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# Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure

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# Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure

## **Abstract**

Mediation has been touted as the magic band-aid to solve end-of-life conflicts. When families and health care providers clash at the end of life, bioethicists and conflict theorists alike have seized upon mediation as the perfect procedural balm. Dissonant values, tragic choices, and roiling grief and loss would be confronted, managed, and soothed during the emotional alchemy of the mediation process. But what is happening in a significant subset of end-of-life disputes is not mediation as we traditionally understand it. Mediation's allure stems from its promise to excavate underlying needs and interests, identify common ground, and push disputants toward more moderate, creative, and mutually satisfying outcomes. But in the growing number of intractable medical futility cases, there is no movement to middle ground. Rather, we have a conversation that leads to a predictable outcome. The provider backs down, and the surrogate gets the treatment that she wants.

Mediation's failure was inevitable. It cannot succeed in the shadow of current health care decisions law that gives surrogates so much power. To make mediation work for these cases, we must equalize bargaining power by giving providers a clearly-defined statutory safe harbor to unilaterally refuse requests for inappropriate treatment.

## **Keywords**

Medical futility, Mediation, End-of-life, Bioethics

## **Disciplines**

Dispute Resolution and Arbitration | Medical Jurisprudence

# Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure

THADDEUS M. POPE\*  
ELLEN A. WALDMAN\*\*

## ABSTRACT

Mediation has been touted as the magic Band-Aid to solve end-of-life conflicts. When families and health care providers clash at the end of life, bioethicists and conflict theorists alike have seized upon mediation as the perfect procedural balm. Dissonant values, tragic choices, and roiling grief and loss would be confronted, managed, and soothed during the emotional alchemy of the mediation process. But what is happening in a significant subset of end-of-life disputes is not mediation as we traditionally understand it. Mediation's allure stems from its promise to excavate underlying needs and interests, identify common ground, and push disputants toward more moderate, creative, and mutually satisfying outcomes. But in the growing number of intractable medical futility cases, there is no movement to middle ground. Rather, we have a conversation that leads to a predictable outcome. The provider backs down, and the surrogate gets the treatment that she wants.

Mediation's failure was inevitable. It cannot succeed in the shadow of current health care decisions law that gives surrogates so much power. To make mediation work for these cases, we must equalize bargaining power by giving providers a clearly-defined statutory safe harbor to unilaterally refuse requests for inappropriate treatment.

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## I. INTRODUCTION

Alex Barlow was diagnosed with a brain tumor when he was 17-years-old.<sup>1</sup> Alex and his family chose "an aggressive course of treatment involving

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<sup>1</sup> NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, *BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS* 15 (United Hospital Fund of New York 2004); Nancy Neveloff Dubler & Carol B. Liebman, *Bioethics: Mediating Conflict in the*

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surgery, radiation therapy, and chemotherapy." But despite these interventions, Alex continued to deteriorate. For the past two months, "Alex was intubated, unconscious, and unresponsive" with multiple organ failure "secondary to the effects of the brain tumor, sepsis, and a chronic lung infection."<sup>2</sup>

Given Alex's condition and prognosis, his health care team considered further aggressive treatment to be medically inappropriate. But Alex's health care agent, his sister, emphasized in repeated discussions with the team that "she would never, under any circumstance, agree to any measure that would shorten his life by even a moment."<sup>3</sup> This is a medical futility dispute.

A mediator was called to help the sister and the health care team reach consensus. The mediator first explained that Alex would not be administered any more platelets because they were, at that moment, a scarce resource and other patients had a greater capacity to benefit from them. The sister agreed that "Alex would not be eligible to receive platelets."<sup>4</sup> The mediator next explained that given the fragile nature of Alex's lungs and other systems, there would be no way to resuscitate him from a cardiac arrest. The sister also agreed to a DNR order.<sup>5</sup>

Dubler and Liebman offer this narrative to help make "the case for mediation."<sup>6</sup> But while the sister and the team reached agreement, the Barlow case overstates the case for mediation of futility disputes. The case is too limited to its peculiar facts.

Dubler and Liebman note that the mediator succeeds here by "plac[ing] some constraints on the range of possible decisions"<sup>7</sup> and "making clear the limits on care."<sup>8</sup> With respect to the platelets, the mediator appeals to the principle of "triage."<sup>9</sup> With respect to the DNR order, she appeals to

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*Hospital Environment*, 59 DISP. RESOL. J. 32, 37 (2004).

<sup>2</sup> DUBLER & LIEBMAN, *supra* note 1, at 15; Dubler & Liebman, *supra* note 1, at 37.

<sup>3</sup> DUBLER & LIEBMAN, *supra* note 1, at 17; Dubler & Liebman, *supra* note 1, at 38.

<sup>4</sup> DUBLER & LIEBMAN, *supra* note 1, at 17; Dubler & Liebman, *supra* note 1, at 39.

<sup>5</sup> DUBLER & LIEBMAN, *supra* note 1, at 18; Dubler & Liebman, *supra* note 1, at 39.

<sup>6</sup> DUBLER & LIEBMAN, *supra* note 1, at 14; Dubler & Liebman, *supra* note 1, at 37.

<sup>7</sup> DUBLER & LIEBMAN, *supra* note 1, at 17; Dubler & Liebman, *supra* note 1, at 38.

<sup>8</sup> DUBLER & LIEBMAN, *supra* note 1, at 19.

<sup>9</sup> Triage is the process of sorting people based on their need and chance of benefiting from medical treatment. *See generally* ALAN MEISEL & KATHY CERMENARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 13.07 (3d ed. 2005 & Supp. 2007) [hereinafter *THE RIGHT TO DIE*]; STEVEN E. PEGALIS, *AMERICAN LAW OF MEDICAL MALPRACTICE* § 6.18 (3d ed. 2005); JCAHO, *MANAGING PATIENT FLOW: STRATEGIES AND SOLUTIONS FOR ADDRESSING HOSPITAL OVERCROWDING* 120–29 (2004). *Cf.* Robert A. Gatter & John C. Moskop, *From Futility to Triage*, 20 *MED. & PHIL.* 191 (1995)

physiological futility.<sup>10</sup> These principles have a sound legal and ethical basis.<sup>11</sup> But they are wholly inapplicable to the vast majority of futility disputes in which the requested treatment is both available and potentially efficacious. For these cases, mediation often cannot succeed.

End-of-life cases continue to bedevil us.<sup>12</sup> One study found that conflict occurred in 78% of cases concerning the limitation of life-sustaining medical treatment (LSMT).<sup>13</sup> While end-of-life cases initially involved a patient's right to die with dignity,<sup>14</sup> they now typically involve, as with Alex Barlow, a surrogate's claim for LSMT that her health care provider deems medically inappropriate.<sup>15</sup> The leading treatise on the subject predicts that these

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(arguing that the entire futility debate should be recast in terms of triage planning). While triage is a well-recognized principle in medical care distribution, many ethics consultants and committees would be wary of refusing families requesting scarce resources on the grounds that such resources could be better utilized elsewhere. *See infra* notes 77–85 & 198–201 (discussing provider unwillingness to refuse treatment notwithstanding well-grounded reasons to do so).

<sup>10</sup> Physiologically futile interventions literally have no effect on the patient. *See* Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. (forthcoming 2008) (reviewing the literature).

<sup>11</sup> Dubler and Liebman recognize that these principles are so well-grounded that the sister's consent was not even required: "The mediation process did not change the outcome in terms of what medical care would be given." DUBLER & LIEBMAN, *supra* note 1, at 19.

<sup>12</sup> *See* John M. Luce & Douglas B. White, *The Pressure to Withhold or Withdraw Life-sustaining Therapy from Critically Ill Patients in the United States*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 1104, 1104–07 (2007) ("[D]isagreements between families and clinicians on end-of-life care are commonplace in the United States."); Keith M. Swetz et al., *Report of 255 Clinical Ethics Consultations and Review of the Literature*, 82 MAYO CLIN. PROC. 686, 689–90 (2007) (finding that futility disputes are one of the primary reasons for hospital ethics consultations).

<sup>13</sup> Catherine M. Breen et al., *Conflict Associated with Decisions to Limit Life-Sustaining Treatment in Intensive Care Units*, 16 J. GEN. INTERNAL MED. 283, 285 (2001). *See also* Julie Rosenbaum et al., *Sources of Ethical Conflict in Medical House Staff Training: A Qualitative Study*, 116 AM. J. MED. 402 (2004) (describing a range of end-of-life conflicts).

<sup>14</sup> *See* THE RIGHT TO DIE, *supra* note 9, at § 1.07; *See also* Thomas J. Murray & Bruce Jennings, *The Quest to Reform End of Life Care: Rethinking Assumptions and Setting New Directions*, HASTINGS CENTER REP., Nov.-Dec. 2005, at S52.

<sup>15</sup> One study found 974 futility disputes in sixteen hospitals over an average four-year period. *See* Emily Ramshaw, *Bills Challenge Limits for Terminal Patients: Some Say 10 Days to Transfer Isn't Enough Before Treatment Ends*, THE DALLAS MORNING NEWS, Feb. 15, 2007, at A1. If this sample is representative, then there may be tens of

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medical futility disputes are "likely to occupy as much, if not more [time and] judicial effort in the coming years as conventional end-of-life cases have in the last three decades."<sup>16</sup> We must attend to how these disputes are resolved.<sup>17</sup>

In the 1970s and 1980s, end-of-life disputes typically went to the courts.<sup>18</sup> But courts were soon recognized to be ill-equipped to handle such disputes. Among other problems, judicial review is cumbersome, an intrusion on patient privacy, and an encroachment on the medical profession.<sup>19</sup> So, instead of courts, end-of-life disputes started going to hospital ethics committees.<sup>20</sup>

Ethics committees' approaches to end-of-life disputes evolved over time. Originally, ethics committees followed a diagnostic decisionmaking model in which they identified the problem(s), gathered the facts, and suggested a

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thousands of disputes nationwide. See American Hospital Association, *Fast Facts on U.S. Hospitals*, <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html> (last visited Sept. 1, 2007) (stating that there are 5756 hospitals in the United States).

<sup>16</sup> RIGHT TO DIE, *supra* note 9, at § 13.01[D]. See also Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES, Mar. 27, 2005, at A1 ("The most common case that comes before the ethics committees are families now insisting on treatment that the doctors believe is unwarranted.") (quoting Dr. John J. Paris).

<sup>17</sup> Cf. DUBLER & LIEBMAN, *supra* note 1, at 8 ("As long as disparate values exist within families, between patients, families, and the health care system, conflicts are inevitable. And if conflicts are inevitable, strategies for managing them are required.").

<sup>18</sup> See ALEXANDER M. CAPRON & IRWIN M. BIRNBAUM, TREATISE ON HEALTH CARE LAW § 18.06 (2004).

<sup>19</sup> See generally THE RIGHT TO DIE, *supra* note 9, at § 3.18; Robin F. Wilson, *Hospital Ethics Committees as the Forum of Last Resort: An Idea Whose Time Has Not Come*, 76 N.C. L. REV. 353, 359–66 (1998) (collecting the relevant literature before questioning the conclusion that courts are an inferior forum). See also *In re Rosebush*, 491 N.W.2d 633, 637 (Mich. App. 1992) ("[T]he decision-making process should generally occur in the clinical setting without resort to the courts . . ."); *In re A.C.*, 573 A.2d 1235 (D.C. App. 1990); *In re Farrell*, 529 A.2d 404, 415 (N.J. 1987) (resolving end-of-life disputes through a judicial process will "take too long"); *In re Quinlan*, 355 A.2d 647, 669 (N.J. 1976) ("[A] practice of applying to a court to confirm such decisions would generally be inappropriate and a gratuitous encroachment upon the medical profession."); I. Glenn Cohen, *Negotiating in the Shadow of Death*, DISP. RESOL. MAG., Fall 2004, at 12, 12 (endorsing "a hands-off approach by courts" because of "a lack of confidence in courts' abilities to deduce and apply legal principles to a complex mix of emotion, culture and religion.").

<sup>20</sup> See generally Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798 (1991); Wilson, *supra* note 19, at 364–66.

solution.<sup>21</sup> According to this consultation model, the ethics committee acted like an expert and supplied answers and recommendations.

But this model has changed.<sup>22</sup> Today, instead of acting as "decision-makers or recommendation-makers" pursuant to a consultation model, ethics committees more often operate according to a classic mediation model.<sup>23</sup> They see their task as choreographing a productive negotiation process rather than as identifying a set solution.<sup>24</sup> Ethics committees' mission statements direct them to be facilitative rather than directive and authoritarian.<sup>25</sup> A

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<sup>21</sup> See Mark P. Aulisio, *Ethics Committees and Ethics Consultation*, in 2 ENCYCLOPEDIA OF BIOETHICS 841, 841–44 (3d ed. 2004); 1 JAY E. GRENIG, *ALTERNATIVE DISPUTE RESOLUTION* § 20.22 (3d ed. 2005); Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 823 (1994); Kimberlee K. Kovach, *Neonatology Life and Death Decisions: Can Mediation Help?* 28 CAP. U. L. REV. 251, 281 (2000).

<sup>22</sup> See Mary Coombs, *Schiavo: The Road Not Taken*, 61 U. MIAMI L. REV. 539, 547, 559 (2007) ("The directive . . . approach is far less common"). A recent study suggests that ethics committees may not have changed as much as thought. See Ellen Fox et al., *Ethics Consultation in United States Hospitals: A National Survey*, 7 AM. J. BIOETHICS 13, 18 (2007) (reporting that 65% of hospitals made a recommendation in 100% of cases).

<sup>23</sup> See Margaret Urban Walker, *Keeping Moral Spaces Open: New Images of Ethics Consulting*, 23 HASTINGS CENTER REP., Mar.-Apr. 1993, at 33 (noting a shift from "content" expert to "process" expert, from "engineer" to "architect"). See also Dipanjan Banerjee, *Principles and Procedures of Medical Ethics Case Consultation*, 68 BR. J. HOSP. MED. 140, 141 (2007) ("Instead of imposing decisions . . . the HEC . . . instead negotiate[s] a dialogue"); Jeanne Ten Broeck, *Bioethics Mediation at the End of Life: An Underused Model?* in CONFLICT STUDIES: THE NEW GENERATION OF IDEAS: CONFERENCE PROCEEDINGS 270, 271 (UMass-Boston 2006); 1 SARAH R. COLE ET AL., *MEDIATION: LAW, POLICY & PRACTICE* § 12.4 (2d ed. 2006); GRENIG, *supra* note 21, at § 20.22 ("Because of dissatisfaction with their role as decision-makers, or recommendation-makers, some hospital ethics committees are exploring the use of alternative dispute resolution, particularly mediation, to resolve bioethical disputes."); Hoffman, *supra* note 21, at 824, 877; Martha Jurchak, *Report of a Study to Examine the Process of Ethics Case Consultation*, 11 J. CLINICAL ETHICS 49, 52–53 (2000); Kovach, *supra* note 21, at 281.

<sup>24</sup> See DUBLER & LIEBMAN, *supra* note 1, at 14 ("Mediation is more inclusive and empowering, and consultation is more authoritarian and hierarchical"). See also *infra* notes 61–76 and accompanying text.

<sup>25</sup> See, e.g., Wake Forest University Health Sciences, Main Ethics Committee By-laws & Procedures, <http://www.wfubmc.edu/bioethics/CommitteeStructure> (last visited Sept. 1, 2007) ("The role of the Ethics Committee will be educational, advisory, and consultative."); University of Louisville Hospital, Overview of the Responsibilities of the Hospital Ethics Committee, <http://uoflhealthcare.org/Default.aspx?tabid=526> (last visited Sept. 1, 2007) ("[T]he committee will provide advisory consultation . . . primary responsibility will be to encourage dialogue, educate, identify issues offer viable



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successful committee intervention does not impose an answer, but rather allows the parties to craft a "shared solution," taking their own interests and needs into account.<sup>26</sup>

Mediation looked like the magic Band-Aid to solve end-of-life conflicts.<sup>27</sup> But if by mediation we mean a process in which both sides work to find a creative solution that differs in some way from their initial starting points,<sup>28</sup> then that is not happening in a significant subset of cases. Rather, in the intractable futility cases disputant bargaining invariably leads to a predictable outcome. Because mediation occurs in the shadow of health care decisions law, which gives surrogates disproportionate power, providers invariably back down and the surrogates get the treatment they want.<sup>29</sup>

This is not what we hope for when we speak of mediation. It is really just a one-sided negotiation in which surrogates are sure to prevail.<sup>30</sup> We should stop pretending that what committees are doing when they intervene in intractable futility cases is "real" mediation. Calling it mediation serves only to mask the normative judgments implicit in the controlling substantive law and delays much needed societal debate. Furthermore, urging providers to invest in mediation to achieve mutually empowering win-win resolutions leads to anger and disillusionment when they consistently lose.<sup>31</sup> And where the law itself lacks transparency, so too may providers' conduct.<sup>32</sup>

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options").

<sup>26</sup> See DUBLER & LIEBMAN, *supra* note 1, at 8 ("Mediation . . . is a private, voluntary, informal process in which an impartial third person facilitates a negotiation between people in conflict and helps them find solutions that meet their interests and needs.").

<sup>27</sup> See *infra* notes 63–69.

<sup>28</sup> See *infra* notes 70–77.

<sup>29</sup> See *infra* notes 77–85 & 198–201 and accompanying text.

<sup>30</sup> Providers and surrogates make most of these decisions, because "less than 5% of patients are able to communicate. . . at the time." Jenny Way et al., *Withdrawing Life Support and Resolution of Conflict with Families*, 325 B.M.J. 1342, 1342 (2002).

<sup>31</sup> Cf. Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, 54 LAW & CONTEMP. PROBS 195 (1991) (mediation is supposed to empower the participants by giving them a voice); Wayne D. Brazil, *Hosting Mediations as a Representative of the System of Civil Justice*, 22 OHIO ST. J. ON DISP. RESOL. 227, 249 (2007) ("[T]wo of the animating purposes of mediation: to empower the parties and to honor and facilitate their self-determination."); Robert A. Burt, *Resolving Disputes Between Clinicians and Families About 'Futility' of Treatment*, 27 SEMINARS IN PERINATOLOGY 495 (2003) (arguing that "grudging acquiescence" will not serve patients well).

<sup>32</sup> See Robert D. Orr, *The Gilgunn Case: Courage and Questions*, 14 J. INTENSIVE CARE MED. 54, 56 (1999) ("All too often clinicians . . . will surreptitiously agree and then

While serious, lack of transparency is not the only problem. Simple provider accession to surrogate demands is also a substantively undesirable outcome.<sup>33</sup> We must consider what might be a better outcome for these cases and what procedural mechanisms might best achieve that outcome. Since it is neither necessary nor appropriate to employ all available technology to sustain corporeal existence as long as possible, we must equalize bargaining power by giving providers a clearly-defined statutory safe harbor to unilaterally refuse requests for inappropriate treatment.

In Section Two, we describe a medical futility dispute as one where a patient's surrogate demands LSMT that the patient's provider judges to be inappropriate. In Section Three, we explain that while mediation has been presented as the best mechanism for resolving medical futility disputes, mediation has proven unable to resolve a significant and growing subset of such cases. Surrogates tenaciously maintain their extreme starting positions and providers acquiesce.

