disease, aging, and death are unnatural acts and all things are remediable."¹

I. INTRODUCTION

ON October 13, 1993, in a hospital in Fairfax, Virginia, Contrenia Harrell gave birth to a girl who would be known to the world only as "Baby K." What marked Contrenia's daughter as different was that she was born without a cerebrum. For whatever period of time her four-and-a-half pound body would live, Baby K would be incapable of any consciousness, any cognition. She would never speak a word nor hear a sound. She was alive only because she had a brain stem, which allowed her body to engage in reflex actions and involuntary functions.

When Baby K had difficulty breathing at birth, the doctors at Fairfax Hospital turned to a mechanical ventilator to sustain her breathing while they confirmed their diagnosis and talked to the child's mother.

The typical result of such parent-physician conversations is an agreement not to prolong the infant's dying, but instead to provide nutrition, hydration and warmth for the few days such infants live. Virtually all physicians and parents see no point in more. Indeed, Baby K's doctors as well as a specially appointed panel of the hospital's ethics committee recommended that further treatment not be given.² Contrenia Harrell, however, knew about mechanical ventilation and she demanded that whenever her daughter needed ventilation she should receive it.

* I owe the phrase "manic aggressive medicine" to Professor William E. May. See William E. May, *When All Is Said and Done*, COMMONWEAL, Oct. 22, 1993, at 26.

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1. Faith T. Fitzgerald, *The Tyranny of Health*, 331 NEW ENG. J. MED. 196, 197 (1994).

2. Linda Greenhouse, *Hospital Appeals Ruling on Treating Baby Born With Most of Brain Gone*, N.Y. TIMES, Sept. 23, 1993, at 10-A, col. 4.

(1365)

The hospital tried to transfer Baby K to another hospital. Predictably, no other hospital would take her. The hospital kept her until, seven weeks after her birth, she was able to tolerate a transfer to a pediatric nursing facility. Baby K's mother agreed to the transfer but only on the condition that the hospital take the child back should she experience respiratory distress.

That move provided only a brief respite for the hospital. Thereafter, Baby K was brought back to the hospital and put on the mechanical ventilator whenever her breathing began to fail. Soon the hospital grew tired of this; it asked the United States District Court for the Eastern District of Virginia to declare it had no obligation to continue ventilation for an anencephalic baby.³ Both the district court, and the United States Court of Appeals for the Fourth Circuit to which the hospital appealed, ruled against it.⁴ The United States Supreme Court refused to hear the case.⁵ The cycle of transporting the child from the nursing home to the hospital for ventilation and then back to the nursing home was to continue for the next two-and-a-half years.⁶

Finally, on April 5, 1995, Baby K succumbed to a cardiac arrest.

3. The formal term for children born without cerebrums. The trial court found:

Anencephaly is a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. There is no treatment that will cure, correct, or ameliorate anencephaly. Baby K is permanently unconscious and cannot hear or see. Lacking a cerebral function, Baby K does not feel pain. Baby K has brain stem functions primarily limited to reflex actions such as feeding reflexes (rooting, sucking, swallowing), respiratory reflexes (breathing, coughing), and reflexive responses to sound or touch. Baby K has a normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function and has gained weight since her birth. Most anencephalic infants die within days of birth.

In re Baby K, 832 F. Supp. 1022, 1025 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

4. *Id.* at 1026. The United States District Court for the Eastern District of Virginia ruled that refusing Baby K the ventilator would violate the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (1988 & Supp. V 1993), the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1994), and the Emergency Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (1988 & Supp. V 1993). *Baby K*, 832 F. Supp. at 1026-29. The district court declined to rule on the question of whether refusing ventilator services would violate the Child Abuse Prevention and Treatment Act, 42 U.S.C. §§ 5101-5106h (1988 & Supp. V 1993) or the statutes and common law of Virginia. *Baby K*, 832 F. Supp. at 1029. The United States Court of Appeals for the Fourth Circuit ruled only that refusal would violate EMTALA; it declined to address the remaining questions. 16 F.3d at 596.

5. *In re Baby K*, 115 S. Ct. 91 (1994).

6. From the time of her birth to October 7, 1994, Baby K was put on the ventilator six times. Marylou Tousignant & William Miller, *Baby K's Mother Gives Her the Prayer That Many Deny She Has*, WASH. POST, Oct. 7, 1994, at A1.

Only then were all the parties to this story—the hospital, the mother, the child, her doctors and the courts—free from the grip of the mechanical ventilator.

The machine that kept Baby K's body breathing, the machine that was a frequent and dominating bedside presence, is a symbol of the technology before which American society, medicine and law genuflect with a mixture of fervor and awe. For Americans, technology, especially medical technology, is the alpha and the omega, the beginning and the end.

Why?

Why do Americans so readily embrace CPR, intubation, EKGs, angioplasty, the coronary by-pass, lithotripsy, MRI and CAT scans? Why do Americans demand that there be a technological test for every ailment—and that they get unambiguous responses?

Why must every American home have a VCR, a computer and a cordless telephone?

Indeed, why did Americans react to the tragedy of the high-tech Gulf War, which killed upwards of 100,000 people, as if it were a video game?

In 1954, a little-known French theorist, Jacques Ellul, predicted we would be asking these questions when he published his controversial book, *La Technique ou l'enjeu du siècle*.⁷ In it Ellul said: "No social, human, or spiritual fact is so important as the fact of technique in the modern world. And yet no subject is so little understood."⁸

Now, more than forty years after Ellul wrote these words and more than thirty years after their appearance in the American publication of the English translation, entitled *The Technological Society*, the importance of "la technique"⁹ to an explanation of our modern condition remains terribly underestimated. Yet the role of technology in the creation of a world that grows more inhospitable to humanity each day has become more virulent, more malignant than ever.

Ellul warned us that technology, which he defined as the one

7. Literally, *Technique or the Stake of the Century*. A student of Ellul, Professor Darrel J. Fasching, states that Ellul's "analysis of the technological society and his own theological response represent a ground-breaking milestone in the history of modern theology." DARREL J. FASCHING, *THE THOUGHT OF JACQUES ELLUL* vii (1981).

8. JACQUES ELLUL, *THE TECHNOLOGICAL SOCIETY* 3 (1964).

9. One might translate Ellul's "la technique" in English as "technology." For a discussion of the terms "technique" and "technology" as used by Ellul, see *infra* note 14. Both terms will be used here depending on the context.

most rational and efficient means of accomplishing any task, presses human value out of any enterprise to which it is applied. Thus, the automobile displaced walking and gave us smog, television displaced conversation and contributed to the destruction of family life,¹⁰ the telephone displaced correspondence and gave us the answering machine.¹¹ Technology displaces the pursuit of the human with the pursuit of the efficient.

Medicine and law simply reflect the values of the larger society in which they are practiced. Thus, the ill effects of technology are no less pernicious in these fields than they are elsewhere in society. Using medical and legal technique as illustrative of the greater problem, I ask in this essay: From what sources does technique draw its power? Can society, law and medicine overcome technique? Can people wrest control of their lives from its dominion?

In this essay I first seek to draw attention to the inherent power of technology, to human weakness for technology, and to the dehumanizing effects of technology. In aid of this effort, I synthesize the salient points of what Jacques Ellul and Eric Cassell have had to say about technology. I then examine *In re Baby K* as a case study of how law and medicine are presently unable to resist technology. Finally, I state what is necessary for society, law, and medicine to recover and maintain our control over technology in general and medical technology in particular.

II. JACQUES ELLUL AND TECHNIQUE

Until his death in May of 1994, Jacques Ellul was a theologian, historian and sociologist of some repute in Europe and to a somewhat more limited extent in the United States. Born in 1912, he was trained in law, history and sociology, obtaining his doctorate in law in 1936. He taught until 1980 in the Department of Law and Economic Sciences at the University of Bordeaux, where his professorship was in history and the sociology of institutions.¹² His thinking was distinctly dialectical, with its roots in both Barth and Kierkegaard. Though he once flirted with the Marxist explanation

10. For an illustration of this point see the film *AVALON* (Baltimore Pictures/TriStar 1990).

11. Ellul also believed modern technology, because it isolates individuals from the community, is simultaneously destroying human culture and creating "networks" that exclude human beings from them. JACQUES ELLUL, *THE TECHNOLOGICAL BLUFF* 146 (1990).