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carry out a 'slow code,' a dishonest pretense of effort to show the family that 'everything was done.'"). Being unable to write a unilateral DNR order in situations that they deemed inappropriate for CPR, providers were known to affix color dots to the patient's wristband or write "N.T.B.R." (Not to Be Resuscitated) in pencil on the chart to be erased after the patient died. Some providers did a "Hollywood Code" or "Show Code" in which they performed a half-hearted or mock resuscitation. Elizabeth Rosenthal, *Rules on Reviving the Dying Bring Undue Suffering, Doctors Contend*, N.Y. TIMES, Oct. 4, 1990, at A1; Marshall Kapp, *Futile Medical Treatment: A Review of the Ethical Arguments and Legal Holdings*, 9 J. GEN. INTERNAL MED. 170, 173 (1994); George P. Smith II, *Euphemistic Codes and Tell-Tale Hearts: Humane Assistance in End-of-Life Cases*, 10 HEALTH MATRIX 175, 184 (2000). Still other providers performed "Slow Code[s]" in which they moved "very slowly." *Slow Codes, Show Codes and Death*, N.Y. TIMES, Aug. 22, 1987, at A26; Cf. David A. Asch et al., *Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflict Between Physicians' Practices and Patients' Wishes*, 151 AM. J. RESPIRATORY CRITICAL CARE MED. 288, 292 (1995) ("Life-sustaining treatment is being withheld or withdrawn without the consent or knowledge of patients or their surrogates."); Kathryn L. Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options After Glucksberg and Quill*, 82 MINN. L. REV. 923, 924 (1998) (arguing that since "a widespread underground practice of physician-assisted [suicide] exists . . . the question is not really whether the practice should occur, but whether the practice should proceed underground and unregulated, or openly and regulated to protect patients"); Simon N. Whitney & Laurence B. McCullough, *Physicians' Silent Decisions: Because Patient Autonomy Does Not Always Come First*, 7 AM. J. BIOETHICS 33 (2007).

<sup>33</sup> See *infra* notes 216–235 and accompanying text.

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In Section Four, we explain that mediation's failure was inevitable. The mediation of futility disputes occurs in the shadow of health care decisions law that gives vastly more bargaining power to surrogates. Surrogates not only have more invested in the outcome, but they are also more willing to risk litigation to achieve that outcome. Providers, on the other hand, are risk-averse, litigation-averse, and less invested in the outcome. Consequently, surrogates are able to make extraordinary demands, knowing that providers will accede.

We must stop asking mediation to do more work than it is structurally equipped to handle. If we want "real" mediation then we must equalize the bargaining power between providers and surrogates. In Section Four, we defend giving providers a clearly-defined statutory safe harbor to unilaterally refuse requests for inappropriate treatment.

### II. BACKGROUND: WHAT IS A FUTILITY DISPUTE?

In a right-to-die situation, the patient or her surrogate wants to limit LSMT but the health care provider resists. In a futility situation, the roles are reversed. A medical futility dispute arises when a health care provider seeks to stop treatment that the patient or surrogate wants continued. The health care provider judges LSMT to be of no benefit and wants to "stop the train" when the patient or surrogate says "keep going."<sup>34</sup>

The provider and surrogate disagree because they have different goals.<sup>35</sup> The surrogate's goals might include cure, amelioration of disability, palliation of symptoms, reversal of disease process, or prolongation of life. The provider, on the other hand, might, under the circumstances, judge these goals to be impossible, virtually impossible, or otherwise inappropriate.<sup>36</sup> It was just this sort of disagreement underlying the recent high-profile case of Baby Emilio.

Emilio Lee Gonzales was born generally healthy on November 3, 2005, but within a few weeks he started exhibiting some neurological abnormalities.<sup>37</sup> By November 2006, Emilio showed "global developmental

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<sup>34</sup> K. Francis Lee, *Postoperative Futile Care: Stopping the Train When the Family Says "Keep Going,"* 15 THORACIC SURGERY CLINICS 481, 481 (2005).

<sup>35</sup> See Griffin Trotter, *Editorial Introduction: Futility in the 21<sup>st</sup> Century*, 19 HEC FORUM 1, 1 (2007); Thomas Mayo, *Health Care Law*, 53 SMU L. REV. 1101, 1110 n.78 (2000) ("[T]he core dispute is. . . over what constitutes a 'benefit' to the patient . . .").

<sup>36</sup> See Pope, *supra* note 10 (reviewing physiological futility, quantitative futility, and four versions of qualitative futility).

<sup>37</sup> Verified Complaint at Ex. B to Ex. 1, *Gonzales v. Seton Family of Hospitals*, No. A07CA267 (W.D. Tex. filed Apr. 4, 2007).

delay and decreased muscle tone and reflexes," and was soon diagnosed with Leigh's disease, a progressive neuron-metabolic disorder which affects the nervous system.<sup>38</sup> In December 2006, Emilio was admitted to the PICU at Children's Hospital of Austin where his neurological status continued to worsen as his brain atrophied.<sup>39</sup> He was dependent on a mechanical ventilator for breathing and a nasojejun tube for eating.<sup>40</sup> He was semi-comatose, unable to move his arms or legs, or empty his bladder. He was having frequent seizures and providers had "great difficulty keeping his lungs inflated."<sup>41</sup>

Emilio's health care providers determined that his condition was irreversible and that continued treatment would only "serve to prolong his suffering without the possibility of cure."<sup>42</sup> They felt that "the burdens associated with his current care plan outweigh[ed] any benefit Emilio [might have been] receiving"<sup>43</sup> and that his "aggressive treatment plan amount[ed] to a nearly constant assault on Emilio's fundamental human dignity."<sup>44</sup>

But Emilio's mother, Catarina, demanded that providers continue the aggressive treatment plan. She refused to consent to the withdrawal of life-sustaining treatment for Emilio,<sup>45</sup> insisting that Emilio's providers maintain him until "Jesus takes him."<sup>46</sup> Catarina would not agree to the providers' recommendations because "every moment of life he has to spend with her is of inestimable value."<sup>47</sup>

During the winter of 2007, Emilio's providers and his mother had multiple conferences to discuss his condition and treatment plan,<sup>48</sup> but they could not reach any consensus. In both February and March of 2007, Catarina met not only with Emilio's providers but also with the hospital's entire Neonatal/Pediatric Ethics Committee. Again, no consensus could be reached.<sup>49</sup> Soon thereafter, Catarina filed two separate lawsuits against both

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<sup>38</sup> *Id.* at ¶ 17.

<sup>39</sup> *Id.* at Ex. B to Ex. 1.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at Ex. D to Ex. 1, at 3.

<sup>42</sup> *Id.* at Ex. A to Ex. 1.

<sup>43</sup> Complaint, *supra* note 37, at Ex. D to Ex. 1, at 4.

<sup>44</sup> *Id.*

<sup>45</sup> *Id.* at ¶ 19.

<sup>46</sup> *Id.* at Ex. B to Ex. 1, at 3.

<sup>47</sup> *Id.* at ¶ 27.

<sup>48</sup> *Id.* at Ex. B to Ex. 1, at 2.

<sup>49</sup> Complaint, *supra* note 37, at Ex. D to Ex. 1.

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the Children's Hospital and individual providers.<sup>50</sup> While these suits were pending, clinical staff continued to provide the treatment that they considered medically inappropriate until May 20, 2007, when Emilio died.<sup>51</sup>

While the *Gonzales* case ended up in the courts, most futility disputes are resolved internally and informally by the health care team. After the team discusses the patient's goals for treatment, the nature of the patient's condition, and the range of options, most surrogates agree with the team's recommendation. For example, in a multi-center study by Prendergast and colleagues, 57% of surrogates agreed immediately with a provider-recommended care-plan, and 90% moved toward agreement within five days.<sup>52</sup> In a more recent study, Garros and colleagues found that consensus was reached in 51% of cases after the first meeting, in 69% of cases after a second meeting, and in 97% of cases after a third meeting.<sup>53</sup>

But a significant and growing number of cases are not resolved even after multiple and extended discussions between families and the health care team. In Prendergast's study, 4% of surrogates continued to insist that treatment be continued.<sup>54</sup> In Garros' study, 2% of surrogates insisted.<sup>55</sup> An even broader study shows 7% of disputes were incapable of resolution.<sup>56</sup> Moreover, the rate of irreconcilability appears to be on the rise.<sup>57</sup>

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<sup>50</sup> *Gonzales v. Seton Family of Hospitals*, No. 86427 (Travis Cty. Probate Ct, Tex. filed Mar. 20, 2007); *Gonzales v. Seton Family of Hospitals*, No. A07CA267 (W.D. Tex. filed Apr. 4, 2007).

<sup>51</sup> Eric Dexheimer, *Mother Who Fought to Continue Son's Treatment Cradles 19-Month-Old at End*, AUSTIN AM.-STATESMAN, May 20, 2007.

<sup>52</sup> Thomas J. Prendergast et al., *A National Survey of End-of-Life Care for Critically Ill Patients*, 158 AM. J. RESPIRATORY CRIT. CARE MED. 1163, 1165 (1998); see also Thomas J. Prendergast, *Resolving Conflicts Surrounding End-of-Life Care*, 5 NEW HORIZONS 62, 67 (1997).

<sup>53</sup> Daniel Garros et al., *Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit*, 112 PEDIATRICS e371, e372 (2003). See also Laurence J. Schneiderman et al., *Effect of Ethics Consultations on Nonbeneficial Life-sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial*, 290 JAMA 1166 (2003) (concluding that ethics consults were useful in resolving conflicts that may have inappropriately prolonged nonbeneficial treatments).

<sup>54</sup> Prendergast, *A National Survey*, supra note 52, at 1165; see also Prendergast, *Resolving Conflicts*, supra note 52, at 67.

<sup>55</sup> Garros, supra note 53, at e373.

<sup>56</sup> H. Comm. Pub. Health, Tex. H.R., *Interim Report 2006*, at 36 (citing written testimony of Greg Hooser).

<sup>57</sup> Surrogates are increasingly likely to make demands for inappropriate LSMT. See *infra* notes 97–128. Providers, on the other hand, are increasingly likely to resist such demands. Today, some physicians do not challenge surrogate demands. Either they have

In these intractable cases, where the health care team is unable to convince the surrogate, the team typically employs an individual (or team of)<sup>58</sup> consultant(s) or mediator(s) to help negotiate an agreement between the physician and the surrogate.<sup>59</sup> At this point, however, mediation often has nothing to offer.

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difficulty talking with surrogates about end-of-life care or they are compensated to perform the requested procedures. Cf. PAULINE W. CHEN, FINAL EXAM: A SURGEON'S REFLECTIONS ON MORTALITY (2007); Murray & Jennings, *supra* note 14, at S54; Norman Paradis, *Making a Living Off the Dying*, N.Y. TIMES, Apr. 25, 1992, at 15; Prendergast, *Resolving Conflicts*, *supra* note 52, at 63. Yet, a recent greater emphasis on palliative care and improved communication, and shifting reimbursement incentives may change this behavior. See *The EPEC Project: Education in Palliative and End-of-Life Care*, available at [www.epec.net](http://www.epec.net) (last visited Sept. 1, 2007); Joanne Kenen, *A New Focus on Easing the Pain: Palliative Care Helps The Very Ill. It May Also Keep Costs Down*, WASH. POST, July 3, 2007; Ronald Schonwetter, *Palliative Medicine Coming of Age*, 10 J. PALLIATIVE MED. 3 (2007); Judy Fortin, *Class Trains Doctors for the Toughest Conversations*, CNN, Apr. 23, 2007, [www.cnn.com](http://www.cnn.com). See also Ronald Bailey, *Pulling the Plug on Unwilling Patients: Should the High Cost of Living Affect Your Chances of Dying?* REASONONLINE, Feb. 10, 2006, [www.reasononline.com](http://www.reasononline.com) ("[I]t is clear that in the real world of limited medical resources that the 'authorities,' whether private or governmental, will unavoidably be making similar life and death decisions in the future."); Eric Gampel, *Does Professional Autonomy Protect Medical Futility Judgments?* 20 BIOETHICS 92, 98 (2006) (predicting "managerial pressures on HCPs to use and extend the category of futility. . ."); MARK HALL, MARY ANNE BOBINSKI, & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS 3 (5th ed. 2003) ("The Baby K situation may become more typical as a result of greater pressure on physicians to limit medical costs."); Liz Kowalczyk, *Mortal Differences Divide Hospital and Patient's Family*, BOST. GLOBE, Sept. 28, 2003, at A1; JOAN M. KRAUSKOPF ET AL., ELDERLAW: ADVOCACY FOR THE AGING § 13.26 (2005); Donald J. Murphy, *The Economics of Futile Interventions*, in MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS 123 (Marjorie B. Zucker & Howard D. Zucker eds., 1997); THE RIGHT TO DIE, *supra* note 9, § 13.01[C] & § 13.09; Ann Wlazelek, *Hospital Procedures Made Clear at Women's Expense*, KANSAS CITY STAR, June 12, 2004.

<sup>58</sup> In addition to individual consultants, sometimes teams (groups of three) or entire committees are brought in to "mediate" between provider and surrogate. See Banerjee, *supra* note 23, at 141–42 (reviewing the major advantages and disadvantages of each model); DUBLER & LIEBMAN, *supra* note 1, at 35–45; Linda Farber Post, *Clinical Consulting: The Search for Resolution at the Intersection of Medicine, Law, and Ethics*, 14 HEC F. 338, 342 (2003); Cynda Rushton et al., *Ethics Consultation: Individual, Team, or Committee*, in ETHICS CONSULTATIONS: FROM THEORY TO PRACTICE 88 (Mark P. Aulisio et al. eds., 2003).

<sup>59</sup> This "staged" approach to dispute resolution is common to both model standards and institutional policies. See, e.g., Susan Carhart, *Process Approach to End-of-Life Care Fails to Eliminate Ethical, Political Issues*, 11 BNA HEALTH L. REP. 1755 (2002);

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Many cases remain unresolved. And even those that are resolved are not concluded in the fashion that mediation typically contemplates. The negotiation process consists in the main of surrogate intransigence and provider capitulation. To assign the term "mediation" to a process that consistently facilitates the predictable, unconditional surrender of one side entails a serious distortion of our ADR vocabulary. Mediation is not working in these intractable end-of-life disputes and we should stop pretending that it is.

### III. PROBLEM: WHILE WIDELY ESPOUSED, MEDIATION DOES NOT RESOLVE MANY FUTILITY DISPUTES

By helping parties to "generate, explore, and exchange information and options,"<sup>60</sup> mediation is supposed to generate creative solutions and push parties toward middle ground.<sup>61</sup> Since the parties "have to build a solution from their own understandings and needs . . . it is characteristic of good mediation that the outcome can never be seen in advance of the process."<sup>62</sup>

This typically does not happen in a significant and growing set of futility disputes. The outcome of these cases is predictable. No options are generated, and there is no movement to middle ground. Instead, surrogates cling to their initial starting positions and providers eventually acquiesce.

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CENTER FOR PRACTICAL BIOETHICS, RECOMMENDED POLICY GUIDELINES REGARDING MEDICAL FUTILITY 17–20 (2006); HEALTH COUNCIL OF SOUTH FLORIDA, MEDICAL FUTILITY GUIDELINES OF SOUTH FLORIDA 28 (2000); Gay Moldow et al., *Why Address Medical Futility Now?*, MINN. MED., June 2004, at 38; NATIONAL ETHICS COMMITTEE OF THE VETERANS HEALTH ADMINISTRATION, DO-NOT-RESUSCITATE ORDERS AND MEDICAL FUTILITY 7–8 (2000); Peter A. Singer et al., *Hospital Policy on Appropriate Use of Life-Sustaining Treatment*, 29 CRITICAL CARE MED. 187, 190–91 (2001); S.Y. Tan et al., *Creating a Medical Futility Policy*, HEALTH PROGRESS, July-Aug. 2003.

<sup>60</sup> Nancy Neveloff Dubler, *Conflict and Consensus at the End of Life*, HASTINGS CENTER REP., Nov.-Dec. 2005, at S19, S24–S25. See also DUBLER & LIEBMAN, *supra* note 1, at 9 ("The mediator works with the parties, helping them identify their goals and priorities, generate and explore options, and exchange information that may be necessary for formulating a solution.").

<sup>61</sup> LEONARD J. MARCUS, *RENEGOTIATING: HEALTH CARE RESOLVING CONFLICT TO BUILD COLLABORATION* 344 (Jossey Bass Publishers 1995).

<sup>62</sup> Jonathan M. Hyman & Lela P. Love, *If Portia Were a Mediator: An Inquiry into Justice in Mediation*, 9 CLINICAL L. REV. 157, 182 (2003).

A. *Mediation Has Been Widely Promoted as the Best Mechanism for Resolving End-of-Life Disputes*

Mediation has been widely espoused as the best mechanism for resolving end-of-life treatment disputes. Such an approach is endorsed by the American Society for Bioethics and Humanities' (ASBH) influential report *Core Competencies for Health Care Ethics Consultation*,<sup>63</sup> and enthusiastic encouragement for mediation appears in medical journals,<sup>64</sup> law reviews,<sup>65</sup> and bioethical literature.<sup>66</sup>

In 1999, the American Medical Association Council on Ethical and Judicial Affairs published an influential report, emphasizing a fair process

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<sup>63</sup> AMERICAN SOCIETY FOR BIOETHICS AND HUMANITIES, CORE COMPETENCIES FOR HEALTH CARE ETHICS CONSULTATION 6 (1998).

<sup>64</sup> See, e.g., Mark Aulisio et al., *Ethical and Palliative Care Consultation in the ICU*, 20 CRIT. CARE CLINICS 505 (2004); M. Gregg Bloche, *Managing Conflict at the End of Life*, 352 NEW ENG. J. MED. 2371 (2005); LeAnna M. DeAngelo, *Mediation in Health Care Settings: Some Theoretical and Practical Concepts*, 7 J. CLINICAL PSYCH. MED. SETTINGS 133 (2000); Michael D. Fetters et al., *Conflict Resolution at the End of Life*, 29 CRIT. CARE MED. 921, 924 (2001); Prendergast, *Resolving Conflicts*, *supra* note 52, at 62; Singer et al., *supra* note 59, at 188.

<sup>65</sup> See, e.g., Chad Bowman, *Dispute Over End-of-Life Care Treated Increasingly with Mediation*, 9 BNA HEALTH L. REP. 1527 (Oct. 5, 2000); Broeck, *supra* note 23, at 273; Nancy Neveloff Dubler, *Heroic Care Cases: When Difficult Decisions About Care Are Near, Mediation Can Help Bridge Communication Gap*, DISP. RESOL. MAG., Spring 1999, at 7; Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Patient-Physician Relationship*, 79 B.U. L. REV. 1091 (1999); Debra Gerardi & Jacqueline N. Font-Guzman, *A Growing Need for Dispute Resolution Practices*, CREIGHTON LAWYER, Fall 2006, at 34–38; Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventative Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329 (1999); Hoffman, *supra* note 21, at 876; Kovach, *supra* note 21, at 252, 283–84; Leonard Marcus, *A Culture of Conflict: Lessons from Renegotiating Health Care*, 5 J. HEALTH CARE L. & POL'Y 447, 456 (2002).

<sup>66</sup> See, e.g., Autumn Feister, *The Failure of the Consult Model: Why 'Mediation' Should Replace 'Consultation'*, 7 AM. J. BIOETHICS 31, 32 (2007); NUFFIELD COUNCIL ON BIOETHICS, CRITICAL CARE DECISIONS IN FETAL AND NEONATAL MEDICINE § 8.58 (2006); Mary Beth West & Jean McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 63 (1992), reprinted in BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE 293, 294–95 (Nancy S. Jecker et al. eds., 1997); Walker, *supra* note 23, at 33.



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mechanism for resolving futility disputes. Specifically, the AMA recommended that if the health care team cannot resolve a dispute, then:

[T]he assistance of an individual consultant . . . is often helpful to reach resolution within all parties' acceptable limits. The role of the individual consultant is not to single-handedly resolve the conflict but rather to *facilitate discussions* that would reach that end.<sup>67</sup>

Position statements and model policies of other professional medical associations similarly endorse mediation.<sup>68</sup>

Moreover, mediation's popularity is not rhetorical only; it has been implemented as an end-of-life dispute resolution mechanism throughout the United States. A nationwide survey of how hospitals resolve futility disputes found that virtually all hospital futility policies "envisioned a primarily consultative, consensus building approach."<sup>69</sup>

Nancy Dubler explains that the role of a bioethics mediator "is not to make the decision but rather to explore the various options . . . to see whether all can reach a consensus about the best care plan for the patient."<sup>70</sup> The mediator "facilitates a discussion between and among the parties to the conflict," helping the parties "to identify their goals and priorities and to generate, explore, and exchange information and options."<sup>71</sup>

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<sup>67</sup> AMA Council on Ethical and Judicial Affairs, *Medical Futility in End-of-Life Care*, 281 JAMA 937, 940 (1999) (emphasis added). See also AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS §§ 2.035, 2.037, at 13–15 (2006–07 ed.).

<sup>68</sup> See, e.g., American College of Obstetricians and Gynecologists, *Committee Opinion: Opinion No. 362: Medical Futility*, 109 OBSTETRICS & GYNECOLOGY 791 (2007) [hereinafter ACOG]; American Thoracic Society, *Withholding and Withdrawing Life-Sustaining Therapy*, 144 AM. REV. RESPIRATORY DISEASE 726 (1991); BRITISH MEDICAL ASSOCIATION, WITHHOLDING AND WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT (2d ed. 2001); Society of Critical Care Medicine Ethics Committee, *Consensus Statement Regarding Futile and Other Possibly Inadvisable Treatments*, 25 CRITICAL CARE MED. 887 (1997).

<sup>69</sup> Sandra H. Johnson et al., *Legal and Institutional Policy Responses to Medical Futility*, 30 J. HEALTH & HOSP. L. 21, 31 (1997).

<sup>70</sup> DUBLER & LIEBMAN, *supra* note 1, at 4, 9 (A mediator does not "decide who is right and who is wrong or impose solutions on the parties."); Mark P. Aulisio et al., *supra* note 64, at 514 (While the mediator helps "facilitate an ethically acceptable resolution of the issue preferably through the building of consensus," the "'involved parties' . . . remain the primary decision makers.").

<sup>71</sup> Dubler, *supra* note 60, at S24–S25. See also Aulisio et al., *supra* note 64, at 514 ("The consultant elicits questions and uncertainties, helps to clarify factual information . . . helps health care providers and family think through the situation and the values at

Dubler explains that for futility disputes, "mediation can provide a process to assist in the formation of a care plan that meets [both] the needs of the patient and family and respects professional commitments."<sup>72</sup> The end-of-life dispute mediator, acting as a process guide, gives patients and providers the space to communicate their concerns and work together so they will reach a mutually agreeable resolution to their dispute.<sup>73</sup>

Accordingly, mediation is supposed to move parties from position-based to interest-based negotiation.<sup>74</sup> Mediation is supposed to build options and generate a new set of choices.<sup>75</sup> In short, mediation is supposed to catalyze creative solutions, guide people toward settlements that satisfy their underlying interests, and generate resolutions that are distributed over a wide range of outcomes.<sup>76</sup>

### B. Mediation Fails to Resolve Many Futility Disputes

However, none of this actually ever happens with respect to a small but significant set of cases. These futility disputes remain immune to mediation's charms. Mutually-endorsed, interest-based solutions remain elusive. Extremism does not, in the crucible of conversation, give way to moderation.<sup>77</sup> And creative solutions hardly ever emerge. Instead, the

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stake."); Richard M. Zaner, *A Comment on Community Consultation*, 7 AM. J. BIOETHICS 29, 30 (2007) (Mediators "help individuals whose situation it is think through their circumstances as thoroughly as possible").

<sup>72</sup> Dubler, *supra* note 60, at S25. See also Nancy Dubler, *Limiting Technology in the Process of Negotiating Death*, 1 YALE J. HEALTH POL'Y L. & ETHICS 297, 298-99 (2001) ("[T]echniques of mediation . . . set the stage, level the playing field, invite discussion, identify positions, and seek consensus among conflicting conceptions of a good care plan").

<sup>73</sup> See Jerry P. Roscoe & Dierdre McCarthy Gallagher, *Mediating Bioethical Disputes*, DISP. RESOL. MAG., Spring 2003, at 21, 22.

<sup>74</sup> See DUBLER & LIEBMAN, *supra* note 1, at 9 (citing ROGER FISHER & WILLIAM URY, *GETTING TO YES* (1981)).

<sup>75</sup> See MARCUS, *supra* note 61, at 344 (discussing "option building" and generating "a new set of choices"); Ruth D. Raisfeld, *Mediators Can Best Help Those Who Help Themselves*, N.Y.L.J., Dec. 1, 2003 ("The goal in mediation is not to 'win,' but to come to an agreement that both sides can live with.").

<sup>76</sup> See CARRIE MENKEL-MEADOW, ANDREA KUPFER SCHNEIDER, & LELA P. LOVE, *MEDIATION: PRACTICE, POLICY AND ETHICS* 95 (2005).

<sup>77</sup> See *infra* notes 78-85 and accompanying text. Of course, if the health care team had poor communication with the surrogate, that leaves the mediator room to correct those errors. In such cases, mediation will more likely be successful. For example, in the

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negotiation leads to a predictable outcome. Surrogates adhere to their extreme starting positions, and they seldom come to think more realistically about possible solutions. Providers explain how medically devastated the patient is. Surrogates reassert their positions. Providers back down, and the patient gets the treatment that the surrogates want.<sup>78</sup>

While health care decision statutes authorize health care providers to refuse compliance with inappropriate treatment requests,<sup>79</sup> providers in these jurisdictions reluctantly continue to accede with such requests. Even Dubler and Liebman admit that since surrogates are empowered in futility disputes, "the vast majority of hospitals require consent from the patient or family to discontinue even futile treatment."<sup>80</sup> Although many health care institutions would like to have futility policies, few actually do.<sup>81</sup>

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Dubler and Liebman's "Davidoff" case, the team never made the patient's condition clear. DUBLER & LIEBMAN, *supra* note 1, at 3 (The patient's wife "was never told directly that his survival would be unprecedented, and so it is not surprising that she continued to demand that 'everything be done.'"). Mediation worked in that case because the mediator corrected the surrogate's misunderstanding. See Leslie H. Youssef, *The Art of Resolving Complex Health Care Disputes*, 19 OHIO ST. J. ON DISP. RESOL. 1145 (2004). Some studies report high resolution rates from bioethics consultations. See, e.g., Aulisio et al., *supra* note 64, at 510–11 (reviewing several studies); David Casarett & Mark Siegler, *Unilateral Do-Not-Attempt-Resuscitation Orders in Ethics and Consultation*, 27 CRIT. CARE MED. 1116 (1999) (ethics consultants resolved disputes in 17 of 31 cases). But "[t]he process and content of these consultations is not described, making it unclear exactly what the consultation offered." Aulisio et al., *supra* note 64, at 511. Mediation is more successful when offered earlier by "promoting regular communication" between the surrogate and provider. *Id.* at 511–12; see also Nancy Dubler, *The Limits of Dispute Resolution: Commentary*, HASTINGS CENTER REP., Nov.-Dec. 2001, at 11 ("Mediation is particularly helpful . . . when the process is triggered at an early stage of the conflict"). But even when optimally deployed, mediation still cannot resolve a significant subset of futility disputes. Cf. Dubler, *supra* note 60, at S25 ("Not all cases can be mediated."); DUBLER & LIEBMAN, *supra* note 1, at 5, 12 ("Mediation does not always succeed.").

<sup>78</sup> See, e.g., Bowman, *supra* note 65, at 1527 ("[D]octors and hospitals will cave"); Stanley A. Nasraway, *Unilateral Withdrawal of Life-Sustaining Treatment: Is It Time? Are We Ready?* 29 CRIT. CARE MED. 215, 216 (2001) ("It is much more common . . . to acquiesce to unreasonable demands").

<sup>79</sup> See *infra* notes 174–186 and accompanying text.

<sup>80</sup> DUBLER & LIEBMAN, *supra* note 1, at 26.

<sup>81</sup> See Bowman, *supra* note 65, at 1528 ("A lot of people want to have policies, but a lot of people don't [have them].") (quoting Shirley J. Paine); Ronald Cranford, *Email to Thad Pope*, July 11, 2004 ("Many hospital lawyers, much more concerned about legal liability and adverse publicity for their institutions, have been extremely tentative, if not outright hostile, to ethics committees formulating and implementing futility policies, even though many of us in the field of clinical ethics feel these guidelines are badly needed."); John Fletcher, *The Baby K Case: Ethical and Legal Considerations of Disputes about*

Even those institutions that have futility policies either are not implementing them or are implementing them very narrowly and infrequently.<sup>82</sup> For example, a health care provider in an institution with a

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*Futility*, 2 BIOLAW: A LEGAL AND ETHICAL REPORTER ON MEDICINE, HEALTH CARE AND BIOENGINEERING S.219, S.229 (1994) ("On coming to the University of Virginia in 1987, I observed many clinicians overtreating hopelessly ill patients primarily due to fears of legal liability. Also, clinicians were acutely aware of the lack of legal backing if they refused to acquiesce"); Moldow et al., *supra* note 59, at 39 ("Fear of legal action has previously discouraged many institutions from adopting policies in the area of medical futility"); Nasraway, *supra* note 78, at 216 ("It is much more common for hospital lawyers to argue in favor of doing the easy thing, i.e. to acquiesce to unreasonable demands"); LAWRENCE J. SCHNEIDERMAN & NANCY S. JECKER, *WRONG MEDICINE: DOCTORS, PATIENTS, AND FUTILE TREATMENT* 32 (1995) [hereinafter *WRONG MEDICINE*]; Benjamin Weiser, *The Case of Baby Rena: A Question of Letting Go*, Wash. Post, July 14, 1991 (describing how physicians' "attempts to discuss unilateral action had fallen flat"). Cf. Lisa Anderson-Shaw et al., *The Fiction of Futility: What to Do with Policy?*, 17 HEC FORUM 294, 299 (2005) ("Absent state or federal statutes specifically guiding futile care activity, many institutions work under a much more informal approach to futile care.").

<sup>82</sup> See, e.g., Bowman, *supra* note 65, at 1527 ("While physicians sometimes disagree with patients or their surrogates over end-of-life care, however, they rarely end care in violation of patient wishes."); Jeffrey Burns, *Does Anyone Actually Enforce their Hospital's Futility Policy?*, LAHEY CLINIC MED. ETHICS J., Fall 2005 ("Despite an increasing number of ethics consults on questions of futility, we do not invoke our own futility policy."); Fletcher, *supra* note 81, at S.230 (noting a "moratorium" on the use of UVA's policy after *Baby K*); Alan Meisel & Bruce Jennings, *Ethics, End-of-Life Care, and the Law: Overview*, in *LIVING WITH GRIEF: ETHICAL DILEMMAS AND END-OF-LIFE CARE* 63, 76 (2005) ("The standard operating procedure in most health care institutions seems to be to accede to the surrogate's demands for treatment if the surrogate cannot be convinced"); Wlazelek, *supra* note 57 (reporting that Lehigh Valley Hospital-Muuhlenberg in Bethlehem, PA has a unilateral decision policy. Nevertheless, the option to refuse treatment "takes courage on the part of the physician because he or she will most likely be sued. No doctor at LVH has refused to treat a patient . . . but some patients have been transferred to other facilities."). See also Robert Fine et al., *Medical Futility in the Neonatal Intensive Care Unit: Hope for a Resolution*, 116 PEDIATRICS 1219, 1221 (2005) (describing that before the Texas statute, "[i]n ~80% of [futility] cases, consultants were able to persuade families . . . However, in the other 20% of cases, families insisted on continued [LSMT], and physicians complied, being unwilling to subject themselves to legal jeopardy by overruling the family/surrogate."); Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743, 744 (2003) ("It is unclear how effective such guidelines could be in the face of legal uncertainty."). Even when ethics committees agreed that treatment was futile, treating physicians were generally unwilling to withdraw life-sustaining treatment. Amir Halevy & Amy McGuire, *The History, Successes and*

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multi-stage futility policy may invoke that policy in an attempt to resolve a dispute. But should the dispute prove intractable, the provider will likely be reluctant to go to the final stage and invoke any unilateral decision provisions of the policy. Instead, the provider will ultimately assent to the surrogate's treatment request. "If you're still at an impasse, the hospital continues to provide maximum support."<sup>83</sup> In short, providers virtually always defer when the dispute proves intractable.<sup>84</sup>

Mediation fails in these cases. There is no agreement, only capitulation under coercion.<sup>85</sup>

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*Controversies of the Texas "Futility" Policy*, HOUS. LAW., May–June 2006, at 38, 38 ("In spite of its adoption as hospital policy . . . no cases went through the entire process . . . . The most likely explanation is that residual legal uncertainty regarding the policy still lingered."); Terese Hudson & Kevin Lumsdon, *Are Futile Care Policies the Answer? Providers Struggle with Decisions for Patients Near the End of Life*, 68 HOSPITALS & HEALTH NETWORKS, Feb. 20, 1994, at 26, 27; Arthur U. Rivin, *Futile Care Policy – Lessons Learned from Three Years' Experience in a Community Hospital*, 166 WEST. J. MED. 389, 391 (1997) ("Despite the recommendations of the physicians and the ethics committee, [Santa Monica] hospital refused to discontinue life support for fear of lawsuit."); Amy V. Schlotzhauer & Bryan A. Liang, *Definitions of Death*, in HEALTH LAW & POLICY: A SURVIVAL GUIDE TO MEDICOLEGAL ISSUES FOR PRACTITIONERS 287, 291 (Bryan A. Liang ed., Butterworth Heinemann 2000) ("[N]othing can be done in cases where families of PVS patients seek to continue treatment indefinitely"); Louise Swig et al., *Physician Responses to a Hospital Policy Allowing Them to Not Offer CPR*, 44 J. AM. GERIATRICS SOC'Y 1215, 1218 (1996) ("[D]espite a policy that allowed them to do otherwise . . . physicians at San Francisco General Hospital usually offered CPR to patients they thought were unlikely to benefit.").

<sup>83</sup> Bowman, *supra* note 65, at 1527 (quoting Thomas Mayo).

<sup>84</sup> See Jeffrey P. Burns & Cynda Hylton Rushton, *End-of-Life Care in the Pediatric Intensive Care Unit: Research Review and Recommendations*, 20 CRIT. CARE CLINICS 467, 470 (2004) (reporting 93% of physicians continue to provide requested therapy they think is futile); see also Laurence J. Schneiderman & Alexander Morgan Capron, *How Can Hospital Futility Policies Contribute to Establishing Standards of Practice?*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 524, 525–26 (2000) (reporting a survey of California hospital representatives in which "almost all acknowledged that their own hospital would probably yield to demands for life-sustaining treatment").

<sup>85</sup> Mediation works where "both parties are willing participants." Cf. Randolph H. Freking, *Advocacy in Mediation: A Plaintiff Attorney's Perspective*, in HOW ADR WORKS 339, 340 n.1 (Norman Brand ed., 2002); ELIZABETH S. PLAPINGER & DONNA STIENSTRA, *ADR AND SETTLEMENT IN THE FEDERAL DISTRICT COURTS: A SOURCEBOOK FOR JUDGES & LAWYERS* 158 (1996). Here, providers are coerced no less than a party "ordered" to mediate a dispute. While the external pressure to reach an agreement comes from the social context of the provider-patient relationship instead of from a court, the pressure is substantial. Hyman and Love argue that parties unaware of their rights in substantive law lack self-determination. See Hyman & Love, *supra* note 62, at 163 n.9. Here, providers

## IV. ANALYSIS: MEDIATION CANNOT SUCCEED IN THE SHADOW OF CURRENT HEALTH CARE DECISIONS LAW

"Negotiation is shaped by power. In the give-and-take of negotiation, the more power people have, the less they must give. Conversely, the less power people have, the more they must give."<sup>86</sup> Bargaining power, in turn, depends primarily on the degree to which one is able to achieve one's goals outside the mediation.<sup>87</sup> Bargaining power is largely shaped by a party's best alternative to a negotiated agreement (BATNA) — the course of action available if the current negotiations fail and an agreement cannot be reached.<sup>88</sup>

While surrogates are typically the weaker party in bioethics mediation,<sup>89</sup> they are the stronger party in futility disputes.<sup>90</sup> Professor Gifford observes

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lack not information but the other component of self-determination: voluntariness.

<sup>86</sup> MARCUS, *supra* note 61, at 45.

<sup>87</sup> See DONALD G. GIFFORD, *LEGAL NEGOTIATION: THEORY AND APPLICATIONS* 67 (1989) (BATNA is the most important source of power).

<sup>88</sup> Your BATNA is the best situation you could achieve through external channels and should establish your bottom line in the negotiation. See ROGER FISHER & WILLIAM URY, *GETTING TO YES* 100 (2d ed. 1991); see also DUBLER & LIEBMAN, *supra* note 1, at 38; GIFFORD, *supra* note 87, at 50–54; MARCUS, *supra* note 61, at 294 ("Your BATNA determines the point at which you walk from the negotiation table. . . Ideally when you invoke your BATNA you have a better option than sticking around").

<sup>89</sup> See DUBLER & LIEBMAN, *supra* note 1, at 25; see also *id.* at 11 ("The power imbalance in a hospital setting comes from many sources: the difference in level of knowledge and expertise between most patients and the treatment team, the highly technical and unfamiliar physical setting . . . The physical and emotional stress of serious illness also contributes to an uneven playing field."); Dubler & Liebman, *supra* note 1, at 36.

<sup>90</sup> See Robert A. Burt, *The Medical Futility Debate: Patient Choice, Physician Obligation, and End-of-Life Care*, 5 J. PALLIATIVE MED. 249, 254 (2002) (observing that while "it frequently appears to everyone that physicians hold all the trump cards[,] patient self determination and the legal system play a strong "counter-balancing role"); Dubler, *supra* note 77, at 11 (noting that in a futility dispute "the family member . . . has all of the cards . . . and is ready to play them to her advantage"); DUBLER & LIEBMAN, *supra* note 1, at 25–26 (arguing that the centrality of patient/surrogate consent in the care process balances an otherwise uneven playing field); E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, 24 HASTINGS CENTER REP., Jan.–Feb. 1994, at 33, 38 (showing that because "a physician faces legal risks," it is "very difficult for him to avoid being coerced by insistent families."); Lawrence J. Schneiderman & Jerry E. Fein, *The Limits of Dispute Resolution: Commentary*, HASTINGS CENTER REP.,

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that the extent of a party's power depends on the alternatives it has if no agreement is reached.<sup>91</sup> Here, the cost of disagreement to surrogates is less onerous than the cost of non-concurrence to providers.<sup>92</sup> A provider's non-settlement alternatives are worse than a surrogate's.