12. DAVID W. GILL, *THE WORD OF GOD IN THE ETHICS OF JACQUES ELLUL* 18-25 (1984); Carl Mitcham, *Jacques Ellul and His Contribution to Theology*, XXXV *CROSS CURRENTS* 1 (1985).

of history, he came to reject its principle that class was at the core of history, believing instead in the central place of technique. His prolific output of writing is characterized by passion, contradiction and hyperbole.¹³

The central thesis of *The Technological Society*, to which Ellul dedicated so much of his life as a scholar and teacher, can be put this way: There is in society a powerful force, the phenomenon of "technique."¹⁴ A technique is the most rational and efficient manner—the "one best means"—for accomplishing any task,¹⁵ whether it be organizing a corporation or communicating through a network of computers. As examples, Ellul cites modern public transportation systems in which people are less important than parcels,¹⁶ hospitals in which patients are but numbers,¹⁷ television which retards human communication,¹⁸ computer games which lead to addiction to the screen,¹⁹ and automobiles which fascinate us with their speed and appearance, drugging us to the reality that they, too, have helped destroy our communities.

Professor Willem Vanderburg explains Ellul's notion of technique this way:

13. Among the best known of his 24 books in English, in addition to THE TECHNOLOGICAL SOCIETY, *supra* note 8, are THE THEOLOGICAL FOUNDATION OF THE LAW (1960), PROPAGANDA: THE FORMATION OF MEN'S ATTITUDES (1965), THE POLITICAL ILLUSION (1967), A CRITIQUE OF THE NEW COMMONPLACES (1968), HOPE IN TIME OF ABANDONMENT (1973), THE NEW DEMONS (1975), THE ETHICS OF FREEDOM (1976), APOCALYPSE: THE BOOK OF REVELATION (1977), THE TECHNOLOGICAL SYSTEM (1980), and THE TECHNOLOGICAL BLUFF, *supra* note 11.

14. Ellul states:

When I use the French word *technique*, normally translated into English as *technology*, I do not mean exactly the same thing as the French word *technologie*, which is also translated into English as *technology*. We have to be meticulous about this simple point of vocabulary. I know that the two are habitually confused. Etymologically, of course, *technologie* means a discourse on *technique*. That is the true meaning of *technologie*. Now when I speak of *technique* [English *technology*], I am speaking of the technological phenomenon, the reality of the technological I know the difficulty of this semantic problem in English, for there is only one single word, *technology*, to designate both *la technique* (the concrete thing) and *la technologie* (the discourse, the teaching of the subject itself). But we must absolutely distinguish between the two [F]or me, *la technique* is a far wider concept, referring to efficient methods applicable in all areas (monetary, economic, athletic, etc.). I would prefer that English retain the word *technique*.

JACQUES ELLUL, PERSPECTIVES ON OUR AGE 32-33 (1981).

15. ELLUL, *supra* note 8, at 21.

16. *Id.* at 5.

17. *Id.*

18. ELLUL, *supra* note 11, at 335.

19. *Id.* at 364-65.

Our world has emerged from what Ellul calls a technical intention, the preoccupation of our civilization with the one best way of doing things. It involves studying every human activity and using the results to build some kind of model. By determining under which conditions the model functions best, one can proceed to restructure that activity to make it as efficient as possible.²⁰

By technique, Ellul does not simply mean machines. Technique is a broader category of which the machine is an example. Technique, says Ellul, "transforms everything it touches into a machine," the result of which is the creation of "an inhuman atmosphere."²¹

Technique invades every aspect of life.²² In science, we find that no technique can resist immediate—and generally thought-

20. Willem H. Vanderburg, *What an Engineer Found in Ellul*, XXXV CROSS CURRENTS 88, 90 (1985). Vanderburg is a member of the faculty of the University of Toronto and is the editor of JACQUES ELLUL, PERSPECTIVES ON OUR AGE, *supra* note 14.

Professor James Grote illustrates the meaning of technique for people:

The heart of technical systems is "efficient ordering." To accomplish this order, human spontaneity and accidents of nature must be minimized. Nothing can be left to chance—except the direction of the entire system! To improve economic productivity, industrial techniques are created. These in turn require the systematization of labor to fit the demands of the machine. To integrate human beings with machines requires new psychological techniques which, in turn, permit the creation of new mechanical techniques that require "new men" to operate them.

James Grote, *Living on Two Levels*, XXXV CROSS CURRENTS 77, 79-80 (1985).

21. ELLUL, *supra* note 8, at 4. Ellul declaims in particular against the cities: Consider the concentration of our great cities, the slums, the lack of space, of air, of time, the gloomy streets and the sallow lights that confuse night and day. Think of our dehumanized factories, our unsatisfied senses, . . . our estrangement from nature And the noise, that monster boring into us at every hour of the night without respite Life in such an environment has no meaning.

Id. at 4-5 (sentences appear in different order in text). Ellul sees the city as the place where technique is most graphically visible, making cities most inhospitable. Theologian Harvey Cox (author of *The Secular City*) has taken issue with Ellul on this point. Harvey Cox, *The Ungodly City: A Theological Response to Jacques Ellul*, 94 COMMONWEAL 351 (1971).

22. In finding that our own machines have replaced us, Ellul concludes: We cannot evade technique. It has laid hold of every domain and activity and reality. Nothing at all is beyond its grasp. It is *causa sui*. Ordinary common sense expresses this in the saying that we cannot stop progress. But this popular phrase has now become the last word in all consideration of these phenomena. When it is a question of dangers, costs, etc., at the end of the argument scientists and technicians close the debate by saying that we cannot stop progress.

ELLUL, *supra* note 11, at 218.

less—implementation. “Technique produces more technique whether it makes sense or not, whether it is needed or not.”²³ Thus, new car models must be produced each year, with one outdoing the other in marginally useful techniques—a button to tell us the temperature, another to raise the radio antenna.

In the invention and application of technique, there is no concern for consequences. Here one might think of the unanticipated effects of the gasoline-powered auto engine with its deadly emissions, its destruction of community life, and the creation of urban sprawl. In public life, one finds that technique accomplishes the sterility brought about by the standardization and rationalization of the social, economic and administrative spheres. Ellul’s reference to hospitals is a too-painful reminder for anyone who has spent time as a patient in a large urban hospital.²⁴

Ellul also explains the synergistic effect of the ensemble of techniques by reference to what he calls the “phenomenon of technique,” which he describes as the convergence of systems of technique upon people, causing “operational totalitarianism.” The result, says Ellul, is that “no longer is any part of man free and independent of these techniques.”²⁵ Humanity is enslaved to technique. Both spontaneity and traditional methods alike die. People find life devoid of meaning.

What accounts for the dominance of technique? According to Ellul there is a set of interrelated, overlapping characteristics that creates the power of technique:

- *Automatism.* The choice to employ a technique at all, as well as the choice among techniques, is automatic. There is no contest between spontaneous activities and technique: technique “automatically eliminates every nontechnical activity or transforms it into technical activity.”²⁶ As for choices among techniques, again there is never any doubt about the result. Technique dictates a decision in favor of “maximum efficiency.”²⁷ Let there be no question here about the extreme nature of Ellul’s meaning. The force of technique operates without the intervention of personal choice,²⁸ until

23. *Id.* at 263.

24. These are but examples. Technique exists in every field of modern life: social, commercial, industrial. We find technique in propaganda, in education, in the media. For a discussion of the characteristics of the technique, see *infra* notes 26-40 and accompanying text.

25. ELLUL, *supra* note 8, at 391.

26. *Id.* at 83.

27. *Id.* at 80.

28. *Id.*

the entire environment is controlled by technique.²⁹

- *Self-augmentation.* A characteristic related to automatism is self-augmentation. Like a snowball rolling downhill, technique acquires more and more weight, speed, power and magnitude the longer it rolls. But there the comparison ends. There is virtually no bottom of the hill at which technology will come to rest. As Ellul puts it, “[t]echnical progression is of the same nature as the process of numbering; there is no good ground for halting the progression, because after each number we can always add 1.”³⁰ As technique grows, the role of people, though always necessary, diminishes to a point near extinction. One who believes, in the face of this reality, that people are masters of the process of production is gripped by illusion,³¹ for in reality technique self-generates.³²

- *Monism.* The ensemble of all techniques creates the technical phenomenon. This phenomenon has no purpose other than to progress. It is not controlled by people nor directed by them toward certain moral ends but, rather, has its own technical morality: the use of technique and the growth of the phenomenon. Continued growth means immediate application of new techniques without examination of the consequences of the uses of the technique which, in the long run, are usually untoward. The phenomenon is driven by the cardinal principle of technique: efficient ordering.³³

- *Universalism.* Technique knows no borders. All cultures, whether first world or third world, are affected by technique in the same way. Traditional cultural and economic forms as well as traditional psychological and sociological structures collapse: technique “dissociates the sociological forms, destroys the moral framework, desacralizes men and things, explodes social and religious taboos, and reduces the body social to a collection of individuals.”³⁴ Where tradition once stood, technique rules. Thus, Ellul is able to say that “technique cannot be otherwise than totalitarian. . . . [E]verything must be subordinated to it Technique can leave nothing untouched in a civilization. Everything is its concern.”³⁵

- *Autonomy.* Technique has dispensed with the need for human creativity. People are mere catalysts for technique, like the slugs that start slot machines: they “start the operation without par-

29. *Id.* at 84-85.

30. *Id.* at 90.

31. *Id.* at 93.

32. *Id.* at 94.

33. *Id.* at 110.

34. *Id.* at 126.

35. *Id.* at 125.

ticipating in it.”³⁶ People are thus reduced in stature because technique accepts no rules or norms but its own. It has but one function: “to strip off externals, to bring everything to light, and by rational use to transform everything into means.”³⁷

The consequences of this characteristic are several. For people, they cannot have liberty in the face of technical autonomy. People must serve technique, not technique people. Perhaps more importantly, technique desacralizes the previously mysterious and then places itself on the throne of the sacred:

Nothing belongs any longer to the realm of the gods or the supernatural. The individual who lives in the technical milieu knows very well that there is nothing spiritual anywhere. But man cannot live without the sacred. He therefore transfers his sense of the sacred to the very thing which has destroyed its former object: to technique itself.³⁸

In a postscript to his description of the characteristics of technique, Ellul charges technique with this final, devastating consequence: “man is no longer able to recognize himself because of the instruments he employs.”³⁹ Eventually,

[w]ith the final integration of the instinctive and the spiritual by means of . . . techniques, the edifice of the technical society will be completed. It will not be a universal concentration camp, for it will be guilty of no atrocity. It will not seem insane, for everything will be ordered, and the stains of human passion will be lost amid the chromium gleam. We shall have nothing more to lose, and nothing to win. Our deepest instincts and our most secret passions will be analyzed, published, and exploited. We shall be rewarded with everything our hearts ever desired. And the supreme luxury of the society of technical necessity will be to grant the bonus of useless revolt and of an acquiescent smile.⁴⁰

36. *Id.* at 135. The “slug starting the slot machine” analogy is Ellul’s. *Id.*

37. *Id.* at 142.

38. *Id.* at 143.

39. *Id.* at 146.

40. *Id.* at 426-27.

III. IN RE *BABY K*: TECHNOLOGY AS ADDICTION

An anencephalic is not and cannot ever be a sentient human being.⁴¹ Thus, while there is much one can do *to* an anencephalic infant,⁴² there is nothing anyone can do *for* such a child. Accordingly, as a general rule, physicians cannot, and do not, treat anencephalics. How did it come about, nonetheless, that Baby K's mother could and did demand that a ventilator be attached to her daughter? How did it come about that the courts ruled for her?

We must recognize, to begin with, the simple fact that the technological means to assist Baby K's breathing existed. Before the ventilator, physicians could only push breath into a patient's lungs by using a rather large and clumsy device called the "iron lung." Technology, however, is never content to stand still; it is *self-augmenting*. With the invention of the modern mechanical ventilator, small enough to push around on a cart, the iron lung became inefficient. There was a more efficient means, the ventilator. The choice to breathe with a new technology became automatic. Why use no means or less efficient means when very efficient ones were available? More to the point, why would one *not* employ the modern technology every time? It is the default position. Because the technology is there, it is used. There is no evidence that Baby K's doctors, like so many others who employ medical technology, gave much thought to, or had much discussion about, *whether* to employ the technology. They simply hooked it up as soon as the child was born.⁴³ Thus, from the start, there is no choice, no independent human volition, no reasoned decision-making. The move to tech-

41. Moreover, as some argue, in certain situations, treatment "is no significant benefit for the patient, it serves no valid medical goals, it can violate the integrity of the medical profession, and physicians would be poor stewards to waste scarce resources on clearly hopeless causes." E. Haavi Morreim, *Futilitarianism, Exoticare, and Coerced Altruism: The ADA Meets its Limits*, 25 SETON HALL L. REV. 883, 886-87 (1995).

42. Baby K, for example, had a tracheotomy and a gastrostomy. Ellen J. Flannery, *One Advocate's Viewpoint: Conflicts and Tensions in the Baby K Case*, 23 J.L. MED. & ETHICS 7 (Spring, 1995).

43. Baby K's mother and her doctors all knew that Baby K would be born with anencephaly because it had been diagnosed prenatally. According to the attorney for Contrenia Harrell, Baby K's doctors had agreed prior to her birth to honor her mother's request to place Baby K on a ventilator at birth. Flannery, *supra* note 42, at 7.

One commentator has called the decision of the doctors to administer ventilation a "medical misjudgment . . . that may have given the mother the impression that the doctors would provide medically inappropriate treatment to her child if she so desired." George J. Annas, *Asking the Courts to Set the Standard of Emergency Care—The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1543 (1994).

nology is *automatic*.⁴⁴

The technology of the ventilator, like all medical technologies, is also largely independent of human morality as a controlling and limiting force. The ventilator will work regardless of whether or not the finger pushing its buttons is connected to a person who has made a moral judgment about whether the technology should be employed. The finger could be attached to Adolph Hitler; the finger could be attached to Mother Teresa. The technology does not care. The ventilator has no moral value and no moral opinion. It can be engaged without the precondition of moral discourse. Indeed, Baby K was put on the ventilator so that the humans involved could have moral discourse *afterwards*. There is no morality to technology; there is only *monism*. The substance of technology is technology.

Once it is in place (admittedly put there by human agency, but much like a slug starts a slot machine⁴⁵), technology needs very little human assistance. Modern ventilators, once they are programmed, operate quite nicely on their own. They are automatically supplied with oxygen by a tube connected to a wall outlet; this tube is then connected to a second tube in the patient inserted through either the patient's nose, mouth or a hole cut in the patient's throat. Assuming a cooperative and stable patient, the machine, which regulates the amount of oxygen and air put into the patient and the timing of the breathing, can then be left running without the need of intervention for hours at a time. It will breathe on its own. The ventilator is *autonomous*.

Even if one were to view this Ellulian interpretation of medical technology as exaggerating the power of technology as a force to itself, one would nonetheless have to concede that there is a powerful human weakness for technology. In his essay *The Sorcerer's Broom*,⁴⁶ Dr. Eric Cassell identifies five *human* characteristics that make the use of technology in the medical profession difficult to resist:

- *Wonder*. Cassell tells the story of a trip to a Pittsburgh medical center where his hosts show him the center's shiny new cardiac cath labs. "Why, [he asks,] didn't they take me by somebody's of-

44. For a gripping account of the difficulty of disentangling technology from the lives of infants for whom there is no hope of survival, see Darcy Frey, "Does Anyone Here Think This Baby Can Live?", N.Y. TIMES, July 9, 1995 (Magazine), at 22.