Indeed, providers have such poor options that surrogates have leverage to dictate the terms of an agreement.<sup>93</sup> Surrogates can effectively direct the outcome of futility disputes. Since they have more power, they do not need to make significant (or any) concessions. Providers, on the other hand, have little power and must consequently give ground to avoid escalating the conflict.

There are three primary sources of surrogates' bargaining power. First, their passionate conviction in the "justness of their cause" serves as a strong power lever. It feeds their intransigence, forcing provider concessions.<sup>94</sup> Second, surrogates are empowered by the misperception that the substantive law is on their side. This misperception leads surrogates to an inflated notion of their BATNA, which spurs them to ever more aggressive negotiating strategies.<sup>95</sup> Third, even apart from this misperception, surrogates are more willing to risk litigation. The ambiguity and confusion surrounding existing legal norms adds a further layer of complexity to the always difficult task of predicting litigation outcomes. Because providers are extremely averse both to risk and to litigation itself, this normative uncertainty pushes in favor of surrogates.<sup>96</sup>

### *A. Mediation Fails Because Surrogates' Passion for Continued Treatment Is Intransigent*

Surrogates are empowered by their own sheer intransigence.<sup>97</sup> "They

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Nov.–Dec. 2001, at 10, 11 (While some "invariably locate the greater power in the doctor who 'trumps' the legitimate interests of the patient . . . the weight of power may lie on the opposite side.").

<sup>91</sup> GIFFORD, *supra* note 87, at 36.

<sup>92</sup> See *id.* See also CHARLES B. CRAVER, EFFECTIVE LEGAL NEGOTIATION AND SETTLEMENT § 4.01[3][d] (5th ed. 2005).

<sup>93</sup> See GIFFORD, *supra* note 87, at 36 ("If a party has no viable options, the other party has leverage to dictate terms").

<sup>94</sup> See *infra* notes 97–136 and accompanying text.

<sup>95</sup> See *infra* notes 137–166 and accompanying text.

<sup>96</sup> See *infra* notes 167–214 and accompanying text.

<sup>97</sup> See generally GIFFORD, *supra* note 87, at 67 (while BATNA is the most important source of power, a party's level of commitment to the matter is also a strong determinant of power); CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES

exude an uncompromising attitude that is intended to make [providers] believe that no further progress can be achieved if [providers] do not modify their current positions."<sup>98</sup> In other words, surrogates are able to convince providers that they must make appropriate concessions if the discussions are to continue.<sup>99</sup>

Recent evidence suggests that surrogates are increasingly likely to make such demands for continued LSMT, to request that "everything be done."<sup>100</sup> A recent Pew study found that in 1990, only 15% of Americans thought health care providers should do everything to save life, but by 2005, 22% of Americans<sup>101</sup> and 27% of Californians<sup>102</sup> thought that doctors and nurses should do everything possible to save a patient.

Several cultural and psychological factors motivate this uncompromising attitude. Surrogates insist on continuing treatment that health care providers consider medically inappropriate because: (1) they mistrust their providers, (2) they have unrealistic expectations of medicine, (3) they are compelled by religious beliefs, (4) they cannot bear the burden of decision, and (5) they do not have to absorb the "costs" of their decisions.

### 1. *Mistrust*

The erosion of the physician-patient relationship and its reciprocal bonds of loyalty<sup>103</sup> has been in full swing since the advent of the managed care

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FOR RESOLVING CONFLICT 378 (3rd ed. 2003) (identifying power sources and defining moral power as "an appeal to strong beliefs, values, or what is considered to be 'right'").

<sup>98</sup> CRAVER, *supra* note 92, § 7.04[2][f].

<sup>99</sup> *Id.*

<sup>100</sup> See, e.g., Luce & White, *supra* note 12; WRONG MEDICINE, *supra* note 81, at 22–34; Julie Sneider, *Medical Ethics Experts See Shift in Care Disputes*, MILWAUKEE BUS. J., Apr. 22, 2005. ("[M]ore families are challenging doctors who believe additional medical treatment of a critically ill patient is unwarranted."). See also John Ellement, *Woman Suing MGH Tells Court of Distress*, BOSTON GLOBE, Apr. 8, 1995, at 18; Donalee Moulton, *Death, Denial and the Law*, 40 MED. POST [Toronto], May 4, 2004, at 29.

<sup>101</sup> THE PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS, MORE AMERICANS DISCUSSING – AND PLANNING – END-OF-LIFE TREATMENT: STRONG PUBLIC SUPPORT FOR RIGHT TO DIE 24 (2006).

<sup>102</sup> CALIFORNIA HEALTH CARE FOUNDATION, ATTITUDES TOWARD END-OF-LIFE CARE IN CALIFORNIA 5, 20 (2006).

<sup>103</sup> See Mark Hall, *Law Medicine and Trust*, 55 STAN. L. REV. 463, 470 (2002).



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era.<sup>104</sup> Changes in reimbursement policy and the fragmentation of care delivery have undermined patient trust and confidence in provider judgment.<sup>105</sup> Aware that physicians in capitated plans benefit financially from limiting patient referrals and procedures, patients wonder if doctors seeking to "stop the train" are merely trying to boost their own profits.<sup>106</sup>

Traditionally marginalized groups are particularly suspicious. Racial disparities in the diagnosis and treatment of serious disease have been highlighted in both news and print media.<sup>107</sup> Minorities are primed for evidence that they are receiving less and poorer care than their white fellows. And this concern leads to dour interpretations of provider action in the end-of-life context.<sup>108</sup> With consumers of medical care across a wide racial and socio-economic spectrum questioning whether patient best interest remains at the core of clinical judgment, it is unsurprising that provider recommendations to limit care at the end of life would precipitate unease and resistance.

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<sup>104</sup> See M. Schlesinger, *A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession*, 80 MILBANK Q. 185, 185–87 (2002).

<sup>105</sup> See, e.g., Belluck, *supra* note 16, at A1 (reporting that some "patients and families . . . are skeptical of doctors' interpretations or intentions"); Joseph Fins, *End-Of-Life Care in the Hospital*, in *A PALLIATIVE ETHIC OF CARE: CLINICAL WISDOM AT LIFE'S END* 77, 78 (2006) ("An especially difficult dynamic can arise when the family believes that the patient's dire condition was precipitated by a medical error or if they are suspicious that substandard care is being provided because the patient is from a traditionally marginalized population."); Lee, *supra* note 34, at 483; Kathryn L. Moseley et al., *Futility in Evolution*, 21 CLINICAL GERIATRIC MEDICINE 211, 212–13 (2005) (collecting cites); Mary Ellen Wojtasiewicz, *Damage Compounded: Disparities, Distrust, and Disparate Impact in End-of-Life Conflict Resolution Policies*, AM. J. BIOETHICS, Sept.–Oct. 2006, at 8–12.

<sup>106</sup> See Bloche, *supra* note 64, at 2373; Dubler, *supra* note 60, at S22; DUBLER & LIEBMAN, *supra* note 1, at 6 ("The growth of managed care and . . . incentives for undertreatment have fueled a growing mistrust . . . that the integrity of the care provided may be affected by factors external to the best interests of the patient."); John M. Luce, *Making Decisions About the Forgoing of Life-sustaining Therapy*, 156 AM. J. RESPIRATORY CARE MED. 1715 (1997); Moseley et al., *supra* note 105, at 212.

<sup>107</sup> See, e.g., Hilary Waldman, *End-of-Life Care, Viewed in Stark Black and White*, L.A. TIMES, Feb. 6, 2006, at F5.

<sup>108</sup> See THE PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS, *supra* note 101, at 6, 24; CALIFORNIA HEALTH CARE FOUNDATION, *supra* note 102, at 5, 19; William Bayer et al., *Attitudes Toward Life-Sustaining Interventions Among Ambulatory Black and White Patients*, 16 ETHNICITY & DISEASE 914 (2006); James M. Garrett et al., *Life-Sustaining Treatments During Terminal Illness: Who Wants What?*, 8 J. GEN. INTERNAL MED. 361, 361–68 (1993).

## 2. Therapeutic Illusions

Even if not distrustful, surrogates might be in denial or under a "therapeutic illusion" that the patient could recover or that a new therapy will come along.<sup>109</sup> Unrealistic television portrayals of medicine contribute to surrogates' over-optimism.<sup>110</sup> Easy access to medical information online bolsters surrogates' confidence in opposing providers' recommendations.<sup>111</sup> Even in the face of clear and dire medical facts, family members often hold out hope that the patient will beat the odds.<sup>112</sup> Having been treated to a steady diet of medical advances and technological developments, patients view Western medicine in semi-mystical terms. Newspapers trumpeting the success stories of 21-week old preemies coaxed into health,<sup>113</sup> impossibly

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<sup>109</sup> See Susan Dorr Goold et al., *Conflicts Regarding Decisions to Limit Treatment: A Differential Diagnosis*, 283 JAMA 909, 910–11 (2000); Stacey A. Tovino & William J. Winslade, *A Primer on the Law and Ethics of Treatment, Research, and Public Policy In the Context of Severe Traumatic Brain Injury*, 14 ANNALS HEALTH L. 1, 2 n.5, 26 n.153 (2005) (discussing "therapeutic illusions" where patients have "false hopes despite the lack of future benefit"); Leigh Middleditch & Joel Trotter, *The Right to Live*, 5 ELDER L.J. 395, 402–03 (1997) (discussing "society's increasing denial of death").

<sup>110</sup> See, e.g., Neal A. Baer, *CPR on TV – Exaggerations and Accusations*, 335 NEW ENG. J. MED. 1605, 1605–07 (1996); Susan J. Diem, *Cardiopulmonary Resuscitation on TV – Miracles and Misinformation*, 334 NEW ENG. J. MED. 1578, 1578–82 (1996).

<sup>111</sup> See Sneider, *supra* note 100.

<sup>112</sup> See Todd Ackerman, *Hospital Rules to Unplug Baby Girl: Leukemia Patient's Parents Scramble to Find New Care Facility*, HOUS. CHRON., Apr. 29, 2005, at B1 (reporting that the mother of Knya Dismuke-Howard, a 6-month old with leukemia in her brain, multiple organ failure, and a life-threatening antibiotic-resistant infection believes "I think she can beat the odds . . . [s]he's a fighter."); Ralph Baergen, *How Hopeful Is Too Hopeful? Responding to Unreasonably Optimistic Patients*, 32 PEDIATRIC NURSING 482 (2006); Belluck, *supra* note 16, at A1 ("Extraordinary medical advances have stoked the hopes of families."); Clare Dyer, *Doctors Need Not Ventilate Baby to Prolong His Life*, 329 BMJ 995 (2004) (reporting that mother of terminally ill infant rejected medical advice because her baby was a "fighter" and "had lived longer than doctors had predicted"); Bill Murphy, *Life-and-Death Matter Goes to Court: Comatose Man's Relative Fighting State Law, Hospital to Keep Him Alive*, HOUS. CHRON., Mar. 18, 2001, at A37 (reporting that relatives opposed to removing life support "don't share the conclusion that his condition is hopeless"). Cf. *In re Guardianship of Schiavo*, 851 So. 2d 182, 186 (Fla. Dist. Ct. App. 2003) ("[W]e understand why a parent . . . would hold out hope . . . If Mrs. Schiavo were our own daughter, we could not but hold to such a faith.").

<sup>113</sup> See, e.g., *World's Youngest Premie*, PEOPLE, Apr. 12, 2007, at 193 (reporting on Amillia Taylor, the youngest premature baby to survive delivery and go home).

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complicated organ transplants,<sup>114</sup> and surgically re-attached limbs<sup>115</sup> lead patients to not only hope for, but expect, marvels. Conscious that innovation, drive, and derring-do have, in the health-care realm, pushed back the borders of what was once thought impossible, surrogates are reluctant to accept that sheer grit and determination won't produce a medical miracle for their loved one.

### 3. Religion

Other times, surrogates appreciate that the odds are exceedingly slim, yet still believe that those odds are worth pursuing. Religious faith leads some to wait for divine intervention and avoid decisions that could be viewed as meddling with life and death decisions that fall outside the jurisdiction of mere mortals.<sup>116</sup> A variety of religious and cultural traditions stress the sanctity of biologic life and some surrogates view efforts to withdraw medical treatment as contrary to those religious teachings.<sup>117</sup>

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<sup>114</sup> See, e.g., Bill Sanderson, *Infant's Guts & Glory - Rebounding After 5-Organ Transplant*, N.Y. POST, Aug. 24, 2007, at 17 (reporting the recovery of Elijah Moulton who received five transplanted organs).

<sup>115</sup> See, e.g., Editorial, *Miracle Surgery Boy on Mend*, HERALD SUN (Melbourne, Australia), Mar. 30, 2005, at 8 (reporting the recovery of Terry Vo, who had three severed limbs reattached).

<sup>116</sup> See, e.g., *In re Baby K*, 832 F. Supp. 1022, 1026 (E.D. Va. 1993) ("The mother opposes the discontinuation . . . because she believes that all human life has value . . . that God will work a miracle"); Burns & Rushton, *supra* note 84, at 475 (31% of parents rated "religious/spiritual beliefs" as very important to end-of-life decision making); Lee, *supra* note 34, at 483; Robert Sibbald et al., *Perception of 'Futile Care' Among Caregivers in Intensive Care Units*, 177 CANADIAN MED. ASS'N J. 1201, 1204 (2007); Ed Yeates, *Parents Fight to Keep Son on Life Support*, KSL Television Broadcast, Oct. 13, 2004 (parents sought an injunction to stop physicians from disconnecting their son from life support even though he was declared dead because "we performed a miracle and I don't see why we can't do that again"); Editorial, *Parents Fear Home Delay May Keep 'Miracle' Baby Charlotte in Hospital*, BIRMINGHAM POST (UK), Jan. 7, 2006, at 3 (reporting that parents of Charlotte Wyatt "are committed Christians" who believe that "miracles do happen").

<sup>117</sup> See, e.g., *Rideout v. Hershey Med. Ctr.*, 30 Pa. D. & C. 4th 57, 62 (Pa. C.P. Ct., Dauphin Cty. 1995) (parents opposed to removing ventilator from daughter because of "religious belief that all human life has value and should be protected"); James Bopp, Jr. & Richard E. Coleson, *Child Abuse by Whom? - Parental Rights and Judicial Competency Determinations: The Baby K and Baby Terry Cases*, 20 OHIO N.U. L. REV. 821, 841 (1994) ("I cannot make that decision to terminate life. God did not give me that power.") (quoting Brief of Appellant, *In re Achtabowski*, No. 93-1247-AV (Mich. Cir. Ct. Aug. 12, 1993) (No. 170251), at 39); Bill Murphy, *Comatose Man Dies After Battle*

#### 4. Family Dynamics

Complex family dynamics, unresolved tensions, and rivalries also contribute to surrogate inflexibility. Surrogates who are estranged from the patient feel unable to "let go" and accept that the reconciliation they once hoped for is impossibly beyond reach. Other surrogates feel that foregoing treatment signals abandonment and that remaining loyal to the patient demands an unflagging commitment to deny death.<sup>118</sup> Others are simply too grief-stricken to stop treatment<sup>119</sup> and lack the emotional strength to face difficult facts or make hard choices. Still others, while emotionally at peace with the prospect of their loved one's passing, believe—consistent with the "technological imperative" in American medicine<sup>120</sup>—that the patient is

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*Over Life Support: Family Cited Spiritual Beliefs*, HOUS. CHRON., Mar. 23, 2001, at A29 (reporting that for "spiritual and cultural reasons[,] the family of Joseph Ndiyob sought an injunction preventing Memorial Hermann Hospital from removing Ndiyob's life support); John Carvel, *Muslim Family Loses Right-to-Life Appeal*, GUARDIAN UNLIMITED, Sept. 2, 2005 (noting the "family's religious conviction"); Lee, *supra* note 34, at 483; Emily Ramshaw, *Children Fight to Save Mom: Carrollton: Hospital Seeks to End Care of Woman with Brain Injury*, DALLAS MORNING NEWS, Aug. 18, 2006, at 1B ("Ruthie Webster is deeply religious and believes only God should give and take life."); Benjamin Weiser, *The Case of Baby Rena: A Question of Letting Go: Who Should Decide When Treatment is Futile?*, WASH. POST, July 14, 1991, at A1 (discussing the religious views of Baby Rena's foster father).

<sup>118</sup> See Goold et al., *supra* note 109, at 911; Jan Hoffman, *The Last Word on the Last Breath*, N.Y. TIMES, Oct. 10, 2006 ("Families often believe that consenting to a D.N.R. order implies they are giving up on their loved one, signing a death warrant"); Lee, *supra* note 34, at 483; John J. Paris et al., *Has the Emphasis on Autonomy Gone Too Far? Insights from Dostoevsky on Parental Decisionmaking in the NICU*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 147, 147 (2006); Wlazelek, *supra* note 57 ("It's dangerous to give the family the last word since guilt and desire to do everything for mom or pop makes it emotionally impossible to stop any treatment.") (quoting Arthur Caplan). See also Fine et al., *supra* note 82, at 1221.

<sup>119</sup> See, e.g., Alexander Morgan Capron, *Abandoning a Waning Life*, HASTINGS CENTER REP., July–Aug. 1995, at 24 (reporting that Mass. General wrote a unilateral DNR for Catherine Gilgunn because "the family's unpreparedness for their mother's death did not justify mistreating the patient"); Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis*, 267 JAMA 2067, 2067 (1992) (family members find that they cannot "let the patient go").

<sup>120</sup> The technological imperative represents the mindset that because we *can* use a given technology, we *should* use that technology. See generally VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE (1974); Kathy L. Cerninara,

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entitled to everything.<sup>121</sup>

### 5. Externalization

Finally, it is easy for surrogates to act on these reasons because the costs of their decisions are externalized. The financial burden is often borne by an insurer. And health care providers, particularly nurses, bear the emotional burden of treating the patient.<sup>122</sup>

In short, many surrogates view their goal not just as important or desirable, but as essential.<sup>123</sup> Consequently, they take a "firm, extreme position, making [no] concessions."<sup>124</sup> They adopt a "hardball"<sup>125</sup> competitive negotiation style centered on this predetermined position such that their initial position is also their bottom line.<sup>126</sup> Due to their

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*Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even When the Answer is "No")*, 15 HEALTH MATRIX 285, 296 (2005); Robert L. Fine, *The History of Institutional Ethics at Baylor University Medical Center*, 17 BAYLOR UNIV. MED. CTR. PROC. 73, 74 (2004).

<sup>121</sup> See, e.g., Arthur E. Kopelman, *Understanding, Avoiding, and Resolving End-of-Life Conflicts in the NICU*, 73 MT. SINAI J. MED. 580, 582–85 (2006); Alan Meisel, *The Role of Litigation in End of Life Care: A Reappraisal*, HASTINGS CENTER REP., Nov.–Dec. 2005, at S47, S49 ("A vocal proportion of the population . . . believes that life per se is a pearl beyond price and must be preserved at all costs . . . . This set of beliefs [is] known as vitalism"); Rivin, *supra* note 82, at 392; James W. Walter, *Medical Futility – an Ethical Issue for Clinicians and Patients*, PRACTICAL BIOETHICS, Summer 2005, at 1, 6. See also Todd Ackerman, *St. Luke's Postpones Removal of Life Support: Man's Family Has Until 3 P.M. to Explore Any Possible Appeals*, HOUS. CHRON., Mar. 12, 2005, at B1 ("[T]he family understands there is no hope . . . '[but] the decision when life support is removed should be ours, not a corporation's.'").