45. For a further discussion of Ellul's "slug" analogy, see *supra* note 36 and accompanying text.

46. Eric J. Cassell, *The Sorcerer's Broom: Medicine's Rampant Technology*, 23 HASTINGS CENTER REP. 32 (Nov. - Dec. 1993).

face (whispering, so as not to disturb) and say, 'There's one of our smartest doctors'? Because everybody loves the new and the shiny. . . ."47

- *The lure of the immediate.* Unlike patients, technologies give us hard and fast data, "unmediated by our own reasoning." For example, doctors prefer computer-generated EKG interpretations to patient interviews and examinations. "Science has ruled out of court the information from values . . . by which we lead our lives One of the advantages of the immediate [by contrast] is that it provides answers—information—when more relevant understanding would require deeper reasoning and greater involvement from doctors as persons."⁴⁸

- *The lure of the unambiguous.* Specific technologies produce specific results. This reality leads, says Cassell, to a diminishment in subtle distinctions and a narrowing down of the "field of difference between what is good and what is bad, so that ultimately one test result is taken to be good and another result bad."⁴⁹

- *The dislike of uncertainty.* It is not unreasonable for humans to seek certainty. Every profession values it. The difficulty lies in the fact that while medicine is a very inexact science, physicians are not trained in the "management of uncertainty As a consequence, they tend to utilize any diagnostic or therapeutic technique that promises to reduce uncertainty. This leads to a . . . law of technology: whatever technique promises greatest certainty, even if inappropriate, will diminish the use of techniques associated with greater uncertainty."⁵⁰

- *The lure of power.* Doctors are drawn to technology because it confers power on them. Our society confers status and rank on people who have control over technologies which gather to themselves space and personnel. Technical power is particularly alluring because it affords young physicians power that they could not otherwise earn except through years of wisdom-building practice.⁵¹

This set of factors helps explain why the American medical es-

47. *Id.* at 33.

48. *Id.* at 34.

49. *Id.* at 35.

50. *Id.* at 37. Elsewhere Dr. Cassell illustrates his point:

Call to mind an intensive care unit with monitors blinking and beeping and remember how all eyes (even family members') go to the machine—and away from the patient. It requires effort *not* to watch the monitors. Technology—machines, instruments, drug treatments—like blinkers on a horse, restrict and define and thus simplify the viewpoint.

ERIC J. CASSELL, *THE NATURE OF SUFFERING* 22 (1991).

51. Cassell, *supra* note 46, at 38.

establishment is quick on the technology trigger.⁵² The effects of such weakness for technology are enormous. While it is widely recognized that the spiraling cost of medical care can be ascribed in part to the misuse and overuse of technologies,⁵³ what is less well-known is the depersonalizing effect technology has on the physician-patient relationship. Cassell makes the case that for the patient, the technology becomes the doctor and for the doctor, the technology becomes the patient. For the patient, the doctor fades in importance except as a technician. For the doctor, the patient is not the object of study, the patient's interaction with technology is the object of study. For each, the technological output, "the test results," become the real authority in the case.⁵⁴

52. There are, of course, other factors which some argue contribute to doctors' use of technology. These include the desire to practice defensive medicine and the ownership by physicians of the diagnostic services to which they refer their own patients. *Defensive Medicine and Medical Malpractice*, 14 PEOPLE'S MED. SOC'Y NEWSL. 1 (Feb. 1995); see MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS* 10 (1993) (discussing financial conflict of interest that is created when physicians refer patients to medical care facilities in which physician has financial interest); Arnold S. Relman, *Dealing with Conflicts of Interest*, 313 NEW ENG. J. MED. 749 (1985) (noting that "practicing physicians now have financial interests in diagnostic laboratories, radiologic imaging centers, walk in clinics, ambulatory surgery centers, dialysis units, physical therapy centers, and other such facilities"); *The High Cost of Referral-for-Profit*, NATION'S BUS., May, 1992, at 64 (noting that "referral-for-profit" is one element in an economic incentive system that contributes significantly to sky-high health care costs).

53. Roger W. Evans, *Advanced Medical Technology and Elderly People, in TOO OLD FOR HEALTH CARE? CONTROVERSIES IN MEDICINE, LAW, ECONOMICS AND ETHICS* 45 (Robert H. Binstock & Steven G. Post eds., 1991); see also ROBERT H. BLANK, *RATIONING MEDICINE* 10-11 (1988) (noting that life-extending technology creates policy dilemma because of simultaneous call for both expensive treatment and cost containment); LARRY R. CHURCHILL, *RATIONING HEALTH CARE IN AMERICA: PERCEPTIONS AND PRINCIPLES OF JUSTICE* 7-8 (1987) (referring to modern technologies as "halfway technologies" because they are very expensive but not curative or are only partially curative); *CRITICAL ISSUES IN MEDICAL TECHNOLOGY* (Barbar J. McNeil & Ernest G. Cravalho eds., 1982) (especially David Blumenthal et al., *Misuse of Technology: A Symptom, Not the Disease*, at 163) (noting that health care technology has been accused of decreasing overall quality of patient life and making medical care less humane and personal); Woodrow E. Eno, *Private Market-Based Health Reform Is the Answer*, KAN. J.L. & PUB. POL'Y, Fall, 1993, at 35, 36 (discussing population's general dissatisfaction with cost of health care and desire for reform). *But see* Arnold S. Relman, *The Trouble with Rationing*, 323 NEW ENG. J. MED. 911, 911 (1990) (attributing problems of health care system to duplication, waste, and excessive overhead and not to technology); Anne A. Scitovsky, *Medical Care in the Last Twelve Months of Life: The Relation Between Age, Functional Status and Medical Care Expenditures*, 66 MILBANK Q. 640, 658 (1988) (cautioning against rationing of high technology care without further study).

54. Americans are not heard to say, of a sick friend or relative, "her doctor is trying to determine what's wrong with her," so much as "she's in for tests."

Daniel Callahan puts the point this way: "Because of the focus on technological intervention, the human relationships are often neglected, judged less important, more dispensable, than the necessity of high-quality technical work."

In *Baby K*, the ventilator took on a much greater presence and authority than Baby K, her physicians or nurses. From the point of view of the patient and her mother, Contrenia Harrell's faith was not in her baby's doctors, who were telling her that based on their experience and study the bodies of anencephalic babies should not be kept breathing on ventilators. Her faith was in the ventilator.⁵⁵ From the point of view of the physicians involved, their faith was not initially in the doctor-patient relationship or even their own medical judgment. Rather, it too, was in the ventilator. Like a bad friend, by putting Baby K on the ventilator, the hospital introduced the patient and her mother to the drug of technology. The patient and her mother quickly became addicted to it.⁵⁶

The inherent dynamic of technology and the attraction of people to technology conspire in Baby K's case to give birth to the "operational totalitarianism" of technology. The ventilator controls

Machines and lab results and scanners become the center of attention; they replace conversation with the patient." DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY* 41 (1993).

Commenting on the Baby K case, Dr. Michael Grodin of the Program on Medical Ethics at the Boston University School of Medicine and Public Health has been quoted as saying, "For a baby that has no brain and is born dying, life for just another minute or another day is not an appropriate goal. It's saying that *it's the technology that has life, not the patient.*" Greenhouse, *supra* note 2, at 10-A, col. 4 (emphasis added).

Dr. Arthur R. Kohrman, chair of the bioethics committee of the American Academy of Pediatrics, states that "The Baby K decision strips away the ability of physicians to act as moral agents and turns them into *instruments of technology.*" Linda Greenhouse, *Court Order to Treat Baby with Partial Brain Prompts Debate on Costs and Ethics*, N.Y. TIMES, Feb. 20, 1994, at 20, col. 1 (emphasis added).

55. This is not what Ms. Harrell actually said, of course. She said that she wanted her daughter to remain on the ventilator so that God could work a miracle. Apparently, Ms. Harrell believed that God might cure the baby's anencephaly. Underlying what appeared to be Ms. Harrell's faith in God was in fact an idolatry of physical life and a *lack* of faith in things spiritual. For a further discussion of spiritual faith in this context, see *infra* notes 87-112 and accompanying text.

56. In most cases, it is the patient, the patient's family, or the patient's representative, not the patient's physicians, who wants to release the dying patient from intrusive medical technology. See, e.g., *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 261 (1990) (mother and father requested that their daughter's artificial nutrition and hydration be terminated because she was in persistent vegetative state); *In re Quinlan*, 355 A.2d 647, 651 (N.J. 1976) (father sought to discontinue all extraordinary medical procedures that were being used to sustain his daughter's vital processes, because there was no hope of recovery); *In re Eichner*, 420 N.E.2d 64, 67 (N.Y. 1981) (priest representing patient sought to turn off respirator which was being used to sustain patient after patient suffered brain damage as complication of surgery). The medical establishment is usually the party resisting the withdrawal of the technology.

While it is true that it was the hospital in Baby K that wanted to eventually deprive the baby of the ventilator, it was the same hospital that put the child on the ventilator in the first instance. Without this initial embrace of the technology, the mother's insistence on its continued use would not have been possible.

all.⁵⁷

IV. LAW AS TECHNIQUE

The Fourth Circuit does nothing to challenge the jurisdiction of technology in its *Baby K* decision. Why? There are two reasons this court is capable of doing little else.

To begin with, this court, like most courts, simply mirrors the norms of the society in which it operates. Why are courts conservative in this way? The answer lies in understanding a court's ability to see that its will is done. The power of a court to enforce its rulings does not grow out of the physical means it has at hand to command enforcement; those means are quite limited. Courts instead rely heavily on whatever moral capital they have on deposit with the general public for compliance. To prevent this account from being overdrawn, a court will issue decisions that require either no, or very little, of the court's own moral capital. *Brown v. Board of Education*⁵⁸ is the preeminent exception to this rule.⁵⁹

Baby K is no *Brown*. Society is addicted to medical technologies.⁶⁰ Ruling against the wishes of Baby K's mother would have meant requiring society to give up its technological fix. Mirroring society at large, the Fourth Circuit did not have the moral resources with which it could free society, Baby K's mother, or itself from dependence on technology.

The second reason the Fourth Circuit did nothing to challenge the rule of medical technology is that the court itself is a captive of technique—in this case, judicial technique. A judicial decision that is pure technique is one that appeals to its authors for its lack of ambiguity, contains the promise of certainty, and is automatic, autonomous, and monistic. *In re Baby K* reflects all these. As such, the opinion is the perfect instrument for reinforcing the ascendancy of medical technology and manic aggressive medicine.

Prior to the passage of the Emergency Medical Treatment and

57. ELLUL, *supra* note 8, at 391.

58. 347 U.S. 483 (1954).

59. What made *Brown* so remarkable from this perspective was that it went against the grain of established norms in ordering desegregation of the nation's schools. On occasion, troops were required to enforce this constitutional mandate. Perhaps the most well-known example of the use of force occurred in Little Rock, Arkansas when President Dwight Eisenhower called in the 101st Airborne Division to safeguard the rights of nine black children desirous of attending an all-white high school. See TAYLOR BRANCH, PARTING THE WATERS 222-24 (1988).

60. See Daniel Callahan's description of "technological monism" in DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE 67-69 (1993).

Active Labor Act of 1986 (EMTALA),⁶¹ hospitals engaged in, and were widely criticized for, a practice known as "dumping."⁶² Dumping occurs when a hospital, presented with an uninsured and impecunious patient in an emergency condition, refuses to treat the patient, sending the patient home or to another facility,⁶³ typically a public or religiously-affiliated hospital.⁶⁴ The results of dumping were predictable: the conditions of many patients suffered as a result of the delay in their care. Some of these patients, in fact, died.⁶⁵ EMTALA was enacted for one clear purpose: to prevent dumping.⁶⁶ Through EMTALA, Congress intended to stop dump-

61. Act of April 7, 1986, Pub. L. No. 99-272, Title IX, § 9121, 100 Stat. 164 (codified as amended at 42 U.S.C. § 1395dd (1988 & Supp. IV 1993)).

62. See Emily Friedman, *Special Report—The Dumping Dilemma: Finding What's Fair*, HOSPITALS, Sept. 16, 1982, at 75, and articles cited therein.

63. *Patient Dumping After Cobra: Assessing the Incidence and the Perspectives of Health Care Professionals*, Office of Inspector General, No. OAI-12-88-00830, [Sept. 1988 - Apr. 1989 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 37,580, at 18,986 (Dec. 12, 1988).

64. Emily Freidman, *Special Report—The "Dumping" Dilemma: The Poor Are Always with Some of Us*, HOSPITALS, Sept. 1, 1982, at 51, 52.

65. See Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1886 (1986) (providing examples of results of dumping); Friedman, *supra* note 64, at 51, 56 (discussing problems associated with dumping).

66. The legislative history of EMTALA, part of the COBRA of 1986, makes the purpose of EMTALA unquestionably clear:

In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. Although at least 22 states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists, and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide emergency care, some are convinced that the problem needs to be addressed by federal sanctions.

As a result of this concern, the Ways and Means Committee reported § 124 of H.R. 3128 (new § 1867 of title 42). This section requires a hospital which has a Medicare Provider Agreement and which operates an emergency department to provide an appropriate medical screening of any individual for whom a request for treatment is made. The purpose of this screening is to determine if an emergency medical condition exists or if the patient is in active labor. If the hospital determines that either condition exists, the hospital must provide further treatment to stabilize the individual or, if it determines to transfer the individual to another facility, it must properly complete this transfer.

H.R. REP. NO. 241, 99th Cong., 2d Sess. 5, pt. 3, reprinted in 1986 U.S.C.A.N. 726-27.

The courts have had no difficulty accepting the prevention of dumping as the purpose of EMTALA. See, e.g., *Tolton v. American Biodyne*, 48 F.3d 937, 943 (6th Cir. 1995) (noting purpose of EMTALA was prevention of dumping); *Vickers v. Nash Gen. Hosp., Inc.*, 875 F. Supp. 313, 316 (E.D.N.C. 1995) (same); *Anadumaka v. Edgewater Operating Co.*, 823 F. Supp. 507, 510 (N.D. Ill. 1993) (same); *Carodenuto v. N.Y. City Health & Hosp. Corp.*, 593 N.Y.S.2d 442, 445 (Sup. Ct.

ing by requiring hospitals that accepted Medicare patients (1) to offer patients who arrive at the hospital "an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists"; and (2) to provide the medical treatment "required to stabilize the medical condition" or to transfer the individual elsewhere if the benefits of a transfer outweigh the risks.⁶⁷

The fact with which the Fourth Circuit could never seem to come to grips was that the Baby K case was *not* a dumping case.⁶⁸ There was never any question that there would be third-party payment.⁶⁹ Indeed, Baby K's hospital bill, totalling nearly \$250,000,

1992) (same). Even the Baby K court recognizes the purpose (and then ignores it). See *In re Baby K*, 16 F.3d 590, 593 (4th Cir. 1994) ("Congress enacted EMTALA in response to its 'concern that hospitals were dumping patients [who were] unable to pay.'").

67. 42 U.S.C. § 1395dd(a)-(c) (1988 & Supp. IV 1993). For a critical view of EMTALA, see Judith L. Dobbertin, Note, *Eliminating Patient Dumping: A Proposal for Model Legislation*, 28 VAL. U. L. REV. 291, 314 (1993) (discussing EMTALA).

68. A fact recognized by the dissent. *Baby K*, 16 F.3d at 598. Strangely enough, in an earlier EMTALA case, the Fourth Circuit specifically recognized the purpose of EMTALA as a factor in its decision not to extend its protection to a plaintiff seeking damages for an EMTALA violation. See *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 884 (4th Cir. 1992) (declining to extend EMTALA beyond plain language).

Supporters of the *Baby K* decision (and others) attempt to deflect the criticism that the court ignored the legislative history of EMTALA by saying, in part, that the clear language of EMTALA has left courts considering this question with no choice but to interpret EMTALA as applying to *all* patients, not simply to those whose less than standard treatment is motivated by economic concerns. See, e.g., Pamela K. Epps, Note, *In Defense of the Masses—An Interpretation of the Emergency Medical Treatment and Active Labor Act*: In *Re Baby K*, 28 CREIGHTON L. REV. 1209, 1237 (June 1995) (supporting court's uses of plain language in *Baby K* decision); Mary J. Fell, Comment, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Protection from Discrimination in Access to Emergency Medical Care*, 43 CATH. U. L. REV. 607, 624 (1994) (advocating use of plain language of EMTALA over legislative history). But see Thomas L. Stricker, Jr., Note, *The Emergency Medical Treatment and Active Labor Act: Denial of Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121, 1130 n.40 (1992) (citing authorities arguing EMTALA designed to protect against denial of medical care for economic reasons). This criticism misses the point. Congress effectuates the purpose of EMTALA when it requires that hospitals screen and treat all patients. By requiring that all be screened and treated, Congress puts the poor and uninsured on a par with all others while simultaneously making it administratively simple for hospitals to follow EMTALA. The purpose of EMTALA is not served, however, by requiring that a hospital give treatment to a patient under EMTALA that it never gives to any other similarly situated patient.