<sup>122</sup> Cf. Goold et al., *supra* note 109, at 913 ("[I]nsured families and patients [push] to prolong inpatient treatment because they do not bear most of the cost"); Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 ISSUES L. & MED. 3, 9 (1995).

<sup>123</sup> Cf. CRAVER, *supra* note 92, § 4.01[2][a].

<sup>124</sup> GARY GOODPASTER, A GUIDE TO NEGOTIATION AND MEDIATION 23–24 (1997).

<sup>125</sup> CONRAD LEVINSON, MARK S.A. SMITH, & ORVEL RAY WILSON, GUERRILLA NEGOTIATING: UNCONVENTIONAL WEAPONS AND TACTICS TO GET WHAT YOU WANT 28–34 (1999) (describing "hardball" negotiators as those who "want their own way [] and . . . are unwilling or unable to consider an alternative position").

<sup>126</sup> See JAY FOLBERG & DWIGHT GOLANN, LAWYER NEGOTIATION: THEORY, PRACTICE, AND LAW 45–46 (2006); GIFFORD, *supra* note 87, at 150–51 (describing "positional commitment" as pledging an "inalterable bargaining position and no more concessions"). See generally Gary Goodpaster, *A Primer on Competitive Bargaining*, 1996 J. DISP. RESOL. 325 (1996); JOHN W. COOLEY, THE MEDIATOR'S HANDBOOK § 4.4.1

"intransigent passions,"<sup>127</sup> they have "neither the interest nor the inclination to compromise"<sup>128</sup>

Normally, a party utilizing such strategic behavior risks a failure in the negotiations. Parties to mediation must want to reach agreement.<sup>129</sup> Since surrogates have no interest in reaching agreement, it is unclear that mediation is even appropriate.<sup>130</sup> "If . . . one of the parties prefers merely to defeat the other side, then the mediation effort most likely will be fruitless."<sup>131</sup>

Here, however, surrogates' unyielding strategy works because providers cannot just walk away: "Stopping short of an agreement is rarely an option."<sup>132</sup> Intransigence works well against risk-averse providers "who fear the real or imagined consequences of non-settlement."<sup>133</sup> Intransigence tests providers' firmness and permits surrogates to see how much concession room exists.<sup>134</sup> Surrogates' uncompromising stance pushes providers to yield their bottom line, what they will maximally give. And, as it turns out, in most instances providers will give all.<sup>135</sup> The obstinate approach works because providers feel they that have no viable option outside the mediation.<sup>136</sup>

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(2000).

<sup>127</sup> Schneiderman & Fein, *supra* note 90, at 10.

<sup>128</sup> Dubler, *supra* note 77, at 10. *See also* Schneiderman & Fein, *supra* note 90, at 11 ("no acceptable compromise"). *But cf.* Hoffman, *supra* note 21, at 868 ("[A] family who is unwilling to consent to removal of a patient from a ventilator or feeding tube might be willing to accept a 'Do Not Resuscitate' (DNR) order.")

<sup>129</sup> *See generally* Heidi Burgess & Guy Burgess, *Intractability and the Frontier of the Field*, 24 CONFLICT RESOL. Q. 177, 180 (2006); Dubler, *supra* note 77, at 11 ("Dispute resolution assumes that both sides want to settle a dispute"); DUBLER & LIEBMAN, *supra* note 1, at 5; LINDA FARBER POST, JEFFREY BLUSTEIN, & NANCY NEVELOFF DUBLER, HANDBOOK FOR HEALTH CARE ETHICS COMMITTEES 151 (2007).

<sup>130</sup> *See* HAROLD ABRAMSON, MEDIATION REPRESENTATION 20–22 (2004) (disputes where a party is unwilling to compromise on principle are not suitable for mediation); DUBLER & LIEBMAN, *supra* note 1, at 12–13 (Where a patient has "strongly held religious beliefs, value preferences" the provider "might need to capitulate"); Hoffman, *supra* note 21, at 863 ("[I]f any party views the dispute as one in which there is a definite right or wrong answer and about which they have a highly moral or fundamentalist view, mediation may not be effective.").

<sup>131</sup> MARCUS, *supra* note 61, at 342.

<sup>132</sup> DUBLER & LIEBMAN, *supra* note 1, at 25. *See also* GIFFORD, *supra* note 87, at 37; Schneiderman & Fein, *supra* note 90, at 10.

<sup>133</sup> CRAVER, *supra* note 92, at § 7.04[2][f].

<sup>134</sup> *See* GOODPASTER, *supra* note 124, at 23–24, 44.

<sup>135</sup> *See id.*

<sup>136</sup> *See* CRAVER, *supra* note 92, at § 7.04[2][f].

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### B. *Mediation Fails Because of the Misconception that Substantive Health Care Decisions Law Disfavors Providers*

Mediation occurs in the "shadow of the law,"<sup>137</sup> against the "backdrop of the likely range of results if the matter [were] fully adjudicated 'at law.'"<sup>138</sup> After all, "if agreement cannot be reached in the mediation session, a series of default rules . . . comes into play."<sup>139</sup>

"[T]he outcome that the law will impose if no agreement is reached gives each [party] certain bargaining chips—an endowment of sorts."<sup>140</sup> Since a party typically will not agree to a settlement that provides less than they could likely obtain in litigation, such entitlements typically determine the minimum that a party will accept through bargaining.<sup>141</sup> Therefore, the party expected to achieve a better outcome through litigation will have a higher minimum and greater bargaining power.

It is widely believed that surrogates can anticipate favorable litigation outcomes in end-of-life disputes. Specifically, based on the outcomes in several well-publicized court cases, commentators consistently conclude that "courts have almost universally sided with the family and against the hospital . . . ."<sup>142</sup> This assessment is widely reprinted in medical journals,<sup>143</sup>

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<sup>137</sup> Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 968 (1979).

<sup>138</sup> Jeffrey W. Stempel, *Forgetfulness, Fuzziness, Functionality, Fairness, and Freedom in Dispute Resolution: Serving Dispute Resolution Through Adjudication*, 3 NEV. L.J. 305, 308 n.14 (2003).

<sup>139</sup> DUBLER & LIEBMAN, *supra* note 1, at 25.

<sup>140</sup> Mnookin & Kornhauser, *supra* note 137, at 968.

<sup>141</sup> See Hyman & Love, *supra* note 62, at 162 ("[P]ublic law provides the norms that guide private resolution . . . Parties often settle . . . by keeping in mind and balancing the entitlements the litigation system promises."); Stephen N. Subrin, *A Traditionalist Looks at Mediation: It's Here to Stay and Much Better Than I Thought*, 3 NEV. L.J. 196, 227 (2003) ("The results of mediation are frequently – I actually believe usually – dependent upon the range of potential results that would come from formal adjudication.").

<sup>142</sup> Jack K. Kilcullen, *A Multilevel Examination of a Critically Ill Patient*, in THREE PATIENTS: INTERNATIONAL PERSPECTIVES ON INTENSIVE CARE AT THE END OF LIFE 123 (David Crippen et al. eds., 2002); Edward F. Mcardle, *New York's DNR Law: Groundbreaking Protection of Patient Autonomy or a Physician's Right to Make Medical Futility Determinations*, 6 DEPAUL J. HEALTH CARE L. 55, 71 (2002) ("Numerous articles have warned physicians of the serious legal risk in unilaterally writing a DNR order").

<sup>143</sup> See, e.g., ACOG, *supra* note 68, at 792 ("Litigation has generally resulted in courts supporting the view of patient or family."); Burt, *supra* note 90, at 250, 254; James E. Szalados, *Discontinuation of Mechanical Ventilation at End-of-Life: The Ethical and*

bioethics journals,<sup>144</sup> and law reviews.<sup>145</sup>

Therefore, whatever the actual litigation risks to providers, they are likely overestimated by all parties to the mediation.<sup>146</sup> Both providers and surrogates believe that substantive end-of-life medical decisionmaking law favors surrogates. Both believe that the law gives surrogates in end-of-life cases a "veto authority" over clinical judgment.<sup>147</sup> Both expect that if agreement were not reached in mediation, surrogates would probably win in court.

But this assessment of providers' non-settlement alternatives is off-base. "Its felicity leads to its lazy repetition; and repetition soon establishes it as a [recognized] legal formula."<sup>148</sup> Not only have providers frequently prevailed in futility cases,<sup>149</sup> but they also now have more legislative protection than

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*Legal Boundaries of Physician Conduct in Termination of Life Support*, 23 CRIT. CARE CLINICS 317, 325 (2007). *But see* Luce & White, *supra* note 12, at 1106 (correctly noting that *Baby K* and *Wanglie* did not "fac[e] the futility issue head on.").

<sup>144</sup> See, e.g., Peter A. Clark, *Medical Futility in Pediatrics*, 23 J. PUB. HEALTH POL'Y 66 (2002).

<sup>145</sup> See, e.g., Johnson et al., *supra* note 69; Patrick Moore, *An End-Of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment That Physicians are Unwilling to Provide*, 48 B.C. L. REV. 433, 439 (2007).

<sup>146</sup> Cf. Regina Ohkyusen-Cawley et al., *Institutional Policies on Determination of Medically Inappropriate Interventions: Use in Five Pediatric Patients*, 8 PEDIATRIC CRIT. CARE MED. 225, 225 (2007) ("[C]ourts have endorsed patient or surrogate insistence on continued intervention, possibly fostering the reluctance of medical professionals to limit nonbeneficial interventions."). Marshall Kapp argues that the legal risks in the early 1990s were not serious, yet concedes that physicians had "overblown anxiety." Kapp, *supra* note 32, at 175; see also Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 L. & CONTEMP. PROBLEMS 119, 119 (1991) ("[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophecy").

<sup>147</sup> Cf. Jacquelyn Slomka, *Clinical Ethics and the Culture of Conflict*, HASTINGS CENTER REP., Mar.-Apr. 2005, at 45, 46 ("An increasingly litigious society as well as a bioethical emphasis on patient and family autonomy . . . have led to physicians' disempowerment"); Burt, *supra* note 90, at 254 (arguing that "[p]hysicians (and hospital attorneys) should know" that a surrogate's ability to bring suit "is a considerable source of bargaining advantage").

<sup>148</sup> *Tiller v. Atlantic Coast Line Co.*, 318 U.S. 54, 68 (1943) (Frankfurter, J., concurring) (referring to "assumption of risk" in tort law). Cf. Schneiderman & Capron, *supra* note 84, at 525 (noting that while legally irrelevant, "the *Baby K* decision captured much attention").

<sup>149</sup> See Thaddeus Mason Pope, *Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQ. ELDER'S ADVISOR (forthcoming 2008) (collecting cites).



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ever before.<sup>150</sup> While some surrogates have successfully litigated medical futility cases against providers, those cases are legally and factually unique and simply cannot support a sweeping statement about the judicial treatment of futility cases.<sup>151</sup>

Most egregiously, the two cases most often cited in support of this dire prediction, *In Re Baby K*<sup>152</sup> and *In re Wanglie*,<sup>153</sup> are inapposite to most futility disputes. In neither case did the court address the propriety of unilaterally refusing life-sustaining treatment. While the answers to the legal questions asked in these two cases disfavored providers, they are not questions lying at the core of most futility cases.

The outcome in *Wanglie* rested on the peculiar legal claim made in that case, petition for appointment of a guardian.<sup>154</sup> Helga Wanglie was an 87-year-old woman who, as a result of a cardiac arrest, remained in a persistent vegetative state and dependent on a ventilator.<sup>155</sup> Since Helga could never appreciate any benefit from continued LSMT, Helga's health care providers advised her husband, Oliver, to remove the ventilator.<sup>156</sup> But Oliver would not consent to stopping LSMT.

The providers petitioned the local probate court to appoint a professional conservator to make health care decisions for Helga.<sup>157</sup> The probate court denied the petition, instead appointing Oliver, Helga's husband of fifty-three years.<sup>158</sup> The providers never requested a court order to "stop any and all treatment for Helga,"<sup>159</sup> so the court never ruled on that claim.<sup>160</sup>

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<sup>150</sup> See Pope, *supra* note 10 (surveying state statutes giving providers civil, criminal, and disciplinary immunity for refusing to comply with inappropriate treatment requests).

<sup>151</sup> See Pope, *supra* note 149. Cf. Meisel, *supra* note 121, at S48 ("Litigation attacks problems piecemeal. Courts only answer questions they are asked and litigants only ask questions that must be answered for the resolution of their particular dispute.").

<sup>152</sup> *In re Baby K*, 832 F. Supp. 1022 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir. 1994).

<sup>153</sup> *In re Wanglie*, No. PX-91-283 (Minn. Dist. Ct. June 28, 1991), *reprinted in* 2 *Biolaw U:2162-2165* (Aug.-Sept. 1991), *reprinted in* 7 *ISSUES L. & MED.* 369 (1992).

<sup>154</sup> *Id.* at 369, 376.

<sup>155</sup> *Id.* at 374-75.

<sup>156</sup> *Id.* at 371.

<sup>157</sup> *Id.* at 371, 376.

<sup>158</sup> *Id.* at 372, 377. This type of claim may be difficult to win where the surrogate's only fault is insisting on LSMT. See Pope, *supra* note 10.

<sup>159</sup> *Wanglie*, at 377.

<sup>160</sup> Cf. Robert Schwartz, *Autonomy, Futility, and the Limits of Medicine*, 12 *CAMBR. Q. HEALTHCARE ETHICS* 159, 161 (1992) (arguing that whether Mr. Wanglie was his wife's best substitute decision maker was the "wrong question.") ("The real question

The outcome in *Baby K* similarly rested on a peculiar legal claim, the coincidental application of a federal statute. Stephanie Keene was born with anencephaly, a birth defect in which part of the skull and the higher brain are missing.<sup>161</sup> While Stephanie was later moved to a nursing home, she was periodically transferred back to the hospital for breathing difficulties. "Because aggressive treatment would serve no therapeutic or palliative purpose [Stephanie's providers] recommended that [she] only be provided with supportive care."<sup>162</sup> But Stephanie's mother would not consent, insisting that Stephanie be provided with a ventilator.

Unlike the providers in *Wanglie*, Stephanie's providers directly and specifically asked the court if they were obligated to provide the requested LSMT. But the court framed their claim under the Emergency Medical Treatment and Active Labor Act (EMTALA). While the court ruled that the providers were so obligated, that holding is limited to the peculiar facts of the case.<sup>163</sup> Only because Stephanie arrived at the hospital in an "emergency medical condition," was the hospital obligated to stabilize that condition.<sup>164</sup> EMTALA's scope is limited and it "cannot be invoked to require treatment in the vast majority of futility cases."<sup>165</sup>

It is unclear whether, as widely thought, the limited universe of legal precedent really favors surrogates. But it is equally unclear that it favors providers. At best, the law is uncertain.<sup>166</sup> But this indeterminacy empowers surrogates no less than the perception of favorable substantive law.

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[should have been] . . . whether the continuation of ventilator support and gastronomy feeding were among the reasonable medical alternatives that should have been available to Mrs. Wanglie or her surrogate decision maker, whoever that might be.").

<sup>161</sup> *Baby K*, 16 F.3d at 592.

<sup>162</sup> *Id.* at 593.

<sup>163</sup> See Schneiderman & Capron, *supra* note 84, at 525 ("*Baby K* actually provides no judicial guidance on the legality of ceasing treatment deemed to be futile.") (citing Alexander Morgan Capron, *Medical Futility: Strike Two*, 24 HASTINGS CENTER REP., Sept.-Oct. 1994, at 42).

<sup>164</sup> *Baby K*, 16 F.3d at 594.

<sup>165</sup> See THE RIGHT TO DIE, *supra* note 9, at § 13.06[C] (explaining that EMTALA does not apply to inpatients). See also Pope, *supra* note 149 (collecting cases that explicitly limit the scope of *Baby K*).

<sup>166</sup> See *infra* notes 186–190 and accompanying text.

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### *C. Mediation Fails Because Legal Uncertainty Strongly Disfavors Providers*

Surrogates are able to engage in strategic behavior because they and providers misperceive substantive norms. But even when substantive norms are more accurately assessed as uncertain, rather than as hostile to unilateral physician action, surrogates still gain a significant advantage in the bargaining process. Specifically, surrogates can exploit providers' risk aversion.<sup>167</sup>

#### *1. Substantive Health Care Decisions Law Is Uncertain*

The outcome of litigation is always uncertain.<sup>168</sup> This is no less true with respect to the litigation of medical futility disputes.<sup>169</sup> In 1999, when the AMA encouraged hospitals to adopt futility guidelines, it noted that "the legal ramifications of this course of action are uncertain."<sup>170</sup> Today, there is *still* significant legal uncertainty.<sup>171</sup>

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<sup>167</sup> Mnookin & Kornhauser, *supra* note 137, at 972–73; Jeremy A. Matz, *We're All Winners: Game Theory, The Adjusted Winner Procedure and Property Division at Divorce*, 66 BROOK. L. REV. 1339, 1355 (2001). Uncertainty weighs more heavily on providers than surrogates, impeding the opportunity for negotiated dispute resolution. While it is hardly clear that surrogates would win in litigation, the effect of uncertainty is the same: providers make wholesale concessions in negotiations, as if it were clear that they would lose in court. *See infra* notes 191–214 and accompanying text.

<sup>168</sup> *See* Subrin, *supra* note 141, at 202–04 (providing a rich description of "the multiple points of uncertainty" in legal proceedings and explaining that it is, therefore, "very difficult to advise the client with any degree of precision").

<sup>169</sup> *See* NATIONAL CENTER FOR STATE COURTS COORDINATING COUNCIL ON LIFE-SUSTAINING MEDICAL TREATMENT DECISION MAKING BY THE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE SUSTAINING MEDICAL TREATMENT CASES 147 (2d ed. 1993) (finding that there is "as yet no consensus . . . on the legal ramifications associated with [futility]"); Jesse A. Goldner, Sandra H. Johnson, & Richard L. Wiener, *Responses to Medical Futility Claims*, in HEALTH LAW HANDBOOK 401, 401 (Alice Gosfield ed., 1997) ("The current legal status of claims of medical futility is confusing."); Nasraway, *supra* note 78, at 217 ("Unilateral withdrawal . . . is still uncharted territory.").

<sup>170</sup> Council on Ethical and Judicial Affairs, *supra* note 67, at 940.

<sup>171</sup> *See* Pope, *supra* note 10; Moore, *supra* note 145, at 433 ("Current precedent in the area provides uncertain guidance"); *id.* at 437 ("The legal answers . . . are inconclusive."); *id.* at 451 ("[i]nconsistent, if not incoherent, message"); *id.* at 462 ("[v]oid . . . in the law" forced providers to "speculate about their respective rights and duties"); Karen Trotochaud, *"Medically Futile" Treatments Require More than Going to Court*, 17 CASE MANAGER 60, 62 (2006) ("Although going to court has resulted in a resolution of each case, no clear process for resolving further cases has evolved.").

Lawyers, bioethicists, health care providers, and policymakers have had enormous difficulty defining "medically inappropriate" treatment.<sup>172</sup> Years of debate failed to produce any consensus.<sup>173</sup> This led policymakers to design an approach with vague standards, giving substantial discretion to health care providers and institutions.<sup>174</sup> Rather than establish a clear framework for determining medical inappropriateness, health care decisionmaking statutes instead leave that determination to the judgment and

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<sup>172</sup> See generally Anderson-Shaw et al., *supra* note 81, at 303; Tom Tomlinson & Diane Czlonka, *Futility and Hospital Policy*, HASTINGS CENTER REP., May-June 1995, at 28, 33 (arguing "against any attempt to base a futility policy on some concrete definition of futility"); David G. Warren, *The Legislative Role in Defining Medical Futility*, 56 N.C. MED. J. 454-55 (1995) ("[T]here may be another wave of proposals in the state legislatures to address the question of . . . medical futility. Drafting difficulties are obvious").