69. The hospital correctly asserted that money was never the issue. All Baby K's bills, nearly \$500,000 in total, were paid by either Kaiser Permanente (Ms. Harrell's health maintenance organization) or Medicaid. Marylou Tousignant & William Miller, *Death of Baby 'K' Leaves a Legacy of Legal Precedents*, WASH. POST, Apr. 7, 1995, at B3. Kaiser paid \$410,000. Tousignant & Miller, *supra* note 6, at A1. Whether expending such an amount—or any amount—on medically futile care

was paid in full.⁷⁰

Despite the well-publicized outcry over dumping that led to the enactment of EMTALA and despite the court's own admission that EMTALA was enacted to prevent dumping,⁷¹ the argument structure of the majority opinion in *Baby K* appears to have been designed by a literalist, textualist court that had no use for the legislative history that makes EMTALA's purpose crystal clear. The argument structure is as follows:

1. There is a federal statute called EMTALA.
2. It requires that hospitals provide stabilizing care to all patients who present with emergency medical conditions.
3. Fairfax Hospital⁷² is a hospital.
4. Respiratory distress is an emergency medical condition.
5. Baby K presented with respiratory distress at Fairfax Hospital.
6. A ventilator can stabilize a patient with respiratory distress.
7. Fairfax must put Baby K on the ventilator.

All this business of applying the statute takes place in only two paragraphs, the second of which concludes that "[i]n sum, a straightforward application of the statute obligates the Hospital to provide respiratory support to Baby K when she arrives at the emergency department of the Hospital in respiratory distress and treatment is requested on her behalf."⁷³ The process is automatic and the opinion is autonomous; the court is just the slug that starts the statute and facts in the process of writing their own opinion. The decision is arrived at through a technical reading of the words of the statute and a mechanical application of it to the facts. In fact the court nearly says as much: "[w]hen a statute is clear and unambiguous, we must apply its terms as written."⁷⁴

for one individual is consistent with principles of distributive justice is the subject of another paper.

70. Tousignant & Miller, *supra* note 69, at B3.

71. *Baby K*, 16 F.3d at 593.

72. Because the parties desired anonymity, neither the hospital nor Baby K and her mother were identified in the *Baby K* opinion. The hospital was later identified in the media. See Greenhouse, *supra* note 2, at A10 (identifying hospital as Fairfax Hospital in Falls Church, Virginia).

73. *Baby K*, 16 F.3d at 594-95.

74. *Id.* at 596 (quoting *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 878 (4th Cir. 1992)).

In the remainder of its opinion, the court rejects the four arguments of the hospital as to why it should not be required to provide ventilation to Baby K. The court's response to these arguments constitutes an effort to limit the discussion, insofar as possible, to the text of EMTALA and therefore keep the opinion on technical grounds.

The hospital's first argument is that EMTALA only requires that emergency patients presenting with the same condition be treated in the same manner. In other words, as long as the Hospital treats Baby K in the same way it treats all anencephalic babies, it would not be liable for violating EMTALA. The court rejects this argument by stating that if the hospital's position were correct, the hospital "could provide any level of treatment to Baby K, including a level of treatment that would allow her condition to materially deteriorate, so long as the care she was provided was consistent with the care provided to other individuals."⁷⁵ This language implies that in some instances anencephalics in fact receive more than comfort care or that, EMTALA aside, they should receive more than comfort care. The reality is, according to the chair of the American Academy of Pediatrics ethics committee, that "[t]here is not a physician in the country who thinks you ought to treat anencephalics."⁷⁶ The court chose, however, to ignore this extra-EMTALA reality.

In further defense of its position, the court quotes an earlier Fourth Circuit EMTALA decision, *Baber v. Hospital Corp. of America*, in which the court stated that "hospitals could theoretically avoid liability by providing cursory and substandard screenings to all patients."⁷⁷ This fanciful reasoning also efficiently restricts itself to the closed system of EMTALA law. What is ignored by the court is simply the entire body of malpractice law. Hospitals which provide only "cursory and substandard screenings to all patients" will be successfully sued by patients injured as a result of such screening. To think that a hospital's risk manager would permit across-the-board "cursory and substandard screenings" is to have an incomplete and unrealistic understanding of the legal world.

The second argument advanced by the hospital was that it was not the intent of EMTALA to force doctors to go outside the prevailing standard of care. The heart of the court's response is found

75. *Id.* at 595.

76. Greenhouse, *supra* note 54, at 20 (quoting Dr. Arthur F. Kohrman, chairman of committee on bioethics of American Academy of Pediatrics).

77. *Baby K*, 16 F.3d at 595 (quoting *Baber*, 977 F.2d at 879 n.7).

in its statement that “[w]e recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute because to do so would ‘transcend our judicial function.’”⁷⁸

Translated, the court is saying: “[I]t is absurd to think that in preventing doctors and hospitals from dumping patients, the Congress intended to require doctors to treat patients whom they are not dumping in ethically and morally inappropriate ways. We are not permitted, however, to exercise our reason to reach this conclusion.” Again, the universe of law is the world of EMTALA law. The use of reason would create inefficiency in that the court would have to take the time and expend the energy to reason from the purpose of the legislation through the facts of this case to a just result.

The hospital’s third argument, that Virginia law⁷⁹ permits physicians to avoid that which is medically or ethically inappropriate, fared no better. The court essentially had two responses: (1) state law must give way to federal law when a valid “ ‘act of Congress, fairly interpreted, is in actual conflict with the law of the state’ ”⁸⁰; and (2) EMTALA does not include exceptions for medically and ethically inappropriate treatment.⁸¹ Once again, this court cannot get beyond the bounds of the EMTALA text. To accept the court’s reasoning here, one must be prepared to first accept the proposition that the statutes are in conflict. EMTALA, however, is silent about ethics and morals. Then, one must accept the proposition that Congress either (1) actually intended to have physicians engage in unethical and immoral practices in order to carry out EMTALA or (2) the Congress never thought about the issue. In either case, it is patently ridiculous to read the ethical and moral standards of doctors out of a statute. Doing so, however, keeps the court’s decision from moving into an area that requires more than just the ability to read.

Finally, the hospital argued that EMTALA only applies to pa-

78. *Id.* at 596 (quoting *Iselin v. United States*, 270 U.S. 245, 250-51 (1926); *Baber*, 977 F.2d at 844).

79. The hospital relied on § 54.1-2990 of the Virginia Health Care Decisions Act, which provides that “[n]othing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate.” VA. CODE ANN. § 54.1-2990 (Michie 1994).

80. *Baby K*, 16 F.3d at 597 (quoting *Savage v. Jones*, 225 U.S. 501, 533, (1912)).

81. The court also noted that EMTALA did not seem to apply to infants. *Id.* at 597 n.10.

tients being transferred from the hospital in an unstable condition. While this is the hospital's weakest argument, the court's handling of it reveals much. The court resorts to interpreting the intent of Congress! But it does so in a peculiar way.⁸² It baldly states that the hospital's interpretation was not the one intended by Congress—without citing as authority a single word of legislative history or offering any textual analysis.⁸³ Rather the court cites two cases from other circuits, neither of which cites any legislative history for the point for which the *Baby K* court cites them.⁸⁴ The result in *Baby K* is a conclusory statement with no authority and no reasoned argument to support it. Surely, this is the most efficient way of all for reaching decisions.

What is the net effect of the court's rejection of the hospital's four arguments and its earlier embrace of the position that the statute's plain terms speak for themselves? The net effect is that the court has *transformed the physician into a technique*. He or she must cast aside all concern for morality and for ethics and connect ventilators to anencephalic babies. He or she must cast aside any use of professional judgment as to what procedures are medically indicated and which are medically futile. The physician is simply an unintelligent slug who starts the machine running.

Baby K gives us this result because the court embraces an approach to law-making that guarantees the security of certainty and avoids the discomfort of ambiguity. Certainty and clarity would be threatened if the opinion were to take seriously the question of whether the *purpose* of EMTALA is fulfilled in this case by requiring the ventilation of an anencephalic baby. While the opinion acknowledges the purpose of EMTALA, the monistic nature of this technical opinion prevents the court from doing more than saying "we cannot ignore the plain language of the statute."⁸⁵ To discuss the human issues is all too difficult for this court. A technical opinion, by contrast, allows the judges in the majority to remove themselves from responsibility. The court in effect says: "We have no role in the decision as to whether this child should be allowed the

82. "The use of the word 'transfer' to describe the duty of the hospital to provide stabilizing treatment evinces a Congressional intent to require stabilization prior to discharge or that treatment necessary to prevent material deterioration of the patient's condition during transfer." *Id.* at 597-98.

83. *Id.* at 598.

84. *Id.* (citing *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990); *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1368 (5th Cir. 1991)).

85. *Id.* at 596.

death that is hers; we are apart from this decision. We can do no more or less than let the statute's words and the facts work their way. We do not prescribe this ritual. We simply stand to the side while it unfolds."⁸⁶

The *Baby K* opinion is thus technique inside technique. In enforcing the regime of medical technique through legal technique, it is part of the operational totalitarianism of which Ellul warned. But should we expect anything more from this or most other courts inasmuch as courts generally reflect the views of the societies of which they are a part?

V. DEFEATING DEATH

We should not—but for an important reason in addition to those already discussed. There is about in the land, and at work in *Baby K*, a powerful factor without mention of which any analysis of the case and of medical technology would be incomplete. Baby K's mother, like so many of us are wont to do, had made a god of physical life. Ostensibly, she professed her faith in a different god, the God of Christianity. Indeed the trial judge wrote of Ms. Harrell that she "*believes God, and not other humans, should decide the moment of her daughter's death.*"⁸⁷ Ms. Harrell, however, was apparently blind to the reality that by insisting on continued ventilation for her dying daughter she was wrestling with God for control over the time of this child's death.

In the context of this case, God for Ms. Harrell was not a spiritual God who transcends the boundaries of life and death, but rather immediate physical life. The continued physical life of her child was the supreme value in her world. Technology was the priest that would negotiate her child's journey down the dark, death-threatening paths she must take and bring her out into the sunshine of continued physical life. With the intercession of this priest, she expected that her child would live on and on.⁸⁸

In this, Contrenia Harrell is not an aberration. She is the per-

86. "It is beyond the limits of our judicial function to address the moral or ethical propriety of providing emergency stabilizing medical treatment to anencephalic infants." *Id.* at 598. By contrast, the dissent takes responsibility for Contrenia Harrell's daughter and for the law that will control her fate. The dissent speaks clearly and forcefully about the purpose of the statute and its application in this case. *Id.* at 599 (Sprouse, J., dissenting) (discussing purpose of EMTALA).

87. *In re Baby K*, 832 F. Supp. 1022, 1026 (E.D. Va. 1993) (emphasis added).

88. Ms. Harrell believed that her daughter would one day be normal. Tousignant & Miller, *supra* note 6, at A1.

fect reflection of modern American society and its reliance on modern, technical American medicine. In our modern-technical culture people are not supposed to die. For every disease there should be a cure, for every problem an answer. The goal is to defeat death—any death, all death, every death. The purpose of technique, after all, is to exert control over inefficient natural and other forces. Just as we conquered smallpox, we are intent on conquering heart disease. After we conquer heart disease, we will conquer cancer. After we conquer cancer, we will conquer Alzheimers. We are to live forever.⁸⁹ This is the illusion to which technique has brought us.

VI. A HUMAN RESPONSE TO TECHNIQUE: THE ROLE OF THE TRANSCENDENT

For Ellul, technology in modern life constitutes a closed system that incorporates and dominates everything around it. It knows no boundaries as it negates the meaning of the individual and suppresses the value of culture and tradition. Indeed, the purposes of existence itself “gradually seem effaced by the predominance of means. Technology is the extreme development of means.”⁹⁰

Technology even attempts to consume that which is uniquely human: “In growing, technique requires that human values be in exact accordance with technological development and that social structures develop purely in terms of technology. This . . . shows that nothing in society remains intact once technique begins to penetrate.”⁹¹ In keeping with the tension of dialectical reasoning, Ellul posits that because that which is within technique inevitably becomes technique, only a force that stands outside of technique can stand against technique. Ellul identifies this force as the transcendent, that which is “outside and cannot be assimilated.”⁹² Although the transcendent exists in a dimension different from the “horizontal” dimension on which we operate in our blindness,⁹³ the

89. Daniel Callahan, an eloquent spokesman for this view, argues that there is a strange moral logic that has brought us to this point:

The scientific imperative of progress, part of the idea of medical science, is broadened to include a moral imperative: if we do not pursue the conquest of disease, we are open to moral blame. People will die who need not die. If we do not use our newly available technologies to save lives, we can be held accountable for the loss of those lives.

CALLAHAN, *supra* note 54, at 61.

90. ELLUL, *supra* note 14, at 50.

91. *Id.* at 42.

92. JACQUES ELLUL, *WHAT I BELIEVE* 183 (1989).

93. *Id.* at 182.

transcendent is also “the presupposition without which there can be no concept of anything external to modern technique.”⁹⁴

The importance of the transcendent cannot be overstated. Ellul says:

If hope is still possible, if there is the possibility of humanity continuing, if there is any meaning in life, if there is an outcome other than suicide, if there is a love that is not integrated into technique, if there is a truth that is not useful to the system, if there is at least a taste, a passion, a desire for freedom, and a hypothesis of freedom, then we have to realize that these can have their basis only in the transcendent⁹⁵

In pre-modern times, humanity found the transcendent in the gods of nature. These, however, were but a mirror on the natural world.⁹⁶ A God who was truly transcendent, however, would be limited neither by the natural world nor by history. Moreover, a transcendent God would be free from humanity’s horizontal perspective. Ellul finds the transcendent, so understood, in the God of Israel,⁹⁷ because such a God is “not in the least coincident with the technological environment,” indeed is “not the product (even a product necessary and indispensable to human survival) of the human heart or human thought.”⁹⁸ Ellul also finds the presence of the transcendent in Jesus Christ through whom the transcendent intervenes in human history and breaks through technique to humanity.⁹⁹

However one defines the transcendent and wherever one finds it, it is clear that to break the hold of medical technology, patients, patients’ families and physicians must be able to discuss, and in some instances call upon, a faith in the transcendent. Only such a faith will permit them to see beyond the God they have made of mere physical existence to some greater reality. Faith in the transcendent will inevitably result in patients and their families recognizing the imposition of medical technology in hopeless end-of-life situations as a *threat* to their most cherished beliefs, not an aid to them. Consider, for example, those cases in which the patient and

94. *Id.* at 183.

95. *Id.* at 182.

96. *Id.* at 184.

97. *Id.*

98. *Id.*

99. ELLUL, *supra* note 14, at 100-02.

the patient's family hold to a belief in the existence of a soul. When the condition of such a patient is terminal, belief in the soul does not merely make withdrawal of futile life support technologies tolerable, it can actually bring a certain comfort and a measure of healing to the patient and the family.¹⁰⁰

The painful fact is, however, that our culture, with its *laissez-faire* attitude toward the spiritual life, is an overly secular culture. A culture without values that transcend the material world is a culture whose law and medicine cannot resist technique.¹⁰¹ In particular, there is not sufficient public discourse on the transcendent to authorize and make comfortable private discussions about the transcendent between and among physicians, their patients and patients' families. Rather, ours is a culture in which it is considered awkward, embarrassing, and even invasive to speak of the transcendent.

A colleague, for example, tells of an oncologist who feels it is not acceptable to raise spiritual matters with patients directly. Instead, he finds himself forced to send indirect signals to his patients that, if they want to talk about the spiritual, he is interested in the subject. (At the end of the first patient-doctor meeting, he sends the patient on his or her way with the remark, "See you next week. You'll be in my prayers.") The caution this physician exercises arises from the nature of our public life which excludes from public discussion serious talk of the spiritual. Indeed most physicians feel so awkward about the spiritual that they would not take even the small step this oncologist takes.

Why does our public environment keep the spiritual life off the agenda? The answer lies in part in the moral and political atmosphere created by a misapprehension of the doctrine of separation of church and state. Properly understood, this doctrine serves us well; by taking government out of religious discourse, it leaves room for all to follow their own individual religious consciences. Improperly understood, however, it harms us when it contributes to a cul-

100. I do not mean to advocate faith in the transcendent as a medicine with which clever and unethical physicians can drug naive and uneducated patients and their families into accepting whatever decisions the doctor wishes to make about the patient's care.