<sup>173</sup> See Moseley et al., *supra* note 105, at 211 ("[D]espite years of debate in scholarly journals, professional meetings, and popular media, consensus on a precise definition eludes us still."); see also Burt, *supra* note 90, at 249-50; Judith Daar, *A Clash at the Bedside: Patient Autonomy vs. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1246 (1993); Goldner et al., *supra* note 169, at 416 (empirical research study "suggests an absence of consensus"); Lee, *supra* note 34, at 482; Eric M. Levine, *A New Predicament for Physicians: The Concept of Medical Futility, the Physician's Obligation to Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care*, 9 J. L. & HEALTH 69, 73 (1995); Mark Strasser, *The Futility of Futility? On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505, 514 (1998); David M. Zientek, *The Texas Advance Directives Act of 1999: An Exercise in Futility*, 17 HEC F. 245, 251 (2005) ("Because of the difficulty in defining futility . . . the [Texas] statute is vague on a number of central issues.").

<sup>174</sup> Bowman, *supra* note 65, at 1527 ("The reluctance of providers to act unilaterally comes in part . . . from a lack of medical agreement on a workable definition for futility and a lack of legal support for overriding patient consent."); Council on Ethical and Judicial Affairs, *supra* note 67, at 937 (rejecting a definition in favor of a process-based approach); Matthew S. Ferguson, *Ethical Postures of Futility and California's Uniform Health Care Decisions Act*, 75 S. CAL. L. REV. 1217, 1220 (2002) (arguing that the UHCDA does not "provide a clear definition of futility and fails to supply adequate ethical context or constraints to guide difficult decisions"); *id.* at 1243 (noting that the statute provides no "usable, clear standard that protects the physician"); *id.* at 1249 ("This currently leaves a wide area of latitude that is without definitive form."); *id.* at 1254 (bemoaning the "lack of a clear demarcation of propriety within the new [California] statute"); Johnson et al., *supra* note 69, at 36 ("Developing clarity in the boundaries of futility is fundamental."); Edmund D. Pellegrino, *Futility in Medical Decisions: The Word and the Concept*, 17 HEC F. 308, 313-14 (2005). (criticizing the process-based approach); Keith Shiner, *Medical Futility: A Futile Concept?*, 53 WASH. & LEE L. REV. 803, 810 (1996) ("[T]he legislative responses are incomplete."); *cf.* THE RIGHT TO DIE, *supra* note 9, § 13.02, at 13-7.

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discretion of the individual health care provider.<sup>175</sup> In this sense, the statutes might be described as "purely enabling legislation."<sup>176</sup>

The most prevalent form of "unilateral decision" statute is modeled on the Uniform Health Care Decisions Act (UHCDA), now adopted in ten states.<sup>177</sup> The UHCDA makes clear that a provider's obligation to comply with a surrogate's decision "is not absolute."<sup>178</sup> A health care provider or health care institution may decline to comply with an individual instruction that requires "medically ineffective health care" or "health care contrary to generally accepted health care standards."<sup>179</sup> A health care provider may also decline to comply for "reasons of conscience."<sup>180</sup> Moreover, as adopted in

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<sup>175</sup> This is hardly surprising given that the inappropriate treatment question concerns tough "issues concerning the meaning that we attach to life . . . self-determination, the nature of the physician-patient relationship, and the just allocation of scarce health care resources." See Shiner, *supra* note 174, at 808–09.

<sup>176</sup> J.K. MASON & G.T. LAURIE, *MASON AND MCCALL SMITH'S LAW AND MEDICAL ETHICS* 596 (7th ed. Oxford 2006). It is not unusual for policymakers to pass responsibility to decision makers when they cannot agree on rules or guidelines. See Carl E. Schneider, *Discretion, Rules, and Law: Child Custody and the UMDA's Best-Interest Standard*, 89 MICH. L. REV. 2215, 2244–45 (1991). See also ROGER B. DWORKIN, *LIMITS: THE ROLE OF LAW IN BIOETHICAL DECISION MAKING* 138–39, 144–45 (Indiana 1996) (arguing that given factual variability of the issues and the lack of public consensus, matters should be left to the medical profession with minimal legal oversight); Elizabeth Day, *Do Not Resuscitate and Don't Bother Consulting the Family*, TELEGRAPH [UK], Mar. 14, 2004, at 22 ("There is the possibility of legislation, but in a field as controversy strewn as medical ethics, a blanket law remains an imperfectly blunt tool.").

<sup>177</sup> Uniform Health Care Decisions Act §§ 1–19, 9 U.L.A. 93 (1993), *reprinted in* 12 ISSUES L. & MED. 83 (2006) [hereinafter UHCDA]. See Pope, *supra* note 10 (describing history and prevalence of the UHCDA).

<sup>178</sup> UHCDA, prefatory note ¶ 7 ("The obligation to comply is not absolute, however. A health-care provider or institution may decline to honor an instruction or decision for reasons of conscience or if the instruction or decision requires the provision of medically ineffective care or care contrary to applicable health-care standards."); *id.* § 4, comment ¶ 9 ("[H]ealth-care instructions . . . are binding . . . subject to exceptions specified in Section 7(e)-(f), on the individual's health-care providers."); *id.* § 5, comment ¶ 7 ("Not all instructions or decisions must be honored, however.").

<sup>179</sup> UHCDA §§ 7(f) & 13(d). See generally ALA. CODE § 22-8A-8(a) (2006); ALASKA STAT. § 13.52.060(f) (2006); CAL. PROB. CODE §§ 4735 & 4654 (2007); DEL. CODE ANN. tit. 16 § 2508(f) (2003); HAW. REV. STAT. § 327E-7(f) (2005); ME. REV. STAT. ANN. tit. 18-a § 5-807(f) (1998); N.M. STAT. ANN. §§ 24-7A-7(F) & 24-7A-13(D) (2004); MISS. CODE ANN. § 41-41-215(6) (2007); TENN. CODE ANN. § 68-11-1808(e) (2006); WYO. STAT. §§ 35-22-408(f) & 35-22-414(d) (2005).

<sup>180</sup> UHCDA § 7(e). See generally CAL. PROB. CODE § 4734; TENN. CODE ANN. § 68-11-1808(c).

several states, the UHCDA confers immunity on providers who exercise these provisions.<sup>181</sup>

But the UHCDA accords the provider substantial discretion in determining the circumstances under which treatment is inappropriate.<sup>182</sup> The UHCDA permits providers to decline to comply with requests for treatment that would be medically ineffective.<sup>183</sup> But "medically ineffective" treatment, in turn, is defined simply as treatment that would not provide "significant benefit."<sup>184</sup> The UHCDA allows the health care provider broad discretion to determine whether the benefit achievable by a treatment is "significant."<sup>185</sup>

Although it would seem that the UHCDA and its progeny are designed to

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<sup>181</sup> CAL. PROB. CODE § 4740 ("A health care provider . . . acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider . . . is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division"). See also ALA. CODE § 22-8A-8(a) ("shall not be liable for such refusal") (2006); DEL. CODE ANN. tit. 16 § 2510(a)(5) (2003); ME. REV. STAT. ANN. § 5-809(a)(2) (1998); N.M. STAT. § 24-7A-9(A)(4); WYO. STAT. § 35-22-410(a)(v).

<sup>182</sup> Ferguson, *supra* note 174, at 1221 ("These sections seemingly create an open-ended excuse for a physician to withdraw treatment. The UHCDA provides a mere framework . . . [and] gives only broad platitudes"). Indeed, the drafters of the UHCDA recognized this, observing "it really provides no immunity at all . . . every question of reasonable care is a jury question." National Conference of Commissioners on Uniform State Laws, Proceedings in Committee of the Whole, *Uniform Health Care Decisions Act*, July 31, 1992, at 142 (Calkins, Comm.). "That is one of the reasons why we want to get something in the black letter that talks about acceptable health-care standards." *id.* at 144 (Franck, Comm.). Louisiana, for example, had a unilateral decision statute in 1998 exempting providers from care that was "medically inappropriate" and "contrary to medical judgment." Sonya Causey's providers sought the protection of this statute when they unilaterally withdrew her LSMT. But since these terms were not defined, a state appellate court had no choice but to remand the family's malpractice case for further litigation to determine the standard of care. *Causey*, 719 So. 2d at 1076.

<sup>183</sup> UHCDA §§ 7(f) & 13(d).

<sup>184</sup> UHCDA comment to § 7(f) ("'Medically ineffective health care', as used in this section, means treatment which would not offer the patient any significant benefit."). As adopted, one UHCDA state defines "medically ineffective treatment" more tightly, as medical procedures which, to a reasonable degree of medical certainty, will not: "(1) Prevent or reduce the deterioration of the health of an individual; or (2) Prevent the impending death of an individual." DEL. CODE ANN. tit. 16 § 2501(m) (2007).

<sup>185</sup> See Ferguson, *supra* note 174, at 1221 ("These sections seemingly create an open-ended excuse for a physician to withdraw treatment. The UHCDA provides a mere framework . . . [and] gives only broad platitudes.").

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shelter physicians from litigation when they seek to limit treatment at the end of life, these statutory safe harbors are not navigable. In order to work safe harbors must be clear and precise.<sup>186</sup> While this vagueness appears to empower health care providers to determine the circumstances under which they may refuse to comply with treatment requests, it also leaves them significantly uncertain about whether they are actually satisfying the requirements for safe harbor status.<sup>187</sup> What are generally accepted health care standards? What is a "significant benefit"?

Some have suggested that, although vague, the unilateral decisions statutes could have been effective if "the medical community . . . [had] articulate[d] and thereafter follow[ed] uniform practice standards regarding futile care . . ."<sup>188</sup> For example, recognizing the dynamic advancement in

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<sup>186</sup> Cf. James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice "Safe Harbors" as a New Role for QIOs?*, 59 VAND. L. REV. 1017, 1049 (2006) (explaining that flexibility is not a desirable objective for a safe harbor).

<sup>187</sup> See generally Ferguson, *supra* note 174, at 1243 (noting that the statute provides no "usable, clear standard that protects the physician"); Anne L. Flamm, *The Texas 'Futility' Procedure: No Such Thing as a Fairy Tale Ending*, LAHEY CLINIC MED. ETHICS J., Spring 2004 ("The promise of immunity, of course, is not guaranteed; patients can challenge a provider's adherence to [the statute]."); Hall, *supra* note 57, at 451 ("On balance, it is difficult to offer much assurance about the existing legal climate regarding futility policies."); Maureen Kwiecinski, *To Be or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 MARQ. ELDER'S ADVISOR 313, 349-50 (2006) ("When treatment can be or should be described as inappropriate is not defined by the statute. . . . This lack of boundaries and oversight allows the providers too much discretion."); Meisel & Jennings, *supra* note 82, at 75 ("[T]he law is unclear on what should be done."); Bryan Rowland, *Communicating Past the Conflict: Solving the Medical Futility Controversy with Process-Based Approaches*, 14 U. MIAMI INT'L & COMP. L. REV. 271, 297 (2006) ("[T]hese statutes provide little guidance in regards to the limiting of the obligation for physicians to provide ongoing care they believe futile."); Schneiderman & Capron, *supra* note 84, at 528 (arguing that unless "limits" and "endpoints" are defined, "end-of-life outcomes are likely to be determined less by medical circumstances and justifiable standards and more by individual healthcare providers' tolerance for risk, patients' and families' varying degrees of knowledge and rhetorical skills, and economic considerations."); Tovino & Winslade, *supra* note 109, at 29 (observing that in futility cases "no widely accepted ethical and legal framework exists to govern decision making"). Cf. *In re Bowman*, 617 P.2d 731, 738 (Wash. 1980) (noting, with respect to brain death, that "[a]doption of [a legislative] standard will alleviate concern among medical practitioners that legal liability will be imposed when life support systems are withdrawn"). But cf. Goldner et al., *supra* note 169, at 409 ("[C]ourts are hesitant to penalize physicians who reasonably rely on what they perceive to be professional standards").

<sup>188</sup> Carol Isackson, *Futile Treatment: The Need for Legislation and Uniform Policies*, HEALTH CARE L. NEWS, Oct. 1994, at 7, 11; see also Kapp, *supra* note 32, at

technology, the drafters of the Uniform Determination of Death Act did not specify any exact diagnoses in the statute itself. Yet, in implementing the UDDA, providers developed clinical criteria.<sup>189</sup> In contrast, with respect to medical inappropriateness under the UHCDA, providers neither articulated nor adhered to any clear universal standards of practice. Consequently, the practice of deferring to surrogate demands itself has become the standard of care.<sup>190</sup>

## *2. Normative Uncertainty Strongly Disfavors Providers Because They Are Risk-Averse*

The uncertain state of the law governing medical futility disputes is not obviously fatal to the mediation of some such disputes. Mediation normally thrives in an atmosphere of normative indeterminacy. In most instances, indeterminacy produces a mediation-friendly environment because neither party wants to roll the dice and risk an unwelcome outcome in litigation. The inability to gauge non-settlement alternatives leaves both parties with questionable BATNAs and incentives to settle.<sup>191</sup> Therefore, one might think that futility disputes would be ripe for mediation.<sup>192</sup>

But this assumes that the possibility of loss in court affects all parties equally, pushing them toward compromise. In futility cases this assumption is false. Substantive uncertainty places party risk-aversion (or risk-attraction) in high relief. Uncertainty about the outcome in court disadvantages the

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172 (noting the need for "broad consensus within the medical community" and "societal agreement").

<sup>189</sup> See James L. Bernat, *The Whole-Brain Concept of Death Remains Optimum Public Policy*, 34 J. L. MED. & ETHICS 35, 40 (2006).

<sup>190</sup> Cf. Peter Albertson, *Clinical Crossroads*, 274 JAMA 69, 73 (1995) ("[T]here's an interesting catch-22 – the medicolegal standard of care becomes what physicians do. If . . . physicians all [provide inappropriate treatment] for fear of being sued if they don't, then eventually if enough of them do it, they'll create the truth of their fear."); Clark C. Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, 54 LAW & CONTEMP. PROBS. 87, 97 (1991).

<sup>191</sup> Cf. Mnookin & Kornhauser, *supra* note 137, at 969 (the legal standards' "lack of precision" provides a "bargaining backdrop clouded by uncertainty.").

<sup>192</sup> See Ellen A. Waldman, *Identifying the Role of Social Norms in Mediation: A Multiple Model Approach*, 48 HASTINGS L.J. 703, 721 (1997) ("[A] conflict involving the provision of arguably futile medical care would be suitable for norm-generating mediation because no ethical or legal consensus exists regarding how futility is to be defined.").



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relatively risk-averse party because that party will accept less in order to avoid the gamble inherent in adjudication.<sup>193</sup> Here, health care providers are the risk-averse party. The overt or implicit threat of litigation plays on providers' vulnerability. Although capitulating to surrogate demands for inappropriate treatment makes providers unhappy, they prefer this unhappiness to the misery of being sued. Distasteful though it may be, they calculate "that the cost of disagreeing with proposed offers transcends the cost of acquiescence."<sup>194</sup>

The law exerts a powerful influence on the conduct of health care providers.<sup>195</sup> This influence generally causes providers to be conservative and ultra-cautious.<sup>196</sup> "Hospitals are risk-averse institutions and physicians

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<sup>193</sup> See Matz, *supra* note 167, at 1358 ("Strategic behavior will be more effective and subtly encouraged as entitlements become more vague.") (citing Mnookin & Kornhauser, *supra* note 137, at 972–73). Surrogates are risk preferers. They would rather take the gamble than accept the certain outcome. Cf. Mnookin & Kornhauser, *supra* note 137, at 970–71.

<sup>194</sup> CRAVER, *supra* note 92, § 7.04[2][b][i]. See also GOODPASTER, *supra* note 124, at 43 (threat of suit plays on vulnerability); GIFFORD, *supra* note 87, at 143–45; Matz, *supra* note 167, at 1358. Because a bluff or threat cannot be evaluated properly if the law regarding the outcome is unclear, there is a higher chance of succeeding through these tactics. So, surrogates can exploit the uncertainty.

<sup>195</sup> See, e.g., Marshall B. Kapp, *Legal Liability Anxieties in the ICU*, in *MANAGING DEATH IN THE INTENSIVE CARE UNIT: THE TRANSITION FROM CURE TO COMFORT* 232, 232 (J. Randall Curtis & Gordon D. Rubinfeld eds., 2001) ("[L]aw-related anxieties are palpable influences on . . . medical care."); RUTH MACKLIN, *MORTAL CHOICES: BIOETHICS IN TODAY'S WORLD* 11 (1987) ("Fear of legal liability frequently drives medical decision-making, thus contaminating the process by introducing considerations that are not patient-centered."); MARCUS, *supra* note 61, at 372 ("There is nothing more professionally disenfranchising than being told you are expendable. The message can come in a number of shapes: . . . the subpoena alerting you to an impending lawsuit"); Rowland, *supra* note 187, at 307 ("Legal considerations are of paramount concern when discussing the discontinuation of care."); Carl E. Schneider, *Regulating Doctors*, 29 *HASTINGS CENTER REP.*, July-Aug. 1999, at 21; CONNIE ZUCKERMAN, *End-of-Life Care and Hospital Legal Counsel: Current Involvement and Opportunities for the Future*, *MILBANK REP.* 4 (Jan. 1999) ("Legal considerations . . . strongly influence how clinicians think about end-of-life care."). Cf. Marc R. Lebed & John J. McCauley, *Mediation Within the Health Care Industry: Hurdles and Opportunities*, 21 *GA. ST. U. L. REV.* 911, 920 (2005) (settling for even one penny "can directly or indirectly negatively impact physicians' ability to maintain good standing with their malpractice carriers, providers, peers, and patients, and may even jeopardize their hospital staff privileges and medical board status.").

<sup>196</sup> See, e.g., MARSHA GARRISON & CARL E. SCHNEIDER, *THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION* 70 (2003) ("Doctors egregiously overestimate the risks of being sued by their patients."); Robert F. Weir & Larry O. Gostin,

are risk-averse professionals."<sup>197</sup>

This ultra-cautious approach is certainly no less true in the context of futility disputes.<sup>198</sup> Before taking unilateral action providers want clear legal

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*Decisions to Abate Life-Sustaining Treatment for Non-autonomous Patients*, 264 JAMA 1846, 1846 (1990) ("[H]ospital attorney[s] . . . are frequently inclined to give advice that is unduly conservative."); Alan Weisbard, *Defensive Law: A New Perspective on Informed Consent*, 146 ARCHIVES INTERNAL MED. 860, 860 (1986) ("[T]he lawyer's . . . advice is likely to become ultracautious and may tend to conflict with the responsible practice of medicine"); ROBERT ZUSSMAN, INTENSIVE CARE MEDICINE: MEDICAL ETHICS AND THE MEDICAL PROFESSION 181 (1992) ("Unfortunately, because of a fear of being sued at a later date, most physicians really are willing to provide every available technology to a patient").