101. A corrosive effect of technology is to break down societies in favor of individuals. Put another way, technology individuates. For example, cars take people out of mass transit and individuate them by putting them in individual vehicles. Computers take bank customers out of the bank lobby and individuate them by permitting electronic banking. Consumers of news can access it not from a newspaper carrier or a newsstand, but from a database. This process destroys the commons, creating an even greater problem with the lack of tradition and culture.

tural understanding that discourse about religion is somehow embarrassing to the speaker, coercive to the listener or invasive of the privacy of others.¹⁰² Thus legitimate public religious discourse is constricted.¹⁰³ Of late, however, the United States Supreme Court and the President have displayed a renewed sensitivity to this distinction. While the Court has, properly enough, done nothing to change its rulings that involuntary prayer in the public schools is a violation of the Establishment Clause,¹⁰⁴ it has prevented school authorities from banning constitutionally permissible religious exercises. For example, in *Westside Community Board of Education v. Mergens*,¹⁰⁵ the court held that high school students could not be banned from having meetings of their religious clubs on school property after-hours when other clubs, also unconnected to the curriculum, were permitted access.¹⁰⁶ In *Lamb's Chapel v. Center Moriches Union Free School District*,¹⁰⁷ the Court held that when a school which permits groups to use its facilities, denies after-hours use of its building to a church because it desires to publicly screen a religious film on family issues, it violates the free speech rights of

102. No more eloquent exposition of this point has been made than STEPHEN L. CARTER, *THE CULTURE OF DISBELIEF: HOW AMERICAN LAW AND POLITICS TRIVIALIZE RELIGIOUS DEVOTION* (1993). Professor Carter states that "[i]n our sensible zeal to keep religion from dominating our politics, we have created a political and legal culture that presses the religiously faithful to be other than themselves, to act publicly, and sometimes privately as well, as though their faith does not matter to them." *Id.* at 3.

Carter's views have been applauded by many and attacked by some. See W. Burlette Carter, *Can This Culture Be Saved? Another Affirmative Action Baby Reflects on Religious Freedom*, 95 COLUM. L. REV. 473 (1995) (criticizing Carter's approach); Sanford Levinson, *The Multicultures of Belief and Disbelief*, 92 MICH. L. REV. 1873 (1994) (discussing Carter's views); see also MICHAEL J. PERRY, *LOVE AND POWER: THE ROLE OF RELIGION AND MORALITY IN AMERICAN SOCIETY* (1991) (discussing relationship of religious morality to politics in society).

103. A wonderful example comes from William F. Baker, President and CEO of Thirteen/WNET, a highly-regarded public television station in New York City whose many programs are broadcast nationwide. This is the story he tells:

I [sat in the offices of WNET], talking to a number of very sophisticated people and suggested that perhaps we do a series on religion, and one of the producers with seniority looked at me and said, "But, Bill, you know, the separation of church and state, it's illegal for us to do a religious program." And that was in the hallowed halls of public television.

Religion and the Media: Three Forums, COMMONWEAL, Feb. 24, 1995, at 40.

104. *Engel v. Vitale*, 370 U.S. 421 (1962). Later, in *Abington School District v. Schempp*, 374 U.S. 203 (1963), the Court banned daily, school-sponsored, in-class Bible-reading and recitation of the Lord's Prayer.

105. 496 U.S. 226 (1990).

106. The Court also ruled that the Equal Access Act, 20 U.S.C. §§ 4071-4074 (1994), did not violate the Establishment Clause.

107. 508 U.S. 384 (1993).

the church.¹⁰⁸ Earlier in *Widmar v. Vincent*,¹⁰⁹ the Court used the free speech provision of the First Amendment to strike down a state university regulation banning the student use of school grounds for “ ‘purposes of religious worship or religious teaching.’ ”¹¹⁰

Similarly, the President has taken the position that just because prayer in schools is impermissible, that does not mean that religious discourse cannot take place there.¹¹¹ As reported by the *New York Times*, the President is going “out of his way to emphasize the protection . . . afforded by the First Amendment, noting that the same clause that bars ‘establishment’ of a state religion also prohibits the Government’s impeding ‘the free exercise’ of religion, a truth he said ‘had been obscured by recent political debate.’ ”¹¹² There is certainly an ever-present establishment danger that government will engage in impermissible discourse any time religion is discussed in the public square; but the Court and the President seem to appreciate that there are equally grave dangers when private individuals are banned from such speech.

Our constitutional jurisprudence, therefore, may yet play a role in permitting the discussion of the transcendent in the public square. The academy can make a similar contribution by helping expand the bounds of what is permissible public discourse. Indeed, there has already been an encouraging discussion in the academy of the reasons the spiritual life as a topic is absent from public discourse in America. In 1993, Professor Stephen Carter’s book, *The Culture of Disbelief*, in which he argued that “we have created a political and legal culture that presses the religiously faithful to be other than themselves,”¹¹³ drew widespread attention, including that of

108. “The principle that has emerged from our cases ‘is that the First Amendment forbids the government to regulate speech in ways that favor some viewpoints or ideas at the expense of others.’ ” *Id.* at 388 (quoting *City Council of L.A. v. Taxpayers for Vincent*, 466 U.S. 789, 804 (1984)). On the heels of *Lamb’s Chapel*, the Court decided *Rosenberger v. University of Virginia*, 115 S. Ct. 2510 (1995). In *Rosenberger*, a controversial 5-to-4 decision, the Court held that the denial of university funds to a student group for the purpose of printing the group’s religious paper constituted an abridgement of the group’s First Amendment speech rights and that payment of the funds would not constitute the establishment of religion.

109. 454 U.S. 263 (1981).

110. *Id.* at 265 (quoting University of Missouri regulations).

111. Todd S. Purdum, *President Defends a Place for Religion in the Schools*, N.Y. TIMES, July 13, 1995, at 1-A.

112. The President also announced that he had “ordered the Government to distribute national guidelines explaining the wide degree of religious expression allowed in schools under current law.” *Id.*

113. CARTER, *supra* note 102, at 3.

the President.¹¹⁴ Shortly afterwards Professor Warren Nord wrote *Religion and American Education: Rethinking a National Dilemma*.¹¹⁵ Professor Nord attacks the warped sense of “neutrality” which educational institutions use to justify the exclusion of the study of religious thought from the public schools, claiming that knowledge of religion is an essential element of a liberal education.¹¹⁶ Earlier Professor Michael Perry published *Love and Power*, in which he defended “religious politics” by which he means “a politics in which persons with religious convictions about the good or fitting way for human beings to live their lives, about the ‘truly, fully, human’ way to live, rely on such convictions, not only in making political choices, but in publicly deliberating about and in publicly justifying those choices.”¹¹⁷ Might this discussion by academics of things spiritual, joined with more toleration, even support for, religious discourse on the public square by the Court and centrist political leaders, be the first steps in the creation of a culture in which belief in the transcendent is taken seriously?¹¹⁸

VII. CONCLUSION

These are, at least, hopeful signs that perhaps one day not too distant, patients, patients’ families and physicians might find themselves in a culture open to those who believe that there is a more important reality than mere physical life. The stage will then be set for people to throw off the dominion of technology. Perhaps we will be emboldened to follow Ellul’s urging to affirm the “transcendent over against technique” and in so doing embrace a certain nonconformity.¹¹⁹ We will revolt against the attachment of respirators to babies without cerebrums, oppose the insertion of feeding tubes into patients without hope of consciousness, and rebel against

114. See Thomas L. Shaffer, *Review Essay: Stephen Carter and Religion in America*, 62 U. CIN. L. REV. 1601 (1994) (book review); *id.* at 1601 n.2 (indicating President Clinton’s support for book).

115. WARREN A. NORD, *RELIGION AND AMERICAN EDUCATION: RETHINKING A NATIONAL DILEMMA* (1995).

116. *Id.* at 200-03.

117. PERRY, *supra* note 102, at 36-37. Professor Perry further argues that religious politics do not have to be authoritarian, sectarian, intolerant or fanatical. *Id.* at 37.

118. For a different approach to throwing off technology’s reign, see Marcia Angell, *After Quinlan: The Dilemma of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1524, 1525 (recommending establishment of presumption that patients in persistent vegetative states (and apparently anencephaly) would not want to be kept alive indefinitely, thus shifting “the burden from those who want to discontinue treatment to those who want to continue it”).

119. ELLUL, *supra* note 92, at 186.

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the administration of chemotherapy to dying patients. Knowing that freedom is often gained in resistance, we will refuse to worship at the altar of technique.