<sup>197</sup> Nancy Neveloff Dubler, *Creating and Supporting The Proxy-Decider: The Lawyer-Proxy Relationship*, 35 GA. L. REV. 517, 527 (2001) ("[P]hysicians and hospitals are still skittish in the face of withholding or withdrawing care."). See also MICHAEL FREEMAN & ANDREW LEWIS, LAW AND MEDICINE 82 (2000) (observing how "the fear of litigation" encourages providers "to adopt risk-averse strategies such as defensive medicine or the avoidance of high risk specialties"); Gatter, *supra* note 65, at 1122 ("Physicians are highly motivated to avoid lawsuits"); MARSHALL B. KAPP, OUR HANDS ARE TIED: LEGAL TENSIONS AND MEDICAL ETHICS 2 (1998) (observing that providers are "highly risk-averse in terms of their own perceived legal exposure").

<sup>198</sup> See, e.g., Allan S. Brett, *Futility Revisited: Reflections on the Perspectives of Families, Physicians, and Institutions*, 17 HEC F. 276, 283-84 (2005) ("[T]he threat of litigation is an important reason, perhaps the major reason, that physicians are reluctant to withhold or withdraw 'futile' life-sustaining treatment unilaterally against the wishes of family members."); MARILYN J. FIELD & RICHARD E. BEHRAMN EDS., WHEN CHILDREN DIE: IMPROVING PALLIATIVE CARE AND END-OF-LIFE CARE FOR CHILDREN AND THEIR FAMILIES 322 (2003) ("[I]t is increasingly clear that before a physician may terminate life support on any patient [where the family objects] . . . she or he should assume that it is necessary to ask a court for an order."); Fletcher, *supra* note 81, at S.230 (noting that health care organizations must "wait for clarification of the law . . . on which futile treatments can be withheld or withdrawn" and in the meantime must "treat until the dispute is resolved"); Hall, *supra* note 146, at 119 ("[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophesy"); Marshall Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 9 ISSUES L. & MED. 111, 119 (2003) (discussing how a "broad fear" of both "regulatory sanctions for providing too little LSMT" and "civil malpractice action[s]" means that "demands for aggressive LSMT virtually always control[] the situation regardless of how inappropriate that demand may be."); Kapp, *supra* note 195, at 242 (recommending that in the absence of "unambiguous legal guidance" providers accede to surrogate requests); John D. Lantos, *When Parents Request Seemingly Futile Treatment for their Children*, 73 MT. SINAI MED. J. 698, 698 (2006) ("Most doctors are not willing to . . . take the risk that punishment, rather than forgiveness, may come their way.").

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protection.<sup>199</sup> Without that protection and unable to secure surrogate consent to stopping LSMT, providers have continued to comply with requests that they consider inappropriate.<sup>200</sup> They have "surrendered their position out of

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<sup>199</sup> See Fletcher, *supra* note 81, at S.231 ("The framers of such futility guidelines would also be well-advised to seek amendments to existing health care legislation that strengthen the authority of clinicians and health care organizations to resolve such disputes."); *id.* at S.229 ("[A]ction was necessary in the Virginia legislature to assure physicians of legal backing if they refused, in certain circumstances, to acquiesce to demands for overtreatment."); Isackson, *supra* note 188, at 10 ("In order to protect providers from arbitrary decisions . . . legislation should be enacted"); Halevy & McGuire, *supra* note 82, at 38 ("Many institutions were interested in pursuing policies that would allow physicians to refuse [but] the legal and ethical uncertainties . . . discouraged institutions from proceeding alone."); Susan Jacoby, *The Schiavo Factor*, AARP BULL., May 2005 ("In states without such [futile care] laws, doctors frequently comply with the family's wishes for fear of being sued."); Weiser, *supra* note 117 (reporting how doctors in the Baby Rena case promised to keep pressing to change the rules, to give doctors the authority they think they need in futile cases).

<sup>200</sup> See, e.g., Belluck, *supra* note 16 ("In the absence of laws like Texas's, hospitals often accede to a family's wishes because they fear being sued."); Robert L. Fine, *The Texas Advance Directives Act of 1999: Politics and Reality*, 13 HEC F. 59, 63 (2001). ("Guidelines in the face of legal uncertainty, however, were not particularly effective. [F]ew physicians were willing to limit such treatment in the face of potential lawsuits from families who disagreed."); Stacey Burling, *Penn Hospital to Limit Its Care in Futile Cases: Severely Brain-Damaged Patients Won't Get Certain Treatments, as a Rule*, PHILA. INQUIRER, Nov. 4, 2002 ("The weak point of virtually all policies is that hospital leaders fear they would lose a lawsuit if they denied care demanded by a family."); Cerminara, *supra* note 120, at 327 ("[G]ood process . . . will not insulate a decision maker from being overturned in court . . ."); Fine et al., *supra* note 82, at 1221 (where families insisted on continued LSMT "physicians complied, being unwilling to subject themselves to legal jeopardy by overruling the family/surrogate"); Flamm, *supra* note 187 ("[T]he previous ambiguity of legal consequences often prevented clinicians from fulfilling ethical obligations against providing medically inappropriate care."); Halevy & McGuire, *supra* note 82, at 38 ("[R]esidual legal uncertainty regarding the policy still lingered."); Kopelman, *supra* note 121, at 585 ("Uncertainty about the legal implications of acting against the patient's or surrogate's wishes often prevents physicians from taking [the unilateral] step, despite agreement among all or almost all clinicians."); Rivin, *supra* note 82, at 392 (noting that of those physicians who thought a case futile, they were unwilling to invoke policy for "fear of a lawsuit"); Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-sustaining Treatment*, 83 AM. J. PUB. HEALTH 14, 19 (1993); (reporting physician uncertainty about legal standards for withdrawing treatment); Swig et al., *supra* note 82, at 1218 (citing "legal considerations" as the explanation for why physicians did not utilize their futility policy). Cf. Brett, *supra* note 198, at 289 (noting the "pragmatic problem with policies that confer no legal protection."); Schneiderman & Capron, *supra* note 84, at 525 ("[T]he *Baby K* decision . . . had a chilling effect on hospitals' willingness to implement futility policies."); FIELD & BEHRAMN, *supra* note 198, at 322 ("[T]he findings of an ethics committee have no legal

their fear of a capricious legal system."<sup>201</sup>

Just as mediation may be inappropriate in light of surrogates' intransigence,<sup>202</sup> it may also be inappropriate given the extreme differential in bargaining power.<sup>203</sup> The extreme "mismatch" between providers' and surrogates' risk tolerance and risk aversion disadvantages risk-averse

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standing and cannot be used alone as the basis for termination of life support.").

<sup>201</sup> Sibbald et al., *supra* note 116, at 1203 (reporting from a survey of ICUs: "When participants were asked why they followed the instructions of families or substitute decision makers instead of doing what they feel is appropriate, almost all cited a lack of legal support."); William D. Strinden, *Ethics, Cost of Futile Care*, HOUS. CHRON., May 8, 2007, at B8. Of course, legal liability is based on probabilities, depending on available evidence, factfinders, and so on. See John E. Calfee & Richard Craswell, *Some Effects of Uncertainty on Compliance with Legal Standards*, 70 VA. L. REV. 965, 968-69 (1984). Different providers and their counsel have different levels of risk tolerance. See Lee, *supra* note 34, at 488 ("As difficult as it might seem, some surgeons might adhere to their professional conscience and withdraw life-sustaining treatments over the surrogate's objections. They then must be willing to accept the risk of legal action as in *Gilgunn*, *Bryan*, and *Causey*"). Notable among the less risk-averse providers is Massachusetts General Hospital. See Troyen A. Brennan, *Ethics Committees and Decisions to Limit Care*, 260 JAMA 803, 806-07 (1988) (describing the "Optimum Care Committee's" recommendation of unilateral DNR orders despite legal uncertainty); Nasraway, *supra* note 78, at 215 ("[T]he hospital's risk management division had uncommon determination in supporting the care providers toward unilateral withdrawal of therapy."). For example, in the *Gilgunn* case, the "hospital's legal office . . . told [the attending physician] he was 'okay' legally; as long as he was acting in the patient's best interests he could withhold [LSMT]."). See Capron, *supra* note 119, at 25. While Massachusetts law only allows health care providers to decline treatment requests for moral or religious reasons, it also seems to authorize a proxy to make only those health care decisions that are "consistent with responsible medical practice." Compare MASS. GEN. LAWS ANN. Ch. 201D §§ 13-14, with §§ 1 & 5 (2007). Since many state statutes confer immunity on providers refusing to comply with a surrogate's decisions made "outside her authority," this argument seemingly could ground much unilateral decisionmaking.

<sup>202</sup> See *supra* notes 129-131.

<sup>203</sup> See, e.g., Dubler, *supra* note 77, at 11 (Mediation is "inappropriate for long-fester[ing] conflict[] where one side has all the cards ([in a futility dispute] the family member) and is ready to play them to her advantage."); POST ET AL., *supra* note 129, at 152 (mediation is futile where "conflict is out of control before it comes to the attention of the mediator."); Hoffman, *supra* note 21, at 861 (arguing that disputes are typically "appropriate for mediation" when "the parties have 'relatively' equal bargaining power"); Post, *supra* note 58, at 347 ("Mediation presupposes that the parties [have] relatively equal . . . power. This level playing field permits the collaborative crafting of a mutually satisfying resolution."); LEONARD L. RISKIN & JAMES E. WESTBROOK, DISPUTE RESOLUTION AND LAWYERS 115 (1987) ("[M]ediation is appropriate only where disputants are about equally powerful.").

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providers while tending to benefit risk-preferring surrogates.<sup>204</sup> That is, risk-averse providers would rather accept a known agreement than risk an unknown adjudication.<sup>205</sup> They have "an easier path to bailing out,"<sup>206</sup> a greater incentive to reach an agreement—on any terms.

Providers' risk aversion weakens their bargaining position by weakening their BATNA. If the alternative to mediation is litigation and providers are eager to avoid litigation, then they are all-too-ready to make huge concessions. But risk aversion is not the whole story. Normative uncertainty feeds not only providers' aversion to risk but also their aversion to litigation itself.<sup>207</sup>

Health care providers are distressed and offended by administering inappropriate treatment.<sup>208</sup> Yet, they are not invested in pressing the issue of futile care because the costs of continuing to fight are typically greater than the costs of settling on the surrogate's terms.<sup>209</sup> While distressed at providing what they judge to be inappropriate treatment, no individual physician has to

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<sup>204</sup> Stempel, *supra* note 138, at 313. "The risk acceptant disputant can take advantage of this [risk tolerance mismatch] by driving a hard bargain in [mediation] or only participating cosmetically in the [mediation] procedures. After all, the risk-preferring disputant is just as happy to roll the dice through adjudication unless it can get a really good deal in [mediation]." *Id.*

<sup>205</sup> *Cf.* Matz, *supra* note 167, at 1357 (citing Mnookin & Kornhauser, *supra* note 137, at 971–72).

<sup>206</sup> Stempel, *supra* note 138, at 313. *See also* Hyman & Love, *supra* note 62, at 170 n.31 ("When gross power disparities are present, the fairness of a process based on autonomous bargaining becomes questionable.") (citing Joseph Stulberg, *Fairness and Mediation*, 13 OHIO ST. J. ON DISP. RESOL. 909, 924–25 (1998)).

<sup>207</sup> *Cf.* Subrin, *supra* note 141, at 206 ("The entire litigation process is anxiety-provoking and privacy-invading.").

<sup>208</sup> *See infra* notes 223–24 and accompanying text.

<sup>209</sup> *Cf.* RANDALL R. BOVJBERG & BRIAN RAYMOND, PATIENT SAFETY, JUST COMPENSATION AND MEDICAL LIABILITY REFORM 6 (Kaiser Permanente Inst. for Health Pol'y 2003) (describing potential adverse consequences of a malpractice suit as "adverse publicity, emotional distress, substantial loss of time from practice . . . , investigation by peer review or institutional management . . . , reporting to the [NPDB] . . . , increased risk of disciplinary action by state authorities and exclusion from managed care networks"); Moore, *supra* note 145, at 458 ("Fear of a lengthy judicial process may result in health care providers adopting de facto policies that encourage indefinite provision of treatment"); Burgess & Burgess, *supra* note 129, at 178; Lee, *supra* note 34, at 488 (observing that for most providers "the risks may outweigh their need for professional autonomy," so they "comply with the surrogate's wishes and continue the life-sustaining treatments"); Meisel, *supra* note 121, at S48 ("Litigation is expensive and emotionally draining"); Morreim, *supra* note 90, at 36 ("The mere prospect of litigation, then, may leave physicians feeling they have no choice but to accede").

deal with this distress for very long. Often either the patient will die or the provider will round-off service for that patient.<sup>210</sup> In short, litigation lasts longer and is more stressful than just waiting for the problem to "go away."<sup>211</sup>

Since providers perceive such an undesirable BATNA, any outcome in mediation appears preferable. They would rather accept a certain outcome in order to avoid the risk of litigation.<sup>212</sup> They are, as Leonard Marcus puts it, "opposed to exercising any BATNA."<sup>213</sup> But this unwillingness ultimately impairs providers' negotiation effectiveness. Surrogates can and do detect this attitude. And when they realize that providers have ruled out any BATNA, surrogates understand that there is no limit to what they can demand.<sup>214</sup>

#### V. SOLUTION: AMEND SUBSTANTIVE NORMS TO CLARIFY SAFE HARBORS AND EQUALIZE BARGAINING POWER

While we may call it "mediation," the guided facilitation of intractable

<sup>210</sup> See Carhart, *supra* note 59, at 1756; Capron, *supra* note 119, at 24; Meisel, *supra* note 121, at S48 ("[I]n many end of life cases the patient expires before the litigation does.").

<sup>211</sup> Cf. LEARNED HAND, 3 LECTURES ON LEGAL TOPICS, ASSOCIATION OF BAR OF THE CITY OF NEW YORK 105 (1926) ("After now some dozen years of experience, I must say that as a litigant I should dread a lawsuit beyond almost anything else short of sickness and death.").

<sup>212</sup> MARCUS, *supra* note 61, at 296 ("At what point are conditions so deplorable that you are willing to accept the financial uncertainty of unemployment, the professional risks of a public scandal, or the high costs of a court battle?").

<sup>213</sup> *Id.* at 296 ("There are others who . . . maintain that persistence at the negotiation table is the only way to settle differences. These people will continue collaborating, talking, or conceding, no matter the cost."). Grenig recommends that when "a party finds the negotiations have fallen below the minimum acceptable position, the party should invoke its BATNA and walk away from the negotiations." GRENIG, *supra* note 21 § 3.10, at 54 (citing FRASCOGNA & HETHERINGTON, *THE LAWYER'S GUIDE TO NEGOTIATION: A STRATEGIC APPROACH TO BETTER CONTRACTS AND SETTLEMENTS* 55 (2001)). But in a futility dispute providers will never do that.

<sup>214</sup> See MARCUS, *supra* note 61, at 296. Mnookin and Kornhauser observe that litigation is more likely where a party has "distaste for negotiation." Mnookin & Kornhauser, *supra* note 137, at 974-75. Here, it is just the opposite. Providers' distaste for litigation not only makes it more likely that the dispute will be mediated but also gives surrogates more bargaining strength to extract agreement. Since providers are so desperate for agreement, surrogates demand more, knowing that providers will give in.

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futility disputes is no such thing. The negotiation is one-sided and the outcome is fixed and predictable.<sup>215</sup> Given providers' and surrogates' different levels of commitment and risk tolerance, the shadow of the law is outcome-determinative.

The mislabeling of current conciliation efforts at the end of life is regrettable as a definitional matter. But process confusion is hardly the greatest ill. Rather, the biggest problem with the status quo is substantive. Not only are existing outcomes fixed and predictable, they are undesirable as a matter of policy. To avoid these outcomes, we must equalize providers' bargaining power by giving them a purely process-defined safe harbor to refuse inappropriate treatment requests.

### A. *The Shadow of the Law Produces Unacceptable Outcomes*

We hardly have the space, here, to make a complete argument for empowering providers to refuse inappropriate treatment requests. But we can at least quickly review the leading arguments. There are five main reasons for empowering providers: (1) to protect the integrity of the medical profession, (2) to reduce patient suffering, (3) to avoid instilling false hope, (4) to rationalize the use of scarce resources, and (5) to relieve surrogates of the burden of decision.

#### 1. *Protecting the Integrity of the Medical Profession*

Physicians should not be "indentured servants,"<sup>216</sup> "reflexive automatons,"<sup>217</sup> "vending machines,"<sup>218</sup> or "prostitutes"<sup>219</sup> beholden to whatever patients or surrogates want. Patient autonomy has never been construed as requiring a health professional to provide a particular type of treatment.<sup>220</sup> Medicine is not a consumer commodity like breakfast cereal

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<sup>215</sup> Cf. Prendergast et al., *supra* note 52, at 63 (noting that the "simplest way" to suppress conflict is to have "a single arbiter, one party invested with sole authority for making those decisions").

<sup>216</sup> Morreim, *supra* note 90, at 37.

<sup>217</sup> WRONG MEDICINE, *supra* note 81, at 58. See also *id.* at 103-04.

<sup>218</sup> *Id.* at 9.

<sup>219</sup> *Id.* at 126.

<sup>220</sup> See Loane Skene, *Disputes About the Withdrawal of Treatment: The Role of Courts*, 32 L.J. MED. & ETHICS 701, 701 (2004) (citing Schwartz, *supra* note 160).

and toothpaste.<sup>221</sup> Rather, the medical profession is a self-governing one with its own standards of professional practice.

The "integrity of the medical profession" is an important societal interest that must be balanced against patient autonomy.<sup>222</sup> The definition of the goals and values of medicine may be a shared responsibility between the medical profession and the rest of society. But it certainly need not categorically cede to patient autonomy.

In particular, many health care providers do not consider the practice of medicine to include measures aimed solely at maintaining corporeal existence and mere biologic functioning. Under these circumstances, providers feel that it is just "wrong" to provide treatment. It is "bad medicine . . . medicine being used for the wrong ends."<sup>223</sup> Moreover, they find it gruesome, distressing, and demoralizing to provide treatment that is, on balance, harmful to patients.<sup>224</sup>

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<sup>221</sup> George J. Annas, *Asking the Courts to Set the Standard of Emergency Care — The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1545 (1994) (arguing for avoidance of the scenario where "[p]hysicians will do whatever patients want (as long as they can pay for it) because medicine will be seen as a consumer commodity like breakfast cereal and toothpaste."); Tomlinson & Czlonka, *supra* note 172, at 29 ("[T]he value assumptions made in cases of futility will have to receive their warrant from . . . values for the profession."). *But see* Eric Gampel, *Does Professional Autonomy Protect Medical Futility Judgments?*, 20 BIOETHICS 92, 97 (2006) (arguing that while limits on patient autonomy are set by the norms of the medical community rather than by individual providers, that these limits do not extend to the futility context).

<sup>222</sup> *See generally* Washington v. Glucksberg, 521 U.S. 702, 731 (1997); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 416, 425 (Mass. 1977); *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976); Ferguson, *supra* note 174, at 1239–43 (noting that the UHCDA attempts to protect the ethical integrity of the medical profession).

<sup>223</sup> *See* Benjamin Weiser, *Who Should Decide When Treatment Is Futile? In Many Cases, Physicians Are Asking Whether Patient Autonomy Has Gone Too Far: The Case of Baby Rena*, WASH. POST, July 14, 1991, at A19 (quoting Dr. Murray Pollack).

<sup>224</sup> *See* Burling, *supra* note 200; Burt, *supra* note 90, at 253; Hoffman, *supra* note 118, at F1 ("[D]oing CPR [to PVS and end-stage patients] felt not only pointless but like I was administering blows to someone who had already had a hard enough life.") (quoting Dr. Daniel Sulmasy); Terese Hudson & Kevin Lumsdon, *Are Futile Care Policies the Answer? Providers Struggle with Decisions for Patients Near the End of Life*, 68 HOSPITALS & HEALTH NETWORKS, Feb. 20, 1994, at 26, 27; Rosenthal, *supra* note 32, at B20 ("Doctors and nurses . . . describe anger and anguish at being forced by a patient or family to inflict pain on the dying, knowing that it is to no avail."); Liz Kowalczyk, *Mortal Differences Divide Hospital and Patient's Family*, BOST. GLOBE, Sept. 28, 2003, at A1 (nurse refused to participate in continued aggressive treatment of



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### 2. Reducing Patient Suffering

A second reason to empower providers to resist inappropriate treatment requests is out of concern for the patient. Continued interventions can be inhumane, invasive, pointless, intrusive, cruel, burdensome, abusive, degrading, obscene, violent, or grotesque.<sup>225</sup> CPR, for example, can be painful, causing rib or sternal fractures in approximately 50% of cases.<sup>226</sup> Health care providers want to relieve patient suffering, not cause or prolong it.<sup>227</sup>

### 3. Avoiding False Hope

A third reason to empower providers to resist requests for inappropriate treatment is to stop offering false hope. If providers act as though a medically inappropriate option is "available," then that creates a psychological burden

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Barbara Howe); Liz Kowalczyk, *Hospital, Family Spar over End-of-Life Care*, BOST. GLOBE, Mar. 11, 2005, at A1 ("Howe's longtime doctors and nurses believe . . . that keeping her alive is tantamount to torture."); Benjamin Weiser, *The Case of Baby Rena: While Child Suffered, Beliefs Clashed*, WASH. POST, July 15, 1991, at A1 (physicians and nurses viewed every day that Baby Rena spent in the ICU as a "day of torture" and "viewed themselves as the torturers"); ZUSSMAN, *supra* note, 196, at 181. Cf. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 38 (5th ed. 2001) (defending the physician's right of "conscientious objection" where the patient request is for something "medically unconscionable").

<sup>225</sup> See, e.g., *Wendland v. Sparks*, 574 N.W.2d 327, 328–29 (Iowa 1998) (doctor unilaterally decided not to attempt CPR as "an act of mercy" because "I just can't do it to her"); *In re Dinnerstein*, 380 N.E.2d 134, 137 (Mass. App. 1978) (characterizing LSMT as "pointless, even cruel, prolongation of the act of dying."); *In re Doe*, 418 S.E.2d 3, 4 (Ga. 1992) (hospital alleged continued treatment would constitute "medical abuse"); *Nguyen v. Sacred Heart Med. Center*, as reported in John Altomare & Mark Bolde, 11 *ISSUES L. & MED.* 199, 200 (1995) (hospital alleged continued treatment was "inhumane"); Appellant Brief, *In re Baby K*, 1993 WL 13123742, at 3 ("This tragic case involves a parent's attempt to require physicians to provide to a dying infant treatment that is medically unreasonable, invasive, burdensome, inhumane, and inappropriate."); Martha Kessler, *Massachusetts Court Orders Hospital to Comply with Decisions Made Under Health Proxy*, 13 *BNA HEALTH L. REP.* 527, 2004 (Massachusetts General Hospital successfully argued to a Boston court that CPR for Barbara Howe would be "severe, invasive and harmful").

<sup>226</sup> See generally Paul C. Sorum, *Limiting CPR*, 57 *ALB. L. REV.* 617, 618 (1994); *WRONG MEDICINE*, *supra* note 81, at 94.

<sup>227</sup> See Capron, *supra* note 119, at 24 (unilateral termination can avoid "mistreating the patient"); *WRONG MEDICINE*, *supra* note 81, at 100–01.

on surrogates to elect that option.<sup>228</sup> Naturally, surrogates want to take all reasonable measures. By offering a particular intervention, the treating physician suggests that the intervention is reasonable. It is unfair and deceptive to offer the option of continuing care—thereby giving surrogates a sense that the patient is making progress when, in fact, no progress is possible.<sup>229</sup>

#### 4. Rationalizing the Use of Scarce Resources

A fourth reason to empower providers to resist inappropriate treatment requests is to maximize the utility of scarce resources.<sup>230</sup> We must be good "stewards" of both "hard" resources like ICU beds and "soft" resources like health care dollars.<sup>231</sup> As the population of elderly and ill rapidly grows, it is becoming evident that there is just "not enough money to give everyone a treatment with a one-in-a-million chance of success."<sup>232</sup>

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<sup>228</sup> See, e.g., Annas, *supra* note 221, at 1543 (calling the provision of mechanical ventilation to Baby K after birth a "medical misjudgment" that gave the mother a false impression); See Brett, *supra* note 198, at 281–82, 285 (2005). *But cf.* Fletcher, *supra* note 81, at S.224 (suggesting that the court documents in *Baby K* showed the physicians had good reasons to intubate).

<sup>229</sup> See Howard Brody, *The Physician's Role in Determining Futility*, 42 J. AM. GERIATRIC SOC'Y 875, 876–77 (1994) (unethical to mislead patients by falsely raising hopes); Hudson & Lumsdon, *supra* note 224, at 28 (John Popovich arguing that physicians who offer meaningless care are "charlatans"); See Paris et al., *supra* note 118, at 150; Tomlinson & Czlonka, *supra* note 172, at 28 (offering futile care is "a bogus choice" and "a deception"); *id.* at 30 (arguing providers should seek "acceptance" rather than "consent").

<sup>230</sup> See Rosenthal, *supra* note 32, at B20 ("Doctors and nurses . . . question whether futile resuscitations, which can cost thousands of dollars and tie up precious intensive care beds, makes sense in an era of rising health costs."). *Cf.* WRONG MEDICINE, *supra* note 81, at 42 (cost for treating estimated 14–25,000 PVS patients between \$1 and \$7 billion per year); Leonard M. Fleck, *Models of Rationing: A Democratic Decision Making Approach*, 140 U. PA. L. REV. 1597, 1611 (1992) (The care of Nancy Cruzan cost nearly \$1 million).

<sup>231</sup> *Cf.* Steven H. Miles, *Informed Demand for Non-Beneficial Medical Treatment*, 325 NEW ENG. J. MED. 512, 514 (1991).

<sup>232</sup> Julie Appleby, *Debate Surrounds End-of-Life Health Care Costs*, USA TODAY, Oct. 19, 2006. See generally THE CENTER FOR THE EVALUATIVE CLINICAL SCIENCES, DARTMOUTH MEDICAL SCHOOL, THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS: AN ONLINE REPORT ON THE MEDICARE PROGRAM BY THE DARTMOUTH ATLAS PROJECT (2006); Jeremy Olson, *Aggressive Care Often Extends Costs, Not Life*, PIONEER PRESS, Nov. 12, 2006.

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### 5. *Relieving the Burden of Decision*

Finally, empowering providers to resist inappropriate treatment requests may reduce the very scope of irreconcilability. Ensuring that each side has some practical measure of independent authority and power to exert against the other maximizes the likelihood that the parties will seriously engage with the negotiating process.

Some feared that empowering the providers would be a conversation stopper.<sup>233</sup> But the evidence suggests this has not happened. Instead, provider empowerment prompts surrogates to seriously propose and weigh compromise measures. Some surrogates, besieged by guilt and worry about being disloyal, are not prepared to make this sort of momentous decision to stop LSMT. But if someone else could make the decision, they are prepared to acquiesce and relieve themselves of the burden of decision.<sup>234</sup>

If we think that physicians should be able to declare some care off-limits, then let's change the default rules and clarify that decisional authority.<sup>235</sup> Equalizing the power imbalance between surrogates and providers should facilitate negotiation settlements by giving both sides concern about their BATNA. "To the extent the judiciary [or legislature] can provide firmer shadows, firmer predictions of legal results . . . mediated settlements will more accurately reflect what a fair result should be."<sup>236</sup> Shoring up statutes to give providers a real safe harbor creates greater normative clarity which, in

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<sup>233</sup> See, e.g., Dubler, *Limiting Technology*, *supra* note 72, at 298–99 ("[T]echniques of mediation . . . will be far more helpful than asserting and insisting on physician power to decide—the essence of the futility discussion."); Prendergast et al., *supra* note 52, at 62.

<sup>234</sup> See Fine, *supra* note 200, at 71; Fine, *supra* note 120, at 82 ("[F]amilies come to understand that there is a finite limit . . . that they are not in total control of the situation."); Fine et al., *supra* note 80, at 1221 ("[T]he family was relieved because they had 'put up the good fight' . . . but now the decision was out of their hands."); Fine & Mayo, *supra* note 80, at 746 ("[T]he greatest significance of the law is how it changes the nature of the conversations . . . about futile treatment situations by providing conceptual and temporal boundaries.").

<sup>235</sup> See Burt, *supra* note 90, at 254 ("If negotiating a settlement . . . it is important for each party to the conflict to have a mutually recognized, independent source of influence and authority to exert against the opposed party."); Dubler, *supra* note 77, at 11 (need "boundary setting, clear and directive management, and gutsy administration"); Schneiderman & Fein, *supra* note 90, at 11 ("Something in addition to process is needed.").

<sup>236</sup> Subrin, *supra* note 141, at 227.

turn, gives providers greater bargaining power.<sup>237</sup>

### *B. Mediation Can Work with Clear Safe Harbor and Equalized Bargaining Power*

There are two ways to shore up existing legislation to create a true safe harbor for healthcare providers. The first way entails making more concrete and precise the statutory standards that define provider authority to refuse inappropriate treatment. The second approach abandons substantive standards altogether and instead uses a purely process-based approach.<sup>238</sup>

Consensus on precise substantive measures of medical inappropriateness has proven unachievable.<sup>239</sup> Perhaps this should not be too surprising. In very few areas of medicine do we find professional standards that are "sufficiently mandatory and concrete" to operate as a safe harbor.<sup>240</sup> Rarely do we have what is necessary for immunity, "a precise and plain statement of the acceptable medical practice."<sup>241</sup> Instead, professional standards are typically set ex post by "selectively drawn expert witness testimony."<sup>242</sup> If we cannot achieve even professional consensus, we are even less likely to achieve the broader social consensus necessary for legislation.

There exists no general understanding about what sort of life, what sort of existence is worth the deployment of medical resources. We are fundamentally at odds on the question of who gets to decide when enough is enough. Because we are flummoxed by these questions, as a society we are unable to come up with a "real" definition of "futile care." We are not yet

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<sup>237</sup> Cf. Dubler, *supra* note 197, at 527 ("I think that this tipping to continued life and a preference for medical interventions in situations of uncertainty is being challenged at the moment."). Unilateral treatment termination laws allow providers to end a provider-patient relationship just as "unilateral divorce allows marriages to end where one person wants out of the marriage but the other person wants to remain married." Cf. Betsey Stevenson & Justin Wolfers, *Bargaining in the Shadow of the Law: Divorce Laws and Family Distress*, 121 Q. J. ECON. 267, 268 (2006).

<sup>238</sup> Cf. Calfee & Craswell, *supra* note 201, at 999–1000.

<sup>239</sup> See *supra* notes 172 and 176.

<sup>240</sup> See Hall, *supra* note 146, at 121, 127–28, 144–45.

<sup>241</sup> *Id.* at 134.

<sup>242</sup> Blumstein, *supra* note 186, at 1028. Cf. *Causey*, 719 So. 2d at 1075, 1076 (noting that while the statute permits providers to decline "medically inappropriate" treatment, "[u]nfortunately, medically inappropriate and medical judgment are not defined." Consequently, the case had to go to a "medical review panel" to determine the standard of care).

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prepared to specify the proper ends of medicine, the acceptable criteria for rationing, or the legitimate restrictions on patient autonomy.

Given this absence of consensus on substantive norms, a more promising approach is a pure process mechanism.<sup>243</sup> As Carrie Menkel-Meadow observes, "even if we cannot all agree on substantive norms and goals, we can probably [at least] agree on some processes for making decisions that will enable us to go forward and act."<sup>244</sup>

The Texas Advance Directives Act (TADA) is an example of Professor Menkel-Meadow's pure process mechanism. It abandons all effort to define the circumstances under which a provider may make a unilateral decision. In contrast to the approach in other states, the Texas Act makes no reference to health care standards, only to procedures. When a provider refuses to honor a surrogate's request for continued LSMT, the provider must commence a multi-stage review process. LSMT must be provided during this review process.<sup>245</sup>

The first stage entails an ethics committee's review of the attending physician's determination. The surrogate must be notified of the ethics committee review process at least forty-eight hours before the committee meets.<sup>246</sup> The surrogate is also entitled to attend the meeting and to receive a written explanation of the committee's decision.<sup>247</sup>

If the ethics committee agrees that LSMT is inappropriate, the provider is obligated to continue to provide LSMT for ten days after the surrogate is given the ethics committee's written decision.<sup>248</sup> During this time, the provider must attempt to transfer the patient to another provider that is willing to comply with the surrogate's treatment request.<sup>249</sup> If the patient has

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<sup>243</sup> Cf. Burt, *supra* note 90, at 249 (noting the retreat from "hard principles" to a "soft process"). Dubler and Liebman write that "[w]hen mediation does not result in an agreement, it is . . . most likely, an indicator that another process is better suited to resolving the dispute." DUBLER & LIEBMAN, *supra* note 1, at 13.

<sup>244</sup> CARRIE MENKEL-MEADOW, DISPUTE PROCESSING AND CONFLICT RESOLUTION: THEORY, PRACTICE AND POLICY xiii (2003) (citing STUART HAMPSHIRE, JUSTICE AS CONFLICT (2000)). See also Burt, *supra* note 90, at 253 ("The absence of hard resolving principle shifts our attention to the interactive processes . . . negotiated settlement").

<sup>245</sup> TEX. HEALTH & SAFETY CODE § 166.046(a) (2007) (ethics or medical review committee).

<sup>246</sup> *Id.* § 166.046(b)(2).

<sup>247</sup> *Id.* § 166.046(b)(4)(B). The surrogate is also entitled to a copy of a registry with the name of providers willing to accept the patient upon transfer. *Id.* § 166.046(b)(3)(B).

<sup>248</sup> *Id.* § 166.046(e). A court may extend this time period only if "there is a reasonable expectation" that a transfer can be made. *Id.* § 166.046(g).

<sup>249</sup> TEX. HEALTH & SAFETY CODE § 166.046(d). Transfer is unlikely. See Pope,

not been transferred, then the provider may unilaterally stop LSMT on the eleventh day.<sup>250</sup>

When the TADA first went to Governor Bush in 1997, he vetoed the bill because it "eliminates the objective negligence standard for reviewing whether a physician properly discontinued the use of life-sustaining procedures."<sup>251</sup> But this was precisely the point, as reflected in the 1999 legislation that Bush did sign:

[A] physician, health care professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to disciplinary action by the person's appropriate licensing board if that person has *complied with the procedures* outlined in Section 166.046.<sup>252</sup>

Unlike the UHCDA and other unilateral decision statutes which specify vague substantive standards such as "significant benefit," the safe harbor of TADA is defined solely in terms of process.<sup>253</sup>

Texas providers who follow TADA's prescribed notice and meeting procedures are immune from disciplinary action and civil and criminal liability.<sup>254</sup> Since the statute's requirements are concrete and measurable, there is little, if any, uncertainty of compliance. Consequently, providers are empowered to stand up to surrogate demands.<sup>255</sup>

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*Futility Statutes*, *supra* note 10.

<sup>250</sup> See Pope, *supra* note 10 ("The physician and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after the written decision.").

<sup>251</sup> Tex. Legis. J. 4928 (June 20, 1997), *vetoing* Tex. S.B. 414, 76th Leg. (1997). See also Interim Report, *supra* note 56, at 33-34.

<sup>252</sup> TEX. HEALTH & SAFETY CODE § 166.045(d) (emphasis added).

<sup>253</sup> TEX. HEALTH & SAFETY CODE § 166.046(g). See also *Nikolouzos v. St. Luke's Episcopal Hosp.*, 162 S.W.3d 678, 683 (Tex. App. 2005) (finding medical evidence "irrelevant" since the "hospital's ethics committee has determined the care is inappropriate."); *Interim Report*, *supra* note 56, at 35 ("The court considers whether another provider who will honor the patient's directive is likely to be found; it does *not* address the issue of whether the decision to withdraw life support is valid.") (emphasis added); Iliana L. Peters, *Perspectives on the Texas Medical Futility Statute as Amended in 2003*, HEALTH LAW. WKLY, Oct. 22, 2004 ("Importantly, the statute does not attempt to define 'medical futility.' Any attempt to do so might result in a definition that is either too broad or too narrow.").

<sup>254</sup> TEX. HEALTH & SAFETY CODE § 166.045(d).

<sup>255</sup> See Ramshaw, *supra* note 15 (study of sixteen Texas hospitals over five years found that, on average, each hospital had made the decision to unilaterally stop treatment

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The TADA is far from perfect. Ten days may not be a reasonable or sufficient time for surrogates to locate an alternative facility willing to accept the patient.<sup>256</sup> It may violate procedural due process to place the ultimate decision in the hands of an institutional ethics committee comprised of physicians and administrators who look to the hospital for their economic livelihood.<sup>257</sup> But these mechanics of the TADA process can be and are being refined.<sup>258</sup> A pure process approach works. And such an approach does and should serve as a model for other states.<sup>259</sup>

## VI. CONCLUSION

Mediation has proved remarkably useful in resolving some end-of-life disputes. We should recognize that success, and equip health care institutions accordingly. But we must also attend to the limits of mediation's abilities. Since it cannot resolve the significant and growing set of intractable futility disputes, we must address the substantive norms to empower providers to resist inappropriate treatment requests.

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at least once each year); Robert D. Truog & Christine Mitchell, *Futility—From Hospital Policies to State Laws*, 5 AM. J. BIOETHICS 19, 20 (2006). ("Clinicians in Texas may also be much more confident and bold in applying the policy, knowing that they are protected by the law."). Texas' unilateral decision statute appears to have had a significant impact. In one study at Baylor University Medical Center (in Dallas), the authors found that the law gave physicians "more comfort," thereby increasing ethical consultations regarding futility disputes by 67%. Fine & Mayo, *supra* note 82, at 745.

<sup>256</sup> *Hearing on S.B. 439 Before the Senate Committee on Health and Human Services*, 80th Leg. (Tex. Apr. 12, 2007).

<sup>257</sup> *Id.* see also Robert D. Truog, *Tackling Medical Futility in Texas*, 357 NEW ENG. J. MED. 2 (2007); *Hearing on Advance Directives Before the House Committee on Public Health*, 80th Leg. (Tex. Apr. 25, 2007).

<sup>258</sup> See, e.g., Tex. S.B. 439, 80th Leg. (2007).

<sup>259</sup> See, e.g., Arthur E. Kopelman et al., *The Benefits of a North Carolina Policy for Determining Inappropriate or Futile Medical Care*, 66 N.C. MED. J. 392 (2005); Wisconsin Medical Society, Resolution 1 – 2004, [www.wisconsinmedicalsociety.org/member\\_resources/gov/res04\\_1.cfm](http://www.wisconsinmedicalsociety.org/member_resources/gov/res04_1.cfm) (last visited Nov. 1, 2007).

